CONTROLLER AND AUDITOR-GENERAL
Tumuaki o te Mana Arotake

Performance audit report

Progress in delivering publicly funded scheduled services to patients

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Progress in delivering publicly funded scheduled services to patients

This is the report of a performance audit we carried out under section 16 of the Public Audit Act 2001

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Auditor-General's overview

New Zealand will always have more patients than our publicly funded non-urgent medical and surgical services (scheduled/elective services) can cope with at any one time. Common scheduled services include treating cataracts; inserting grommets to fight recurring ear infections; replacing hip and knee joints; repairing hernias; and unblocking damaged blood vessels or arteries. New Zealand is not alone with this challenge, as public health systems throughout the world continue to struggle to prioritise patients' needs and to balance the demand for scheduled services with available resources.

So, how does the health system decide who should be seen and treated, and when?

In 2000, our public health system changed from using waiting lists to a new strategy. The strategy aimed to ensure that patients are seen and treated within six months. These days, about 90% of patients (about 61,200 people) are getting scheduled services within this six-month limit. In the last five years, more patients have been getting services because of increased funding. However, about 6800 people do not receive required services in the six-month time frame and some have waited up to two years.

There is also no certainty that the "right" patients are always seen or treated in the appropriate order. Prioritisation matters because patients should not suffer unreasonable distress, ill health, or incapacity while they are waiting their turn or miss out on treatment. Equity is also important. Patients and their families should be confident that access to scheduled services is the same regardless of where they live.

Despite the encouraging improvements made in the last 10 years, we do not yet have a system for scheduled services that can demonstrate national consistency and equitable treatment for all. Our audit suggests that such a system is achievable. There are useful steps being taken, such as the introduction of a new tool to prioritise patients for cardiac surgery. I encourage the Ministry of Health, district health boards, and medical specialists to identify any disincentives and focus on putting in place systems and tools to make sure that the right patients get access to services at the right time.

This is a complex topic and deserves detailed consideration. Readers with limited time may prefer to read only our summary of progress against the strategy's main objectives. I thank all those who shared information about scheduled services with my staff.

Lyn Provost
Controller and Auditor-General

7 June 2011

Our recommendation

We recommend that the Ministry of Health and district health boards agree:

- what they will do to improve their progress in more fully achieving the Strategy's objectives; and
- when they will do it and how they will demonstrate that improvements have been achieved.

The priority areas that we recommend they focus on are ensuring that:

- patients are more consistently selected for first specialist assessments;
- patients are more consistently prioritised for treatment;
- a greater proportion of patients receive scheduled services within the expected time limits;
- a greater proportion of patients are treated in priority order; and
- progress is made in quantifying the level of unmet need for scheduled services.

The Ministry supports our recommendation. It agrees that the five priority areas that we have identified have merit. The Ministry believes that these five areas are reflected in its current work programme and the activities of, for example, the National Health IT Board and the National Cardiac Surgery Clinical Network.

We plan to publicly report on the Ministry's and DHBs' progress as part of our series of annual reports called *Public entities' progress in implementing the Auditor-General's recommendations*. We plan to do this for the first time in 2013.

Summary of progress against the Strategy's main objectives

This is a summary of progress towards achieving the main objectives of the government strategy *Reduced Waiting Times for Public Hospital Elective Services: Government Strategy* (the Strategy). This summary highlights where further progress is needed. It is not a full summary of our report, and readers with more time should read the whole report.

The Strategy's main objectives are to ensure:

- that patients wait no more than six months for their first assessment with a specialist (first specialist assessment, or FSA);
- that all patients with a level of need that can be met within the resources (funding) available are provided with surgery within six months of assessment;
- a level of publicly funded service that ensures access to scheduled services before patients reach a state of unreasonable distress, ill health, and/or incapacity; and
- national equity of access to scheduled services, which means that patients with a similar level of health need and ability to benefit from treatment have similar access to scheduled services, regardless of where they live.

Waiting times for first specialist assessment and treatment

At the end of June 2003, there were 36,190 patients still waiting for an FSA or treatment that they should have received within six months. District health boards (DHBs) made relatively fast progress in reducing these numbers. By 30 June 2007, this figure was 7688. Since then, progress has slowed.

At the end of June 2010, there were 6821 patients who had not yet received scheduled services that they should have received within six months (see Figure 3). At the end of each month during 2009/10, between 3500 and 5500 patients had not received their FSA within six months, and between 2700 and 3600 had not been treated within six months (see paragraph 4.60).

Of the patients seen and treated in June 2010:

- 89% of surgical patients received an FSA within six months (see Figure 5);
- 93% of medical patients received an FSA within six months (see Figure 6);
- 89% of surgical patients were treated within six months (see paragraph 4.65 and Figure 7); and
- 95% of medical patients were treated within six months (see paragraph 4.65 and Figure 8).

From 2006 to 2010, most patients who received treatment in June of each year were treated within four months. By June 2010, fewer patients had waited longer than nine months before receiving treatment (see Figures 7 and 8).

The Strategy's implementation has provided increasing certainty that, as a group, patients who are offered scheduled services will receive them within six months. This is an improvement on the waiting list system and early booking systems that the Strategy replaced. That 89% to 95% of patients received scheduled services within six months is a good result compared to the past situation. However, under the Strategy, each individual patient is meant to wait no more than six months for an FSA or treatment. The results for June 2010 mean that 10% of patients did not receive scheduled services within six months.

DHBs need to improve their ability to match the number of patients accepted for scheduled services to their resources. We expect DHBs to achieve this by making scheduled services more effective and efficient (or by increasing resources used for scheduled services) rather than by raising the thresholds for access to scheduled services. In Part 4, we suggest some improvements that DHBs could make.

We consider that the public's perception of the DHBs' performance would be improved if DHBs took a different approach to publicly reporting on their progress. We consider that our approach in Figures 5-8 gives DHBs credit for good performance and shows where there are any emerging or increasing problems. For example, Figure 7 indicates that, from 2006 to 2010, fewer patients waited longer than nine months for treatment, but an increasing number were treated in six to nine months.

National equity of access to scheduled services

National equity of access to scheduled services means that patients with a similar level of need and ability to benefit from treatment will have similar access to scheduled services, regardless of where they live. Two sets of national tools were considered necessary to implement the Strategy – selection (sometimes called triaging) tools to decide which patients would get an FSA within six months and prioritisation tools to decide which patients had priority for treatment within six months.

