NEW SOUTH WALES AUDITOR-GENERAL'S REPORT

PERFORMANCE AUDIT

Waiting Times for Elective Surgery in Public Hospitals: NSW Department of Health

THE AUDIT OFFICE
OF NEW SOUTH WALES

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In accordance with section 38E of the *Public Finance and Audit Act 1983*, I present a report titled **Waiting Times for Elective Surgery in Public Hospitals: NSW Department of Health.**

R J Sendt
Auditor-General

Sydney
September 2003

AUDITOR-GENERAL'S REPORT

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Foreword

Having to be admitted to hospital can be traumatic for any of us, especially if surgery is involved. And the emotional and psychological trauma can increase if admission is unduly delayed.

Most people requiring elective (i.e. non-urgent) treatment would accept that emergency cases should take priority. They would also generally accept that hospitals have to meet a wide range of demand for different services, and that they will have to wait some time before they have their needs met.

Almost all patients face some delay in being admitted for elective surgery in the Australian public hospital system.

In New South Wales, the average waiting time has increased over the last decade to around 1.8 months. However, behind this average waiting time is a large variation in individual patients' experiences. Waiting times can vary considerably, depending on the surgical procedure, on the doctor and on the hospital.

Two particular categories of concern are those patients (over 4,000 at March 2003) who have been waiting more that 12 months for admission and those patients in the two most 'urgent' categories whose admissions are overdue (2,600 at March 2003).

This report looks specifically at waiting *times*. In the past, much attention was paid to waiting list *numbers*. But from the perspective of both the health system and the individual patient, waiting time is a far more relevant measure.

I hope this report provides some insight into the factors that can cause admission delays. It provides no single, simple solution - because there is none. Many factors - not all under the control of NSW Health - play a part in causing delays.

R J Sendt
Auditor-General

September 2003

Executive Summary

Executive Summary

Elective Surgery

Elective surgery refers to surgery that is deemed necessary by a doctor but is not an emergency, that is it can be delayed for at least twenty-four hours.

For the year ended 31 March 2003, around 188,000 patients underwent elective surgery in public hospitals in New South Wales, a fall of 7 per cent since 1997.

The cost of this type of patient care was estimated to be $648 million for 2000-01.

Patients awaiting elective medical or surgical treatment are:

- given a priority for treatment in keeping with the urgency of their clinical condition, and
- placed on a 'waiting list' awaiting treatment.

The priority reflects 'benchmark' times, established by NSW Health, within which patients should undergo treatment, depending on their clinical condition.

The 'urgency' benchmarks are:

- emergency - requires surgery within 24 hours
- urgency 1 (U1) - requires attention within 7 days
- urgency 2 (U2) - requires attention within 30 days
- urgency 7 (U7) - requires attention within 90 days
- urgency 8 (U8) - attention recommended within 12 months.

Patients who have been waiting longer than twelve months for treatment are referred to as 'long-wait' patients. A further category, referred to as U9, comprises patients considered 'not-ready-for-care'. Categories U3 to U6 are not used.

NSW Health maintains a 'waiting list' of patients belonging to categories U1 to U8. Patients in category U9 are not included in 'long-wait' patient numbers.

The Audit

The length of time that patients wait for elective treatment is seen as an important indicator of how well a health system functions. It is a far more relevant measurement than the number of patients on the waiting list.

This audit examined the efficiency and effectiveness of the management of waiting times for elective surgery in public hospitals in New South Wales. This covers both public and private patients in public hospitals.

Audit Opinion

We recognise that managing waiting times is a difficult and complex task. Waiting times are influenced by many factors, some of which are outside the control of NSW Health. There are, however, steps which NSW Health could, and should, take to ensure that the processes to manage waiting times are efficient and effective.

By all measures used by NSW Health, patients are waiting longer for elective treatment today than six or seven years ago. In March 2003 patients admitted to elective medical or surgical treatment had waited, on average, 1.8 months, whereas in March 1997 they would have waited on average 1.1 months.

The Department establishes targets for elective treatment to be achieved by Area Health Services (Areas) and provides funding to Areas for a range of health services including elective treatment. No Area achieved its performance agreement targets for elective surgery for the year ended 30 June 2002.

While the Department relies on Areas to balance funding between competing programs, it has no assurance that the total funds available will be sufficient to deliver services in accordance with targets.

In our opinion the Department needs to develop more direct and transparent links between the funds allocated to Areas and expected activities, service levels and targets.

NSW Health has a shortage of nurses and surgeons. The shortage is expected to persist in the foreseeable future. This raises doubts as to whether Areas will be able to achieve their performance targets for elective treatment.

Some doctors also add more patients to the waiting list than they can handle. In these circumstances, many of these will become 'long-wait' patients. The Department needs to ensure that health system planning and operations reflect the need to treat all patients on the waiting list within benchmark times.

NSW Health's management information systems are not able to provide timely and consistent information to managers on operating theatre performance and on costs, and are of limited use for benchmarking to identify best practice.

A wide variation in reported costs of some procedures between like hospitals suggests that there is also a wide variation in efficiency.

Initiatives taken to improve information systems have yet to be implemented. We consider that NSW Health should accelerate its program of improvements to management information and information systems.

We believe there is a need to strengthen accountability between Areas and the Department. The Performance Agreements of Area Boards contain approximately 100 targets, seven of which relate to elective surgery. While these reflect the complexity of programs that compete for funds and other resources, the Department should identify a smaller number of key performance indicators.

In some cases the comments in Annual Reports of NSW Health on the performance of elective surgery are selective, and in other cases could be misleading. In our opinion, the Department needs to improve the content and consistency of its publicly-reported performance information.

Audit Findings

Important performance indicators for elective treatment are included in the table below.

	March 1997	March 2003	Change	Change %
Patients undergoing elective surgery (last 12 months)	201,882	187,952	-13,930	-7
Number on waiting list (medical and surgical 'ready-for-care')	63,363	67,011	3,648	+6
Average waiting time (medical and surgical) (months)	1.1	1.8	0.7	+64
Number of 'long-wait' patients (medical and surgical)	2,689	4,188	1,499	+56
Number of 'overdue' U1 and U2 patients (medical and surgical)	3,495	2,644	-851	-24

Demand

The annual number of patients undergoing elective surgery declined by 7 per cent since 1997 as increasing numbers receive alternative treatment, for example, as outpatients. The number of patients waiting for surgery has, however, increased by 6 per cent.

Waiting Times

NSW Health's Annual Reports for 1999-2000 and 2000-01 identified the following goal:

> ... to ensure waiting times for health services have been reduced.

However, the average waiting time for elective medical or surgical treatment has increased from 1.1 to 1.8 months since 1997.

'Long-wait' Patients

The 2000-01 and 2001-02 Annual Reports forecast a shift of focus in the management of elective surgery:

- from a reduction in waiting times
- to a reduction in numbers of 'long-wait' patients.

The number of 'long-wait' patients had increased significantly in 1996, 1997, 1999 and 2000, reaching a peak of over 10,000 in January 2001. Thereafter the number fell to 3,302 in January 2003.

However, 'long-wait' patient numbers again climbed between January and March 2003. At the end of March 2003:

- 784 patients had been waiting for surgery longer than 2 years, of whom
- 225 had been waiting longer than 3 years.

Nearly 19 per cent of 'long-wait' patients have been waiting for longer than two or three years.

'Overdue' Patients

The number of U1 and U2 patients who had not received treatment within 30 days reached its peak in March 1997. Following this, and coinciding with waiting list reduction activities, it fell to 696 in February 1999. However it has since increased again. By March 2003, 2,644 U1 and U2 patients were overdue for treatment (representing 30 per cent of all U1 and U2 patients).

'Not-Ready-for-Care' Patients

The number of 'not-ready-for-care' patients:

- increased from 16,405 to 20,538 during the 2002 calendar year, an increase of 25 per cent
- increased by over 40 per cent in six Areas during 2002.

The number of 'not-ready-for-care' patients has since fallen to 19,569 by the end of March 2003.

'Not-ready-for-care' patients are not subject to the same levels of transparency and accountability as 'ready-for-care' patients. It is suggested that they be:

- provided a realistic date for admission
- included specifically in Performance Agreement targets
- reported on a basis consistent with 'ready-for-care' patients.

Funding

It is suggested that the funding of elective medical and surgical treatment be more directly and transparently aligned to levels of activity and to targets and outcomes required.

Variations in Clinical Priority

Surgeons can differ markedly in the clinical priority which they give to patients undergoing the same procedures.

It is suggested that NSW Health continue to work with other jurisdictions on development of assessment tools to assist clinicians in allocating patients priority categories for surgery, and to adopt these where they will be of benefit. Barriers to more extensive and effective use of clinical audit procedures to verify the appropriateness of priorities allocated to patients also need to be addressed.

Health System Capacity

The Department has service and capital planning processes. However, a long-term deterioration in waiting list performance indicators suggests that an appropriate balance has yet to be achieved between growing overall demand for public health services and the capacity of the system to meet that demand.

Overall staff numbers have increased, but Areas nonetheless report shortages of nurses and certain types of specialists. Shortages tend to be more acute in rural Areas.

Most shortages of doctors are long-term, and are outside the control of Areas. These can only be addressed through coordination between the Department, the Commonwealth, and the Specialist Colleges.

The Department needs to provide assurance that its targets for elective treatment are achievable with the workforce available.

Information Systems

The use of different procedures and computer software systems for the same function within and between Areas contributes to the inefficient use of information between Areas and the Department.

Much patient data are not generally transferable between hospitals electronically. This incompatibility hampers:

- an Area and state-wide approach to managing elective surgery
- the identification and promulgation of best practice, and
- improving the efficiency of service delivery.

The Department uses several means of collecting cost information. It has limited ability to link costs to activities in a consistent and timely manner. Its ability to measure and compare efficiency and effectiveness across Areas and hospitals is correspondingly weakened.

The number of patients receiving elective treatment as 'outpatients' is increasing. While NSW Health appears to collect a broader range of data than other states, its information systems do not permit consistent and all-inclusive reporting or management. There also appear to be no performance standards or targets, such as exist for waiting list patients, to ensure accountability.

Procedures and Compliance

There are some deficiencies in the Department's *Booked Patient and Waiting Time Management Operating Guidelines*. However, a more pressing concern is the lack of compliance and consistency with these and with other procedures and business rules. The Department needs to clarify whether guidelines and instructions are mandatory or whether they are only recommendations.

Reporting of Performance

Waiting time performance data quoted in Annual Reports of NSW Health could be misleading, are selective, and are not consistent either from year to year or with other performance measures used by NSW Health.

Internal Review of Waiting Lists

Between January and March 2003, the Department conducted an inquiry into waiting list records maintained by Areas.

The inquiry revealed evidence of misreporting of 'not-ready-for-care' patients at five hospitals.

The Department has referred the results of its inquiry to the Independent Commission Against Corruption and has signalled further investigation at these hospitals. The Minister for Health has instructed that the Department audit all waiting list data expeditiously and put in place an ongoing program of random audits. We support these actions.

Since the inquiry commenced, the number of patients classified 'not-ready-for-care' has fallen, while the number of 'long-wait' patients has climbed.

Recommendations

We recommend that the Department of Health:

The Guidelines	▪ review the adequacy of existing Guidelines for key areas of practice including booked patients, 'not-ready-for-care', waiting times, delays and extended waits. ▪ based on a risk assessment, monitor compliance with the Guidelines across Areas and hospitals.
Funding	▪ ensure that funding of elective medical and surgical treatment is more directly and transparently aligned to levels of activity and to targets and outcomes required.
Human Resources	▪ ensure that targets reflect activity levels, the relative priority of other health programs, and the numbers of doctors and nurses available.
Compliance	▪ review compliance with information business rules, monitoring and auditing procedures to ensure a consistent level of transparency and accountability in the management and reporting of all elective patients.
Information Systems	▪ accelerate its program for improving and integrating its management information, costing and reporting systems.
Performance Indicators	▪ develop an integrated suite of elective medical and surgical performance indicators for all categories of patients ('inpatient' and 'outpatient', 'ready-for-care' and 'not-ready-for-care') for internal use and for public reporting.
Performance Agreements	▪ provide that Area Performance Agreement targets for elective patients include all categories of patients.
Practice Tools	▪ identify and adopt best practice tools and procedures to improve consistency in assessing patients' priority for surgery and in conducting clinical audits.

Response from the NSW Department of Health

I refer to your draft performance audit Report about waiting times for elective surgery in public hospitals which you forwarded to me on 8 August 2003 for comment.

I enclose comments by the Department of Health on the specific recommendations in the Report.

There are, however, some general comments that I to make to ensure that readers of your Report understand the context in which elective surgery is provided in NSW public hospitals.

First, elective surgery is only one of an array of health services provided by the public health system. Other comprehensive services include ambulance services, primary health care, ambulatory programs, rehabilitation and aged care programs. Along with elective surgery these public health services will expend almost $9.4 billion in 2003-04.

Your report places particular and undue emphasis on the numbers of people waiting for elective surgery. A change in the number of people waiting over time is not an indicator of the performance of public hospitals. Yet there is one brief remark in your report that concedes that ***'the numerical size of the waiting list is of itself no indication of effectiveness or efficiency'****.*

A more appropriate indicator of measuring performance is how long patients of the public hospital system may wait to have elective surgery performed. In March 2003 patients on the medical and surgical waiting list waited on average 1.8 months - which is about 8 weeks.

NSW Health has focused on reducing the number of persons who, for a variety of reasons, have waited more than 12 months for their elective surgery. Your Report acknowledges the achievements for this group with the number of 'long wait' patients declining significantly between January 2001 and January 2003 - a fall from over 10,000 to 3,302 (approximately 70% reduction).

The majority of long wait patients remaining on the list are the patients of a very small number of doctors across the system. Area Health Services do offer these patients alternatives to the long waiting time of these particular doctors. However, these patients often choose to wait for their preferred doctor rather than having their surgery performed sooner by another doctor. There needs to be more emphasis on surgeons working together to treat patients on the hospitals waiting list, thus reducing waiting times. This strategy requires wider implementation across the health system.

There are also resource availability issues that will continue to impact on elective surgery waiting times. The public health system needs more doctors and nurses educated at universities to overcome chronic shortages. The shortage of Ear Nose and Throat and Orthopaedic Surgeon training positions is impacting on the ability of the public health system to treat patients in these specialties. It is these specialties where there is a large number of patients waiting for treatment.

While the specialist workforce shortage is the responsibility of the Federal Government, NSW Health is doing what it can to attract more medical staff to the health system.

Also, the preference of Ophthalmologists to work in the private sector means that there is a large number of patients waiting for treatment for eye conditions in the public hospital sector.

The availability of beds in public hospitals is another issue. On any one day there can be around 800 aged people who should be in nursing homes but who occupy acute care beds in public hospitals, simply because there are not enough nursing home beds available.

Additionally, private health insurance initiatives of the Federal Government have created an incentive for private hospitals to concentrate on more profitable, less complex elective surgery. Private hospitals in general, discourage emergency and complex medical and surgical admissions. The majority of private hospital growth has been in areas such as lens procedures (cataracts), chemotherapy, colonoscopies and dental extractions and restorations.

As a result of the factors outlined above, the state public hospital systems have taken on an increasing share of the emergency workload for the entire system. In 2001-02, the public hospital system treated 95% of all emergency admissions.

From 1999-2000 to 2001-02, emergency admissions to NSW public hospital increased by 11.3% or 61,000. This increase in emergency workload undermines the ability of the public system to treat elective surgical patients. This should be regarded as a far more influential factor in your Report than some of those mentioned.

I trust that those who read your report will consider on my comments.

(signed)

Robyn Kruk
Director-General

Dated: 5 September 2003

Response from the NSW Department of Health (continued)

General

NSW Health has reviewed the findings of the Performance Audit - Waiting Times for Elective Surgery in Public Hospitals.

Elective Surgery is only a small component of services provided by NSW Health. The increasing demands, particularly for emergency medical services within the public health system should be considered in the context of this Report.

The National shortage of Ear Nose and Throat and Orthopaedic Surgeons should also be considered, as it is these specialties where there is a large number of patients waiting for treatment.

Data Interpretation

The way that services are delivered in the Health system is under a process of constant monitoring and review. NSW like other health systems has been providing more day only services for minor procedures without admitting the patient to hospital. Caution needs to be exercised when interpreting figures over many years when a significant component of work that was included in the figures of earlier years is not included in the figures of the later years. Although this issue is raised in the Report, its importance in interpretation of the figures must not be forgotten. It is not possible to adjust the figures to correct for the impact of this change in practice. National reporting standards require that only admitted patients are recorded for waiting list and waiting time reporting.

Data Comparisons

Many of the waiting list figures have significant volatility from month to month. There are also some significant seasonal factors in hospital activity. For example the table on the percentage of patients that are ready for care or not ready for care in section 2.6 is comparing January and December 2002 figures. A comparison of June 2002 to June 2003 shows a 13.9% decline in long wait ready for care patients and a 13.3% decline in long wait not ready for care patients. Different months and different timeframes may lead to significant variation in the figures.

Emergency Admissions and Private Health Insurance Initiative

Demand for Emergency admission for medical conditions has been rising. Access to Elective Surgery has been impacted upon by growth in Emergency Admissions. From 1999-2000 to 2001-02 Emergency Admissions to NSW public hospitals increased by 11.3% or 61,000. This increase in Emergency workload undermines the ability of the public health system to treat public patients. The Commonwealth's Private Health Insurance Initiative has increased the incentive for private hospitals to admit surgical patients in preference to emergency medical patients.

A response to each of the recommendations is set out below:

Recommendation

The Guidelines

Review of the adequacy of existing guidelines for key areas of practice including booked patients, 'not-ready-for-care', waiting times, delays and extended waits.

Based on a risk assessment, monitor compliance with the Guidelines across Areas and Hospitals.

Health's response

***Agree**. NSW Health has reviewed the guidelines as recommended. New specific guidelines have been distributed. A revised set of the guidelines will issue shortly.*

Recommendation

Funding

Ensure that funding of elective medical and surgical treatment is more directly and transparently aligned to levels of activity and to targets and outcomes required.

Health's response

***Agree**. This is consistent with the policy of 'episode of care' funding being implemented across NSW Health*

Recommendation

Human Resources

Ensure that targets reflect activity levels, the relative priority of other health programs, and the number of doctors and nurses available.

Health's response

***Agree in principle**. As identified in the Report there is a large number of factors that impact on the provision of health services. Some of these factors are within the control of NSW Health while others are not.*

Commonwealth policy and funding is a major factor in the number of doctors and nurses available. Training and university places need to be increased.

Recommendation

Compliance

Review compliance with information business rules, monitoring and auditing procedures to ensure a consistent level of transparency and accountability in the management and reporting of all elective patients.

Health's response

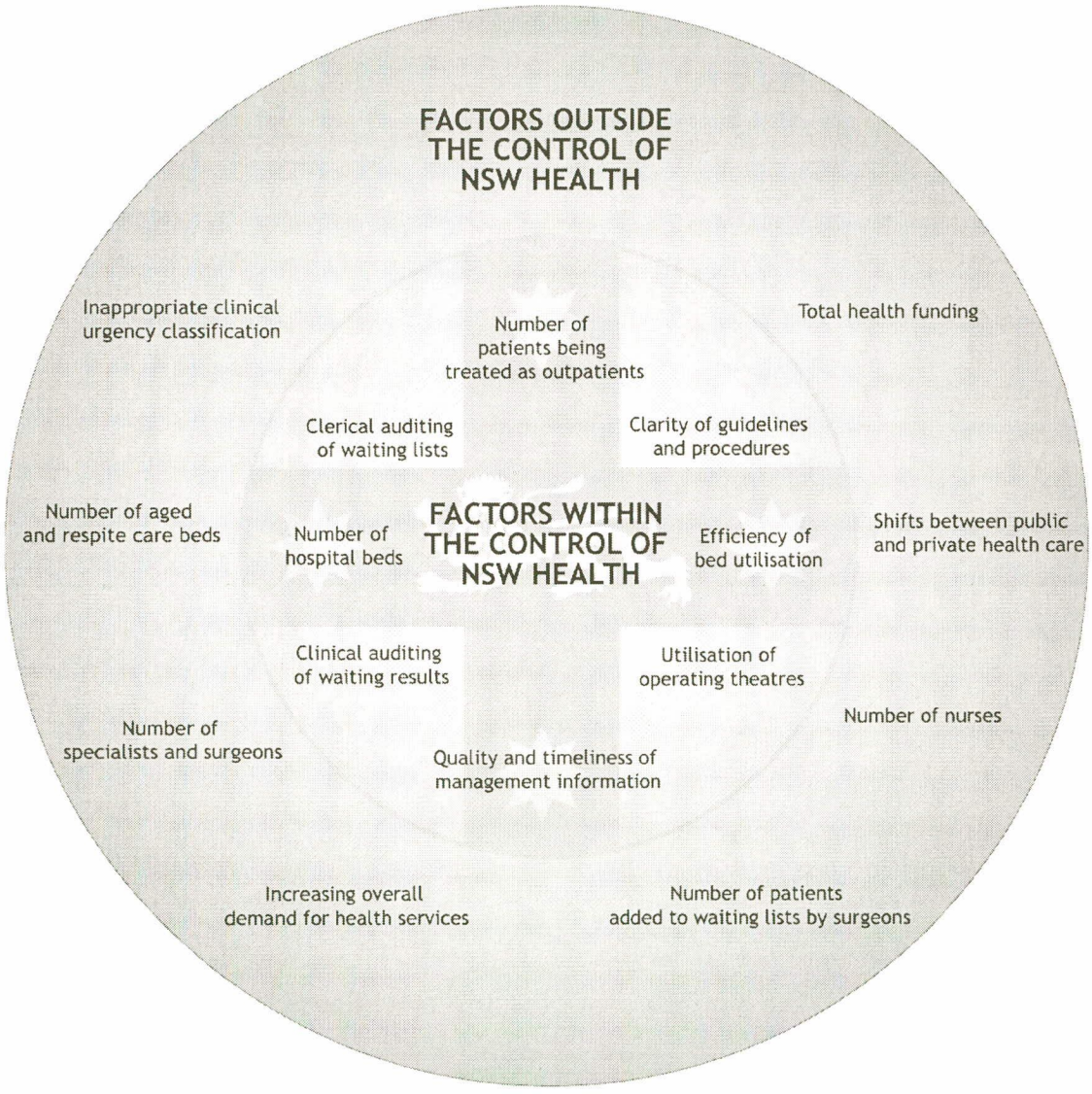
***Agree**. All NSW waiting lists will have undergone an audit process by October 2003. An ongoing program of random audits of waiting lists will be progressed.*

	Recommendation
Information Systems	Accelerate its program for improving and integrating its management information, costing and reporting systems.
Health's response	***Agree.*** *A number of initiatives in this area include the clinical costing system and the business objects reporting system.*
	Recommendation
Performance Indicators	Develop an integrated suite of elective medical and surgical performance indicators for all categories of patients ('inpatient' and 'outpatient', 'ready-for-care' and 'not-ready-for-care') for internal and for public reporting.
Health's response	***Agree.*** *A set of performance indicators as outlined has been developed.*
	Recommendation
Performance Agreements	Provide that Area Health Service performance agreement targets for elective patients include all categories of patients.
Health's response	***Agree.*** *In future, performance agreements will include 'not ready for care'. The number of not-ready-for-care elective surgical patients is already reported on the NSW Health web site.*
	Recommendation
Practice Tools	Identify and adopt best practice tools and procedures to improve consistency in assessing patients' priority for surgery and in conducting clinical audits.
Health's response	***Partly Agree:*** *NSW Health will continue to review the tools being used internationally.* *NSW Health will continue to provide information to Area Health Services and doctors where there is significant variation in the pattern of clinical urgency codes allocated to similar groups of patients.*

1. Introduction

1.1 Introduction

Management of waiting times is complex and demanding. There is no single factor which can ensure that waiting times will meet the community's expectations. Waiting times depend upon the interplay of a number of different factors, some of which are outside the control of NSW Health.



