REVIEW OF ACCESS TO ELECTIVE SURGERY IN PUBLIC HOSPITALS – EXECUTIVE SUMMARY

PRIVATE PRACTICE ARRANGEMENTS FOR ACCESS TO ELECTIVE SURGERY IN VICTORIAN PUBLIC HEALTH SERVICES

A report on how clinical urgency, complexity, and categorisation affects waiting times for elective surgery for public and private patients in Victorian public health services

Professor David A Watters AM OBE

Alfred Deakin Professor of Surgery

Deakin University and Barwon Health

University Hospital Geelong, Bellerine St, Geelong 3220

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Victorian Auditor General in a 2019 report, 'Managing Private Medical Practice in Private Hospitals'[1], found examples of private patients offered preferential access to elective surgery over their public counterparts at Sunbury Day Hospital.

I was appointed to review private practice arrangements in Victorian public health services to determine whether private patients are being prioritised over public patients with regards to access to elective surgery on the grounds of their insurance status and/or ability to pay.

The National Health Reform Agreement and Victorian Elective Surgery Access Policy (2015)[2] clearly state that a patient should only be prioritised on the grounds of clinical urgency and not on their insurance status. Everyone also has the right to choose to be treated in a public hospital, either as a public or a private patient.

I acknowledge the support of analysts from the Department of Health and Human Services to develop reports of public versus private waiting times for elective surgery against the urgency category, specialty and common procedures. The major source of data from which the reports were generated was the Elective Surgery Information System (ESIS)[3]. These reports were sent to health services, together with a short structured survey, addressing how patients are prioritised, the escalation pathway to be followed if private patients were preferentially treated, and what level of monitoring of equity of access takes place. Where the reports showed apparent differences between private and public patients, specific questions were raised to clarify the local reasons for these.

Key findings

[1] Victorian Auditor-General's Office (VAGO). Managing Private Medical Practice in Public Hospitals. June 2019.

[2] Department of Health and Human Services. Elective surgery access policy 2015. Chapter 6, p 6 and Chapter 11 p 17.

[3] DHHS. Elective Surgery Information System (ESIS) Manual 21st Edition 2018-2019

1. In 2018-19, only 9.2% of patients receiving elective surgery in ESIS-reporting public hospitals are private patients (Table 1, p13).

2. I found no evidence of private patients currently being consistently prioritised over public patients in Victorian public health services.

3. Health services aim to follow the Elective Surgery Access Policy (2015) and are aware of the recent VAGO report. However, most do not generate or review health-service level reports that inform them as to whether they achieve equity of access between private and public patients.

4. Where there were apparent differences in median waiting times there were a number of potentially valid reasons. These included patient complexity or acuity, resource requirements, the need for multiple surgical teams required to treat a patient, the format of waiting lists (individual surgeon, unit or specialty), private lists within the operating template, and theatre efficiency/utilisation.

5. In some health services a proportion of private patients only elect to be private when admitted for surgery. During their waiting time, their insurance status may be noted as public or not declared. This makes it difficult to identify whether patients waiting for elective surgery are 'private' patients.

6. There are too few private patients to generate valid and reliable 'treat in turn' reports by urgency category, specialty and procedure for private patients. Treat in turn reports have value but need to take into account waiting lists formats within a health service - whether listed by surgeon, unit or specialty.

7. Most health services schedule private patients on public operating lists and no longer retain private lists within their operating template. There are still some that do offer private lists. VAGO report recommendation 7 addressed the issue of private patients on private lists being kept separate from the waiting list for public operating lists.

Recommendations[4]

[4] [The agency(ies) responsible to address the recommendation in parenthesis]

1. Policy and Communication: A revised Elective Surgery Access Policy espousing the same principles, can provide clearer guidance on the issues affecting private patients in public hospitals [DHHS]. The document 'Private patients - principles for public hospitals' should be updated to be made more contemporary [DHHS].

2. Monitoring: Equity of access should be monitored through reports provided annually to health services that compare public and private patients against categorisation, waiting times, specialty, common procedures, and hospital-initiated postponements [DHHS]. The health services would value and respond to such reports.

3. Monitoring and Policy: The urgency categorisation for public and private patients should be reported against the national recommended categories, but the recommended categories for individual common procedures may require some revision in consultation with surgical specialties [DHHS and Surgical Directors].

4. Monitoring: Treat in turn rates (percentages) should be reported for urgency category, specialty and common procedures for public and private patients combined [DHHS].

5. Monitoring : In addition to DHHS reports, health services also should monitor their own performance against urgency categorisation and waiting times by specialty, commonly performed procedures, and, if necessary, unit and specialist, depending on how their waiting lists are structured.[Health Services]

6. Process: Health services should ensure that treating clinicians are aware that private patients should not be prioritised on the grounds of their insurance status, nor the ability to pay, and should ensure that there is an escalation policy where categorisation or prioritisation appear to be out of line with the Elective Surgery Access Policy. Reports on equity of access should be provided to clinicians and units [Health Services and Clinicians].

7. Process: Health services should reconsider the value of private lists to their community and organisation. Where they do retain them, health services should work with DHHS to ensure that private patients being treated on private operating lists (where these form part of the operating template) are not counted in reports

comparing public and private access, as per recommendation 7 of the VAGO report.[5] Also the patient's choice of being treated as public or private should be recorded as soon as possible in ESIS to enable better identification of private and public patients within ESIS [Health Services and DHHS].

Summary

The data available within the Elective Surgery Information System provides reassurance that in general, private patients are not being prioritised over public patients on the grounds of their insurance status. There is still value in public and private patient waiting times being reported and fed back to health services on an annual basis, as scrutiny of these will promote attention by health services, waiting list managers and clinicians. Although reports will raise apparent (but usually not real) differences between equity of access for private and public patients, such reports are deserving of, and likely to be valued by, local health service review to use them to inquire what are the (often valid) underlying reasons. The escalation process to manage inequity of access within a health service should be clearly defined. Feedback from health services suggests that once escalation reaches the level of the Director of Surgery, clinicians prone to over-prioritise private patients will respond and comply with the Elective Surgery Access Policy. DHHS review of recommended urgency categorisation for individual procedures is recommended, as is the reporting of treat in turn performance for public and private patients combined.

[5] VAGO report. Managing Private practice in public hospitals. June 30 2019, p11 and Section 2.2