Access to an FSA

We found that patients are selected for an FSA using three main methods. Two of these methods are likely to achieve consistency within the DHB even if selection tools are not used (see paragraphs 5.7-5.13).

National selection tools are needed to achieve consistency throughout the country. To the best of our knowledge, there are currently no such up-to-date tools (see paragraphs 5.14-5.17). This means that specialists are using local tools or outdated national tools, which may not produce the same scores for patients in similar circumstances. As a result, we consider that it is unlikely that patients seeking an FSA are selected consistently throughout the country.

Access to treatment

Under the Strategy, national prioritisation tools are meant to ensure that each patient's level of health need and ability to benefit from treatment is assessed consistently throughout the country. There are 30 currently available national prioritisation tools, but they do not apply to all patients who are prioritised for scheduled services. Some of these tools are not of good quality and may not meet the Strategy's objectives.

DHBs also use local tools. Each DHB's version of these tools may not produce the same or similar priority scores for patients in similar circumstances. This means that access by priority score cannot be used to fairly compare thresholds for access to treatment between DHBs. We are also aware of practices within DHBs that have not changed in any material way since the Strategy was introduced (see paragraphs 5.32-5.34).

We consider that not all patients are consistently prioritised for treatment (see paragraph 5.36 and Figure 10). Without consistency in priority scores, the objectives of prioritisation (such as applying standard processes, defining levels of need, and ensuring similar access between specialties or procedures) are simply not achievable.

Treating patients in priority order

Once patients are allocated a priority score, they should be treated in priority order. Figure 9 shows how this is done for cardiac surgery patients. The principle is the same for all patients waiting for scheduled treatment. Figure 9 demonstrates that there is no problem in quickly treating patients with low scores as long as patients with higher scores are treated within a suitable period.

To test whether DHBs apply this principle in practice, we compared the results in 2006 and 2010 for patients in one DHB who had received cardiac, general gynaecology, and hip and knee replacement surgery. We expected that the graphs for 2010 (see Figures 12, 14, and 16) would show the pattern of treatment set out in Figure 9, but over six months. General gynaecology surgery came the closest (see Figure 14), but some patients had waited much longer than other patients with similar scores.

We are particularly concerned that problems with treating adult cardiac surgery patients in priority order are longstanding (see paragraphs 5.40-5.42). We consider that DHBs need to address this problem as soon as possible.

Improving progress

Some DHBs told us that progress towards achieving national equity had been slow and needed to improve. They raised doubts about the commitment to prioritisation. We consider that there have been muddled responsibilities for the life cycle of the prioritisation tools, which may have contributed to slow progress in this area (see paragraphs 5.56-5.65).

We consider that the specialists' professional groups should be responsible for:

- preparing, introducing, and using national access criteria for FSAs;
- preparing, introducing, and using a full suite of national tools to prioritise patients for treatment;
- ensuring that these tools are able to:
  - produce scores that reflect a patient's need and ability to benefit from treatment relative to other patients; and
  - produce scores that have a matching clinically appropriate treatment period (see paragraph 5.26-5.28); and
- analysing and/or auditing the results that the national tools produce so as to improve them (see paragraphs 5.53-5.55).

Increasing the supply of scheduled services to prevent unreasonable distress

Under the Strategy, patients are meant to receive scheduled services before they reach a state of unreasonable distress, ill health, and/or incapacity.

Before the Strategy was introduced, DHBs were to reduce the backlogs of patients waiting for an FSA and/or treatment and add no new patients to these lists. The backlogs had more than halved by the time the Strategy was introduced. They were finally cleared in 2006. DHBs achieved this at the same time as trying to ensure that newly referred patients were seen and/or treated within six months.

The number of surgical operations decreased in 2001/02 and 2002/03 before slowly increasing up to 2005/06. Since 2006/07, the number of operations has increased more quickly – partly as a result of increased funding (see Figure 17).

We agree that more work is needed to know whether increased scheduled services have reduced unmet need (see paragraph 5.56). If we had been able to fairly compare the priority scores at which patients got access to scheduled services, we might have been able to examine this matter in more detail and draw conclusions. Until this is possible, it is difficult to know whether:

- the patients who needed treatment the most were treated, regardless of where they live;
- patients were able to receive surgery before suffering unreasonable distress, ill health, and/or incapacity; and
- increases in the provision of treatment had occurred in the specialties or procedures where it was needed the most, regardless of where patients live.

In the meantime, the Ministry of Health (the Ministry) is using other means, such as standardised intervention rates, to help scheduled services keep up with changes in population demographics and population growth, and to remedy inequitable access between DHBs (see paragraphs 6.9-6.11).

Improving service delivery

Setting priorities

We found that one DHB's progress in improving scheduled services stalled while it waited for its neighbouring DHB(s) to catch up. This can be a problem when DHBs share a patient's care (see Appendix 4). We also observed that clever ideas and improvements in one DHB had not been taken up by other DHBs. The reasons for this are not entirely clear. Differing priorities are a contributing factor, as are each DHB's capacity and capability. Sometimes, a single DHB has found it difficult to improve its systems and methods entirely on its own. More could be achieved if DHBs shared some of the workload and costs.

Therefore, we suggest that the Ministry and DHBs agree on a set of priorities for better managing scheduled services and implement them in a series of five-year plans. For example, regional booking systems are needed to:

- effectively manage the care of patients whose care is delivered by more than one DHB;
- help DHBs to improve inter-regional equity; and
- make the best use of theatre time and the specialist workforce.

Having agreed a set of priorities, the Ministry would be in a position to advise the Government on how any proposed changes to scheduled services would affect the agreed priorities.

Care pathways

Even when DHBs are able to provide all FSAs and treatment on time, the value of this to each patient is undermined if their care "from start to finish" is delayed by inefficient service delivery.

Figure 1 details our understanding of how a patient who needs surgery moves through the scheduled services system. Applying this generic approach to patients with specific health needs produces a care pathway. Appendix 5 provides an example of a care pathway for patients needing a hip or knee replacement.

Care pathways enable DHBs to "join the dots" by bringing together the decisions and activities that make up scheduled services. Care pathways outline the care that the patient should receive and when, which means that care pathways cross traditional boundaries between community and hospital care. Care pathways can help to make the best use of available resources.