NSW Health has identified certain operational factors which influence waiting times[1]:

The length of time you wait for admission is affected by a number of factors, including the type of treatment you need, who your specialist doctor is and the hospital at which you are to be admitted. Your waiting time may also be affected by:

- changing health needs of the community
- the time of year - fewer operations are performed in hospitals over public holidays and during school holidays because many people prefer not to be hospitalised at these times of year. However, emergency treatment continues all year round.
- same day treatment - waiting times for treatments that do not require you to stay overnight in hospital are sometimes shorter.
- the number of referrals the specialist doctor receives from GPs.
- the amount of operating time the specialist doctor has allocated to him/her by the hospital (note that many doctors perform significant amounts of work in private hospitals).
- in some cases patients undergoing relatively minor procedures such as endoscopies may be treated on an outpatient basis at some hospitals.

In addition, during the course of this audit, management of Area Health Services identified other difficulties and constraints[2].

... Surgeons have refused to perform additional work remunerated by sessional payments ...

The surgeon with the largest number of long wait patients is unable to commit additional time to the hospital. An additional surgeon position has been advertised ...

One surgeon is unwilling to perform any additional operating sessions, and has actually been reducing his commitment to the hospital ...

The Department of Ear, Nose and Throat Surgery at Hospital A has unanimously declined to take up the offer of additional theatre time at Hospital B [35 to 45 minutes away by public transport] and insufficient theatre time is available at Hospital A due to emergency and highly complex work.

Availability of anaesthetists is limited in all this Area's hospitals ... any unexpected changes to availability of anaesthetists could pose major problems.

The majority of patients ... are for joint replacement requiring expensive prostheses. Budgetary constraints prevent the hospital from reducing the waiting list more quickly ... The rate of improvement [in the waiting list] is also slower than anticipated due to the reduction in Metropolitan Hospital money allocated to [the Area].

The Orthopaedic Department at Hospital C has not accepted previous offers of additional sessions at Hospital D [35 to 40 minutes away by public transport].

The high cost of prostheses and budgetary constraints prevent the hospital from reducing the waiting list more quickly at this time.

The Area is finding it difficult to achieve the number of additional [operating theatre sessions] necessary to reduce the long wait patients due to the availability of anaesthetists. Recruitment is ongoing and locum anaesthetists are utilised where possible ...

> Agreement for provision of anaesthetic services through [Hospital E] is being negotiated ... New part time anaesthetist secured for 3 sessions per week and pursuing use of locum anaesthetists ... Negotiating with anaesthetists for an additional 3 theatre sessions per week for emergency cases to reduce the number of elective cases being delayed due to emergencies.
>
> ... The surgeon has reduced his activity by one operating session per week because there has not been an anaesthetist available. Anaesthetic recruitment is currently underway and will result in an increase in session availability for the surgeon.

1.2 The Structure of this Report

In order to understand the issues which influence waiting times, it is necessary to understand some of the basic issues, processes and terms associated with managing waiting times. These are dealt with in the remainder of this chapter.

But it is also necessary to understand the current level of performance in order to make some recommendations for improving results. Some of these matters are discussed in the next chapter.

Chapter Three and later chapters discuss funding, capacity and organisation and information and information systems, and identify areas where there is potential to improve the management of waiting times.

1.3 The Cost of Public Health in New South Wales

In New South Wales, health expenditure represents 25 per cent of general government expenditure, ahead of:

- education (24 per cent)
- public order and safety (10 per cent), and
- transport (9 per cent)[3].

The budget of NSW Health includes the following programs[4]:

Program		Expenditure ($m) 2001-02
1.1	Primary and Community Based Services	686
1.2	Aboriginal Health Services	29
1.3	Outpatient Services	769
2.1	Emergency Services	784
2.2	Overnight Acute Inpatient Services	3,325
2.3	Same Day Acute Inpatient Services	469
3.1	Mental Health Services	589
4.1	Rehabilitation and Extended Care Services	833
5.1	Population Health Services	205
6.1	Teaching and Research	326
Total		8,015

The Cost of Elective Surgery

Expenditure on elective surgery is included in:

> Program 2.2 Overnight Acute Inpatient Services
> Program 2.3 Same Day Acute Inpatient Services[5].

Although there is no separate program for elective surgery, its costs can be estimated[6]:

Year	Expenditure on Elective Surgery
1998-99	$603 m
1999-2000	$594 m
2000-01	$648 m

Corporate Goals

The 1999-2000 and 2000-01 Annual Reports of NSW Health included a corporate goal of *Fairer Access*:

> ... to ensure waiting times for health services have been reduced[7].

The 2001-02 Annual Report contained no equivalent goal. It reported Department performance against six priorities[8] ('attributes' in *Strategic Directions for Health 2000-2005*[9]), but with no specific reference to elective surgery.

Strategic Directions for Health 2000-2005 also includes four goals for NSW Health:

- *Healthier People*
- *Fairer Access*
- *Quality Health Care*
- *Better Value.*

However, the 2001-02 Annual Report did not comment on progress in *Fairer Access* or any other goals. In the interests of accountability and transparency in public reporting, progress against each goal should be reported annually.

1.4 Elective Surgery

Patients in Public Hospitals

Patients can seek elective surgery in public or private hospitals.

Medicare covers people electing to receive treatment as public patients in public hospitals. Private hospitals and health clinics cater for privately insured or self-paying patients. Public hospitals cater for both public and private patients.

This report is about patients who seek elective surgical or medical treatment in public hospitals, whether as public or private patients.

Medical and Surgical Treatment

The terms 'medical' and 'surgical' have specific meanings in the health system. These are included, along with other terms used in this report, in Appendix 1. Elective surgical procedures include the following:

- cardiothoracic
- ear, nose and throat (ENT)
- general
- gynaecology
- neurosurgery
- ophthalmology
- orthopaedic
- plastic surgery
- urology
- vascular[10].

Some treatments are excluded from national definitions of elective surgery, including renal dialysis, dental and obstetric procedures, cosmetic surgery, organ transplants, etc[11].

Elective medical treatments included in New South Wales data mainly comprise procedures such as bronchoscopy, colonoscopy, endoscopy, gastroscopy, etc[12].

As indicated in the exhibit[13] below, elective surgery patients in New South Wales represent:

- over 80 per cent of all patients on the waiting list, and
- 99 per cent of patients waiting longer than 12 months.

Procedure	Patients on Waiting List	Patients Waiting Longer than 12 Months	Average Waiting Time (Months)
Surgical	55,324	4,129	2.26
Medical	11,687	59	1.02

1.5 The Process

The Process

The elective surgery process usually starts when a person consults a general practitioner (GP). The GP will refer the patient to a surgeon[14] if surgical treatment seems warranted.

After the initial GP consultation, patients usually have to wait before seeing the surgeon to whom they are referred.

This waiting time is outside the control of the public health sector but is equally important to patients[15].

If the surgeon decides that the patient requires surgery, and the patient wishes or needs to attend a public hospital, the specialist will complete a *Recommendation for Admission* form (RFA)[16]. This enables the patient to be 'booked' or included on the hospital's waiting list.

Once the hospital's admission staff receive the RFA:

- the details are entered into the hospital's Patient Administration System (PAS)
- the patient is recorded on NSW Health's waiting list
- hospital staff confirm the booking with the patient
- hospital staff advise the patient of the planned date of admission or the expected waiting time before surgery[17].

As the date for admission approaches, hospital staff will arrange for the patient to undergo any necessary tests, and will advise the patient of any requirements such as fasting prior to an operation.

In accordance with standard procedures, the hospital contacts those patients who have waited for treatment for longer than six months. This contact seeks to establish:

- if the patient still requires admission for medical or surgical treatment
- whether there has been any change to the patient's condition.

> Patients who have waited more than six months should be provided with information and/or options to access alternative arrangements (where available), as determined by the Area/hospital management[18].

Some patients may no longer require surgery because:

- their condition has improved
- they have undergone treatment elsewhere
- they have died.

In some cases patients may not be contactable at the nominated residential address.

Surgeons

Surgeons:

- are contracted to the hospital to provide an agreed level of availability to conduct emergency and elective surgery
- perform surgery in the public hospital's operating theatre and monitor the patient's condition post-surgery
- generally also work in the private health system[19].

All doctors have professional and legal responsibilities to their patients[20]. One effect of this is that, in most cases, a surgeon will not operate on another surgeon's patient without first examining the patient to ensure that he or she considers that the planned surgery is appropriate.

Allocating Priority

A surgeon will allocate a clinical priority to a patient based upon the surgeon's assessment of the patient's condition. The priority is expressed in days, weeks or months. NSW Health refers to these time periods as 'benchmarks':

Category[21]	Clinical Priority	Benchmark Admission Time
U1	Urgent	Within 7 days
U2	High priority	Within 30 days
U7	Semi-urgent	Within 90 days
U8	Non-urgent or other	Within 12 months[22]
U9	Not-ready-for-care (staged or deferred)	NA

While some of the codes U3 to U6 have been used in the past, none is now used.

Different surgeons sometimes allocate different priorities to patients presenting with similar conditions[23].

The NSW Health website indicates that the above benchmark admission times are advisory only:

> **Urgent and high priority patients**: people who are classified in an urgent or high priority category and should be admitted within 30 days
>
> **Semi-urgent patients**: people categorised as semi-urgent and should be admitted within 90 days[24].

This is consistent with national definitions which treat the benchmark admission times as 'desirable':

> All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery ...
>
> - Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
> - Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency[25].

NSW Health has advised that benchmark admission times are regarded as best practice:

> ... and as such they form the basis of formulating target admission times that may at times be less than best practice[26].

1.6 Types of Patients and Treatments

Emergency Surgery

Emergency patients are those whose clinical condition indicates that they require admission to hospital within 24 hours[27].

Because of its higher priority, the demands of emergency surgery may result in the postponement of elective surgery.

'Inpatients'

Most patients undergo elective surgery as 'inpatients', defined as patients who are:

> ... formally admitted to a hospital or health service facility. Formally admitted patients can be same day or overnight[28].

Patients admitted for elective surgery, either overnight or same day, will receive treatment in an operating theatre under some form of anaesthetic[29]. They may occupy a bed as part of post-operative care.

'Outpatients'

For many years minor procedures have been provided at outpatient clinics. The range of procedures offered to 'outpatients' has increased as technology and practices have changed.

'Outpatients' are defined as:

> ... patients who receive medical, surgical, allied health or diagnostic services in a hospital outpatient facility, who are not formally admitted to the hospital at the time of receiving the service [30].

Today around 16,000 minor elective surgery procedures per annum are performed on 'outpatients' in public hospitals. NSW Health reports show that 10,000 of these would have been done as 'inpatient' procedures five years ago[31].

Colposcopies[32] and cataract extractions are the most frequent 'outpatient' surgical procedures. Westmead Hospital, for example, now performs all cataract extractions as an outpatient procedure[33].

Some NSW Health representatives claim that treatment as an 'outpatient' has benefits for:

- patients, as they spend less time in hospital, and
- the health system, as it is a more effective use of resources.

From the point of view of the patient, the difference between having a cataract operation as an outpatient at Westmead Hospital and as a 'booked' patient at another hospital is probably negligible.

'Ready-for-care' Patients

'Ready-for-care' patients are those awaiting treatment who are able to be admitted to hospital and who, in the opinion of the surgeon, are ready to be admitted.

'Overdue' Patients

Medical and surgical patients who have not received treatment before the benchmark time for their urgency category are overdue, e.g. a U7 patient who has not received treatment within 90 days.

National standards have only a single category equivalent to the combination of the U1 and U2 New South Wales codes. NSW Health overdue patient statistics are consistent with this, and report as overdue those U1 and U2 patients who have not received surgery within 30 days[34].

'Long-wait' Patients

'Ready-for-care' medical and surgical patients who have been waiting for elective surgery longer than 12 months are termed 'long-wait' or 'extended wait' patients[35].

'Long-wait' patients may seek or be offered earlier treatment by a different surgeon and/or different hospital[36].

'Not-ready-for-care' Patients

Medical or surgical patients are 'not-ready-for-care' if their treatment has been deferred or staged.

Deferred

Treatment may be deferred if the patient:

- declines a reasonable offer of a shorter waiting time for surgery by another surgeon or in another public hospital, or
- is unable to accept a date for surgery for personal reasons such as work commitments or holidays[37].

Staged

Patients are staged if their medical condition is such that they are not ready for surgery until some future date. A patient's current state of health may, for example, prevent an anaesthetic being administered[38].

'Not-ready-for-care' patients are given the urgency category of U9[39].

Staged and deferred surgical patient numbers are reported on NSW Health's website[40]. However, elective medical patients are excluded. Routine internal reporting, such as the *Waiting List Performance* report, does not specifically show 'not-ready-for-care' patients[41].

Between January and April 2003 the Department conducted an internal inquiry into waiting list management, which found irregularities in the classification by five hospitals of patients as 'not-ready-for-care'. This is discussed in *2.9 Inquiries into Waiting List Manipulation*.

The Department has referred the findings of its inquiry to the Independent Commission Against Corruption.

1.7 Types of Service Delivery

Change and Improvement

In the past, elective surgery generally meant a stay in hospital of at least one night. For example:

- patients would be admitted to hospital the day before surgery
- after surgery a patient would spend a few days in a ward, under observation or receiving post-operative treatment, and finally
- the patient would be discharged.

Surgical and medical techniques and technology have improved worldwide. There has been a global trend to increasing the amount of elective surgery being done 'same-day' or as 'day-of-surgery-admission', with benefits to the patient of a shorter length of stay and lower complication rates.

'Same-Day-Surgery'

The main feature of 'same-day-surgery' (or 'day surgery') is that patients do not stay in hospital overnight following surgery. This:

- frees up beds, and thereby
- reduces the risk that other elective surgery is postponed (a shortage of beds is a reason often cited for postponing elective surgery).

'Same-day-surgery' patients are classified as admitted inpatients.

It is claimed that 'same-day-surgery' has important clinical benefits for the patient:

> Day only surgery significantly reduces the risk of infection and is recognised as an effective and appropriate way to provide better surgical services to patients[42].

According to waiting list data, 'same-day-surgery' represented around 49 per cent of all elective surgery admissions in 1995-96[43]. It now represents around 58 per cent[44].

'Day-of-Surgery-Admission'

'Day-of-surgery-admission' (DOSA) patients are admitted to hospital on the day of surgery, rather than the day before, and spend at least one night in hospital.

The percentage of overnight elective surgery patients who have surgery on the day of admission is increasing. In 1998 only 55 per cent of overnight patients had 'day-of-surgery-admission', while today the figure is more than 80 per cent[45]. 'Day-of-surgery-admission' has similar operational and patient benefits as 'same-day-surgery':

> DOSA means that patients ... don't have to spend unnecessary time in hospital before their surgery. It also decreases the chance of post-operative infections and blood clots[46].

1.8 Waiting Times

There is an interval of time between a patient being added to the waiting list for elective surgery and undergoing surgery:

> Some queuing for surgery is necessary to achieve maximum efficiency for hospitals and doctors[47].

A patient's condition will influence the length of time he or she waits for surgery. The most urgent patients should receive the highest priority for surgery.

1.9 The Waiting List

Hospitals maintain 'waiting lists' for operational management of the hospital and communication with patients and their doctors.

The waiting list provides a focus for planning and resource allocation within the hospital:

> No waiting list means empty beds and less efficient use of doctors' time. Therefore the waiting list that is complete and comprehensive provides a focus for planning and resource allocation within the hospital.
>
> The state-wide waiting list enables the NSW Health Department to provide information to hospitals across the state about the comparative situation and allows planning to occur[48].

The number of patients on the waiting list is not, of itself, a useful indicator of how efficiently patients receive treatment:

> The absolute numerical size of lists is frequently quoted but this figure has little meaning without the knowledge of how quickly patients are treated. The size of a list is by itself no guide to effectiveness or efficiency. The critical issue is that care be given in a timely manner. Long lists are only a problem when individual patients are required to wait too long before their condition is treated[49].

Patients appearing on the waiting list are usually managed by the hospital's waiting time coordinator who advises the patient of:

- the expected waiting time and date of surgery, and
- arrangements for admission to hospital.

Coordinators are also expected to manage 'long-wait' patients:

> Health services are encouraged to ensure that those non-urgent patients who do not wish to wait a long time are admitted within twelve months (at most) of going on a list[50].

1.10 Reading this Report

In reading this report, and unless stated otherwise, a reference to:

- *elective surgery* is also a reference to 'booked' surgery
- *elective surgery patients* refers to those patients appearing on the waiting list and includes 'inpatients' but does not include 'outpatients' who undergo elective surgery
- *waiting list* or *elective patients* usually includes both medical and surgical elective treatments, except where specifically noted
- *NSW Health* includes the Department of Health and Area Health Services
- an *Area* means an Area Health Service of NSW Health.

While this report mainly considers 'inpatient' elective surgery, many of its comments and recommendations also apply in principle to 'outpatients'.

The report also comments on some issues specific to 'outpatient' elective surgery management.

Other terms used in this report are described in Appendix 1.

2. Overview of Performance

2.1 Demand on the Public Health System

Overall demand

The overall number of patients attending public hospitals, including those being admitted to Emergency Departments, is increasing.

As illustrated below, more patients are also being treated as outpatients or are receiving other types of treatment which do not require admission to hospital:

	Patients Admitted[51]	Emergency Department Attendances[52]	Non-Admitted Patient Services[53]
1993-94	1,239,711	1,615,212	19,283,498
1994-95	1,273,963	1,565,043	20,188,780
1995-96	1,328,195	1,617,009	20,810,160
1996-97	1,336,544	1,629,261	21,144,518
1997-98	1,388,732	1,716,239	21,868,193
1998-99	1,411,811	1,446,082	21,419,883
1999-2000	1,398,360	1,671,981	22,061,519
2000-01	1,427,143	1,778,822	20,475,350
2001-02	1,458,555	2,000,120	22,629,220

Demand for Elective Surgery

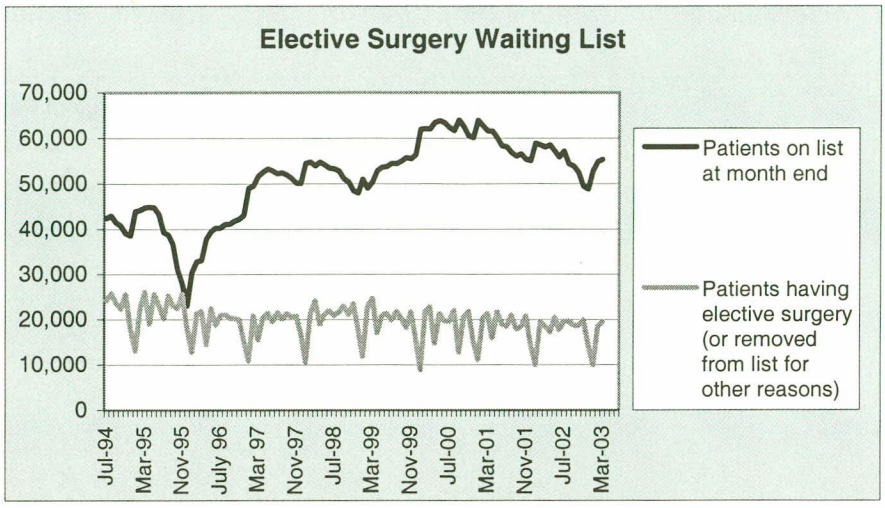
While overall demand on the public health system is increasing, NSW Health data show a regular decline in the number of booked patients undergoing elective treatment. Part of this decline may be due to a greater proportion of services being provided as 'outpatient' treatments.

Year Ended 31 March[54]	Patients Added to the Waiting List	Change %	Patients Undergoing Elective Surgery	Change %
1997	246,150	NA	201,882	NA
2003	225,637	-8	187,952	-7

Since 1997 the number of patients added annually to the waiting list has declined by 8 per cent, and the number undergoing elective surgery by 7 per cent[55].

Waiting List Trends

The chart below shows the number of patients awaiting elective surgery and the number who have had elective surgery or have been removed from the waiting list for other reasons[56].



Year Ended 31 March	Elective surgery patients[57]	Elective medical patients	Total 'Ready-for-care' patients on Waiting List[58]	Change %
1997	51,589	11,774	63,363	NA
2003	55,324	11,687	67,011	+6

Audit Observations

The number of booked patients actually having elective surgery has continued to decline even though the number of patients on the waiting list for elective surgery increased significantly between 1997 and 2000.

This indicates that the level of elective surgery conducted has not matched demand, and the size of the waiting list has grown accordingly.

2.2 Waiting Times

The numerical size of the waiting list is of itself no indicator of effectiveness or efficiency:

> Long lists are only a problem when individual patients are required to wait too long before their condition is treated[59].

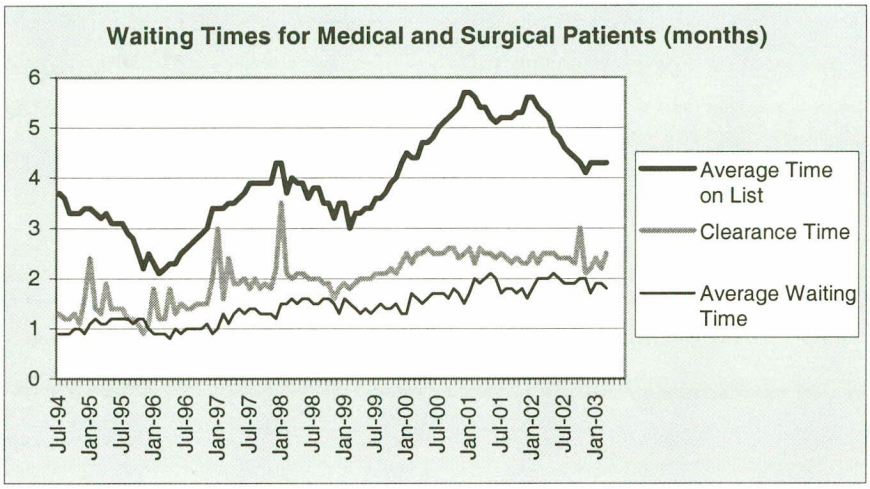
NSW Health uses three measures of the length of time patients wait for elective surgery:

- average time on list
- average waiting time, and
- expected waiting (clearance) time.

These measures are explained in Appendix 1.

Performance

Waiting time performance is displayed in the following exhibit[60].



Audit Observations

According to the three measures:

- the average time on the waiting list increased between 1994-95 (when records were first kept) and early 2001
- average waiting time ('a more common measure of waiting time'[61]) almost doubled over the same period, and is currently 1.8 months[62]
- clearance time has also increased significantly.

The chart shows some improvement in all three measures in recent years. However, the management of elective medical and surgical patients has not, over the long term, achieved any significant reduction in waiting times.

2.3 'Long-Wait' Patients

The 1999-2000 and 2000-01 Annual Reports of NSW Health indicate that priority was being given to the management of 'long-wait' patients[63], being those patients waiting longer than 12 months for treatment.

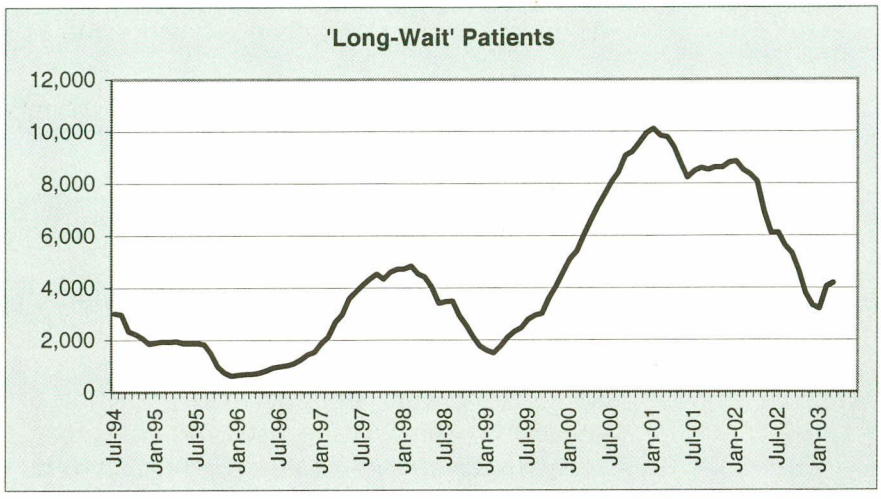
In February 2001 the Department set Areas the target of zero 'long-wait' patients. Performance Agreements of Areas reflect this target for June 2003. The Department subsequently requested that Areas achieve the target by January 2003[64].