A few DHBs have introduced, or are planning to introduce, care pathways for some or all medical and surgical specialties. There is a real risk that 20 DHBs could produce 20 different sets of care pathways (and so different standards of clinical practice) for the same set of conditions, which would not be desirable. DHBs are responsible for the quality of care that they deliver, and we expect them to want that care to be of a consistently high standard throughout the country. We also consider that such duplication would be a waste of public funds and scarce clinical resources.

Diagnostic tests

The Strategy discussed services to provide access to diagnostic tests in its description of problems with waiting lists for scheduled services. Getting access to a test at the right time is useful in determining whether or how quickly patients should be seen by a specialist or treated.[1] Protocols to implement care pathways would set out whether diagnostic tests could be requested by the GP directly or by the specialist after an FSA or virtual FSA.

We understand that improved access to diagnostic tests by GPs is being dealt with as part of the Better Sooner More Convenient initiative in primary health care. However, specialists also need timely access to diagnostic tests from their Home DHB and/or Treating DHBs. We consider that there is a risk that access to diagnostic test services will further fragment unless access criteria are based on patient need rather than who orders the test.

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1 In December 2008, the Royal New Zealand College of General Practitioners estimated that one in five patients waiting for an FSA were waiting because they needed access to diagnostic tests. The patients may or may not have needed to have an FSA before receiving a diagnostic test.

Part 1
Introduction

1.1 In this Part, we explain:

- our approach to this topic;
- what scheduled services are;
- why scheduled services are important to the public;
- how much is spent on publicly funded scheduled services; and
- the cost of not providing scheduled services.

Our approach to this topic

1.2 In March 2000, the then Government released its strategy to reduce waiting times for scheduled services – *Reduced Waiting Times for Public Hospital Elective Services: Government Strategy* (the Strategy). The Strategy set out proposed improvements to booking systems of district health boards (DHBs) and their management of scheduled services. The Strategy introduced maximum waiting times (of six months each) for scheduled specialist advice and treatment. DHBs continue to implement the Strategy.

1.3 During 2009 and 2010, we sought to understand how the Strategy was being carried out and the progress that had been made towards the Strategy's objectives. We have broadly assessed the public health sector's progress in implementing the Strategy. We did not specifically audit the performance of any of the DHBs, the Ministry of Health (the Ministry), or the Accident Compensation Corporation (ACC).

1.4 Appendix 1 sets out more details about our methodology. We have not adjusted the statistics that we report to account for population growth. The terms used in this report are explained in a Glossary at the end.

What scheduled services are

1.5 Broadly, there are two types of scheduled services for medical and surgical conditions:

- specialist advice; and
- treatment.

1.6 Patients can receive their care entirely in the public or private sectors. Alternatively, they can move between the public and private systems to get these services. They can receive their specialist advice (and any related diagnostic tests) from the public system and be treated privately, or the reverse.

1.7 A patient's primary care professional, such as a general practitioner (GP), optometrist, or dentist, can seek specialist advice. In the private sector, patients are sometimes able to see specialists without a referral – for example, for dermatology services. Specialists in one branch of medicine can refer patients to specialists in another branch. Specialist advice can be delivered by telephone, electronically, or by letter and may or may not require the patient to attend an appointment with a specialist.

1.8 GPs can ask for specialist advice to:

- reach or confirm a diagnosis;
- get the patient access to a diagnostic test that the GP is not allowed to order; or
- check that the current treatment regime is the best one for the patient.

1.9 GPs can also ask a specialist to take over the patient's care until the patient can be safely returned to the GP's care.

1.10 Treatment can be recommended or offered to a patient when a specialist considers that it would improve the patient's quality of life – by reducing pain or discomfort, improving independence, or increasing the patient's ability to engage in the activities of daily life – or life expectancy. Treatment can be provided to the patient in an out-patient, day stay, or in-patient setting. Examples of common scheduled treatments are operations or procedures to:

- treat cataracts;
- insert tubes, called grommets, to treat recurring ear infections;
- replace hip and knee joints affected by arthritis;
- remove gallbladders, prostates, and uteruses;
- repair hernias;
- repair or unblock damaged blood vessels or arteries; and
- relieve angina by using a blood vessel from the patient's chest or leg to bypass clogged heart arteries.

1.11 We found some disagreement about the importance of scheduled services. Some specialists and DHB staff consider that scheduled services are those that DHBs provide only after they have assigned funds to all other services.

1.12 In part, the Strategy was introduced because of a concern that some operations were difficult to get in public hospitals. Patients in some parts of the country were waiting too long and were very unwell before they were treated. Therefore, the Strategy was prepared in a political and policy environment that considered that scheduled services were an integral part of our public health system.

1.13 DHBs have some discretion about the mix of scheduled services that they fund and/or provide. In other instances, the Ministry sets targets for DHBs to provide a certain number of some operations, such as cataract and hip and knee replacement operations. Currently, a Health Target monitors DHBs' combined progress against the number of surgical procedures they must provide during a financial year. Since 2008, DHBs have been expected to increase the number of patients receiving scheduled surgery each year by an average of 4000 operations nationally. Only surgical operations, excluding dental operations, count towards this Health Target. Information about the Health Targets is available from www.moh.govt.nz.

Why scheduled services are important to the public

1.14 Internationally, the public, politicians, health departments, and bodies such as the Organisation for Economic Co-operation and Development consider that long waiting lists for publicly funded scheduled services suggest that a health system is performing poorly.

1.15 Public and political interest in the availability of these services is persistent in our country. More often than not, the main public and political concern is about the availability of scheduled surgery. News media stories regularly highlight problems with patients' access to specialist advice or waiting times for surgery.

1.16 The systems to provide scheduled services are complex, and scheduled services are not isolated from other health and disability services. A "bottleneck" in one part of the system can affect the delivery of scheduled services or whether patients can get some services. For example, until patients receive certain diagnostic tests, it can be difficult to know whether they need unscheduled or scheduled services – or no services at all.

1.17 Evidence about the effect of waiting for scheduled services is limited. Research findings tend to conclude that serious, irreversible, or catastrophic effects of waiting are rare but can occur if surgery for life-threatening conditions is delayed for significant periods of time.

1.18 Some evidence exists of deterioration in health while waiting for treatment for some conditions. While waiting for scheduled services, some patients may need unscheduled services for an exacerbation of their problem or for a new problem, such as a heart attack. If their scheduled treatment is delayed for too long, patients might:

- lose their jobs and need a sickness benefit;
- need publicly or privately funded home support services, or extra support from family;

- suffer from side effects from pain, limited mobility, or medication that, in turn, need treatment or make recovery from surgery more difficult; or
- experience disrupted social relationships.

How much is spent on publicly funded scheduled services

1.19 We estimate that about $1.23 billion was spent on publicly funded scheduled services in 2009/10. This comprised about $1 billion from the Ministry to DHBs and about $234 million from ACC to DHBs and private hospitals or surgeons.

1.20 Funding for scheduled services makes up about 7.7% of the Ministry's total funding to DHBs.

1.21 ACC has contracts with private hospitals and DHBs to deliver scheduled surgery. In 2009/10, it spent about $195 million (83% of its total spending) on scheduled services delivered in the private sector and about $39 million (17% of its total spending) on scheduled services delivered by DHBs. We discuss ACC's overall approach to scheduled services in more detail in Appendix 2.

1.22 From 2005 to 2007, 30% of all scheduled services were privately funded. Most of these patients were low risk (see paragraph 3.25).

The cost of not providing scheduled services

1.23 It is difficult to quantify the cumulative cost of not providing effective and efficient scheduled services. Good information is sometimes available about the cost of some ineffective or inefficient scheduled services, the cost of delaying surgery for too long, or the cost to the country of not publicly funding some types of surgery. For example, studies have calculated the benefits of replacing hip and knee joints or performing cataract operations earlier in a person's life.[2]

1.24 However, that is only some of the information that DHBs need to consider when deciding what proportion of their funding to allocate for scheduled services. The New Zealand Public Health and Disability Act 2000 (the Act) requires each DHB to regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB considers may adversely affect the health status of that population, and the needs of that population for services (see section 23(1)g of the Act).

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[2] For example, Fielden, Jann M et al (2005), "Waiting for hip arthroplasty: economic costs and health outcomes", *The Journal of Arthroplasty*, Vol. 20, No. 8, page 990-997.

Part 2

Reasons for introducing a strategy for delivering scheduled services

2.1 In this Part, we discuss the introduction of the Strategy and its principles and main objectives.

Introducing the Strategy in 2000

2.2 Booking systems were introduced in 1996 to replace waiting lists, and all public hospitals were to have a booking system in place from 1 July 1998. In 2000, the then Government's response to problems that arose with the booking systems was to release the Strategy, which changed the booking systems and introduced other measures.

2.3 The Strategy states that the quantity of scheduled services that taxpayer funding can support is limited. Under the Strategy, public hospitals are expected to tell patients if they are unlikely to receive, or will not receive, publicly funded scheduled services. Patients who are not offered scheduled services can have their condition managed in some other way, such as by their GP or in the private sector. Otherwise, they wait until their condition worsens enough to qualify for publicly funded treatment.

2.4 By implication, the Strategy acknowledges that scheduled services will be delivered jointly by the public and private health systems. Many factors determine the specific contribution of the private health system, such as whether the public health system offers the service and whether services offered are enough to meet the health need. Whether patients get scheduled services in the private sector is also affected by:

- their willingness to accept the rules used to decide their access to scheduled services in the public system;
- how long they may wait for scheduled services at a public hospital; and
- whether it is feasible for them to opt out of the public system.

The Strategy's principles and objectives

2.5 Three principles – clarity, fairness, and timeliness – underpin the Strategy's four main objectives, which are to ensure:

- that patients wait no more than six months for their first assessment with a specialist (first specialist assessment, or FSA);
- that all patients with a level of need that can be met within the resources (funding) available are provided with surgery within six months of assessment;
- a level of publicly funded service that ensures access to scheduled services before patients reach a state of unreasonable distress, ill health, and/or incapacity; and

- national equity of access to scheduled services, which means that patients with a similar level of health need and ability to benefit from treatment have similar access to scheduled services, regardless of where they live.

2.6 The Strategy identified seven sub-strategies to achieve these objectives. We have focused on the first three of these, and the actions to implement them, because they are the most important to patients. They are:

- give patients certainty;
- achieve nationally consistent clinical assessment; and
- increase the supply of scheduled hospital services.

Part 3

How the Strategy is meant to work

3.1 In this Part, we discuss:

- how scheduled services are rationed for groups of patients;
- how scheduled services are rationed for individual patients;
- whether patients are able to receive scheduled services from other DHBs;
- the pathway from referral to treatment; and
- what happens when ACC declines requests to fund scheduled surgery.

Rationing scheduled services for groups of patients

3.2 In 2004, the Ministry began to set minimum levels of funding for scheduled services. Before an individual patient and GP consider whether the patient needs scheduled services, the Government, the Ministry, and each DHB have already decided how much funding is available for:

- scheduled services, compared to all other services that the Home DHB funds;
- specialties within scheduled services that the Home DHB provides; and
- patients who will be treated by a Treating DHB.

3.3 Ideally, these decisions would be made using information about the health needs of each DHB's population, national priorities, and the cost-effectiveness of scheduled services at the population level and for individuals. In reality, these decisions are affected by a complex interaction of factors, such as:

- hesitation to use economic tools, such as Quality Adjusted Life Years or Patient Reported Outcome Measures, to decide which scheduled services to fund and by how much;
- historical funding and service provision;
- inadequate information about the cost-effectiveness of many treatments;
- increasing sub-specialisation in medicine and surgery;
- local concerns and lobbying by community groups or health professionals;
- the available workforce;
- the DHB's financial situation; and
- the priorities of the Government.

Rationing scheduled services for individual patients

3.4 Rationing is not needed if everyone who needs treatment can have it. However, funding for health care is always limited compared with the demand, and health workforce shortages are a continuing problem. The Strategy accepts that no-one is automatically entitled to scheduled services. Some conditions or levels of health need have no realistic prospect of treatment within the public system.

3.5 Specialists and health authorities have always decided “who will get what”, but the methods for reaching those decisions were not necessarily clear and consistent. Conceptually, the Strategy sets out a relatively simple method for systematically rationing the resources available for scheduled services to individual patients. For each patient, the system involves a series of important decisions about whether they could benefit from scheduled services and, if they could, whether the DHB can deliver those services within time limits set by the Government.