To support the emphasis on reducing 'long-wait' patient numbers, additional funding has been made available to Areas[65].

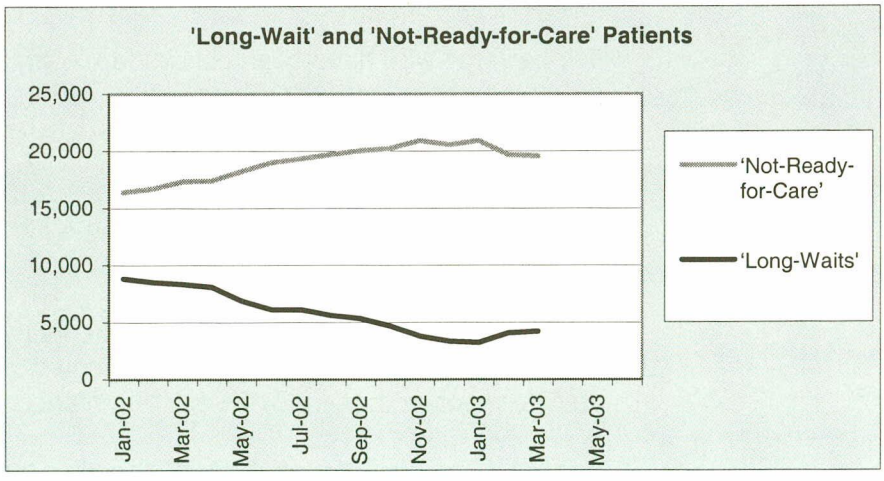
Performance

NSW Health records[66] show that the number of 'long-wait' patients:

- increased from approximately 1,500 in February 1999 to over 10,000 in January 2001 (a sixfold increase)
- declined to 3,202 in January 2003, or five per cent of all patients ready and able to undergo elective treatment.



However, since the Department initiated its internal investigation into alleged misreporting of waiting lists[67], the number of 'long-waits' has increased by 31 per cent to 4,188 at the end of March, reversing a two-year declining trend. While 'not-ready-for-care' patient numbers rose steadily during 2002, this trend also reversed coinciding with the Department's internal review.



Despite the overall decline in 'long-wait' numbers, some patients have been waiting several years for elective treatment. Furthermore, the number of patients waiting for such long periods has increased markedly in recent months:

	'Ready-for-care' patients waiting longer than[68] ...	
	2 years	3 years
January 2003	635	143
March 2003	784	225
Change	+23%	+57%

The most pronounced change has been in South Eastern Sydney:

	'Ready-for-care' patients waiting longer than[69] ...	
	2 years	3 years
January 2003	16	4
March 2003	174	66

Nearly 19 per cent of 'long-wait' patients have been waiting for longer than two or three years[70].

Some 'long-wait' patients had priorities of U1 or U2 when first placed on the waiting list, and therefore should have received treatment within 7 or 30 days respectively. However, some may have been coded inappropriately.

	U1 and U2 patients waiting[71] ...	
	1 to 2 years	Longer than 2 years
January 2003	37	2
March 2003	47	2
Change	+27%	0%

571 patients who have been classified U7 since being placed on the list (and hence requiring admission within 90 days) have been waiting for longer than 12 months. 140 of these have been waiting for longer than 2 years[72].

Audit Observations

The Department's target of zero 'long-wait' patients by January 2003 was not met.

The number of 'long-wait' patients has increased over the longer term. This would suggest that Areas and hospitals have not been able to manage demand with existing resources.

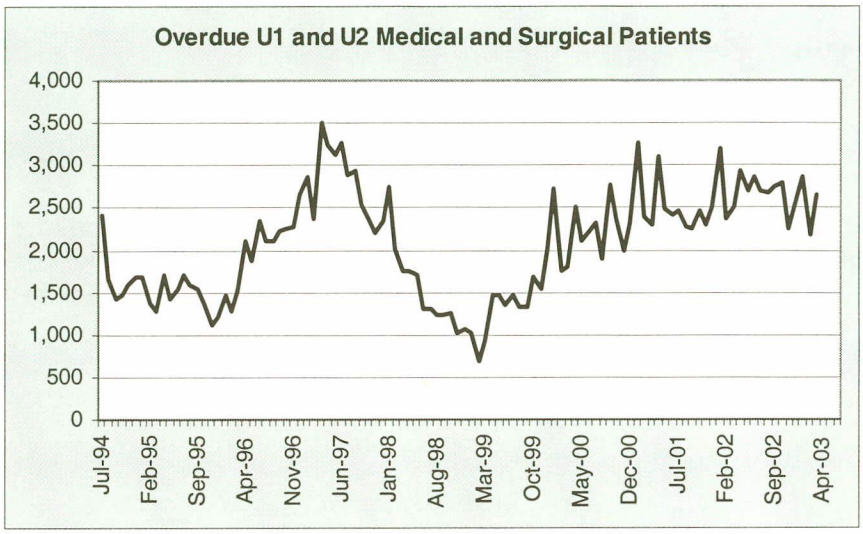
Recent data suggest that some of the apparent reduction in 'long-wait' patient numbers has been achieved by reclassifying patients as U9.

2.4 'Overdue' Patients

U1 and U2 patients are those with the highest urgency categories, and are expected to undergo treatment within 7 and 30 days respectively.

Performance

NSW Health data show that the number of overdue U1 and U2 patients (that is those who have not received surgery within 30 days)[73] has increased markedly since early 1999. Thirty per cent of U1 and U2 patients were overdue at the end of March 2003[74].



Specialists allocate patients a priority code for treatment.

The Department has expressed concern that some specialists have allocated urgency codes inappropriately and that these practices have affected reported performance[75].

Audit Observations

The long-term trend in 'overdue' patients suggests an imbalance between the priority that should be afforded this category of patient and the priority that is actually afforded. That U1 and U2 patients do not receive treatment within the recommended times (7 and 30 days respectively) has clear implications for the well being of those patients.

2.5 Performance by Specialty

Specialties and surgical procedures vary widely in complexity, in the time and resources required, and in cost.

Orthopaedic procedures are amongst the most costly and time consuming elective procedures. Many orthopaedic procedures, such as knee and hip replacements, require expensive prostheses. The patient's average length of stay during recovery after surgery also tends to be lengthy.

Specialty	'Overdue' U1 and U2 Patients	'Long-wait' Patients
Orthopaedic	264	1,348
ENT	169	1,015
Ophthalmology	42	574
General	428	455
Vascular	47	190
Gynaecology	246	159
Plastic	117	135
Urology	266	98
Neurosurgery	53	6
Other	24	1
Cardiothoracic	93	0
NSW Total	1,749	3,981

Audit observations

The above analysis[76] shows that orthopaedic surgery comprises 34 per cent of all 'long-wait' patients. However, orthopaedic patients represent only 14 per cent of all patients undergoing elective surgery[77].

Patients for ENT surgery account for another 25 per cent of 'long-waits'.

2.6 'Not-Ready-for-Care'

Waiting list targets for delays and for rates of same-day surgery and day-of-surgery-admission include all patients, both 'ready-for-care' and 'not-ready-for-care'. However, targets for 'overdue' and 'long-wait' patients include only those classified as 'ready-for-care'[78].

This is consistent with national definitions and guidelines.

'Not-ready-for-care' or priority U9 patients are those who are either clinically not ready for admission (staged) or who wish to defer admission for personal reasons (deferred).

The website of NSW Health displays the number of 'not-ready-for-care' elective *surgery* patients. At the end of March 2003 this totalled 14,726.

'Not-ready-for-care' elective *medical* patients (an additional 4,843) are not shown on the website.

On this basis the website does not indicate a comprehensive record of all patients deemed 'not-ready-for-care'.

Earlier Committee findings

The 1996 Select Committee on Hospital Waiting Lists and the General Purpose Standing Committee No. 2 of the Legislative Council in 2002 both referred to the practice of classifying patients 'not-ready-for-care'. The relevant comments are summarised in Appendix 4.

Performance

Trends in 'not-ready-for-care' patient numbers during 2002 are shown below[79].

Medical and Surgical Patients			
Month	'Not-ready-for-care'	Total 'Ready-for-care' and 'Not-ready-for-care'	'Not-ready-for-care' %
January 2002	16,405	87,054	19
February	16,725	86,963	19
March	17,326	86,732	20
April	17,417	87,678	20
May	18,244	86,795	21
June	18,995	86,399	22
July	19,330	86,362	22
August	19,698	85,544	23
September	20,041	84,980	24
October	20,241	83,815	24
November	20,906	80,734	26
December	20,538	79,223	26
January 2003	20,900	85,115	25
February	19,668	86,226	23
March	19,569	86,580	23

Medical and Surgical 'Not-ready-for-care' Patients				
Area	January 2002	December 2002	Change	Change %
Southern	273	469	+196	+72
Wentworth	458	742	+284	+62
South Western Sydney	1,539	2,267	+728	+47
Illawarra	885	1,275	+390	+44
South Eastern Sydney	1,842	2,613	+771	+42
Hunter	1,179	1,654	+475	+40
Central Coast	1,138	1,437	+299	+26
New England	634	797	+163	+26
Northern Rivers	1,156	1,451	+295	+26
Macquarie	362	439	+77	+21
Mid North Coast	1,914	2,286	+372	+19
Mid Western	345	412	+67	+19
Central Sydney	1,376	1,557	+181	+13
Greater Murray	605	659	+54	+9
Northern Sydney	713	771	+58	+8
Western Sydney	829	799	-30	-4
Far West	133	123	-10	-8
Children's Westmead	1,024	787	-237	-23
Total	**16,405**	**20,538**	**+4,133**	**+25**

Audit Observations

'Not-ready-for-care' patients:

- represent 23 per cent of all 'ready-for-care' and 'not-ready-for-care' patients
- increased from 16,405 to 20,538 during the 2002 calendar year, an increase of 25 per cent
- increased by over 40 per cent during 2002 in six Areas (Southern, Wentworth, South Western Sydney, Illawarra, South Eastern Sydney and Hunter).

Between January and March 2003 the Department conducted its inquiry into waiting lists (discussed in *2.9 Inquiries into Waiting List Manipulation)*. During this period 'not-ready-for-care' patient numbers fell by 6 per cent, after rising steadily during 2002.

In the same period the number of 'long-wait' patients increased by 31 per cent, reversing a two year decline.

'Not-ready-for-care' patients are:

- not governed by specific targets
- not explicitly included in Performance Agreements[80]
- not shown in *Waiting List Performance* reports.

In the interests of accountability and transparency, and to more accurately reflect demand for elective surgery, it is suggested that NSW Health consider:

- providing all patients, 'ready-for-care' and 'not-ready-for-care', with a realistic date for surgery
- including these patients in internal and external waiting list reports (including the *Waiting List Performance* report)
- including all patients (including 'not-ready-for-care') in Performance Agreement targets
- ensuring that planning and resource decisions for elective surgery reflect 'not-ready-for-care' patients.

2.7 Interstate Comparisons

The Australian Institute of Health and Welfare (AIHW) collects comparative data on the health systems of Australian states and territories, including summary data on waiting times for elective surgery.

There is some variation in the methods used by the states and territories to calculate waiting times for patients, particularly those:

- whose clinical priority changed while on the waiting list, or
- who were transferred from a waiting list managed by one hospital to that managed by another.

The possible effect of different participation rates should also be noted. All New South Wales public hospitals are included in the latest data, but this is not the case for some other states[81]. The AIHW[82] and the Department[83] also advise that there are some differences in definitions.

Nonetheless the figures are indicative of performance across jurisdictions. The Department has used national data to report its performance in the past, despite the reservations it now expresses on such comparisons:

> Patients in NSW have the shortest waiting times for surgery in Australia according to the latest Productivity Commission report[84].

Waiting Time Statistics 2001-02 by Public Hospital Peer Group[85]									
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Total number of hospitals	221	144	157	89	80	25	2	5	723
Number of reporting hospitals	107	26	33	10	7	3	2	5	193
Est. coverage of surgical separations %	100	70	98	72	61	99	100	100	84
Days waited at 50th percentile	28	28	23	25	34	34	40	29	27
Days waited at 90th percentile	220	210	132	217	203	339	268	230	203
% waited more than 365 days	5.0	4.4	3.6	4.1	3.6	9.0	6.8	4.4	4.5

Audit Observations

AIHW data for 2001-02 show that the median (50th percentile) wait in New South Wales is broadly similar to the Australian average. New South Wales lags most other states and territories for days waited at the 90th percentile, and the percentage of patients waiting longer than a year[86].

In the AIHW report for 1999-2000[87], 2.4 per cent of New South Wales patients waited longer than a year, compared to 5.2 per cent in 2000-01[88] and 5.0 per cent in 2001-02. Long-term trends are not available, as AIHW has only reported data in the above format for the last three years.

2.8 Waiting List Data

At state level, policy decisions are frequently influenced by factors such as waiting times and the length of waiting lists.

Areas and hospital management rely on waiting list information to inform decisions about the targeting of resources.

A patient's choice of specialist may be influenced by the specialist's published waiting times.

Hence a number of different users rely on the accuracy of waiting list data.

Reports

The Department uses a number of reports to reflect waiting list performance, including:

- *Waiting List Performance* (an internal report)
- *Current Waiting Times and Lists by Specialties* (a publicly available report).

Senior management in the Department use the *Waiting List Performance* report to monitor the performance of Area CEOs against the Performance Agreement targets.

The *Current Waiting Times and Lists by Specialties* report shows medical and surgical patients separately, and summarises the number of 'not-ready-for-care' booked surgical patients.

The source of the data for both reports is the Patient Administration System maintained by hospitals. This system manages the records of patients booked or admitted for elective medical and surgical treatment.

Hospitals use relevant extracts of the reports and other self generated information at an operational level to inform decisions such as:

- scheduling operating theatre sessions
- targeting special groups of patients (e.g. 'long-wait' and overdue patients), and
- monitoring performance against performance agreement targets.

'Outpatients'

Increasing numbers of patients are undergoing elective surgery as 'outpatients'. This shift is likely to continue, as it is seen to have benefits for the patient and for the efficiency of the health system.

The accountability of Areas and hospitals for managing 'outpatients' is not as rigorous as for elective surgery patients on the waiting list:

- 'outpatients' do not have the same safeguards offered by standardised procedures and guidelines similar to those of *Booked Patient and Waiting Time Management Operating Guidelines*
- there are no performance targets such as those provided by performance agreements, or oversight by the Department of Health
- there is no publicly available information such as on the NSW Health Waiting Times Information website[89]
- there is no benchmarking of performance with other jurisdictions, as has been developed for inpatient data with AIHW and the Productivity Commission.

Audit Observations

The *Waiting List Performance* report shows 55,324 'ready-for-care' surgical patients on the waiting list as at March 2003.

However, the *Current Waiting Times and Lists by Specialties* report shows 49,691 'ready-for-care' surgical patients on the waiting list at the same date. This report also routinely shows negative numbers of patients on waiting lists for some specialties at some hospitals.

The Audit Office suggests that the Department eliminate the discrepancy in 'ready-for-care' numbers between the reports (if both reports are considered necessary).

Both reports indicate 4,188 medical and surgical patients waiting longer than 12 months for treatment.

2.9 Inquiries into Waiting List Manipulation

The UK Waiting List Inquiry

In 2001 the National Audit Office of the United Kingdom (the NAO) conducted an audit into that country's waiting lists. The report noted:

> ... At the majority of trusts that we visited there was no evidence that the trusts were deliberately or otherwise adjusting, inappropriately, their waiting list figures. However there have been a number of cases where trusts have adjusted inappropriately their waiting list figures[90].

A subsequent audit confirmed the inappropriate adjustment of waiting lists:

> Nine NHS trusts inappropriately adjusted their waiting lists, three of them for some three years or more, affecting nearly 6,000 patient records. For the patients concerned this constituted a major breach of public trust and was inconsistent with the proper conduct of public business[91].

At seven out of the nine NHS trusts, waiting lists were found to have been adjusted by 'inappropriate suspensions', that is by inappropriately classifying patients to the broad equivalent of the 'not-ready-for-care' category used in New South Wales public hospitals.

> The adjustments varied significantly in their seriousness, ranging from those made by junior staff following established, but incorrect, procedures through to what appears to be deliberate manipulation or misstatement of the figures[92] ...

An extreme case was recounted:

> ... allegedly patients were deliberately offered admission during their known holiday dates and then suspended for a longer period when admission was declined, and patients were offered non-existent dates to come in at short notice and when those dates were declined, their records [were] amended to hide the fact that they would breach the 18 month maximum wait[93].

The NAO commented on the disciplinary action taken by the NHS trusts concerned:

> At four trusts seven staff were suspended. Four Chief or Deputy Chief Executives (three of whom were suspended) subsequently resigned or had previously left, receiving compensation payments ... covered by confidentiality clauses[94] ...

The NAO recommended that:

> The [UK] Department of Health should seek assurances from the Chief Executive of each NHS trust that there have been no inappropriate adjustments to waiting lists. For example, they could investigate in more detail those trusts where more than 10 per cent of patients are suspended and which have more than 2 per cent of patients waiting more than twelve months for treatment ...
>
> As part of the guidance the Department of Health should take steps to ensure that effective inquiries are carried out into alleged irregularities, sufficient to ensure that they can be used as a basis for determining whether to take disciplinary action against individuals concerned[95] ...

Inquiry by NSW Health

The scope of the Department's internal inquiry between January and March 2003 was 14 hospitals which had atypical patterns of:

- additions to their waiting lists, and/or
- patients classified U9 or 'not-ready-for-care'.

The inquiry found that 'five of [the hospitals reviewed] had misrepresented data'[96].

Some findings of the inquiry were reported in the media:

> The four-month inquiry by NSW Health found evidence of misreporting at St George, Bankstown, St Vincent's, Prince of Wales, Sydney and the Sydney Eye Hospital, and concluded that the five should become the subject of further 'independent examination'.

> A report by the Director-General of NSW Health, Robyn Kruk, to the Health Minister, Morris Iemma, also recommends that the chief executives of NSW Area Health Services have their employment contracts rewritten to make them 'personally accountable' for the accuracy of their waiting lists.
>
> According to Ms Kruk's report, examination of 24,000 patient records indicated that a conservative estimate of 2,800 may be inaccurate[97].

As well as forwarding the inquiry findings to the Auditor-General and the Independent Commission Against Corruption, the Director-General of the Department recommended:

> ... an independent investigation of waiting list management at [the] five hospitals where the reviewers found evidence of misreporting[98].

The Minister for Health has:

> ... instructed NSW Health to thoroughly audit all of the waiting list data over the next six months [and] ... requested NSW Health to put in place an ongoing program of random audits to sample waiting list data information[99].

Audit Observations

The Audit Office supports the recommendations of the Director-General and the Minister (above) and in keeping with the approach recommended in the United Kingdom suggests that:

> ... The inquiry team should be independent, external and sufficiently resourced to enable a thorough review to be undertaken within a reasonable timeframe[100] ...

2.10 Guidelines and Procedures

Guidelines of NSW Health

The Department's current *Booked Patient and Waiting Time Management Operating Guidelines* were issued in March 1998, replacing earlier policies[101]. These guidelines have since been supplemented by others[102].

The objective of the guidelines is:

> To provide accurate information on waiting times and lists to clinicians, administrators and patients in order to enhance the management of booked patients[103].

Strengths and Weaknesses of Guidelines

The Area and hospital staff and management we interviewed during this audit did not raise any concerns with the guidelines. Some provided samples of reports which they used to manage their waiting lists in accordance with them.

Management of one Area initiated an external review of implementation of and compliance with the guidelines. The review identified some deficiencies:

> The guidelines are silent:
>
> ... on the treatment of cosmetic surgery ...
>
> ... on who is responsible (the AMO or the Admission Clerk) for booking a patient onto a surgery list ...
>
> ... on when an RFA should be date stamped ... if the minimum data set has not been completed ...
>
> ... on the treatment of an AMOs' waiting list where the AMO ceases with the Area and is not replaced[104] ...

The first point is justified: the guidelines do not refer to cosmetic surgery.

The second point appears to reflect a very literal interpretation of the guidelines, which state that the AMO is responsible for 'complet[ing] the RFA, ensuring that the mandatory information is supplied'[105]. The Waiting Time Coordinator is responsible for 'facilitat[ing] the timely processing of admissions including coordination of the relevant patient information required for admission'[106]. While it is not specifically stated, it can be inferred that the AMO is responsible for providing the information, and the Waiting Time Coordinator (or Admission Clerk) for 'booking a patient onto a surgery list'.

The third point appears to indicate a lack of initiative in ensuring that AMOs are aware of the importance of completing RFAs. In comparison another Area, South Western Sydney, reported in 1998 that it had sent a letter:

> ... to all AMOs advising them of need to comply with 'minimum data required' for booking patients onto waiting lists[107].

Staff in the Area which conducted the review also stated that:

> The term 'guidelines' when used as a title and description for the Guidelines may cause difficulties ... in requiring AMOs to follow the required procedures contained within, as the AMOs might consider 'guidelines' to be advisory and not a requirement, as in the case of 'policy'[108].

However, since early 2001 NSW Health circulars have included a statement:

> In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health[109].

As the guidelines have been issued under circulars, this indicates clearly that they are 'policy':

> ... policy is taken to mean a document that contains material that is expected to be known by relevant staff and implemented by the New South Wales public sector health system[110].

A more fundamental problem was also noted in this review:

> Admission Office staff who collect and process the RFAs from AMOs often feel intimidated, or believe it is not their place, to seek clarification from the AMOs about the RFAs[111].

This also demonstrates a lack of initiative in ensuring patient welfare. Admission staff and waiting time coordinators in other hospitals visited face similar problems, but made clear their willingness to raise them with AMOs. In most cases they reported that problems with RFAs were readily rectified by such consultation.

The guidelines do not describe the circumstances under which patients can be staged or deferred, and hence become 'not-ready-for-care'. However, *Instructions for the New South Wales Waiting Times Collection* contain adequate complementary information[112].

The guidelines do detail comprehensively the steps which should be undertaken to monitor and report 'not-ready-for-care' patients[113].

Clinical Audit

Clinical audit procedures, conducted by a surgeon, provide assurance that patients have been given the appropriate priority for treatment, based on their medical condition.

Senior Department management had noted during the audit that urgency priority statistics are distorted by:

> ... the small number of doctors that code inappropriately[114] ...

To identify such anomalies the Department produced benchmark data in order to analyse the clinical priorities assigned by different doctors for similar procedures[115].

The guidelines specify clinical audit of patients in a number of circumstances, and particularly for 'long-wait' patients:

> 3.1.1 Clinical Priority
>
> ii. For cases that require review if not treated within a certain time frame (e.g. tonsillectomy, arthroscopy), a time for clinical review should be determined when being placed on the list. This review should be undertaken by the General Practitioner in consultation with the referring medical officer.
>
> 3.2 Patient Focus
>
> iv. Patients who have a long waiting time should be given special consideration, including a review by their Attending Medical Officer to verify clinical urgency and the exploration of options to expedite their admission.

However, management in some Areas advised of difficulty in conducting clinical audits because of the absence of suitably qualified local doctors to conduct the audits, and, in some cases, tensions between Area administration and surgeons.

Clerical Audit

The guidelines provide for a clerical audit of booked patients:

> Each Area/hospital is required to audit to ensure an accurate and complete waiting list and to report to management the results and areas of concern[116].

Clerical audits are conducted by a Waiting Time Coordinator or by hospital admission staff.

Most of the Areas and hospitals visited had shown evidence of compliance with the guidelines. However, the review mentioned above reported that:

> The guidelines require audit procedures to be undertaken as part of the waiting list process [but] a number of required management reviews are not being undertaken, thus failing to provide [Area] management with assurance that the waiting list figures are accurate ... prior to this review [Area] Internal Audit did not undertake any review or audit procedures in respect of the waiting list process[117].