3.6 To help reduce unrealistic expectations, some DHBs send to GPs lists of the conditions – such as haemorrhoids, hernias, varicose veins, and bunions – that they do not routinely manage. This is because most patients with these conditions will have low priority relative to other patients. These may not be the same conditions in every DHB.

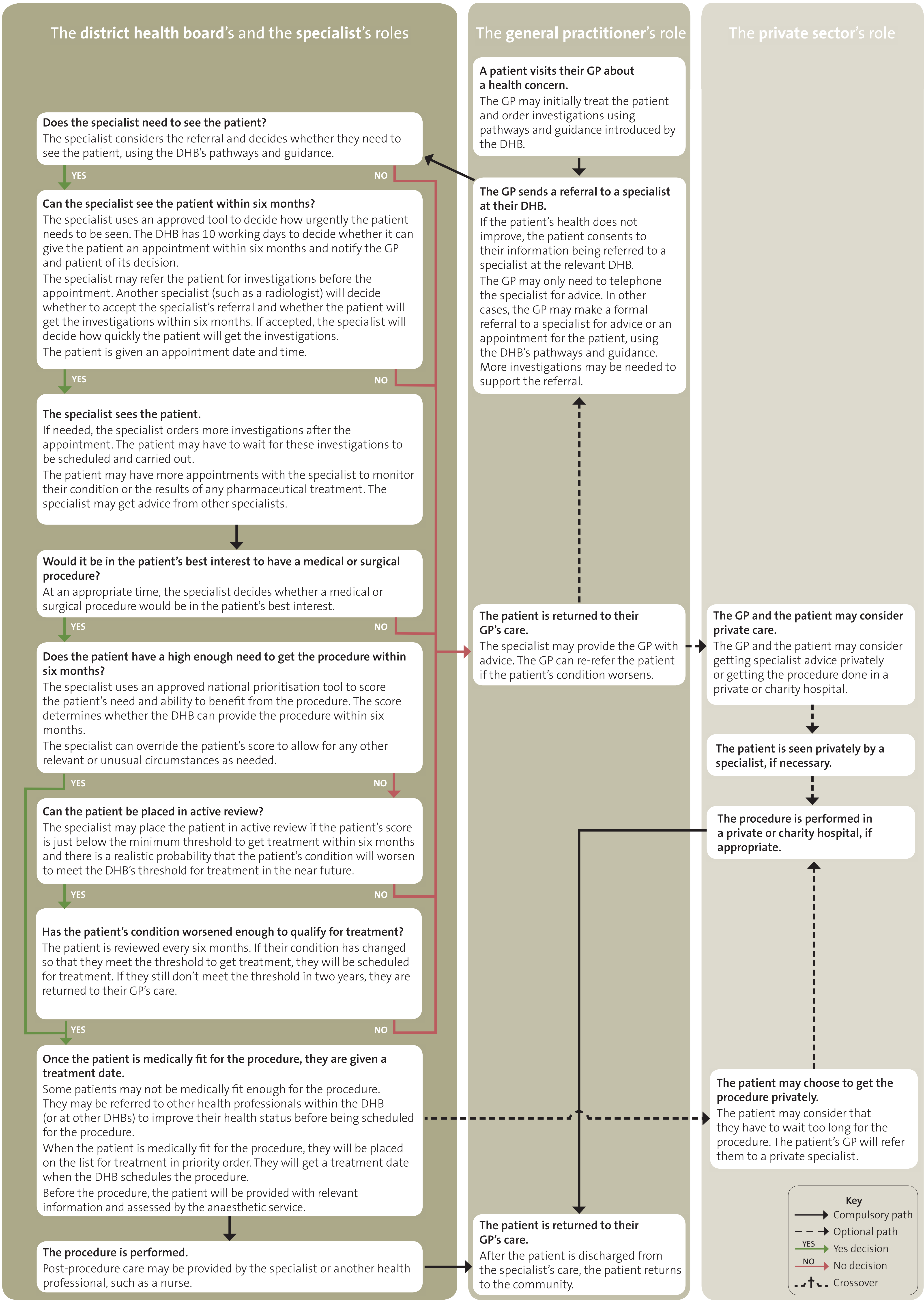
3.7 Figure 1 sets out the intended process for making prioritisation decisions. It separates the responsibilities and decisions of the GP, specialist, and DHB in determining whether patients receive scheduled services. In summary:

- With the patient’s agreement, the GP decides whether to put the patient forward for specialist advice and/or treatment, and provides information and advice to the specialist.
- The specialist selects those patients who would benefit from an FSA or treatment. The specialist might provide information and advice to the patient and GP about the patient’s care, whether or not the patient needs an FSA.
- The DHB decides whether the patient can receive scheduled services within six months (with the existing resources) and provides the administrative system and management support for GPs, specialists, and patients.

Figure 1
Intended process for managing a patient referral for scheduled services

See the A3 fold-out on the facing page.

Intended process for managing a patient referral for scheduled services



The **district health board**'s and the **specialist**'s roles

Does the specialist need to see the patient?
The specialist considers the referral and decides whether they need to see the patient, using the DHB's pathways and guidance.

YES NO

Can the specialist see the patient within six months?
The specialist uses an approved tool to decide how urgently the patient needs to be seen. The DHB has 10 working days to decide whether it can give the patient an appointment within six months and notify the GP and patient of its decision.

The specialist may refer the patient for investigations before the appointment. Another specialist (such as a radiologist) will decide whether to accept the specialist's referral and whether the patient will get the investigations within six months. If accepted, the specialist will decide how quickly the patient will get the investigations.

The patient is given an appointment date and time.

YES NO

The specialist sees the patient.
If needed, the specialist orders more investigations after the appointment. The patient may have to wait for these investigations to be scheduled and carried out.

The patient may have more appointments with the specialist to monitor their condition or the results of any pharmaceutical treatment. The specialist may get advice from other specialists.

Would it be in the patient's best interest to have a medical or surgical procedure?
At an appropriate time, the specialist decides whether a medical or surgical procedure would be in the patient's best interest.

YES NO

Does the patient have a high enough need to get the procedure within six months?
The specialist uses an approved national prioritisation tool to score the patient's need and ability to benefit from the procedure. The score determines whether the DHB can provide the procedure within six months.

The specialist can override the patient's score to allow for any other relevant or unusual circumstances as needed.

YES NO

Can the patient be placed in active review?
The specialist may place the patient in active review if the patient's score is just below the minimum threshold to get treatment within six months and there is a realistic probability that the patient's condition will worsen to meet the DHB's threshold for treatment in the near future.

YES NO

Has the patient's condition worsened enough to qualify for treatment?
The patient is reviewed every six months. If their condition has changed so that they meet the threshold to get treatment, they will be scheduled for treatment. If they still don't meet the threshold in two years, they are returned to their GP's care.

YES NO

Once the patient is medically fit for the procedure, they are given a treatment date.
Some patients may not be medically fit enough for the procedure. They may be referred to other health professionals within the DHB (or at other DHBs) to improve their health status before being scheduled for the procedure.

When the patient is medically fit for the procedure, they will be placed on the list for treatment in priority order. They will get a treatment date when the DHB schedules the procedure.

Before the procedure, the patient will be provided with relevant information and assessed by the anaesthetic service.

The procedure is performed.
Post-procedure care may be provided by the specialist or another health professional, such as a nurse.

The **general practitioner**'s role

A patient visits their GP about a health concern.
The GP may initially treat the patient and order investigations using pathways and guidance introduced by the DHB.

The GP sends a referral to a specialist at their DHB.
If the patient's health does not improve, the patient consents to their information being referred to a specialist at the relevant DHB.

The GP may only need to telephone the specialist for advice. In other cases, the GP may make a formal referral to a specialist for advice or an appointment for the patient, using the DHB's pathways and guidance. More investigations may be needed to support the referral.

The patient is returned to their GP's care.
The specialist may provide the GP with advice. The GP can re-refer the patient if the patient's condition worsens.

The patient is returned to their GP's care.
After the patient is discharged from the specialist's care, the patient returns to the community.

The **private sector**'s role

The GP and the patient may consider private care.
The GP and the patient may consider getting specialist advice privately or getting the procedure done in a private or charity hospital.

The patient is seen privately by a specialist, if necessary.

The procedure is performed in a private or charity hospital, if appropriate.

The patient may choose to get the procedure privately.
The patient may consider that they have to wait too long for the procedure. The patient's GP will refer them to a private specialist.

Key
→ Compulsory path
- - → Optional path
YES → Yes decision
NO → No decision
- -†- - Crossover

Source: Office of the Auditor-General (2011). Reprints of this chart can be downloaded from www.oag.govt.nz.

Receiving scheduled services from another district health board

3.8 If the Home DHB does not have the necessary clinical expertise, patients can be referred to a Treating DHB. It is common practice for GPs to send referrals to Treating DHBs without getting the Home DHB's permission. In other instances, a patient will start out with an FSA at their Home DHB. The Home DHB will refer the patient to a Treating DHB when their health needs are clearer. The Treating DHB will prioritise all referrals using its usual criteria, regardless of the source of the referral.

3.9 Each DHB treats its own patients, refers its patients to be treated by another DHB, and treats patients who are the responsibility of other DHBs. Appendix 4 shows how many patients each DHB treated in each category from 2005/06 to 2009/10. Many DHBs treat patients from neighbouring DHBs.

3.10 If the Home DHB has the expertise to provide the scheduled service that a patient is seeking, but chooses not to for an individual patient, the patient and their GP can try to get the service from another DHB. Whether they achieve this depends on the Treating DHB's capacity and whether the patient meets its threshold for treatment.

Getting treatment that is not available in New Zealand

3.11 Treatments not offered in New Zealand may be got from other countries. The Treating DHB can apply to the Ministry for special funding from the Special High Cost Treatment Pool. The Ministry holds the funding on the DHBs' behalf. In 2010/11, the budget for the pool is $2.5 million. Information about the pool is available from www.moh.govt.nz.

Pathway from referral to treatment

3.12 Under the Strategy, patients are cared for in the community until they reach the threshold for hospital treatment. The Strategy prevents the long hospital waiting lists of the 1970s, 1980s, and 1990s by accepting only those patients who meet the thresholds to receive an FSA or treatment within six months.

3.13 These time limits deal with only part of the patient's experience from referral for an FSA to treatment (sometimes known as end-to-end care or the care pathway). For example, the time that patients wait for most diagnostic tests is not monitored. Figure 1 sets out the care pathway for a generic surgical patient, and we give an example of a care pathway that is specific to patients needing a hip or knee replacement in Appendix 5.

3.14 The Health and Disability Sector Standards, which are used to certify DHBs' services, state that patients should receive services (that is, assessment, planning, provision, evaluation, review, and exit) within time frames that safely meet their needs.[3]

3.15 The Ministry was not able to tell us how long it took for patients to be treated from the time that their referral was received or accepted at each DHB. We were disappointed that these reports were not available by DHB or nationally by specialty.

3.16 We were told that the DHBs have this information (but it may not be readily available), and we understand that they use it to varying degrees to improve the flow of patients through the scheduled services system. We encourage the DHBs to continue with projects to deliver scheduled services to patients in a timely manner. Individual patients will benefit, and DHBs' capacity to treat more patients may increase within the funding that is already available.

3.17 Matters that affect the total time for the patient to progress through the care pathway are:

- access to diagnostic tests and waiting times for these;
- the effect of an increase in the need for unscheduled services on scheduled services;
- potential conflicts of interest for specialists working in public and private sectors; and
- possible "queue jumping" by patients.

Access to diagnostic tests and waiting times

3.18 Access to diagnostic tests plays a critical role in providing effective and efficient scheduled services. For example, a trial at Waikato Hospital showed that it was possible to reduce waiting times for an FSA for patients with suspect skin lesions by using tele-dermatology. Faster access to a suitable diagnostic test meant that patients could be reassured more quickly if their skin lesion was benign or have their treatment arranged and/or provided more quickly if it was not, as either an unscheduled or a scheduled service.

3.19 The need for FSAs can be reduced when GPs are able to order diagnostic tests for their patients. For this reason, the number of FSAs is not especially meaningful for monitoring whether access to scheduled services is adequate. Some DHBs use virtual FSAs to speed up access to diagnostic tests.