Furthermore, Operating Theatre reports provided by one of the five hospitals at which evidence was found of misreporting reveal frequent postponement of elective surgery for the following reasons:

- patient has work commitments
- patient undecided to go ahead with surgery at this stage
- patient changed mind and decided to be a private patient
- patient decided he no longer needed surgery as pain gone
- patient has already had surgery
- patient did not want to have the operation
- patient's mother called to say 'he is well and does not require the procedure'[118].

'Cancellations by patient' accounted for 15 per cent of total cancellations at this hospital, and 'patient did not arrive' for another 17 per cent.

Operating Theatre reports of other hospitals did not show a similar pattern of cancellation for patient-related reasons. It is unfortunate that the above cancellations were not detected by the hospital's admission procedures or by clerical audit. This may have avoided a late cancellation of surgery and any associated waste of resources.

Removal of Patients from List

The guidelines recommend a routine check of waiting lists to ensure that:

- patient contact details are correct
- the patient still requires the elective treatment, and has not already received treatment elsewhere
- the patient's booking is not duplicated on the list of another doctor
- the patient is 'ready-for-care'.

If the patient no longer requires treatment, has a duplicated booking or is unable to be contacted, he or she will be removed from the waiting list. This is referred to within the Department's statistics as a 'removal other'.

These changes are made in consultation with the patient's doctor to ensure that removal from the waiting list is consistent with the doctor's knowledge of the patient's clinical condition and other circumstances.

Over recent years 'removals other' have averaged 14 per cent of the number of booked patients having surgery[119].

Audit Observations

The Audit Office did not directly examine the accuracy of records upon which waiting lists are based.

Areas and hospitals visited as part of the audit conducted regular clerical audits as required by the guidelines, but others apparently do not.

The guidelines do not adequately address some issues, such as the circumstances under which certain procedures should be regarded as an elective or cosmetic procedure.

The Department's inquiry into waiting lists indicated that some elective patients had been reclassified, inappropriately, as cosmetic surgery patients. The effect of this practice is to exclude these patients from waiting list statistics.

The *Instructions for the New South Wales Waiting Times Collection* guide staff on the 'staging' and 'deferring' of patients.

The guidelines do not contain the same or similar information; nor are the guidelines cross referenced to the instructions in the interests of consistency of treatment.

We suggest the guidelines be clarified.

The Department has acknowledged that some doctors allocate clinical urgencies inappropriately, and has offered this as a partial explanation of the extent of 'overdue' U1 and U2 patients.

We suggest that:

- the guidelines be strengthened to reflect greater frequency and rigour of clinical audit
- the obstacles to clinical audit raised by some Area and hospital staff be simultaneously addressed.

Anecdotal evidence suggests that staff of the Area which initiated the consultant's review of its waiting list management processes do not understand, and in some cases did not comply with, waiting list procedures. If true, urgent remedial action is warranted.

Public and Private Patient Comparison

Around 20 per cent of patients undergoing elective surgery in public hospitals are private patients, either privately insured or self-paying[120].

The Department's guidelines do not differentiate between public and private patients:

> A waiting list is a list kept by the hospital which contains the names and details of people registered as requiring elective/booked admission ... These people may or may not have a planned admission date, and may be proposing to be public or private patients[121].

The Department's research suggests that, in general, privately-insured patients are twice as likely to be admitted to hospital for a wide variety of common surgical procedures than are public patients. The vast majority of private patients have these admissions at private hospitals[122].

Privately-insured patients also have the choice of either seeking private elective treatment, or having their procedure as a public patient. One factor in such a decision will often be the current waiting time at their local public hospital.

Perhaps because of this complexity, the Department has not made a major statistical comparison of waiting times for public and private patients since around the time of the 1995 Waiting List Reduction Program. Analyses done at that time and more recently have, however, indicated that there is no significant difference between waiting times for public and private patients in public hospitals.

Audit Observations

The intention of the Department's guidelines is that public and private patients should receive similar treatment in public hospitals. Despite its complexity, the Department should be able to routinely and regularly demonstrate that there is no difference in waiting times between public and private patients when they seek treatment at a public hospital.

Conclusion

While overall demand on the public health system is increasing, the number of elective medical and surgical procedures has fallen in the long term.

NSW Health has responded to an increased demand for health services by, for example:

- reducing the length of stay of patients in hospital
- increasing day surgery rates, and
- shifting patients to more efficient 'outpatient' care where appropriate.

Staff numbers have also been increased[123].

Yet the key measures of performance for elective treatment have deteriorated until recently as indicated in the following table.

	March 1997	March 2003	Change	Change %
Patients undergoing elective surgery (last 12 months)	201,882	187,952	-13,930	-7
Number on waiting list (medical and surgical 'ready-for-care')	63,363	67,011	3,648	+6
Average waiting time (medical and surgical) (months)	1.1	1.8	0.7	+64
Number of 'long-wait' patients (medical and surgical)	2,689	4,188	1,499	+56
Number of 'overdue' U1 and U2 patients (medical and surgical)	3,495	2,644	-851	-24

Waiting times for patients have improved in the last two years, but are still longer than they were five or six years ago.

The number of 'long-wait' patients has also fallen in the last two years, but may have been distorted by the alleged misreporting of 'not-ready-for-care' patient numbers. Changes in 'long-wait' and 'not-ready-for-care' patient numbers after January 2003 suggest that any such distortion had been partially reversed by the end of March.

Significant numbers of patients have been waiting for elective treatment for two or three years or more.

The number of 'overdue' urgent patients has increased steadily since early 1999 and at end of March 2003 represented 30 per cent of all urgent and high priority patients. Some of these patients have been waiting for over a year for elective treatment.

That targets in Performance Agreements have not been achieved over an extended period also raises questions of responsibility and of accountability.

The following chapters will review some of the barriers to improved management of waiting lists.

3. Funding Elective Surgery

3.1 Funding and Performance

Funding is arguably the most critical of all resources.

There will always be limits to the funds that can be applied to the public health sector in the face of competing demands for other government services.

The efficient and effective use of financial resources is therefore paramount.

The Director-General of NSW Health has annual performance agreements with the Board of each Area. These agreements require Areas to:

- deliver services within budgeted levels of funding, and
- meet service level targets related to the operation of Emergency Departments, elective surgery waiting times, hospital throughput, oral health, mental health, drug and alcohol services, etc.

3.2 'Global' Funding

The Minister determines the allocation of consolidated funding to Areas. The recommended allocation to Areas takes into account the Resource Distribution Formula (RDF) and the relative position of each Area.

The RDF:

- seeks to provide Areas with the capacity to meet demand in accordance with state-wide standards, but individual Areas have some discretion over how they will address particular issues
- is not used to determine how funds should be distributed between programs by any particular Area[124].

The RDF does, however, have recognised limitations. It does not reflect actual demand for elective surgery (or any other service) in any particular Area, and is dependent on the accuracy of the population data it uses to estimate demand[125].

The NSW Health Council has commented on the limitations of funding arrangements within NSW Health:

> A stronger link is needed between policy objectives, funding distribution and the way certain services are funded in NSW Health.
>
> We believe that the Department has a legitimate role to play in providing more direction in both areas. This is not to compromise the autonomy and flexibility of Area Health Services, but to ensure that the right funding incentives are consistently used to achieve the best outcomes for consumers.

> There is a need for greater consistency in the way certain services are classified in respect of the standards expected and the outputs intended. We believe there is currently a lack of transparency about the way that each Area Health Service allocates funds to services within its Area. This inhibits the analysis and management of variations in costs or priorities between Area Health Services[126].

Audit Observations

It is not possible to determine any clear relationship between the funding allocation process and the ability of Areas to achieve their elective surgery targets while meeting all others.

3.3 'Enhancement' Funding

The Department has provided to Areas, at the Minister's discretion, specific purpose funding termed enhancement funding. This funding has from time to time included specific targeted funding to improve hospitals' capacity to manage waiting lists.

There have been several waiting list enhancement funding programs over the years, including:

- a Commonwealth Hospital Access Program in 1993
- a program for prostheses (mainly artificial lenses, hips and knees) introduced in 1994
- the Waiting List Reduction Program from May 1995 to December 1995[127]
- Priority Access Strategy (PAS) commencing in 1997-98[128].

The exhibit below shows the amount of elective surgery enhancement funding[129] provided to Areas since the introduction of the *Waiting List Reduction Program*.

1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03
-	$30.1m	$67.0m	$30.1m	$40.1m	$40.1m	$40.1m

1997-98

NSW Health allocated $30 million to Areas as enhancement funding in 1997-98 based on the following performance indicators:

- waiting times (average time on list, average waiting time and clearance time)
- percentage of U1 and U2 patients waiting more than 30 days
- percentage of patients waiting longer than 12 months
- variation in lists between March 1995 and March 1997, and
- best practice performance[130].

1998-99 and 1999-2000

A similar process for enhancement funding was followed for the next two years. Funds provided for 1998-99 were increased by $36.9 million[131].

2000-01

Additional funds of $10 million were approved for 2000-01, 2001-02 and 2002-03, bringing the total for each of these years to $40.1 million[132].

$30.1 million per year continues to be allocated as described above. The additional $10 million is, however, based upon the RDF formula, and as such cannot be directly related to waiting list performance.

There are acknowledged disadvantages to enhancement funding:

- The average cost of enhancement-funded elective surgery can be as much as 50 per cent higher than normal elective surgery[133]
- the 'stop-start' nature of earlier enhancement funding programs stretched resources while funding was available, and under-utilised resources at other times
- demand was encouraged.

The Department claims that the most recent strategy adopted, in conjunction with the three year budgetary cycle, has attempted to overcome these disadvantages by taking a longer-term approach.

The Priority Access Strategy also attempts to reduce the risk that an Area may allocate a disproportionate share of global funds to health care programs other than elective surgery in the knowledge that any deterioration in the waiting list will be addressed by enhancement funding[134].

Audit Observations

Since the introduction of growth and enhancement funding:

- the number of 'long-wait' patients and most measures of waiting time have improved
- 'overdue' U1 and U2 patient numbers have continued to increase since 1999
- the zero 'long-wait' target set for January 2003 was not achieved.

That enhancement funding is necessary suggests that an appropriate long-term balance has not been achieved between:

- the demand for elective surgery
- management of waiting lists and elective surgery resources
- the outcomes sought for elective surgery, and
- funding to all programs of health care using the Resource Distribution Formula.

Despite significant amounts of enhancement funding over the long term, 'long-wait' patient numbers and waiting times have fluctuated widely. This volatility has implications not just for the welfare of patients, but for the availability and use of financial, human and physical resources.

3.4 Growth Funding[135]

Commencing in 2000-01, all Areas received additional funding known as 'growth funding' intended to:

- increase the level of funding in real terms to those Areas which have been identified as receiving less than their appropriate RDF share, and
- provide additional funds to:

  ... improve the quality of patient care and relieve pressure on staff in the health system dealing with ever increasing demands[136].

Areas were required to develop and submit to the Department individual project proposals for the allocation of designated growth funds. Areas were required to consider, on a priority needs basis, the application of the available growth funds to meet the demand for a range of programs and activities within the Area. Proposals were ultimately submitted to the Minister for approval.

The majority of Areas applied some available growth funding to reducing numbers of 'overdue' or 'long-wait' elective surgery patients.

The following exhibit shows the estimated growth funds allocated by Areas towards elective medical and surgical procedures since growth funding was introduced.

2000-01	2001-02	2002-03
$4.6 million	$24.5 million	$60.2 million

Audit Observations

The allocation of growth funding to elective surgery reflects the internal priorities and project proposals of individual Areas.

The process has the advantage of rigour, in that it requires Areas to:

- develop a 'business case' to demonstrate that funds to be allocated to elective medical or surgical treatment offer an appropriate return on investment
- demonstrate appropriate priorities across all programs.

Improvement in waiting times and in 'long-wait' numbers has coincided with the introduction of growth funding. However, as growth funding and enhancement funding have overlapped, and as the Department has done no evaluation of either program, it is not possible to infer how, if at all, this supplementary funding has improved the ability of Areas and hospitals to manage their waiting lists.

Furthermore, as already demonstrated, overdue U1 and U2 patient numbers have continued to increase.

Conclusion

Funding for elective surgery has evolved over the years from an RDF-based global allocation to Areas to meet a range of needs to enhancement funding which specifically targets the waiting list to growth funding for particular initiatives identified by Areas. Areas currently receive the bulk of their funding as a global allocation 'topped up' by enhancement and growth funds.

The Department has attributed the volatility in the management of waiting lists over the last nine years to two factors:

- waiting list reduction programs, the first of which had a significant start/stop component, and
- the large changes in private insurance and workload shift between public and private hospitals, and the instability introduced from the Commonwealth's health insurance changes[137].

The first factor is within the control of the Department, and the growth funding mechanism, in conjunction with recurrent funding approaches, is intended to address the 'stop / start' disadvantages.

The second factor depends on the ability of NSW Health to plan and fund programs in the context of a changing environment.

We suggest the Department develop a funding mechanism which more directly and transparently links funding with the demand for services in the context of a regime of:

- performance indicators to measure efficiency and effectiveness and
- accountability for performance by Areas.

4. Capacity and Organisation

4.1 Available Capacity

Capacity Planning

International literature[138] recognises the need to optimise hospital capacity relative to demand.

The Department, as part of its service and capital planning processes:

- estimates capacity requirements for emergency and elective procedures
- conducts scenario planning for service developments and changes in supply to achieve other system goals such as improved equity and access[139].

The processes produce an estimate of the number of beds required to meet expected demand across New South Wales[140].

The number of beds in the New South Wales public health system has fallen by 20 per cent between 1994 and 2002[141]. However, increasing the number of beds is not necessarily the most appropriate single response to apparent capacity restrictions:

> ... we believe that better access to public hospitals and better quality of care can be achieved through improved utilisation of hospital beds, rather than through increasing numbers of hospital beds[142].

Clinical and operational improvements have reduced the average length of stay of patients in hospitals and increased bed utilisation[143]:

	Average overnight length of stay (days)	Average overnight bed occupancy rate %
1989-90	7.88	72.9
1990-91	7.61	72.4
1991-92	7.49	73.4
1992-93	7.30	75.1
1993-94	6.91	79.6
1994-95	6.86	79.8
1995-96	6.72	82.9
1996-97	6.74	80.3
1997-98	6.61	81.4
1998-99	6.46	82.5
1999-2000	6.33	83.4
2000-01	6.38	85.2
2001-02	6.40	85.0

But there are practical limits to how far productivity can be increased without incurring bottlenecks:

> Recent research indicates that hospitals with average occupancy levels above 85 per cent can expect to have regular bed shortages and periodic bed crises[144].

Operating Theatre Capacity

In general, operating theatres are staffed weekdays and are closed during the Christmas holiday season. All hospitals hence have spare theatre capacity.

> ... there is approximately 40 per cent spare capacity at the moment in Auburn [hospital] ...
>
> ... there is 25 per cent spare Operating Theatre capacity at Mt Druitt [hospital] which would be ideally suited to low complexity elective surgery ...
>
> ... there is 37.5 per cent spare operating theatre capacity at Blacktown Hospital that would be suited to a range of elective surgery and increase the ability to effectively schedule emergency surgery[145] ...

Some stakeholders believe that long waiting times are the result of insufficient operating theatre sessions:

> Orthopaedic surgeons in Australia are being denied access to operating theatres in public hospitals and waiting times for surgery are blowing out as a result, a leading doctors group claimed today.
>
> A survey of 550 orthopaedic surgeons carried out by the Australian Society of Orthopaedic Surgeons found that Australian orthopaedic surgeons were willing and able to operate another 80,000 to 120,000 hours a year in public hospitals, if they could get the theatre time.
>
> The survey found that orthopaedic surgeons had, on average, access to only five hours operating theatre time a week in public hospitals, but wanted, on average, eight hours a week[146].

Discussions with Area and hospital management confirmed that operating theatre capacity was not, of itself, a constraint. The ability to perform additional operations depends on:

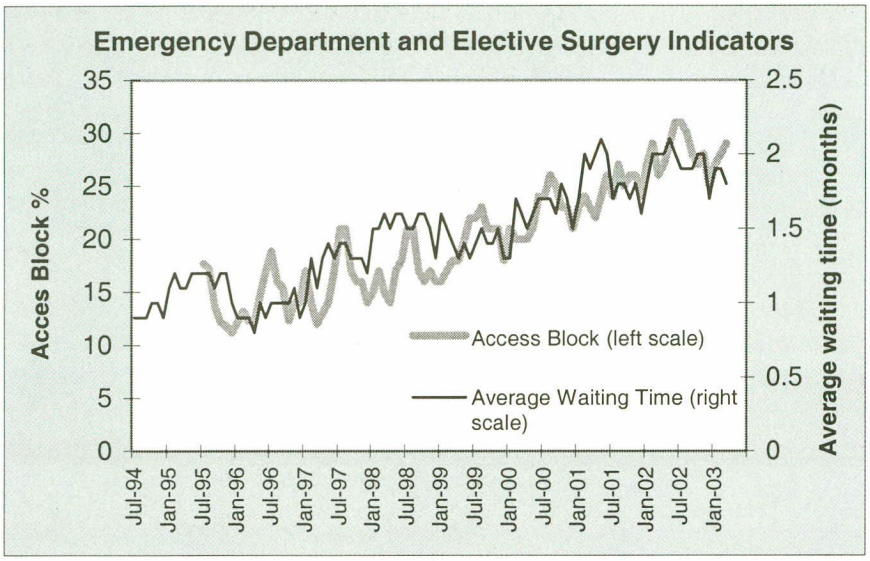
- availability of funding for additional operating theatre sessions
- availability of surgeons, anaesthetists and nurses to staff them, and
- availability of sufficient beds at the time required.

Audit Observations

There is a gap between demand for health services and the capacity of the public health system.

This is evidenced, in part, by the fact that the number of booked patients receiving elective treatment is actually falling, yet the available capacity appears unable to prevent deterioration of waiting times.

The following exhibit indicates an increase in emergency department access block[147] and waiting times for elective surgery[148,149,150].



This suggests that the Department's capacity planning is unable to keep pace with the increasing demand for emergency department admissions.

4.2 Human Resources

Personnel Shortages

In many Areas, particularly rural, there are shortages of surgeons, anaesthetists and nursing staff. These shortages are not confined to NSW Health, but are national and, increasingly, worldwide.

Shortages of surgeons were most frequently mentioned in the orthopaedic, ENT and ophthalmology specialities.

As part of the audit, five Areas were asked to complete a questionnaire which included questions on the adequacy of their personnel levels to meet elective surgery waiting time and activity targets. The results are summarised below.

Nurses	▪ Two Areas reported adequate numbers ▪ One was uncertain whether it would have enough nurses ▪ One Area reported a shortage of approximately 390 nurses in total (100 in direct surgical services) and another a shortage of 30 nurses.
Specialists	▪ Two Areas reported adequate numbers ▪ Two were uncertain whether they would have enough specialists ▪ One reported a shortage of two specialists.
Anaesthetists	▪ Four Areas reported adequate numbers ▪ One was uncertain whether it would have enough anaesthetists.

Overcoming Shortages: Short Term

Areas can respond to shortages in a number of ways.

In the short term, hospital employees can work overtime. However, long hours of work are already common in hospitals, and imposing additional overtime pressures has serious implications for both efficiency and for staff welfare.

Some hospitals use locums to fill casual vacancies. There are some negative aspects of this practice:

- locums are more readily available in metropolitan areas than in rural areas
- locum daily rates can be expensive, and on-costs usually include travel to and from the Area, car and accommodation
- demand for locums exceeds supply, and some Areas complained that costs are bid up by competition between Areas and with the private system.

Locums are not always available for post-operative consultation with patients because their appointments are short term. Some staff and surgeons stated that this has caused dissatisfaction amongst permanent clinical staff.

Areas are also able to recruit overseas medical practitioners under the *Area of Need* program. However, this is a temporary measure only:

> The New South Wales Department of Health makes a significant contribution to addressing medical workforce shortages through the Area of Need program. The program enables the recruitment of suitably qualified overseas trained doctors into a declared Area of Need position, on a temporary basis, while efforts to attract a medical practitioner with general registration on permanent basis continue[151].

Overcoming Shortages: Long Term

The Department has been active in attracting nurses back into the workforce to alleviate acknowledged shortages:

> [The 'Nurses Re-Connect Initiative'] was designed to attract nurses who were currently registered, or enrolled but not nursing, back to the profession ... Since the initiative has commenced it has recruited over 600 nurses. The initiative is a major step in reducing the strain on New South Wales public hospitals caused by the acute, international nurse shortage[152].

However, while shortages of nurses persist, overall NSW Health staff numbers have been increasing[153].

The Australian Medical Workforce Advisory Committee (AMWAC) conducts workforce reviews to identify the required clinical workforce at national and State levels and monitors progress towards achieving the recommended workforce levels.

Its *Workforce Reviews: Summary of Implementation of Recommendations*[154] reported a 'definite shortage' of anaesthetists and 'likely imminent shortages' of ENT and orthopaedic surgeons.

Training is provided in hospital training positions which are accredited through the Royal Australasian College of Surgeons and funded by the hospital[155].

Training of anaesthetists:

> ... remains on track to have all recommended increases in training placements in place by 2006[156].

However, of ENT surgeon positions, AMWAC commented that:

> Only six new training positions have been created since 1997. This number of new positions is 14 short of the recommended target of 60 by the end of 2000. In part this reflects funding difficulties within State health authorities[157].

New South Wales had 14 ENT training positions in 2000, compared to the AMWAC recommendation of 21.

Training positions for orthopaedic surgeons are also below recommended levels:

> The level of first year trainee intake in 2000, and that expected in 2001, is below the AMWAC recommendation but the [Royal Australasian College of Surgeons] has advised that the output from those years will be boosted ... This will need to be monitored closely to ensure that ... trainees from overseas enter and complete the training program as expected[158].

The Chair of the Australian Competition and Consumer Commission (ACCC) reinforced concerns about the adequacy of the future number of surgeons:

> ... several factors suggest that 'there could be a severe shortage of surgeons in the coming years'.
>
> These included the ageing population and surgical workforce, the rise in early retirements by surgeons, and the reluctance of younger surgeons - particularly women - to work the profession's traditionally long hours.
>
> ... existing processes gave the college significant influence over surgeon numbers. Trainee numbers were limited by hospital training posts that meet college standards and overseas surgeons faced limitations[159].

Specialist Colleges control the accreditation and training of specialist doctors. The supply of specialists is a complex issue:

> The President of the Royal Australasian College of Surgeons said the college 'rejected the suggestion that numbers are being deliberately held down for commercial advantage'.
>
> He said the control over training numbers lay with the state governments which funded the positions.
>
> This year there were 100 more people ready to do surgery training than the 200 positions available, the President said[160].

Some Areas related problems in achieving agreement with College representatives on the number of surgeons required to meet the demand in their Area.

Audit Observations

While the Department is active in recruiting nurses to 'reduce the strain' on public hospitals, it appears likely that there will continue to be shortages of clinical professionals. This will continue to constrain the system's ability to meet demand and achieve elective surgery targets.

4.3 Sustaining Service Delivery

The exhibit below indicates a disparity between the rate at which surgeons at a particular hospital:

- add patients to the waiting list
- provide surgery for patients they have placed on the waiting list.

The disparity has implications for patient welfare. If patients are added to the waiting list at a rate faster than they receive surgery, they will be likely to become overdue for surgery, and perhaps eventually 'long-wait' patients.

Over the last 2 years other removals from the waiting list (e.g. because the patient no longer needs surgery, or has had it elsewhere) accounted, on average, for an additional 14 per cent of the number of elective patients admitted to surgery.

In addition, it is to be expected that some patients will change priority, e.g. from U8 to U2, if their condition is deteriorating and the need for surgery becoming more urgent. However, this analysis demonstrates strong evidence of imbalance between the rate at which some patients are added to the waiting list and the rate at which they receive surgery.