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[3] Standards New Zealand (2008), *Health and Disability Services (Core) Standards – Continuum of service delivery*, NZS 8134.1.3, Standard 3.3, Criteria 3.3.3.

3.20 The Strategy discussed access to diagnostic tests in its description of problems with access to scheduled services. Despite this, efficient access to diagnostic tests has not been a consistent and major focus of the Ministry's and DHBs' implementation of the Strategy.

Interaction between unscheduled and scheduled services

3.21 Hospitals need to plan to provide unscheduled and scheduled services. The need to postpone scheduled services because the number of patients needing unscheduled services is more than was planned for can be reduced by good systems and management.

3.22 Postponement is not entirely preventable. Many hospitals have high rates of bed occupancy, which means that relatively small increases in the number of unscheduled in-patients can have disproportionately large flow-on effects. Although an inconvenience – and potentially a cause of increased anxiety for the patient – postponing an FSA or treatment may not necessarily compromise the patient's care (see paragraphs 1.16-1.17).

Potential conflicts of interest for specialists working in public and private sectors

3.23 The public and people working in the public health system sometimes express concern about specialists who work in both the public and private sectors. They consider that these specialists could have conflicts of interest that disadvantage both the public health system and patients who are not able to get treatment privately.

3.24 The main concern is that, during their clinics at the public hospital, specialists may encourage patients to get treatment at a private hospital because they understand that it is likely to be quicker than at the public hospital.

3.25 The risk of this occurring is commonly limited to patients in good general health who need less complicated procedures and who have the ability to pay. Most surgeons and anaesthetists are keen to treat patients at greater risk in a facility that has appropriate back-up. Private hospitals do not necessarily have the services available on site to deal with unexpected major complications or patients with complex health needs. Information supplied by private hospitals to the Ministry for 2005 to 2007 shows that about 99% of patients who funded their treatment privately did not have complex conditions and did not experience complications. (This data might not be complete because, according to the Ministry, some private hospitals do not regularly and routinely provide this data on a timely basis.)

3.26 DHBs' contractual requirements with the Ministry oblige them to tell patients about publicly funded options before the patient chooses to pay for treatment in private facilities. Our observations lead us to consider that this occurs in most instances.

3.27 DHBs are also contractually obliged to offer patients the opportunity for independently vetting any referral that a DHB specialist makes to themselves in a private capacity.[4]

3.28 We saw letters from a DHB to patients offering them surgery within six months that also made patients aware that their surgery might be available at a private hospital in the district. These letters did not tell patients – and should have – that, before they seek private treatment with the surgeon they had seen at the DHB, they are entitled to get a second opinion from the DHB about:

- their priority score;
- the urgency of any proposed treatment; and
- how long they might wait for treatment at a public hospital.

3.29 We consider that DHBs could also publish general information to this effect on their websites. This would enable patients to independently research their options before and after an offer of treatment is made. It is important that patients are not steered towards using the private sector only because they do not have up-to-date information about the services that are available to them in the public sector.

3.30 Most DHBs do not produce or publish information that is reliable enough to enable specialists to indicate when the DHB can provide treatment. When offering patients scheduled treatment, the Ministry's guidelines require DHBs to write to patients confirming that treatment will be provided within six months, the priority score given, and an estimated time for treatment.[5] We saw letters from DHBs to patients that gave a maximum treatment time but did not provide the other information that they should have.

3.31 Some staff at the DHBs we visited told us that they could be more specific about when patients were likely to receive treatment – in some specialties, at least – because they know what the average waiting times for treatment are. However, they were reluctant to be more specific – even to give an indicative range – for fear that patients would complain if scheduled services were not delivered within the estimated period.

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[4] Ministry of Health (2010), *2010/11 Operational Policy Framework*, page 63, paragraph 4.18.10.c, www.nsfl.health.govt.nz.

[5] Ministry of Health (2006), *Generic Requirements for Patient Letters*.

3.32 DHBs' complaints management processes are sufficiently onerous that the prospect of an increase in the number of complaints deters staff from giving patients more specific information. We acknowledge that this is a valid concern, but we consider that it is not a reason to prevent DHBs from trying to provide better information to patients and more fully implement the Strategy.

"Queue jumping" by patients

3.33 GPs refer patients to specialists in the private sector for many reasons, such as convenience, location, the patient's preference, and to have a choice of specialist. The GP and patient might not have up-to-date information about waiting times for FSAs and might assume that private is always quicker. If they do have up-to-date information, they will know which is quicker. However, this may not be the only criterion they use in deciding where to seek scheduled services.

3.34 In some situations, the GP may know that the referral will not be accepted by the DHB because the DHB has stated that it does not routinely care for patients with certain conditions. However, after the patient is seen privately, the specialist might consider that the patient would now meet the DHB's threshold for publicly funded treatment.

3.35 Patients diagnosed in the private sector are considered to have "jumped the queue" if they are put onto the waiting list for treatment sooner than they would have been had they had an FSA in the public health system. To prevent this, a DHB can require these patients to have an FSA before being accepted for treatment, even if this means they will see a specialist who could assign a priority score without an FSA.

3.36 DHBs have different views on this matter, and the Ministry's requirements do not specify whether an FSA is needed to assign a priority score. Many people we spoke to about this matter took a pragmatic approach. They considered that patients should be prioritised for treatment regardless of where they had been diagnosed and that FSAs should be scheduled only if this was necessary. They also considered that patients who had received their diagnosis privately had freed up an FSA for someone else. People expressing this view considered that repeating the FSA was a waste of the DHB's resources and the patient's time. We agree.

What happens when the Accident Compensation Corporation declines a request to fund scheduled surgery

3.37 If ACC declines a request from a surgeon for funding to operate on a patient, the specialist can refer the patient to their Home DHB or a Treating DHB or encourage the patient to get surgery privately. If the patient meets the DHB's thresholds, they will be offered scheduled services. We discuss ACC's approach to scheduled services in more detail in Appendix 2.

Part 4

Giving patients certainty

4.1 In this Part, we discuss the Ministry's and DHBs' progress in carrying out overlapping actions relevant to two of the Strategy's sub-strategies – giving patients certainty and increasing public confidence. The actions to achieve these sub-strategies are to:

- communicate the intent of the scheduled services policy to the public;
- adhere to minimum standards in timeliness and patient information; and
- communicate which scheduled services the public system provides.