Albury Base Hospital[161]: Added and Admitted Rates for all Specialties (Year ended 30 June 2002)												
Specialty	U1 and U2			U7			U8			U9		
	Add Rate	Admit Rate	Admit/ Add %	Add Rate	Admit Rate	Admit/ Add %	Add Rate	Admit Rate	Admit/ Add %	Add Rate	Admit Rate	Admit/ Add %
ENT	104	100	96	201	172	86	27	25	93	1	3	300
General	520	525	101	238	190	80	92	74	80	78	41	53
Ophthalmology	18	18	100	33	19	58	218	165	76	1	10	1,000
Orthopaedic	163	182	112	151	34	23	253	59	23	45	37	82
Plastics	97	90	93	45	53	118	53	23	43	7	9	129
Urology	251	243	97	93	80	86	56	43	77	35	26	74
Vascular	22	20	91	17	14	82	2	1	50	2	1	50
Dental	31	30	97	43	62	144	33	60	182	2	5	250
Other	221	209	95	27	22	82	9	9	100	165	164	99
Total	**1,427**	**1,417**	**99**	**848**	**646**	**76**	**743**	**459**	**62**	**336**	**296**	**88**

Notes: a number of patients added to the waiting list in the period
b number of patients admitted for elective surgery after being on the waiting list in the period
c admit rate/add rate

The exhibit above shows that, on average, U1 and U2 patients were admitted to surgery at 99 per cent of the rate at which they were added to the waiting list. The number of U1 and U2 patients on the waiting list, and their average waiting times, would therefore be expected to remain stable.

On average, U7 patients were admitted to surgery at 76 per cent and U8 patients at only 62 per cent of the rate at which they are added to the waiting list. The waiting list for these priorities would be expected to increase, and waiting times to lengthen commensurately.

The lowest admitted rate for U7 and U8 patients is for orthopaedic surgery. On overage, only one orthopaedic patient was admitted for this type of surgery for every four added to the waiting list.

The waiting list for orthopaedic patients would hence be expected to grow rapidly and waiting times to lengthen accordingly.

Comparison of Albury Base Hospital's 'long-wait' performance by specialty with New South Wales averages confirms this concern. While orthopaedic 'long-wait' patients represent 34 per cent of all 'long-wait' patients in all New South Wales public hospitals[162], for Albury Base Hospital they represent 97 per cent of all 'long-waits'[163].

When the performance of the five orthopaedic surgeons is examined in detail, further disparity can be observed.

Albury Base Hospital: Performance of Orthopaedic Surgeons (Year ended 30 June 2002)									
Surgeon[164]	U1 and U2			U7			U8		
	Add Rate[a]	Admit Rate[b]	Admit/ Add[c] %	Add Rate[a]	Admit Rate[b]	Admit/ Add[c] %	Add Rate[a]	Admit Rate[b]	Admit/ Add[c] %
Surgeon A	22	25	114	28	10	36	62	11	18
Surgeon B	36	37	103	20	11	55	50	13	26
Surgeon C	6	9	150	10	2	20	48	11	23
Surgeon D	64	75	117	63	5	8	60	6	10
Surgeon E	35	36	103	30	6	20	33	18	55
Total	**163**	**182**	**112**	**151**	**34**	**23**	**253**	**59**	**23**

Surgeon D added 123 U7 and U8 patients to the waiting list, but only operated on 11 patients. Hence this surgeon performed surgery on only one in ten of the patients which he or she added to the list.

Together, the five orthopaedic surgeons added 404 U7 and U8 patients to the waiting list, but only operated on 93.

The waiting list for orthopaedic patients will inevitably grow under these circumstances, and the patients will almost automatically become 'long-wait' patients.

One of the five Areas, in responding to the questionnaire's inquiries on changes which would improve ability to meet waiting time targets, suggested:

> ... acknowledgement by surgeons of their responsibility to continue management, including periodic reviews of patients whom they have placed on their list and [who] may have an inappropriate wait.

It suggested that Areas should have:

> ... contractual capacity to ensure surgeons only book the number of patients [on which] they have the contracted hours to operate, and/or are prepared to be available.

Audit Observations

Hospitals have no direct control over:

- the number of patients being added to the waiting list at the instigation of surgeons
- the clinical priority allocated to patients by surgeons.

A surgeon's ability to book more patients on the waiting lists than he or she has the contractual (and often personal) capacity and legal[165] responsibility to treat may place a burden on hospitals beyond their existing operational capacity.

This analysis shows that, at the hospital concerned, some surgeons have added patients to the waiting list up to ten times faster than they operate on them. Patients in the specialty of these surgeons represent 97 per cent of 'long-wait' patients at that hospital, whereas at other hospitals they average 34 per cent of 'long-waits'.

We suggest the Department:

- encourage Areas to conduct similar analyses to ensure that doctors do not commit themselves, and hospitals, to unrealistic surgery workloads
- take steps to ensure that health system planning and operations reflect the capacity of surgeons and hospitals to treat all patients on the waiting list within benchmark times.

4.4 Improvement Opportunities

Some initiatives have shown potential to improve waiting times through better organisation and management, particularly of operating theatres:

> A six-month surgical trial at Auburn Hospital aimed at reducing the waiting times for hernia operations has proved so successful that surgeons ran out of suitable patients within four months ...
>
> This fantastic program was the idea of surgeons at Auburn Hospital ... [who] decided to give patients a guaranteed date for their surgery, pooled their waiting lists and established a standard 6½ hour operating list. The trial has had dramatic results:
>
> - waiting times for gall bladder removal dropped from 117 days to 71 days
> - waiting times for hernia removal dropped from 135 to 65 days
> - only one patient was cancelled, and this was due to a surgeon falling ill
> - twice as many patient were handled in a given time compared to standard procedures
> - there were significant reductions in length of stay required
> - the new procedures were cost effective in the order of 15 per cent cheaper than normal[166].

Audit Observations

The media release indicates that the trial at Auburn Hospital has achieved improvements in costs, waiting times, productivity and length of stay.

Funding through the Greater Metropolitan Transition Taskforce of $9.441 million has been allocated for surgical improvements in district hospitals such as the Auburn trial[167].

The Department needs to encourage widespread adoption of innovative practices which offer proven improvements in waiting list management and reductions in waiting times. Greater Metropolitan Transition Taskforce funds need to be applied to such improvements.

Conclusion

The number of patients undergoing booked medical and surgical treatment has declined, yet waiting times have increased. One explanation of this is a mismatch between the demand for services and the capacity of the public health sector to meet the demand.

The deterioration in elective surgery performance over the long term (especially average waiting times and overdue U1 and U2 patient numbers) undermines the credibility of the Department's targets.

It is not possible to conclude whether or not failure to meet targets[168] has been primarily caused by shortage of human resources. The Department needs to ensure that performance targets are achievable and reflect expected levels of activity, competing priorities of other programs, and the numbers of doctors and nurses which it expects to have available.

Most shortages of doctors are long-term, and are outside the control of Areas. These can only be addressed through coordination between the Department, the Commonwealth, and the Specialist Colleges.

There is evidence some surgeons add patients to their waiting lists much faster than they operate on them. We suggest the Department needs to ensure the practice is not widespread.

The Department needs to encourage sharing of experience and of best practice. Projects such as the Auburn trial, which offer potential for significant improvements in efficiency and in patient welfare, need to be rigorously evaluated and, if of demonstrable benefit, adopted widely.

5. Information and Information Systems

5.1 Good Information: Good Management

Objectives

Each organisation must tailor its information and systems to the needs of users at various levels.

Objectives common to all systems are to support:

- the responsibility for the management of resources
- management decision making
- day to day operations
- decision support for clinical processes.

A management framework is needed to cater for the responsibilities of managers.

The framework should incorporate clinical, financial, operational, and management reports to produce information that is relevant, timely, accurate, complete and aggregated according to the needs of a range of users.

Organisational Performance

Organisational performance can be improved by better use of information which provides:

- better support for strategic planning, organisational change, benchmarking and the identification of best practice
- increased efficiency and timeliness of information
- cost reductions from improved reporting, analysis and benchmarking
- the ability to relate information from different sources and thereby improve the relevance of information for improving performance and decision making
- rationalisation of data and increased integrity of data in reports.

Organisations such as NSW Health will also benefit from information which better supports clinical decision-making.

5.2 Information Systems

Strategic Initiatives

NSW Health's *Information Management and Technology Strategic Plan* of December 2001 includes the following planned outcomes:

> - ... clinicians [will] have access to high quality, timely information when it is needed to diagnose a patient's condition, and to develop treatment plans to bring about the best possible outcome for the patient
> - information is available to support best practice and evidence based medicine
> - access to information is improved, both to clinicians and to the community
> - better information is available to inform service planning and management of resources to enable the health system to respond effectively to the dynamic social, political and technological environment[169] ...

A report of September 2002 by NSW Health titled the *Operating Theatre Management Project Report* has referred to the potential benefits of improved management information systems:

> Improving the management of planned admissions, better utilisation of beds, structured discharge planning and widespread use of clinical pathways were strategies designed to improve access and quality of care.
>
> Access to and blockage in emergency services and waiting lists are closely related to managing the demand for operating theatres, demand for intensive care unit beds and demand for beds in wards[170].

In terms of elective surgery, the report identified opportunities for improving management through:

- forecasting utilisation of operating theatres
- waiting list management
- operating theatre session management
- bed management
- elective surgery management
- discharge management
- post-hospital management[171].

The report's recommendations, which have not yet been implemented, include (inter alia):

> 1. Area Health Services and hospitals apply the *Integrated Operating Theatre Management Framework* to review operating theatre management processes.
>
> 2. Area Health Services and hospitals develop strategies for improving practices in utilisation forecasting and management of waiting lists, sessions, elective and non-elective surgery, intraoperative and discharge and post-hospital planning.
>
> 3. NSW Health, through an industry network, facilitate the collaborative development of continuing better practices for operating theatre management[172].

Current Practice

Areas use different systems and formats for:

- patient admission management
- patient information management
- operating theatre planning and reporting.

In some Areas (for example South Eastern Sydney and Hunter) hospitals are not able to exchange patient data electronically because they use patient administration systems which are not compatible[173,174].

It is necessary for patients being transferred between hospitals to be discharged from one hospital and admitted to another. Where there are two different Patient Administration Systems, this requires the patient details to be re-entered in the receiving hospital's system. Hospitals then confirm these arrangements by telephone.

Operating Theatre information systems vary across sites, and there is, as yet, no strategy to rationalise these[175,176]. However there is a strategy to standardise information definitions and performance indicators.

Some Areas face more fundamental software problems. For example, the ORSOS software used by certain hospitals for monitoring operating theatre performance is no longer supported in Australia.

The lack of integration of computer systems mitigates against:

- opportunities to benchmark and thereby effect improvement
- Area and state-wide efforts in managing and improving elective surgery in all hospitals.

In particular, the wide variety of operating theatre systems in use is a significant constraint and mitigates against:

- detection of patterns of regular cancellation of elective surgery (such as demonstrated in *2.10 Guidelines and Procedures*), and
- identification of best practice.

As noted above NSW Health has identified some opportunities for improving management information systems. However, the timetable for funding and implementation appears uncertain.

For example state-wide deployment of the new Patient Administration System (which is necessary before 'outpatient' waiting times can be monitored) is not scheduled for completion until 2006, as is 'results reporting within and between Areas'[177].

The NSW Health Council has identified similar deficiencies in the information systems of NSW Health:

> ... both NSW Health and the State's health system have fallen behind many other industries where information technology has revolutionised responsive and effective client service. This is evidenced by the comparatively low rate of investment in information technology in NSW Health, where expenditure is less than one per cent of budget ...
>
> - ... there are a number of legacy systems which have been developed over many years but which are incompatible, do not allow for the transfer of information between providers, and/or do not provide a complete record of a patient's history
> - there are inconsistent standards for coding and classifying patient information and clinical information ...
> - there are variations in work practices that impede the introduction of more uniform systems[178] ...
> - information cannot be transferred between hospitals. Although each hospital has a patient administration system, its data capture is confined to that hospital. In some cases information cannot be transferred between different parts of a hospital, for example from Emergency department to a ward or the ICU[179].

5.3 Information on Costs

Program Structure and Reporting

Elective medical and surgical treatment is split between two different programs[180].

This limits the ability to 'drill-down' through programs to analyse expenditure at activity level.

Costs of elective surgery were estimated for this audit by multiplying the number of patients who have undergone treatment by the 'average' cost for the procedure. The number of patients is available relatively promptly, but 'average' costs are calculated using the Hospital Cost Data Collection process[181], and results of this census are not available until at least six months after the end of the financial year[182].

The time lag means that there can be no real time financial data on elective treatment. Hence while waiting list performance statistics are available within a few days of month end, there is no facility for linking these with financial data in any timely sense.

Costing Systems

Hospitals use two methods to measure costs of surgery:

- 19 hospitals use patient-level or clinical costing, which collects costs associated with the treatment of individual patients
- 67 hospitals rely on a cost census (annual historical costs in conjunction with cost modelling) to determine current costs of surgery[183].

These methods differ in costing accuracy and in timeliness. Patient costing systems are potentially more accurate and timely, but require a significantly greater level of investment, which may not be appropriate for many small hospitals[184].

However, the existing computer application system used to provide most patient level costing, Trendstar, has a limited life:

> ... the technology base of Trendstar is obsolete and the product will not be supported by the Vendor in the long term[185].

NSW Health's present costing systems have other shortcomings:

> The current systems configuration does not deal with all current needs ...
>
> ... Quality control processes need to be developed and implemented as part of the overall costing systems strategy. Factors that could impact on data quality include:
>
> - a lack of standardisation in accounting practices and procedures
> - inconsistently applied Chart of Accounts
> - inconsistency in the application of current costing standards
> - insufficient or inadequate audit, and
> - insufficient investment in the training of staff that operate costing systems[186].

Variations in Cost

The same procedure in hospitals of the same peer group[187] should show a degree of consistency and comparability in cost.

However, costs of a sample of surgical procedures conducted in different hospitals of the same peer group[188] were observed to vary widely:

- the cost of a Carpal Tunnel Release at Belmont Hospital is 8 times that at Goulburn Base Hospital
- the cost of a Tonsillectomy/Adenoidectomy at Tweed Heads is 3 times that at Maitland
- the cost of a Male Sterilisation at Shellharbour is 2.4 times that at Grafton.

Such variations may be a result of:

- variations in volume and mix of elective and emergency surgery
- variations in costing arising from:
  - different cost centre structures across hospitals
  - different level of devolution of certain costs, e.g. pathology and pharmacy, to cost centres
  - different approaches to attributing component costs across Diagnosis Related Groups[189]
- different medical practices or protocols for the same procedure.

The NSW Health Council report had also expressed concern about cost variation:

> We are concerned that a hip replacement in one hospital can cost up to 1.5 times more than in another hospital of similar size and function, with no discernible difference in quality of care or severity of condition[190].

A potential implication of such variation in costs is that a hospital with higher costs will have less scope to carry out the same number of operations as a hospital with lower costs, all other things being equal:

> ... the extra costs incurred because of this apparent inefficiency result in a reduction of other patients' access to services[191].

The wide variation in costs of these procedures, and the delay of at least six months in being able to compile such cost data, limits the ability to compare budget costs and levels of activity to actual on a timely and regular basis. This in turn limits NSW Health's ability to identify best practice and to reduce these wide cost and efficiency variations.

A standardised approach to the collection of costs is necessary to identify and promulgate best practice, to improve operational efficiency, and for consistent financial budgeting and reporting.

Strategic Directions for Health 2000-2005

Health's *Strategic Directions* includes, under a goal of *Better Value*,

> **Services are efficient**
>
> - Managers and clinicians work together to understand the link between cost, clinical practice and services provided
> - Funding for [Areas] is linked to the achievement of agreed levels of activity, based on the principles linking funding to activity and performance improvement
> - [Area] planning and decision-making are based on evidence of best practice, comparisons of results, trend analysis[192] ...

There is little evidence that the Department has in place information or information systems of sufficient timeliness or consistency to achieve these improvements.

5.4 Consistency of Process and Information

Operating Theatres

The efficient utilisation of operating theatres is an important component of service delivery.

There is, however, little consistency in the way the utilisation of operating theatres is reported[193]. Reports for some hospitals in the same Area differ in format and content. Systems, or software, do not consistently identify reasons for:

- the cancellation of operations or
- late starting times of operations.

Staff and doctors expressed concern that operating theatres were not available as planned:

> *Cancellation rates by reason* were identified as a potential key performance indicator, but no comparable data items or definitions across hospitals was available[194].

Others were concerned that late starting times impacted the efficient use of theatres. But:

> ... most facilities recorded session start and session finish times. However there was no data to identify the method or specifications used to define session time periods[195].

Some hospitals continue to collect and analyse data on operating theatre performance manually.

The findings of the Greater Metropolitan Services Implementation Group reflected the expectations of users:

> Improving the management of planned admissions, better utilisation of beds, structured discharge planning and widespread use of clinical pathways were strategies designed to improve access and quality of care. Access to and blockage in emergency services and waiting lists are closely related to managing the demand for operating theatres, demand for intensive care unit beds and demand for beds in wards[196].

Waiting Lists

One Area commissioned a firm of consultants to conduct a review of the waiting list processes at its hospitals.

The review identified a number of inconsistencies in the way in which similar tasks were carried out within the Area, and even in the way in which standard processes were implemented:

> There is limited consistency in roles and responsibilities of those involved in the waiting list process
>
> The format of the RFA forms is not consistent across the Area
>
> Waiting list performance data are not consistently reported to the Executive Directors of hospitals, and where the data are reported, the data cannot be compared to the data reported to NSW Health
>
> There are differing interpretations among some AMOs[197] and Admission Staff regarding the urgency classifications
>
> The Guidelines are not consistently applied across the Area[198].

The report found inconsistencies in interpretations of urgency classifications and application of guidelines and indicates possible reasons for this:

> Admission Office staff receive limited training and there is limited written policy and procedures ... there is lack of management and Internal Audit review in the current waiting list process, providing limited assurance as to the integrity of the information[199] ...

Consistency of Clinical Priority

To address its concern that some surgeons may be allocating inappropriate urgency codes, the Department undertook a benchmarking study[200]. This confirmed that clinical priorities assigned to the same procedures can differ markedly between surgeons[201].

Procedure Code (ICD10AM)	Procedure	By Doctor	Patients by Priority Category (%)			
			U1	U2	U7	U8
49318-00	Total arthroplasty of hip unilateral	Doctor A	0.0	100.0	0.0	0.0
		Average for all NSW doctors	2.8	15.1	29.1	53.1
49518-00	Total arthroplasty of knee unilateral	Doctor A	0.0	100.0	0.0	0.0
		Average for all NSW doctors	1.2	10.6	20.2	68.0
41789-01	Tonsillectomy with adenoidectomy	Doctor B	0.0	2.0	6.1	91.8
		Average for all NSW doctors	1.7	19.9	34.3	44.1

The benchmarking also reveals that all surgeons at one hospital assign priorities to some procedures which differ markedly from those assigned by surgeons at other hospitals.

Procedure Code (ICD10AM)	Procedure	By Doctor	Patients by Priority Category (%)			
			U1	U2	U7	U8
38212-00	Cardiac electrophysiological study 4 or more catheters	Average for all doctors at Hospital X	2.9	81.8	13.2	2.0
		Average for all NSW doctors	6.7	66.6	19.6	7.0
38218-00	Coronary angiography with left heart catheter	Average for all doctors at Hospital X	8.2	82.5	7.1	2.2
		Average for all NSW doctors	31.5	46.4	16.5	5.6

The Health Council had also questioned the consistency and appropriateness of some clinical decision-making:

> ... we question why a woman living in one Area is twice as likely to undergo a hysterectomy than women living in other Areas[202].

Clinical Priority Tools

Equity of access to elective surgery requires a consistent application of priority categories, particularly for more urgent priorities.

At present there are no state-wide assessment tools, guidelines or criteria to assist surgeons in allocating patients a priority category. Each patient's priority represents the surgeon's opinion of how long it is reasonable for the patient to wait for surgery.

If the priority allocated by a surgeon is unnecessarily urgent, then one patient may receive treatment at the expense of another with a more urgent condition.

If the patient waits longer for surgery than should be the case because of inappropriate priority, then it may increase risk to the patient.

Experience in Other Countries

In general the priority tools developed in other countries use a number of criteria such as:

- clinical urgency
- pain and distress
- potential for harm through delay
- loss of mobility, and
- disruption to normal life[203].

The tools are intended to discriminate between patients of differing levels of urgency and thus achieve transparency and consistency in treatment priorities and access to elective care. However, experiences so far in Australia and overseas indicate that waiting time priority tools offer only marginal improvement over present methods.

Conclusion

Different users within NSW Health have different information needs.

The Department has a need for aggregated information in order to provide advice to government, to report against budgets, and to monitor performance against targets.

Despite having similar information needs, particularly the ability to obtain patient-level information, and to improve the quality of 'outpatient' information, Areas use a number of different information systems with limited compatibility and little consistency. Electronic communication between hospitals and Areas is minimal. Ability to take an Area-wide or state-wide approach to managing elective patients is constrained. Opportunities for using benchmarking to identify best practice are restricted.

There are also significant time delays in extracting cost data at activity level. Consequently management do not have timely reports on costs linked to activity levels. This will persist while the Department relies on annual census to estimate costs.

NSW Health has identified a number of opportunities for improving management information system but these have yet to be implemented.

The wide variation in costs demonstrated suggests corresponding variations in efficiency. There appears to be a considerable amount of work to be done in identifying and eliminating unjustifiable variations in cost. However, the lack of consistency between information systems renders this task more difficult.

Until the differences in practice which underlie the differences in cost for elective treatment are eliminated there is a risk that the high-cost hospitals will not be able to carry out the same number of operations as their low-cost peers.

The Department should also consider whether its program structure (with elective treatment straddling two separate programs) inhibits its ability to ensure that program expenditure is applied efficiently and effectively at activity level.

Variations in waiting times between Areas for patients undergoing the same procedure with the same priority are likely to impact on equality of access to services. Inconsistencies in clinical priority may also have implications for patient care and therefore welfare.

In order to support clinicians in making consistent decisions about patient priority for treatment, the Audit Office suggests NSW Health continue to work with other jurisdictions in seeking practicable priority tools which can be applied consistently state-wide.

6. Measuring and Monitoring Performance

6.1 Performance Agreements

Targets

The Performance Agreement of Area Chief Executives is pivotal to organisational performance:

> Performance management for CEOs is related to both the overall performance of the organisation as well as the personal performance of the CEO ... The purpose of the CEO performance agreement is to document the key accountabilities and the local health priorities for planning and review purposes, including remuneration reviews, and to provide a framework for the performance agreements of the executive team[204].

A typical Area CEO Performance Agreement contains around 100 targets. Approximately 40 of these are quantified, of which seven relate to elective surgery.

The targets for elective surgery are:

Numbers of 'booked' patients on the waiting list:

- 'Ready-for-care' booked surgical patients (U1, U2, U7 & U8)
- Urgent medical and surgical patients (U1 and U2) waiting longer than 30 days (i.e. overdue)
- 'Long-wait' medical and surgical patients (U1, U2, U7 & U8).

Percentage of 'booked' surgery undertaken:

- on a day only basis
- on day of admission basis.

Percentage of 'booked' admissions experiencing:

- single delay
- multiple delays.

The performance of Areas against four of these performance agreement targets for elective surgery is shown in the following exhibit.

Performance Agreement Waiting List Targets and Actual Performance (year ended 30 June 2002)										
	'Overdue' Patients U1 & U2 > 30 days			'Long-Wait' Patients U1, U2, U7 & U8> 12 months			Delayed Patients		Multiple Delays	
Area	Target[a]	Actual	Variance	Target[a]	Actual	Variance	Target[a]	Actual	Target[a]	Actual
Central Sydney	250	343	-93	300	426	-126	3.0	4.2	0.02	0.02
Northern Sydney	110	148	-38	80	106	-26	4.0	6.2	0.05	0.08
Western Sydney	38	220	-182	250	391	-141	1.5	2.5	0.01	0.04
Wentworth	72	182	-110	150	531	-381	2.0	4.1	0.06	0.16
South Western Sydney	150	325	-175	115	528	-413	2.3	3.3	0.06	0.06
Central Coast	3	12	-9	300	330	-30	1.0	2.3	0.00	0.05
Hunter[b]	120	163	-43	180	103	+77	1.5	2.1	0.01	0.00
Illawarra	150	399	-249	343	650	-307	1.0	2.0	0.01	0.03
South Eastern Sydney	130	369	-239	550	501	+49	2.0	4.2	0.02	0.13
Children's Westmead[b]	18	33	-15	10	53	-43	2.0	3.5	0.07	0.00
Subtotal Metro	**1,041**	**2,194**	**-1,153**	**2,278**	**3,619**	**-1,341**				
Northern Rivers	30	166	-136	350	417	-67	1.5	2.1	0.01	0.06
Mid North Coast	75	298	-223	460	831	-371	1.0	1.1	0.00	0.01
New England	21	22	-1	33	89	-56	2.0	3.2	0.01	0.00
Macquarie	50	76	-26	80	313	-233	1.0	2.2	0.00	0.00
Mid Western	7	11	-4	75	93	-18	1.0	1.7	0.01	0.00
Far West	3	27	-24	0	5	-5	2.0	1.4	0.01	0.00
Greater Murray	14	52	-38	360	722	-362	2.8	3.8	0.10	0.09
Southern	5	16	-11	30	21	+9	1.0	3.1	0.00	0.00
Subtotal Rural	**205**	**668**	**-463**	**1,388**	**2,491**	**-1,103**				
NSW	**1,246**	**2,862**	**-1,616**	**3,666**	**6,110**	**-2,444**	**1.8**	**3.0**	**0.03**	**0.05**

Notes: a Area targets as included in 2001-02 Performance Agreements for June 2002

b Data above are for the full financial year. However, in respect of Hunter Area and Westmead Hospital, actual data for January 2002 were not available and were substituted by November 2001 data for Hunter and December 2001 data for Westmead.

The above exhibit shows that:

- none of the 18 Areas achieved all four of the waiting list targets reviewed
- 3 Areas achieved two of the targets
- 8 Areas achieved one of the targets
- 7 Areas achieved none of the targets.

The 1998 report of the Independent Pricing and Regulatory Tribunal of New South Wales (IPART) was critical of some aspects of performance agreements:

> Performance agreements have been developed in an attempt to clarify the respective roles of NSW Health and AHSs. While these agreements represent a significant improvement in performance monitoring, they are generally considered to be an excessively lengthy attempt to capture every micro accountability of an AHS. The performance agreements could be improved through the integration of:
>
> - a clear and timely suite of key performance indicators due to the long time lags in processing benchmarking data
> - an effective system of performance based rewards and penalties[205].

Quality of Forecasts

Each year Areas forecast their monthly 'long-wait' patient numbers. The exhibit below compares the forecast with actual numbers of 'long-wait' patients.

Month	Forecast[206]	Actual[207]	Variance %
July 2002	6,109	6,114	0
August	5,566	5,622	+1
September	4,734	5,318	+12
October	3,568	4,670	+31
November	2,386	3,786	+59
December	1,459	3,325	+228
January 2003	390	3,202	+721

Audit Observations

The actual number of 'long-wait patients' exceeded the forecasts by an increasing margin between July 2002 and January 2003.

Only two Areas, New England and Macquarie, achieved the forecasts of July to January[208].

The Department has advised that there was a surge in Emergency Department presentations in August and September 2002. This may have reduced the resources able to be dedicated to 'long-wait' reduction.

Notwithstanding this, the forecast reductions in 'long-wait' patients exceeded any past performance by a significant margin. On this basis the forecasts were optimistic and unrealistic.

The actual performance of CEOs in managing elective surgery waiting lists has not met Performance Agreements targets.

Furthermore, absence of specific targets for all elective patients, both 'ready-for-care' and 'not-ready-for-care', meant that an opportunity for detecting the atypical patterns of reclassification of patients as 'not-ready-for-care' was lost. Future Performance Agreements should incorporate such targets as safeguards against the risk of inappropriate adjustment of 'not-ready-for-care' patient numbers.

6.2 Public Reporting of Performance

NSW Health publishes information on elective surgery in its Annual Reports and on its website.

Website

The website information:

- displays waiting times for procedures by clinical priority, hospital and medical practitioner
- is intended to assist the public and medical practitioners.

Waiting times for Westmead Hospital have not always been included on the website:

> ... Due to problems with implementation of a computer system, information for doctors practising at Westmead hospital is not currently on this site, but will be made available as soon as possible[209].

As discussed above[210], the *Current Waiting Times and Lists by Specialties* published each month on the website shows the number of 'ready-for-care' patients on the waiting list, the number of surgical 'not-ready-for-care' and the number of 'long-waits'.

Accuracy of Data

NSW Health's website is intended to provide information to users other than the medical profession. It also advises users on the accuracy of its data:

> The waiting times listed are derived from historical data provided monthly and, as such, represent a retrospective and aggregated view of the actual amount of time patients have waited for admission to hospital. The times are not necessarily an accurate predictor of any one person's future wait.
>
> The best estimate of current and future waiting times may be obtained by consultation with your specialist or with the hospital where your booking has been made[211].

To ensure the accuracy of waiting times quoted on the website, medical practitioners are regularly sent reports of their waiting times for verification prior to publication. Some Areas have stated that few, or often no, doctors provide any feedback on quoted waiting times.

Doctors have a choice of receiving the *AMO Patient Details Report* or the *AMO Summary Report*.

The *AMO Summary Report* does not contain sufficient data to enable checking:

AMO:	Dr R			
Hospital:	Hospital M	Annual		
Urgency		Median waiting time	90th percentile waiting time	Annual Admissions
Procedure 020	Colonoscopy			
Total RFC		7 days	5 weeks	296
Urgent		5 days	3 weeks	7
Semi-urgent		13 days	5 weeks	285
Non-urgent		11 days	5 weeks	4

The *AMO Patient Details Report* does contain sufficient data, but doctors would need to be willing and able to commit additional time to analysing more voluminous data. One such sample report provided to the Audit Office showed the median and 90th percentile waiting times for 48 different procedures at one hospital for one doctor, all of which would have to be verified.

The Audit Office suggests that NSW Health:

- undertake a 'thorough and systematic consultation with current and potential users'[212] on a regular basis to ensure that website information meets the needs of users and is credible
- consider alternative ways of encouraging and facilitating verification of website waiting times by doctors.

Annual Reports

Annual Reports of NSW Health contain some information on elective surgery waiting times, usually reported under the heading *Booked Patient Access*.

This chapter comments on the completeness of that information for the three years 1999-2000 to 2001-02, having regard to the interpretation that a reasonable but uninformed reader would place on the information.

1999-2000

The 1999-2000 Annual Report includes the following comments on waiting times for elective surgery:

Booked Patient Access

With respect to patients who were not admitted within recommended times, the performance was urgent/high priority patients waiting less than 30 days (87 per cent of target); semi-urgent overdue patients on a list less than 90 days (83 per cent of target) and non-urgent patients on a list for less than 12 months (93 per cent of target). Area Health Services will be set targets for reducing the number of non-urgent patients on waiting lists for more than 12 months[213].

The report also refers to the performance targets of senior executives in managing waiting times in the following terms:

- 'reduction of long wait patient numbers'[214]
- 'met all activity and waiting time targets'[215], and
- 'all waiting time targets met'[216].

The information on waiting times in the 1999-2000 Annual Report is not clearly expressed, and presents a selective view of performance.

By only reporting performance at the end of the period, the comment omits important information on deteriorating trends:

- the number of 'ready-for-care' patients waiting longer than 12 months increased from 2,463 at the end of June 1999 to 7,581 by the end of June 2000, at that time the highest recorded level
- 'overdue' semi-urgent (U7) patient numbers increased from 3,571 at the end of June 1999 to 6,462 at the end of June 2000, an increase of over 80 per cent to the then highest recorded level
- the proportion of 'overdue' urgent and high priority (U1 and U2) patients increased from 20 per cent to 28 per cent during the year.

The segment in the Annual Report on senior executives' performance in managing waiting lists needs to be more specific and more consistent to enable readers to form a judgement about performance.

For annual reporting purposes, performance targets need to be identified and compared to actual performance in a consistent manner. Information on trends, rather than the result at the end of the period, may be relevant.

2000-01

The 2000-01 Annual Report includes the following comments on waiting times for elective surgery.

Booked Patient Access

Waiting lists for booked surgery reduced by more than 5,000 during 2000-01, while the number of patients waiting longer than 12 months remained relatively stable. Long-wait patient management is a focus for 2001-02[217].

The above extract refers to the 'stability' of patients waiting longer than 12 months for surgery.

Data maintained by NSW Health indicate that the number of 'long-wait' patients:

- increased from 7,581 at the end of June 2000 to 10,093 in January 2001, and
- fell to 8,225 by the end of June 2001 (or 8 per cent higher than at the start of the year).

The figures quoted in the Annual Report hence could be misleading.

The performance indicators reported in 2000-01 differ from those reported in 1999-2000.

For performance reporting to be useful there is a need for consistency of information between years of:

- performance targets in absolute terms
- projected levels of performance, and
- performance over time.

2001-02

The Annual Report for 2001-02 advises that:

> New South Wales waiting times for elective surgery are among the lowest per capita compared with other states[218].
>
> The number of patients waiting longer than 12 months for booked surgery was reduced by more than 2,100 during 2001-02. Long-wait patient management continues to be a focus for 2002-03[219].

The report lists strategies and achievements under each of six priority areas for health care identified for 2001-02 to 2002-03. The strategies and achievements do not refer to the *Fairer Access* goal or to elective surgery.

The claim concerning the reduction in the number of patients waiting longer than 12 months for elective surgery is correct and consistent with the focus on 'long-wait' patients reported in 2000-01.

The information given on performance is, however, selective. The number of 'overdue' U1 and U2 (urgent and high priority) patients increased from 2,414 at end June 2001 to 2,862 12 months later, an increase of 19 per cent. The Annual Report does not mention this deterioration in performance.

On this basis the information in the Annual Report could be misleading or may selectively inform readers.

Audit Observations

There is little information publicly available with which to convey an informed view of the efficiency and effectiveness of the management of waiting times by NSW Health.

AIHW and the Productivity Commission publish comparative data for all states and territories. However, the NSW Health website and Annual Reports offer no systematic data from which a reader can discern trends or performance over time, or performance relative to a benchmark. NSW Health's waiting times website does not link to AIHW statistics.

The only performance indicator for elective surgery consistently mentioned in NSW Health's last three Annual Reports is the number of 'long-wait' patients. Otherwise the performance information reported has not been consistent over the three years reviewed.

The public would be better informed on the management of elective surgery waiting times if an agreed suite of performance indicators were published regularly. This would ideally present performance by Area, and (perhaps through links to AIHW data) with the performance of other states and territories (where data are comparable).

6.3 Internal Reporting of Waiting Times

Reporting within NSW Health

At month end the Department compiles a report on Area performance against targets, which is submitted to the Finance and Performance Committee (chaired by the Director-General). The report is distributed to the Chief Executives Forum (formerly the Senior Executive Forum).

Any necessary subsequent actions, such as meetings with Area management, are arranged after review of this information by relevant staff within the Department.

Audit Observations

The internal and Board reports on waiting list performance indicators viewed during this audit varied in content and presentation. However, all reported the key indicators either in tabular form or as charts showing trends. Some included graphical projections of 'long-wait' patient numbers, consistent with the Department focus.

Conclusion

The Department and Areas gather and report information on waiting times for internal management purposes.

The Department monitors the waiting list performance of Areas monthly, and reviews it against targets in the Performance Agreements of Area Boards and their management. However, the existence of targets in Performance Agreements for waiting lists has not been effective in ensuring their achievement by Areas.

NSW Health reports annually on waiting list performance under the heading *Booked Patient Access* in its annual reports. It also publishes information for doctors and patients on its website, but has no satisfactory means of ensuring that doctors can and do verify their own statistics.

The information reported by NSW Health in its Annual Reports needs to be improved in terms of its content and consistency. The information is not sufficient to allow a reader to form a realistic and balanced view of how NSW Health is performing in managing its elective surgery waiting lists.

The internal and Board reports on waiting list performance indicators viewed varied in content and presentation, but all reported the key indicators either in tabular form or as charts showing trends. Some included graphical projections of 'long-wait' patient numbers, consistent with the Department focus.

Appendices

Appendix 1: Terms Used in this Report

Access Block

Access block is the proportion of admitted patients not moved to a hospital ward within eight hours from commencement of active treatment[220].

Acute Care

Public, Department of Veterans Affairs (repatriation) and private hospitals, which provide services primarily to admitted patients with acute or temporary ailments. The average length of stay is relatively short.

Admitted patients

Patients accepted by a hospital for inpatient care[221].

AMWAC

The Australian Medical Workforce Advisory Committee. AMWAC was formed in early 1995 to assist with the development of a more strategic focus on medical workforce planning in Australia.

AMWAC is an advisory body which reports to the Australian Health Ministers' Advisory Committee, and through it to Australian Health Ministers.

The prime focus of AMWAC's work is Australian medical workforce research and data analysis, although AMWAC also aims to provide workable policy solutions where appropriate.

Area Health Service (Area)

An Area Health Service is the administering authority for public health activities within a designated geographic area. Currently, there are 17 Area Health Services covering the whole of New South Wales. In addition, the Ambulance Service, Corrections Health Service and the Children's Hospital at Westmead operate as separate entities within their respective fields.

Attending Medical Officer (AMO)

A senior clinician (a visiting practitioner, staff specialist or academic clinician) with admitting rights to a hospital[222].

Average Time on List

This refers only to patients who have not yet been admitted to hospital and who are still waiting to be admitted. It is the average of time they have waited so far on the list[223].

Average Waiting Time

This usually refers to all the patients admitted within a particular month and is the average time that these patients have had to wait for admission to hospital[224].

Booked Patients

Patients are those who require non-emergency admission to hospital, i.e. admission is required but need not occur within 24 hours, and who have been placed ('booked') on the hospital's booking (or 'waiting') list.

Booked Surgery

In broad terms, a booked surgery procedure is one performed in an operating theatre facility under some form of anaesthesia, where admission is not required within 24 hours of the decision to admit and the procedure is performed by a surgeon [225].

Booked or elective surgery excludes procedures such as:

- renal dialysis
- dental and obstetric procedures
- cosmetic surgery
- cochlear implants
- cosmetic surgery.

See also *Elective Surgery* and *Elective Medical Treatment*.

Clearance Time

If the booking list has 20 patients and the average number of admissions from the list is 10 per month, the average prospective patient can expect to wait 2 months for admission. This expected waiting time is usually referred to as the clearance time[226].

Clerical Audit

A regular and routine clerical check usually by the Wait List Coordinator that the information the hospital has of patients waiting for admission is correct. It follows a set of guidelines set out by the Department of Health[227], and includes identification of patients who no longer require treatment.

Clinical Audit

A clinical review of the patient and of the urgency priority code applied to patients.

See *Clinical Urgency Categories*

Clinical Urgency Categories

A clinical priority allocated to a patient based upon the surgeon's assessment of the patient's condition:

Category	Priority	Admission recommended within
U1	Urgent	7 days
U2	High Priority	30 days
U7	Semi-Urgent	90 days
U8	Non-Urgent or Other	12 Months[228]
U9	Not-ready-for-care	NA

Clinician

A clinician is a person mainly involved in the area of clinical practice, i.e. diagnosis, care and treatment, including recommended preventative action, to patients or clients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine)[229].

Day of Surgery Admission (DOSA)

Patients are admitted into hospital for surgical procedures on the day the procedure occurs. They remain in hospital overnight for at least one night, following their surgery[230].

Day Only Surgery

Booked surgical procedures not requiring overnight admission to hospital[231].

Deferred

See 'not-ready-for-care'.

Deferred patients are those unable to accept a date for admission due to social or personal reasons, such as work commitments, holidays or other inconvenience[232].

Delay

A patient's booked surgery may be postponed by the hospital due to high emergency admissions, or other hospital-related reasons.

Elective Medical Treatment

Booked or elective medical procedures are predominantly non-surgical procedures, but are also deemed by NSW Health to include procedures such as bronchoscopy, colonoscopy, endoscopy, gastroscopy, etc.

Elective Surgery

Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians[233].

See also *Booked Surgery* and *Elective Medical Treatment*.

Emergency Patients

Patients whose clinical conditions indicate that they require admission to hospital within 24 hours.

Episode of Care

A phase of treatment during which the patient receives a particular type of care (e.g. acute, rehabilitation, etc). When that type of care is concluded the episode of care is ended and the patient undergoes either a type change separation to a different type of care or a formal separation and leaves the hospital.

Fiftieth Percentile Waiting Time

Fifty per cent (half) of the people admitted to hospital are admitted by this time. For example, a 50th percentile waiting time of two months for surgery means that half the patients admitted had their admission within two months[234].

General Practitioner

A doctor (also known as a family doctor or family practitioner) who is the main agent of primary health care, through whom patients make first contact with health services for a new episode of illness or fresh developments of chronic diseases[235].

Practitioners recognised by the Health Insurance Commission include vocationally registered practitioners, participants in the Royal Australian College of General Practitioners (RACGP) training program and fellows of the RACGP[236].

Inpatient

Patients who are formally admitted to a hospital or health service facility. Formally admitted patients can be same day or overnight[237].

KPIs

Key performance indicators.

KPIs are [performance] measures that demonstrate the current and future condition of an entity in terms of the programs it supports and the results it achieves ... KPIs exist within a context defined by objectives. KPIs are useful instruments for several reasons:

- service improvement
- management improvement
- accountability
- legal requirements[238].

List Transfers

List Transfers are an administrative change in where waiting list details are kept. In some cases doctors maintain, in their rooms, a list of patients awaiting admission to hospital, only notifying the hospital of the patient's details at or close to the time of the patient's admission. In these cases patients are not put on a hospital's waiting list until very shortly before their admission. Department of Health policy is that hospitals should endeavour to acquire details of these patients at the time the doctor makes the decision to admit them. When doctors agree to supply these lists to the hospital rather than keeping them in their rooms the patients are added to the hospital's waiting list. This is known as a list transfer. It is not a change in demand for hospital services[239].

Doctors who keep lists in their own rooms are likely to have their waiting times underestimated[240].

Locum

Locum tenens; a doctor who stands in temporarily for a colleague who is absent or ill and looks after the patients in his practice[241].

'Long-Wait' Patients

'Ready-for-care' medical and surgical patients who have been waiting for elective surgery longer than 12 months are termed 'long-wait' or 'extended wait' patients[242].

'Long-wait' patients may seek or be offered earlier treatment by a different surgeon and/or different hospital[243].

Medical

1. ... of or relating to medicine, the diagnosis, treatment and prevention of disease.
2. ... of or relating to conditions that require the attention of a physician rather than a surgeon[244].

Ninetieth Percentile Waiting Time

Ninety per cent of the people admitted to hospital are admitted by this time. For example a 90th percentile waiting time of ten weeks means that ninety per cent of patients admitted were admitted within ten weeks of going on the list[245].

'Not-Ready-For-Care' (NRFC)

'Not-ready-for-care': patients who are either 'staged' or 'deferred'.

'Not-ready-for-care' patients are those patients who are clinically not ready for admission or who wish to defer for personal reasons. They may be either 'staged' or 'deferred'.

- Deferred patients are those unable to accept a date for admission due to social or personal reasons, such as work commitments, holidays or other inconvenience.
- Staged patients are those whose medical conditions are such that they will not be ready for admission until some future date, such as patients awaiting a check cystoscopy in some months time, or patients currently not fit to undergo an anaesthetic[246].

The number of elective surgery patients staged or deferred is shown on Health's Waiting Times website.

Outpatient

Patients who receive medical, surgical, allied health or diagnostic services in a hospital outpatient facility, who are not formally admitted to the hospital at the time of receiving the service[247].

PAS

Patient Administration System

Peer Group

Public Hospitals of like size, operating with like levels of complexity and/or resource consumption required by patients.

Peer groups should be categorised using evidence on hospital activity such that each peer group has the following characteristics:

a. sufficient number of hospitals in each group
b. groupings should be based on relatively strong evidence
c. reliability and robustness.

Hospitals in each peer group should also have:

d. relative case-mix homogeneity
e. relative resource homogeneity
f. relative similar hospital structure[248].

Pooled Lists

At some hospitals doctors in particular specialties have agreed to include their public patients on a combined list for that specialty. This means that patients may be treated by any one of the doctors belonging to the group. Patients may therefore be added to a waiting list by one doctor but admitted under another doctor. This does not mean that if a particular doctor is part of a pooled list group, that this doctor does not also list and admit patients apart from the pooled list patients. Pooled lists are generally set up for the more common routine procedures but certain more complex procedures would remain as part of a particular doctor's list and admissions. A doctor's private patients would also not be included on a pooled list[249].

Private Patients

Persons admitted to a private hospital; or persons admitted to a public hospital who decide to choose the doctor(s) who will treat them. This means they will be charged for medical services, food and accommodation.

Public Hospital System

Australia's public hospital system is funded jointly by the Commonwealth, State and Territory Governments and is administered by State or Territory health departments[250].

Public Patient

A patient admitted to a public hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared ward accommodation. This means the patient is not charged.

'Ready-For-Care' (RFC)

'Ready-for-care' patients are those who are prepared to accept admission for the awaited procedure should it be offered in the near future and who, in the opinion of the treating clinician, are ready to be admitted. The data on NSW Health's website site refers to people who are 'ready-for-care' and who have been classified as urgent, semi-urgent or non-urgent[251].

Resource Distribution Formula (RDF)

A funding formula that looks at each Area's population demographics, its specific health needs, and its outflows and inflows of patient deliveries.

Same Day Surgery

Same-day surgery involves the patient being admitted and discharged on the day of surgery[252].

Separations Separations are episodes of care from admission to discharge, transfer or death. Target separation levels form part of the performance agreement between health entities and the Department and are one of the factors in determining funding levels. A weighting is applied to recognise the various levels and complexities of separations.

Specialists Doctors who have extra qualifications in one or more clinical areas of practice. Some examples of specialists are gynaecologists, ophthalmologists and neurosurgeons[253]. The terms doctor, surgeon and specialist have been used in this report although, strictly speaking, they are not interchangeable.

Specialty The term used to describe the particular field of medicine in which a specialist doctor practises, e.g. orthopaedics, urology, gynaecology[254].

Staged See 'Not-ready-for-care'.

Staged patients are those whose medical conditions are such that they will not be ready for admission until some future date, such as patients awaiting a check cystoscopy in some months time, or patients currently not fit to undergo an anaesthetic[255].

Surgeons Doctors who undertake the treatment of injuries or disorders by the performance of surgery[256]. The terms doctor, surgeon and specialist have been used in this report although, strictly speaking, they are not interchangeable.

Surgery The branch of medicine concerned with treatment of injuries or disorders of the body by incision, manipulation or alteration of organs with the hands or with instruments. In broad terms, a booked surgery procedure is one performed in an operating theatre facility under some form of anaesthesia, where admission is not required within 24 hours of the decision to admit and the procedure is performed by a surgeon[257].

Urgency See *Clinical Urgency Categories*.

Waiting List A waiting list is a list kept by the hospital which contains the names and details of people registered as requiring elective/booked admission to that hospital. Admission may be for same day (admission and discharge on the same day) or other acute inpatient services requiring overnight or longer stay. These people may or may not have a planned admission date, and may be proposing to be public or private patients[258].

Waiting lists are used as a performance indicator for health services nationally. Each State collects and publishes statistics on waiting times. Within each State, some hospitals submit their statistics to the Australian Institute of Health and Welfare. These statistics are published annually to provide a State-by-State comparison.

Waiting Time Coordinator The person in each hospital/Area responsible for managing issues associated with booked patient waiting lists and waiting times[259].

Waiting Times The amount of time (reported in days, weeks or months) that a patient has waited for admission to hospital. It is measured from the day the hospital receives a *Recommendation for Admission* form for the patient until the patient is admitted[260].

Appendix 2: About the Audit

Audit Objectives

To review the effectiveness and efficiency of hospital and Area Health Service systems and practices which impact on patient waiting times for non-emergency medical procedures.

Audit Scope

The scope of the audit will include examination of:

- the accuracy and reliability of published waiting list data for non-emergency procedures
- allocation of operating theatres, beds, staff and other resources to ensure efficient patient flow
- planning, budgeting, monitoring and reporting of waiting time performance.

Audit Criteria

1. Availability and Reliability of Waiting List Information

The extent to which published waiting time information offers a user-friendly and accurate guide for patients, general practitioners and hospital management.

Issues to be examined include:

- availability of comprehensive and up to date waiting times for all doctors, hospitals and surgical procedures
- reliability of published waiting times
- consistency of application of clinical priority
- effectiveness of audits of admission and booking procedures, clinical priorities, and administration and management of waiting lists
- monitoring of extended-wait patients to ensure clinically-appropriate and timely treatment.

2. Management of Hospital/Area Resources

The extent to which adequate systems, procedures and guidelines exist for the efficient and timely management of elective patients.

Issues to be examined include:

- effectiveness of procedures for planning and coordinating of admissions and separations to reflect clinical demand and priority of patients on elective surgery list and to accommodate demands of emergency and other treatments
- effectiveness of budgets and targets for resource allocation, performance monitoring and reporting
- procedures for pooling of lists between surgeons and across hospitals within an Area to balance supply and demand
- use of performance standards and targets (KPIs, standard costs and times, etc)
- procedures for ensuring appropriate utilisation of theatre time and other limiting resources
- management of patient flow to minimise delayed and cancelled procedures
- governance/communication/clinical decision-making.

3. Planning, Budgeting, Monitoring and Reporting

The extent to which patient waiting times are treated as core business in developing financial budgets and managing Area and hospital performance.

Issues to be examined include:

- extent to which Area and hospital business plans and budgets reflect agreed levels of activity for emergencies, elective surgery, etc
- the reliability of elective surgery data, both its sources and the way it is maintained
- effectiveness of monitoring by boards and senior management of efficiency and effectiveness measures relevant to waiting list performance.

Audit Approach and Methodology

The audit approach and methodology included:

- research, review and analysis of relevant literature and audits and studies undertaken (nationally and internationally)
- review of NSW Health guidelines, reports, data and statistics
- interviews with NSW Health and management and staff from a sample of Area Health Services
- discussions with a sample of surgeons who operate in the public health system.

Letters were written to the Australian Medical Association, the Royal Australasian College of Surgeons, the Australian & New Zealand College of Anaesthetists and the Australian Orthopaedic Association to advise them of the audit and to offer the opportunity for discussion. All but the AMA responded.

Audit Cost

The cost of the audit was $304,522. This figure includes the estimated cost of printing the report ($7,000).

The audit team comprised:

Denis Streater (Engagement Controller)

Geoff Moran (Project Leader)

Louise Thomson

Sandra Tomasi.

Appendix 3: Organisational Structure

The Law

The *Health Administration Act 1982* and the *Health Services Act 1997* govern the responsibilities of:

- the Minister for Health
- Director-General of NSW Health
- Boards of Area Health Services, and
- Chief Executive Officers of Area Health Services

for the delivery of public health services in New South Wales.

The Acts provide, in part, for the following arrangements.

The Director-General of NSW Health

The Director-General of NSW Health:

- may enter into a performance agreement with a Board of an Area
- reports to the Minister of Health on the outcomes of the performance agreement
- may inquire into the management, services and/or administration of an Area
- has no authority to give directions to any Area Health Service unless the Minister has delegated her/his authority under s21 of *Health Administration Act 1982*.

The Board of an Area

The Board of an Area is:

- subject to the control and direction of the Minister for Health
- required to consult with the Director-General
- to exercise its functions in accordance with the performance agreement with the the Director-General
- to report on this activity to the Director-General.

The Chief Executive Officer of an Area

The Chief Executive Officer of an Area:

- is employed by, and is responsible to, the Board (of the Area) for the day to day operations of the Area
- is appointed by the Governor and can only be removed by the Governor.

Employees of an Area

An area may appoint and employ such employees as may be necessary for the purpose of exercising its functions.

Appendix 4: Earlier Committee Findings

1996 Select Committee

In the months following the 1995 election the Government instituted the Waiting List Reduction Program[261] which sought to reduce by half the number of people waiting for elective surgery.

The program commenced in May 1995 and ended in December 1995[262].

The Legislative Council of the NSW Parliament established a Select Committee to monitor the Government's performance in managing waiting lists for elective surgery.

In December 1996 the Committee reported that:

- the waiting list had been halved within the promised 12 months
- there had been no changing of definitions[263] or falsification or manipulation of data[264] or (save in a few cases) of procedures
- no evidence was found that patient care had been compromised by the program.

> The Committee finds that there are both positive and negative longer term effects of the Waiting list Reduction Program.
>
> The positive effects include improvements in overall productivity, the increased use of same-day surgery, increased incidence of day-of-surgery admissions and peri-operative clinics, better networking of services, better collection and use of data, pooling of lists between practitioners, the development and use of benchmarks and the significant reduction in the number of patients waiting long periods for their surgery.
>
> The negative effects of the Program include financial problems in those hospitals which could not switch off the increase in activity and the opportunity costs of not spending the funds elsewhere[265].

Evidence presented to the Select Committee suggested that the 'not-ready-for-care' classification was inappropriately used to remove patients from the waiting list[266]. The Committee found that in only a few cases had removal of patients been inconsistent with guidelines:

> **Finding No 12**
> [Urgency 9][267], or not-ready-for-care patients, who had never been reported in official waiting lists, more than doubled during the course of the Waiting List Reduction Program. Their number increased by about 7,600. This occurred through practices such as more frequent and thorough clerical auditing of the lists. Although clerical auditing was mandated by long-standing policy, there is no doubt the increase in not-ready-for-care patients shows that hospital administrators increasingly used this category to reduce numbers on urgencies [1,2, 7 and 8][268] of the waiting list. In a few cases this audit activity was contrary to Department of Health policy. Where identified, the Department of Health appears to have addressed the situation[269].

General Purpose Standing Committee

In 2002 General Purpose Standing Committee No. 2 of the Legislative Council conducted an inquiry into some aspects of care in public hospitals. Its Terms of Reference were:

> That General Purpose Standing Committee No. 2 inquire into and report upon the following matters concerning the quality of care for public patients and value for money in major non-metropolitan hospitals throughout New South Wales.
>
> (a) The implementation of quality of care and value for money indicators in public and contracted major non-metropolitan hospitals during the period 1995 to 2001.
>
> (b) Mechanisms for comparing quality of care and value for money between these hospitals.
>
> (c) Progress in improving quality of care and value for money and reducing variability in quality of care in these hospitals during the period 1995 to 2001.
>
> (d) The strategies and measures in place or proposed for improving the quality of care and value for money and for reducing the variability in quality of care in these hospitals for the period 2001 to 2003[270].

The report discussed the use of the 'not-ready-for-care' urgency classification:

> One of the more significant issues to arise from the hearing concerns the possible manipulation of waiting lists ... The practice of reclassifying patients to reduce waiting lists was openly conceded by [the Director of Hospitals, Northern Region, Mayne Health, Port Macquarie Base Hospital] in his evidence ... The Committee acknowledges that this manipulation of waiting lists is not an issue peculiar to Port Macquarie, and as is clear from the evidence the fault in this practice lies with NSW Health, not Mayne Health. In view of its moves to transparency in other areas this ongoing practice remains completely unacceptable[271].

The discussion concluded with:

> **Recommendation 4**
> That to be consistent with other moves to greater transparency, NSW Health cease the practice of using reclassification of long-wait patients as a strategy to reduce waiting lists[272].

Appendix 5: Variations in Cost of Surgical Procedures

The following variations in costs were observed between hospitals of the same peer group[273].

Hospital	Procedure	Number of Patients	Average Length of Stay (Days)	Cost of Procedure per Patient
Belmont	Carpal Tunnel Release	8	1.00	$2,890
Armidale & New England	Carpal Tunnel Release	19	1.00	$1,359
Tweed Heads District	Carpal Tunnel Release	26	1.00	$1,160
Grafton	Carpal Tunnel Release	67	1.00	$1,116
Shellharbour	Carpal Tunnel Release	10	1.00	$1,034
Shoalhaven & District	Carpal Tunnel Release	23	1.00	$773
Bathurst Base	Carpal Tunnel Release	61	1.03	$772
Maitland	Carpal Tunnel Release	49	1.00	$714
Broken Hill Base	Carpal Tunnel Release	26	1.04	$692
Griffith Base	Carpal Tunnel Release	25	1.00	$639
Bowral and District	Carpal Tunnel Release	25	1.00	$577
Goulburn Base	Carpal Tunnel Release	43	1.09	$358
Tweed Heads District	Tonsillectomy, Adenoidectomy	90	1.07	$2,061
Bathurst Base	Tonsillectomy, Adenoidectomy	24	1.04	$1,871
Belmont	Tonsillectomy, Adenoidectomy	28	1.07	$1,848
Armidale & New England	Tonsillectomy, Adenoidectomy	44	1.09	$1,791
Grafton	Tonsillectomy, Adenoidectomy	88	1.06	$1,771
Broken Hill Base	Tonsillectomy, Adenoidectomy	31	1.52	$1,691
Griffith Base	Tonsillectomy, Adenoidectomy	47	1.62	$1,561
Bowral and District	Tonsillectomy, Adenoidectomy	40	1.52	$1,321
Shoalhaven & District	Tonsillectomy, Adenoidectomy	124	1.22	$1,040
Goulburn Base	Tonsillectomy, Adenoidectomy	47	1.21	$938
Maitland	Tonsillectomy, Adenoidectomy	32	1.00	$692
Shellharbour	Sterilisation, Male	43	1.00	$1,762
Armidale & New England	Sterilisation, Male	10	1.00	$1,205
Maitland	Sterilisation, Male	49	1.00	$1,164
Broken Hill Base	Sterilisation, Male	16	1.00	$1,075
Griffith Base	Sterilisation, Male	26	1.00	$956
Shoalhaven & District	Sterilisation, Male	25	1.00	$948
Tweed Heads District	Sterilisation, Male	22	1.00	$790
Bathurst Base	Sterilisation, Male	43	1.00	$783
Bowral and District	Sterilisation, Male	69	1.00	$724
Grafton	Sterilisation, Male	57	1.00	$722

End Notes

[1] NSW Health Waiting Times Information, www.health.nsw.gov.au/waitingtimes/definition/
[2] Responses from Area and hospital management to letter *Extended Wait Patient Management* from the Director of Health System Performance, 24 September 2002
[3] *Budget Statement 2002-03: Budget Paper No* 2, Chapter 2: Service Delivery, Chart 2.1; NSW Treasury, Chart 5.
[4] NSW Department of Health Annual Report 2001-02, p45.
[5] *Booked Surgery Data*; letter to Audit Office from Chief Financial Officer, Finance and Business Management Division, Finance Branch, NSW Health, 6 March 2003
[6] Pivot Table.xls dated 21 February 2003; file provided by Director Funding and Systems Policy Branch, Policy Division, NSW Health
[7] NSW Department of Health Annual Report 1999-2000, p1; Annual Report 2000-01, p5.
[8] NSW Department of Health Annual Report 2001-02, p5, 13-21; the latter pages are incorrectly titled *Department performance during 2000-01.*
[9] *Strategic Directions for Health 2000-2005;* NSW Health, October 2000, p1
[10] *National Health Data Dictionary Version 10*; National Health Data Committee, Australian Institute of Health and Welfare, Canberra 2001; AIHW Catalogue Number HWI 30, p80
[11] ibid, p315-316
[12] NSW Health Waiting Times Information: Summary Information; Waiting Times by Procedure Across the State: Waiting Times for Non-Urgent Booked Procedures; www.health.nsw.gov.au/waitingtimes/data/nonurgent.pdf
[13] *Current Waiting Times and Lists by Specialties for NSW Hospitals: Elective Patients:* March 2003; www.health.nsw.gov.au/waitingtimes/data/curr-wtimes.pdf. Transfers since March 95 have to be added to *List less Transfers*, consistent with the Department's explanation of the discrepancy between the *Waiting List Performance* and *Current Waiting Times and Lists by Specialties* reports in *2.8 Waiting List Data.*
[14] The terms surgeon and specialist have been used in this report although, strictly speaking, they are not interchangeable: '**Specialists** are doctors who have extra qualifications in one or more clinical areas of practice. Some examples of specialists are gynaecologists, ophthalmologists and neurosurgeons. **Surgeons** are doctors who undertake the treatment of injuries or disorders by the performance of surgery'; NSW Health Waiting Times Information: General Waiting Times Definitions; www.health.nsw.gov.au/waitingtimes/definition/glossary.html.
[15] The waiting time between seeing a GP and consultation with a surgeon has been the subject of a number of audits, e.g. *Access to Care*, UK Audit Commission, 24 Oct 2002, p9 and *Department of Health: Inpatient and outpatient waiting in the NHS;* National Audit Office, July 2001, p7.
[16] *Booked Patient and Waiting Time Management Operating Guidelines*, March 1998, 4.3.1, p17.
[17] ibid, 2.5.1, p4 and 4.3.6, p20.
[18] ibid, 2.5.9, p7.
[19] Australian Orthopaedic Association: Board of Directors, www.aoa.org.au/bod.asp
[20] See Tai v Hatzistavrou [1999] NSW Court of Appeal 306, 25 August 1999; *Doctor's Duty to Give Reminders to Patients*; Autumn 2000 newsletter, www.mahons.com.au/newsletter/autumn_2000/newsletter_autumn_2000_1.html.
[21] *Instructions for the New South Wales Waiting Times Collection;* Patient Data Management Unit, Information & Data Services Branch, NSW Health, November 1997, Section III-2; *Waiting for Health Care: an overview of Waiting Lists and Waiting Times in NSW*; Performance Management Division Evaluation and Monitoring Branch, NSW Health, May 2000, p4. The other priorities 'missing' from this sequence (U3, U4, etc) are no longer used: U3 was split into a 3 month and 6 month category (U7 and U8) to enable NSW to comply with National Definitions. U4 was renamed U9 at the same time.
[22] This is usually shown as 12 months: 'Health services are encouraged to ensure that those patients who do not want to wait for a long time are admitted within twelve months (at most) of going on a list'; *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, 3.1, p9. However, an earlier document shows it as 6 months: 'Requiring admission within no specified time but expected within 6 months'; *Instructions for the New South Wales Waiting Times Collection;* op cit, Section II-1.
[23] See *6.43 Consistency of Information*
[24] NSW Health Waiting Times Information: General Waiting Times Definitions; op cit
[25] *National Health Data Dictionary Version 10*; op cit, p394.
[26] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[27] NSW Health Waiting Times Information: General Waiting Times Definitions; op cit.
[28] *Performance Reports Health: Glossary*; Council on the Cost and Quality of Government; www.ccqg.nsw.gov.au/performance_reports/health/health_glossary.htm.
[29] *Instructions for the New South Wales Waiting Times Collection;* op cit, Section II-1
[30] Performance Reports Health: Glossary; op cit.

[31] *Number Changed from Inpatient to Outpatient over last 5 years;* Monthly Reporting of Ambulatory Procedures, January to December 2002, data provided by A/Deputy Chief Information Officer, NSW Health, 28 January 2003.
[32] '(Colposcopy) is an examination of the cervix through a special instrument called a colposcope ... The examination does not take long, possibly ten or fifteen minutes and is done while you are awake in the rooms'; Melbourne Gynaecology website; www.melbgyn.com.au/colposcopy.htm.
[33] 'All cataracts are done as outpatients in the ambulatory care service unless there is a co-morbidity that identifies they need to be an admission. This is in a very small percentage of cases'; summary of information provided to Audit Office by Western Sydney Area Health Service, 17 January 2003.
[34] *2001-02 Acute Services Access Performance Targets: Booked Patient Management*, no date.
[35] ibid
[36] *Guidelines for the Management of Extended Wait Patients*; November 1999, 5.6.1, p27
[37] *Instructions for the New South Wales Waiting Times Collection;* op cit, Section II-5.
[38] ibid, Section II-5, 6.
[39] ibid, Section III-2.
[40] *Current Waiting Times and Lists by Specialties for NSW Hospitals: Elective Patients*; op cit
[41] See *Appendix 1: Terms Used in this Report* for definitions of reported performance indicators
[42] *Day only surgery in hospital*; www.asnsw.health.nsw.gov.au/hospitalinfo/measures/dayonly.html
[43] Sameday.xls Same Day Surgery (all urgencies, elective surgery), data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003. An earlier performance audit showed that in 1995 only 30% of surgery was performed as 'same-day' surgery (*Department of Health: Same Day Admissions*; the Audit Office, December 1995, p6) based upon Inpatient Statistics (ISC) data. At that time definitions differed markedly between ISC and waiting list collection data.
[44] 12 months average to March 2003, Sameday.xls, data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003.
[45] Dosa.xls Day of Surgery Admissions (all urgencies, elective surgery); data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003.
[46] *Day of surgery admission*; www.asnsw.health.nsw.gov.au/hospitalinfo/measures/dosa.html
[47] *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, 1.2, p2.
[48] ibid, 1.2, p2.
[49] *Select Committee on Hospital Waiting Lists: Final Report*; Parliament of NSW Legislative Council, December 1996, 2.6.2, p9.
[50] *Guidelines for the Management of Extended Wait Patients*; op cit, 5.1, p25.
[51] *Selected data for Area Health Services: Admissions adjusted for reclassification [to non-inpatient]*; NSW Department of Health Annual Report 2001-02, p96.
[52] *Selected data for Area Health Services: Emergency Department Attendances;* NSW Department of Health Annual Report 2001-02, p96. A footnote warns against comparisons of Emergency Department attendance data because of the mix of different counting methods and systems used by NSW Health: 'The actual increase in metropolitan Emergency Department attendances [for 2001-02] over 2000-01 is 0.6%, not the 18% implied'.
[53] *Selected data for Area Health Services: Non-Admitted Patient Services;* NSW Department of Health Annual Report 2001-02, p96.
[54] ELACT.XLS Additions to List and Removals Admitted for 12 months; data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003. This file only includes 'ready-for-care' patients undergoing elective surgery, not medical treatment.
[55] Waiting list trends were first systematically recorded during 1994-95. However, as 1994-95 and 1995-96 results may have been affected by the Waiting List Reduction Program from May 1995 to December 1995, this table uses 1997 as a basis of comparison. Other analysis of waiting list trends displays results graphically and so reveals any discrepancies between the first two years and later years.
[56] See discussion of removal of patients from waiting list in *2.10 Guidelines and Procedures*
[57] ELACT.XLS Number on list at end of month; data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003. This only includes patients undergoing elective surgery, not medical treatment.
[58] Ovdue.xls Total ready-for-care; data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003. This includes medical and surgical patients.
[59] *Select Committee on Hospital Waiting Lists: Final Report*; op cit, 2.6.2, p9
[60] *Waiting Times (months), July 1994 to March 2003*; data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003.
[61] *Waiting for Health Care: an overview of Waiting Lists and Waiting Times in NSW*; op cit, p7.
[62] At end of March 2003.
[63] 'Long-wait patient management is a focus for 2001-02'; NSW Department of Health Annual Report 2000-01, p15; 'Long-wait patient management continues to be a focus for 2002-03'; Annual Report 2001-02, p12.
[64] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[65] See *4.3 'Enhancement' Funding* and *4.4 Growth Funding.*

[66] Ovdue.xls *Medical and Surgical Overdue Patients on List*; data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003.
[67] See *2.9 Inquiries into Waiting List Manipulation.*
[68] *Booked Surgery - On List Waiting Times, January 2003* and *March 2003*; data provided by NSW Health 25 March and 3 June 2003 respectively.
[69] ibid
[70] 784 (number of 'ready-for-care' surgical patients at March 2003 waiting longer than 2 years)/ 4,188 (total number of 'long-wait' medical and surgical patients at March 2003) = 18.7%
[71] *Booked Surgery - On List Last Urgency Waiting Times, January 2003* and *March 2003*; data provided by NSW Health 25 March and 3 June 2003 respectively: '[The report shows] the amount of time waited at the current urgency e.g. a patient may have waited 12 months at urgency 8 and then moved to urgency 7 only one month ago. This report counts only the amount of time waited at urgency 7 (i.e. one month)'.
[72] *Booked Surgery - On List Last Urgency Waiting Times, March 2003*; data provided by NSW Health 3 June 2003. The increase in these numbers between January and March 2003 is around 6%.
[73] Refer to the reporting convention for overdue U1 and U2 patients in *1.6 Types of Patients and Treatments.*
[74] *Medical and Surgical Overdue Patients on List*; data provided by NSW Health 3 June 2003.
[75] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003; see also *5.4 Consistency of Process and Information.*
[76] Mar03Au2.xls NSW Surgical Waiting List Data by Specialty, March 2003; data provided by A/Deputy Chief Information Officer, NSW Health, 8 July 2003.
[77] Mar03Au2a.xls NSW Surgical Waiting List Data by Specialty, March 2003; data provided by A/Deputy Chief Information Officer, NSW Health, 15 July 2003.
[78] *2001-02 Acute Services Access Performance Targets: Booked Patient Management*, no date.
[79] Data from NSW Health WLCOS reports MLC653RX for January to December 2002 (run 10 March 2003) and nrfcmar03.xls report provided 3 June 2003
[80] 'Not-ready-for-care' patients are included in targets for delays and for rates of same-day surgery and day-of-surgery-admission.
[81] *Australian hospital statistics 2001-02*; Australian Institute of Health and Welfare, 2003, Table 5.1.
[82] 'Some of the definitions used varied slightly among the States and Territories in 2000-01 and in comparison with previous reporting periods. Comparisons between jurisdictions and between 2000-01 and previous reporting periods should therefore be made with reference to the notes on the definitions used'; *Australian hospital statistics 2000-01*; Australian Institute of Health and Welfare, 2002, p69.
[83] 'Given the difference in coverage and definitions, [AIHW data] should not be used as evidence of below average performance'; comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[84] *Waiting Lists and Waiting Times*; Health Public Affairs Media Release, NSW Health, 6 April 2000.
[85] *Australian hospital statistics 2001-02*; op cit, Table 5.2.
[86] ibid, Table 5.2.
[87] *Waiting times statistics for patients admitted from waiting lists, by State and Territory and hospital peer group, 1999-2000*; Waiting times for elective surgery in Australia 1999-2000; Australian Institute of Health and Welfare, Canberra, January 2002, Table 2.1
[88] *Australian hospital statistics 2000-01*; op cit, Table 5.1.
[89] NSW Health Waiting Times Information, www.health.nsw.gov.au/waitingtimes/
[90] *Department of Health: Inpatient and outpatient waiting in the NHS;* National Audit Office, July 2001, p22
[91] *Inappropriate adjustments to NHS waiting lists*; National Audit Office, December 2001, p1
[92] ibid, p1
[93] ibid, p2
[94] ibid, p3
[95] ibid, p3
[96] Extract from NSW Legislative Assembly Hansard; Article Number 23, p120 of 30 April 2003.
[97] *Hospitals fudged figures to slice waiting lists*; Sydney Morning Herald, 1 May 2003.
[98] Letter from Director-General NSW Department of Health to Auditor-General, 30 April 2003
[99] Extract from NSW Legislative Assembly Hansard; Article Number 23, p120 of 30 April 2003.
[100] *Inappropriate adjustments to NHS waiting lists*; op cit, p3
[101] 'This circular replaces the following documents: *A Waiting List Policy for NSW* (April 1994); *Hospital Waiting List Clerical Audit Policy* (Circular No 94/72); *Management of Waiting Lists, Admissions and Discharge Policy* (Circular No 94/57)'; NSW Health Circular No 98/18, 23 March 1998.
[102] For example *Guidelines for the Management of Extended Wait Patients* (November 1999) and *Guidelines for the Management of Booked Patient Delays* (February 2002)
[103] *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, 2.1, p3
[104] *Review of booked patient waiting list process*; KPMG, June 2003, p12. The identity of the Area which commissioned this review has been disguised.
[105] *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, 4.3.1 ii, p17
[106] ibid, 4.3.6 iv, p20

[107] *Status Report as at 30 April 1998: Recommendations from Waiting Time Management Review*; letter from CEO of South Western Sydney Area Health Service, 20 May 1998
[108] *Review of booked patient waiting list process*; op cit, p12
[109] *Strategic Management - Notification of Health Policies and Procedures for Issue of Department of Health Circulars and Information Bulletins to the Health System*; Circular No 2001/12, 29 January 2001, www.ppc.health.nsw.gov.au/fcsd/rmc/cib/circulars/2001/cir2001-12.pdf
[110] ibid, 2.1, p2
[111] *Review of booked patient waiting list process*; op cit, p2
[112] *Instructions for the New South Wales Waiting Times Collection*; op cit, Section II p5, 6.
[113] *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, 2.5.7, p6
[114] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[115] See *5.4 Consistency of Process and Information*
[116] *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, 2.4, p3
[117] *Review of booked patient waiting list process*; op cit, p12, 13
[118] *Operations Cancelled for the Financial Year 2002-03*; Sydney Hospital and Sydney Eye Hospital Operating Suite, October, November and December 2002
[119] Calculated from ELACT.XLS Removals Admitted and Removals Other for 24 months; data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003
[120] WTs_U1&2.xls, WTs_U7.xls, WTs_U8.xls and WTs_U9.xls; data provided by NSW Health 16 June 2003 and WLCOS (admitted): Waiting time and patient numbers for Urgency 1 & 2 (surgical admissions) by specialty 2001-02; data provided by NSW Health 27 July 2003
[121] *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, p1
[122] *Private Insurance and Public: Activity and Separation Rate Analysis*; Draft report prepared by A/Deputy Chief Information Officer, NSW Department of Health, 17 July 2003
[123] See *4.2 Human Resources*
[124] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[125] *Health care funding in New South Wales: from health care needs to hospital outputs*; Don Hindle, Australian Health Review Vol 25, Number 1, 01/01/2002, p53
[126] *A Better Health System for NSW*; Report of the NSW Health Council 03/2000, March 2000, p50
[127] *Waiting for Health Care: an overview of Waiting Lists and Waiting Times in NSW*; op cit, p3
[128] Letter to Audit Office from Chief Financial Officer, Finance and Business Management Division, Finance Branch, NSW Health, 6 March 2003, p2
[129] Shown as constant dollars. The current value of the $40.1 million in 2002-03 is $45.865 million; *Booked Surgery Data*; op cit, Table B
[130] *Priority Access Strategy for 1997-98 and 1998-99*; Department of Health Performance Management Division, 18 April 1997, p8
[131] Letter to Audit Office from Chief Financial Officer, Finance and Business Management Division, Finance Branch, NSW Health, 6 March 2003, p2
[132] Current dollars
[133] '...government does not get good value from these programs, the average costs tend to be in the vicinity of 50% higher than average costs'; *Waiting for Health Care: an overview of Waiting Lists and Waiting Times in NSW*; op cit
[134] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[135] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003; data originally provided in letter to Audit Office from Chief Financial Officer, Finance and Business Management Division, Finance Branch, NSW Health, 6 March 2003, Table A.
[136] *$2 billion cash injection in response to NSW Health system reviews*; Health Public Affairs Media Release, NSW Health, 8 March 2000
[137] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[138] *Booked inpatient admissions and hospital capacity: mathematical modelling study*; Gallivan et al, *BMJ* 2002;324:280-282 (2 February); *Long waiting lists in hospitals*; Harald Buhaug, *BMJ* 2002;324:252-253 *Solving the surgical waiting list problem? New Zealand's 'booking system'*; Gauld R, Derrett S, Int J Health Plann Mgmt 2000; 15 (2 February): 259-272; *Mathematical model misses the point*; Hugh Rogers, et al, bmj.com, 4 Apr 2002
[139] *Forward planning*; email from Director, State-wide Services Development Branch, NSW Health, 24 January 2003
[140] Methodology used in supply and demand projections; paper provided by Acting Director, State-wide Services Development Branch, NSW Health, 23 January 2003
[141] *Selected data for Area Health Services: Average available beds*; NSW Department of Health Annual Report 2001-02, p96.
[142] *A Better Health System for NSW*; op cit, p13

[143] Health reports the *Bed Occupancy Rate* in its annual reports. However this is distorted by the productivity improvements yielded by increased day surgery rates and outpatient treatment, which increase bed turnover and can give bed occupancy rates of well in excess of 100%. Use of the overnight occupancy rate as above eliminates this distortion. Data included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[144] *Inpatient Admissions and Bed Management in NHS Acute Hospitals*; [UK] National Audit Office, 24 February 2000, p7
[145] *Western Sydney Area Health Service Surgical Review*; Bryant Stokes, Consultant Neurosurgeon and Clinical Professor Neurosurgery, 8 October 2002, p5,6,7
[146] *Surgeons unable to operate, waiting times blow out*; Australian Society of Orthopaedic Surgeons media release 18 October 2000, www.asos.org.au/index.php?subdir=media_rel/2000/&filename=18oct00
[147] See *Appendix 1: Terms Used in this Report*
[148] Audit_ED Mar95_to_Mar03.xls; *NSW Health Department, Emergency Department Data Collection*; data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003
[149] *Waiting Times (months), July 1994 to March 2003*; data provided by A/Deputy Chief Information Officer, NSW Health, 3 June 2003.
[150] As discussed above, demand for elective surgery has actually been declining while overall demand increases; see *Demand for Elective Surgery* in *2.1 Demand on the Public Health System.*
[151] NSW Health *Area of Need Program*; www.health.nsw.gov.au/othp/
[152] NSW Department of Health Annual Report 2001-02, p9
[153] *Selected data for Area Health Services: Average Staff Employed (EFT)*; NSW Department of Health Annual Report 2001-02, p96.
[154] *Workforce Reviews: Summary of Implementation of Recommendations*; Australian Medical Workforce Advisory Committee, no date (apparently August 2000), www.health.nsw.gov.au/corporate-services/amwac/progress2000.pdf
[155] *The Orthopaedic Workforce in Australia: Supply, Requirements and Projections 1995 - 2006*, AMWAC Report 1996.2, January 1996; *The Ear, Nose and Throat Surgery Workforce in Australia: Supply and Requirements 1997 - 2007*, AMWAC Report 1997.6, October 1997 and *The Specialist Anaesthesia Workforce in Australia: an Update: 2001 - 2011*, AMWAC Report 2001.5, September 2001
[156] *Workforce Reviews: Summary of Implementation of Recommendations*; op cit
[157] ibid
[158] ibid
[159] *Surgeons' grip on intakes 'too tight'*; Mark Metherell, Sydney Morning Herald, 7 February 2003, www.smh.com.au/articles/2003/02/07/1044498924281.html
[160] ibid
[161] Data provided by Greater Murray Area Health Service, 15 May 2003
[162] See *Section 2.5 Performance by Specialty*
[163] RFC Waiting > 12 months; Data provided by Greater Murray Area Health Service, 20 May 2003
[164] The identity of individual orthopaedic surgeons has been disguised as A, B, C, etc.
[165] See Tai v Hatzistavrou [1999] NSW Court of Appeal 306, 25 August 1999
[166] *Auburn trial points the way for the future of District Hospitals*; Health Public Affairs Media Release, NSW Health, 18 June 2002.
[167] *Metropolitan Hospitals Report: Service Enhancement and New Roles for Metropolitan Hospitals*; Greater Metropolitan Transition Taskforce, August 2002, p20, 21
[168] See *7.1 Performance Agreements*
[169] *Information Management and Technology Strategic Plan*; NSW Health Information Management Division, December 2001
[170] *Operating Theatre Management Project Report*; NSW Health, September 2002, www.fwahs.health.nsw.gov.au/pubs/program_eval/Op_Theatre_Mgmt_Report.pdf, p5
[171] ibid, p20
[172] ibid, p25
[173] *A Better Health System for NSW*; op cit, p22
[174] The questionnaire completed by five Areas identify the different systems.
[175] *Operating Theatre Management Project Report*; op cit, p6
[176] *Operating Theatre Management Project Supplementary Report on Process Mapping*; www.fwahs.health.nsw.gov.au/pubs/program_eval/Op_Theatre_Supplementary.pdf, p1
[177] *Information Management and Technology Strategic Plan*; op cit
[178] *A Better Health System for NSW*; op cit, p21
[179] ibid, p22
[180] See *1.3 The Cost of Public Health in NSW*
[181] The deadline for the 2000-01 'final acute data submission to the Commonwealth by [State] coordinators' is end March 2002; National Hospital Cost Data Collection Hospital Reference Manual Round 5 for the 2000-01 Financial Year; October 2001, Commonwealth Department of Health and Aged Care, p4, 5.

[182] 'Detailed information on costs is reported approximately six months after the end of the financial year in which expenditure is incurred'; comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[183] NSW Program and Product Data Collection Standards Manual, Appendix: B Role Delineation & Peer Groups, 20 September 2002
[184] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[185] *New South Wales Department of Health Costing Systems Strategy Review Project Draft Main Findings Report*; KPMG Consulting, October 2001, p7
[186] ibid, p2, 22
[187] See *Appendix 1: Terms Used in this Report*
[188] See *Appendix 5: Variations in Cost of Surgical Procedures*
[189] Comments on draft report included in correspondence from Chief Information Officer, NSW Health, 23 April 2003.
[190] *A Better Health System for NSW*; op cit, p58
[191] ibid
[192] *Strategic Directions for Health 2000-2005*; op cit, p14
[193] *Operating Theatre Management Project Supplementary Report on Process Mapping*; op cit, p7
[194] *Operating Theatre Management Project Report*; op cit, p3
[195] ibid, p8
[196] ibid, p5
[197] See *Appendix 1: terms used in this Report*
[198] *Review of booked patient waiting list process*; op cit, p2, 3
[199] ibid, p2, 3
[200] See *2.4 Overdue Patients*
[201] *Urgency Allocation by AMO Jul01_Jun02* series of spreadsheets; provided by Health System Performance Branch Information Management Division, 16 December 2002; identity of surgeons and hospitals disguised. The minimum number of procedures for any doctor in this sample is ten, whereas the Waiting Times website publishes data for doctors who have conducted two or more procedures.
[202] *A Better Health System for NSW*; op cit, xxi
[203] See, for example, *Victorian Waiting List Prioritising Study*; Department of Epidemiology & Preventive Medicine, Monash University and Department of Orthopaedics, Alfred Hospital, December 2002, www.electivesurgery.health.vic.gov.au/clinpriortho.pdf; *Clinical Prioritisation Issues & Approaches: Scoring, Reliability Variation in clinical Judgment, & Implications for Priority Systems Development*; Andrew MacCormick (University of Auckland) and Justin Roake (Otago University, conference paper March 2003, www.patientneeds.com/demand/day2.htm
[204] NSW Health Senior Executive Service (Chief Executive Officers) Performance Management System: model Performance Agreement for 1 July 2001 to 30 June 2002, p2; www.health.nsw.gov.au/er/human_resources/ses/employment_conditions/performance_agreements/ceo-perf-ag.pdf
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[206] projections0203.xls; data provided by Information Management Directorate, NSW Health, 11 November 2002
[207] Long wait projections + actual.xls: calculated from projections0203.xls and ovdue 0303.xls
[208] Far West and Southern Areas had a maximum of only 18 long-wait patients between them during this period.
[209] NSW Health Waiting Times Information: Information for General Practitioners; www.health.nsw.gov.au/waitingtimes/gpsinfo/ as at 11 July 2003.
[210] See *2.8 Waiting List Data*
[211] NSW Health Waiting Times Information: Accuracy; www.health.nsw.gov.au/waitingtimes/dwt/accuracy.html
[212] *E-government: User-friendliness of Websites*; the Audit Office, 26 June 2002, p5
[213] NSW Department of Health Annual Report 1999-2000, p7
[214] ibid, p38
[215] ibid, p104
[216] ibid, p105
[217] NSW Department of Health Annual Report 2000-01, p15
[218] NSW Department of Health Annual Report 2001-02, p5
[219] ibid, p12
[220] ibid, p98
[221] NSW Health Waiting Times Information: General Waiting Times Definition; op cit
[222] *Medical Staff Management Handbook*; Postgraduate Medical Council of New South Wales, www.medeserv.com.au/pmc/medadmin/medstaffbook/msm_26.htm
[223] *Waiting for Health Care: an overview of Waiting Lists and Waiting Times in NSW*; op cit

[224] *ibid*
[225] NSW Health Waiting Times Information: General Waiting Times Definition; op cit
[226] *Waiting for Health Care: an overview of Waiting Lists and Waiting Times in NSW*; op cit
[227] *Booked Patient and Waiting Time Management Operating Guidelines*, op cit
[228] 'Health services are encouraged to ensure that those patients who do not want to wait for a long time are admitted within twelve months (at most) of going on a list'; *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, 3.1, p9
[229] *National Health Data Dictionary Version 10*; op cit, p75
[230] *Health Working as a Team - NSW Government Action Plan Bulletin 2*
[231] ibid
[232] NSW Health Waiting Times Information: General Waiting Times Definition; op cit
[233] *National Health Data Dictionary Version 10*; op cit
[234] NSW Health Waiting Times Information: General Waiting Times Definition; op cit
[235] Concise Medical Dictionary; Oxford University Press, 1994
[236] Health Care; Department of Veterans' Affairs, www.dva.gov.au/health/provider_fees/feepaymp.htm#A
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[238] *Developing KPIs in the Public Sector*; CPA Australia, 2001
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[240] NSW Health Waiting Times Information: General Waiting Times Definitions; op cit
[241] Concise Medical Dictionary; Oxford University Press, 1994
[242] *2001-02 Acute Services Access Performance Targets: Booked Patient Management*, no date.
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[245] NSW Health Waiting Times Information: General Waiting Times Definition; op cit
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[247] *Performance Reports Health: Glossary*; Council on the Cost and Quality of Government; www.ccqg.nsw.gov.au/performance_reports/health/health_glossary.htm
[248] NSW Health Services Comparison Data Book 1998-99, Appendix 4; www.health.nsw.gov.au/iasd/iad/yb9899/append4.html
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[250] *Your Health*; www.hic.gov.au/yourhealth/our_services/am.htm
[251] NSW Health Waiting Times Information: General Waiting Times Definition; op cit
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[253] ibid
[254] ibid
[255] ibid
[256] ibid
[257] ibid
[258] *Booked Patient and Waiting Time Management Operating Guidelines*, op cit, p1
[259] NSW Health Waiting Times Information: General Waiting Times Definition; op cit
[260] ibid
[261] *Select Committee on Hospital Waiting Lists: Final Report*; op cit, p1
[262] ibid, p10
[263] '... the basic policies and definitions did not change during the program ...'; Finding No 8, ibid, ix
[264] '... even though there is some question as to the precise reduction, between March and December 1995, elective surgery lists were halved ...'; ibid, ix
[265] ibid, xiii
[266] ibid, p28 et seq
[267] The report actually shows this as Urgency 4. The classification have since been changed, and Urgency 4 in 1996 means the same as Urgency 9 currently means.
[268] The report actually shows these as urgencies 1-3. The classifications have since been changed, and urgencies 1-3 in 1996 mean the same as Urgencies 1, 2, 7 and 8 currently mean.
[269] *Select Committee on Hospital Waiting Lists: Final Report*; op cit, x
[270] *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in New South Wales: Final Report*; General Purpose Standing Committee No. 2, Ordered to be printed 4 September 2002, iv
[271] ibid, p23-25
[272] ibid, p25
[273] avgdrg_GM.xls; data provided by NSW Health Funding and Systems Policy Branch, 5 February 2003

Performance Audits by the Audit Office of New South Wales

Performance Auditing

What are performance audits?

Performance audits are reviews designed to determine how efficiently and effectively an agency is carrying out its functions.

Performance audits may review a government program, all or part of a government agency or consider particular issues which affect the whole public sector.

Where appropriate, performance audits make recommendations for improvements relating to those functions.

Why do we conduct performance audits?

Performance audits provide independent assurance to Parliament and the public that government funds are being spent efficiently and effectively, and in accordance with the law.

They seek to improve the efficiency and effectiveness of government agencies and ensure that the community receives value for money from government services.

Performance audits also assist the accountability process by holding agencies accountable for their performance.

What is the legislative basis for Performance Audits?

The legislative basis for performance audits is contained within the *Public Finance and Audit Act 1983, Part 3 Division 2A*, (the Act) which differentiates such work from the Office's financial statements audit function.

Performance audits are not entitled to question the merits of policy objectives of the Government.

Who conducts performance audits?

Performance audits are conducted by specialist performance auditors who are drawn from a wide range of professional disciplines.

How do we choose our topics?

Topics for a performance audits are chosen from a variety of sources including:

- our own research on emerging issues
- suggestions from Parliamentarians, agency Chief Executive Officers (CEO) and members of the public
- complaints about waste of public money
- referrals from Parliament.

Each potential audit topic is considered and evaluated in terms of possible benefits including cost savings, impact and improvements in public administration.

The Audit Office has no jurisdiction over local government and cannot review issues relating to council activities.

If you wish to find out what performance audits are currently in progress just visit our website at www.audit@nsw.gov.au.

How do we conduct performance audits?

Performance audits are conducted in compliance with relevant Australian standards for performance auditing and operate under a quality management system certified under international quality standard ISO 9001.

Our policy is to conduct these audits on a "no surprise" basis.

Operational managers, and where necessary executive officers, are informed of the progress with the audit on a continuous basis.

What are the phases in performance auditing?

Performance audits have three key phases: planning, fieldwork and report writing.

During the planning phase, the audit team will develop audit criteria and define the audit field work.

At the completion of field work an exit interview is held with agency management to discuss all significant matters arising out of the audit. The basis for the exit interview is generally a draft performance audit report.

The exit interview serves to ensure that facts presented in the report are accurate and that recommendations are appropriate. Following the exit interview, a formal draft report is provided to the CEO for comment. The relevant Minister is also provided with a copy of the draft report. The final report, which is tabled in Parliament, includes any comment made by the CEO on the conclusion and the recommendations of the audit.

Depending on the scope of an audit, performance audits can take from several months to a year to complete.

Copies of our performance audit reports can be obtained from our website or by contacting our publications unit.

How do we measure an agency's performance?

During the planning stage of an audit the team develops the audit criteria. These are standards of performance against which an agency is assessed. Criteria may be based on government targets or benchmarks, comparative data, published guidelines, agencies corporate objectives or examples of best practice.

Performance audits look at:

- processes
- results
- costs
- due process and accountability.

Do we check to see if recommendations have been implemented?

Every few years we conduct a follow-up audit of past performance audit reports. These follow-up audits look at the extent to which recommendations have been implemented and whether problems have been addressed.

The Public Accounts Committee (PAC) may also conduct reviews or hold inquiries into matters raised in performance audit reports.

Agencies are also required to report actions taken against each recommendation in their annual report.

To assist agencies to monitor and report on the implementation of recommendations, the Audit Office has prepared a Guide for that purpose. The Guide, *Monitoring and Reporting on Performance Audits Recommendations,* is on the Internet at www.audit.nsw.gov.au/guides-bp/bpglist.htm

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian and international standards. This includes ongoing independent certification of our ISO 9001 quality management system.

The PAC is also responsible for overseeing the activities of the Audit Office and conducts reviews of our operations every three years.

Who pays for performance audits?

No fee is charged for performance audits. Our performance audit services are funded by the NSW Parliament and from internal sources.

For further information relating to performance auditing contact:

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Performance Audit Reports

No.	Agency or Issue Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
64*	Key Performance Indicators	*Government-wide Framework* *Defining and Measuring Performance (Better practice Principles)* *Legal Aid Commission Case Study*	31 August 1999
65	Attorney General's Department	*Management of Court Waiting Times*	3 September 1999
66	Office of the Protective Commissioner Office of the Public Guardian	*Complaints and Review Processes*	28 September 1999
67	University of Western Sydney	*Administrative Arrangements*	17 November 1999
68	NSW Police Service	*Enforcement of Street Parking*	24 November 1999
69	Roads and Traffic Authority of NSW	*Planning for Road Maintenance*	1 December 1999
70	NSW Police Service	*Staff Rostering, Tasking and Allocation*	31 January 2000
71*	Academics' Paid Outside Work	*Administrative Procedures* *Protection of Intellectual Property* *Minimum Standard Checklists* *Better Practice Examples*	7 February 2000
72	Hospital Emergency Departments	*Delivering Services to Patients*	15 March 2000
73	Department of Education and Training	*Using Computers in Schools for Teaching and Learning*	7 June 2000
74	Ageing and Disability Department	*Group Homes for people with disabilities in NSW*	27 June 2000
75	NSW Department of Transport	*Management of Road Passenger Transport Regulation*	6 September 2000
76	Judging Performance from Annual Reports	*Review of Eight Agencies' Annual Reports*	29 November 2000
77*	Reporting Performance	*Better Practice Guide* *A guide to preparing performance information for annual reports*	29 November 2000
78	State Rail Authority (CityRail) State Transit Authority	*Fare Evasion on Public Transport*	6 December 2000
79	TAFE NSW	*Review of Administration*	6 February 2001
80	Ambulance Service of New South Wales	*Readiness to Respond*	7 March 2001
81	Department of Housing	*Maintenance of Public Housing*	11 April 2001

No.	Agency or Issue Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
82	Environment Protection Authority	*Controlling and Reducing Pollution from Industry*	18 April 2001
83	Department of Corrective Services	*NSW Correctional Industries*	13 June 2001
84	Follow-up of Performance Audits	*Police Response to Calls for Assistance* *The Levying and Collection of Land Tax* *Coordination of Bushfire Fighting Activities*	20 June 2001
85*	Internal Financial Reporting	*Internal Financial Reporting including a Better Practice Guide*	27 June 2001
86	Follow-up of Performance Audits	*The School Accountability and Improvement Model (May 1999)* *The Management of Court Waiting Times (September 1999)*	14 September 2001
87	E-government	*Use of the Internet and Related Technologies to Improve Public Sector Performance*	19 September 2001
88*	E-government	*e-ready, e-steady, e-government: e-government readiness assessment guide*	19 September 2001
89	Intellectual Property	*Management of Intellectual Property*	17 October 2001
90*	Intellectual Property	*Better Practice Guide* *Management of Intellectual Property*	17 October 2001
91	University of New South Wales	*Educational Testing Centre*	21 November 2001
92	Department of Urban Affairs and Planning	*Environmental Impact Assessment of Major Projects*	28 November 2001
93	Department of Information Technology and Management	*Government Property Register*	31 January 2002
94	State Debt Recovery Office	*Collecting Outstanding Fines and Penalties*	17 April 2002
95	Roads and Traffic Authority	*Managing Environmental Issues*	29 April 2002
96	NSW Agriculture	*Managing Animal Disease Emergencies*	8 May 2002
97	State Transit Authority Department of Transport	*Bus Maintenance and Bus Contracts*	29 May 2002
98	Risk Management	*Managing Risk in the NSW Public Sector*	19 June 2002
99	E-government	*User-friendliness of Websites*	26 June 2002
100	NSW Police Department of Corrective Services	*Managing Sick Leave*	23 July 2002

No.	Agency or Issue Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
101	Department of Land and Water Conservation	*Regulating the Clearing of Native Vegetation*	20 August 2002
102	E-government	*Electronic Procurement of Hospital Supplies*	25 September 2002
103	NSW Public Sector	*Outsourcing Information Technology*	23 October 2002
104	Ministry for the Arts Department of Community Services Department of Sport and Recreation	*Managing Grants*	4 December 2002
105	Department of Health Including Area Health Services and Hospitals	*Managing Hospital Waste*	10 December 2002
106	State Rail Authority	*CityRail Passenger Security*	12 February 2003
107	NSW Agriculture	*Implementing the Ovine Johne's Disease Program*	26 February 2003
108	Department of Sustainable Natural Resources Environment Protection Authority	*Protecting Our Rivers*	7 May 2003
109	Department of Education and Training	*Managing Teacher Performance*	14 May 2003
110	NSW Police	*The Police Assistance Line*	5 June 2003
111	E-Government	*Roads and Traffic Authority Delivering Services Online*	11 June 2003
112	State Rail Authority	*The Millennium Train Project*	17 June 2003
113	Sydney Water Corporation	*Northside Storage Tunnel Project*	24 July 2003
114	Ministry of Transport Premier's Department Department of Education and Training	*Freedom of Information*	28 August 2003
115	NSW Police NSW Roads and Traffic Authority	*Dealing with Unlicensed and Unregistered Driving*	4 September 2003
116	NSW Department of Health	*Waiting Times for Elective Surgery in Public Hospitals*	September 2003

* Better Practice Guides

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OF NEW SOUTH WALES

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Assisting Parliament improve the accountability and performance of the State

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