4.2 In assessing progress on these matters, we discuss:

- communicating the Strategy's aims to the public;
- telling patients about thresholds for access to scheduled services;
- telling patients about waiting times for FSAs or treatment;
- how DHBs ensure that individual patients receive specific information about scheduled services;
- the number of patients who do not receive an FSA or treatment within six months;
- how long patients who received scheduled services in 2009/10 waited for FSA and treatment;
- improving waiting times for FSAs and treatment;
- publishing reports about actual waiting times;
- whether hidden waiting lists exist; and
- whether transaction costs in the scheduled services system have reduced.

Communicating the Strategy's aims to the public

4.3 The Strategy said that one of the most critical failings of the traditional waiting-list system was that it did not provide basic information to patients, such as the expected waiting time, options for care, and who was responsible for their care at the various stages of the process. This lack of information was considered to have contributed greatly to the perception of poor service from the public health system.

4.4 In response to these concerns, the Strategy set out specific commitments in a pledge to patients. They are that patients:

- will know within 10 working days of the DHB receiving the referral whether they will receive access to specialist advice or treatment;
- will be given an FSA within six months of their referral being accepted;

- will receive treatment within six months of it being offered; and
- in active review (see Appendix 7) can receive up to three six-monthly clinical assessments.

4.5 The Ministry monitors DHBs' performance using Elective Services Patient-flow Indicators (or ESPIs). Figure 4 and Appendix 6 provide more detail about each of the ESPIs. The Ministry can impose financial penalties on DHBs when they do not meet the requirements imposed by the ESPIs.

4.6 General information about scheduled services needs to be easy to find. It needs to be up to date if patients and GPs are to have confidence in it. The Ministry has issued a series of brochures outlining what the public can expect when seeking publicly funded scheduled services. The current brochure was released in 2008 and is called *A Guide to Elective Services at Public Hospitals*. It is available on the Ministry's website (www.moh.govt.nz/electiveservices) in seven languages: English, Chinese, Cook Islands Māori, Korean, Māori, Samoan, and Tongan.

4.7 The Ministry has information about scheduled services on two websites. One is www.electiveservices.govt.nz. The other information is found by going to www.moh.govt.nz, finding Health Topics A-Z, and selecting "elective services". The Ministry's websites contain useful information about the Strategy, define technical terms, and provide a lot of information about the data that the Ministry uses to monitor the flow of patients through the scheduled services system. The Strategy is available from the Ministry's web page for publications released in 2000.

4.8 Both of the Ministry's websites need to be visited to find all of the information that is available about scheduled services. Some information is duplicated on the sites. Some information at www.electiveservices.govt.nz is out of date, and the date that each page was last updated is not recorded. For example, the "Innovative Ideas" web page has not been added to since 2004. We encourage the Ministry to consider consolidating the two websites into one and keeping the information up to date.

4.9 We visited all the DHBs' websites on 14 May 2010. Nine of 20 DHBs provided general or customised information about scheduled services on their websites or linked to the Ministry's relevant web pages. They were Auckland, Bay of Plenty, Hawke's Bay, Hutt Valley, Lakes, MidCentral, Nelson Marlborough, Northland, and Taranaki DHBs.

4.10 We encourage all DHBs to make better use of existing information about scheduled services on the Ministry's website(s) by providing the relevant link(s) on their own websites. We suggest that all DHBs link to the Ministry's elective services website and publish an overview of how their DHB manages scheduled services.

4.11 In our view, DHBs should also briefly explain how they receive and manage referrals (such as by a central booking office or other means) and how patients can find out what is happening with their referral.

4.12 Anecdotally, we found that members of the public broadly know that:

- a referral from their GP to a hospital to see a specialist does not mean they will always receive an appointment;
- seeing a specialist is no guarantee of receiving publicly funded surgery; and
- a promise of an appointment or treatment within six months is not a guarantee that either will occur within that period.

4.13 This indicates that members of the public understand that they are not entitled to scheduled services unless their health needs meet certain thresholds, even if they are not always happy about it. We found that people often distrusted their DHB's performance. They were not confident that they or a family member would be dealt with fairly or in a timely manner. We found that people tended to assume that scheduled services would not be available more than they assumed that they would be. As a result, people were anxious about how they would be dealt with if they needed scheduled services.

4.14 Some people told us they were frustrated that, when they visited a GP to discuss a problem, the first question asked of them when considering referral for specialist advice was often "Do you have health insurance?" Even if they had health insurance, they would incur some expenses because only some costs would be reimbursed. They may also need to get advance approval, which some people considered stressful. Some people we spoke to wanted GPs to give them the option of using publicly funded scheduled services first.

Telling patients about thresholds for access to scheduled services

4.15 Under the Strategy, patients are meant to know which scheduled services the public health system provides. In practical terms, this means that patients would know whether they meet a DHB's threshold for access to FSAs and treatment.

4.16 We consider that it is reasonable for DHBs to make this information available to patients through their GP or specialist. The referral guidelines are often technical documents that need to be interpreted by a health professional, which means that there is little value for patients in DHBs publishing the guidelines on their websites. Many DHBs have prepared these guidelines and might have involved GPs' representatives. We found that DHBs' practices vary. For example:

- Some DHBs have prepared referral guidelines for some specialties and not others.
- One DHB started to distribute referral guidelines to its GPs only in 2010.
- One DHB does not distribute referral guidelines unless a GP asks for them. The GPs in this district need to know whether the specialists have updated the guidelines before they can ask for them.

4.17 Some DHBs told us that referral patterns do not necessarily change even when referral guidelines are updated. They said that sometimes GPs hold off making referrals or refer patients privately because they assume that access to a service is difficult. Or they make referrals when access has been reduced. Other DHBs tell us that GPs are more likely to make appropriate referrals when the DHB has distributed good quality referral guidelines that are easy for GPs to access and use and that are up to date. DHBs need to be consistent to retain GPs' confidence.

4.18 The way that the Strategy has been carried out means that the thresholds for scheduled services may need to alter in response to changes in DHBs' capacity and funding. DHBs risk becoming noncompliant with ESPI 3 if they change the thresholds too fast. DHBs also risk becoming noncompliant with ESPI 2 or ESPI 5 if they do not change their thresholds to respond to changes in capacity.

4.19 Overall, it appears that changes to thresholds in each specialty occur infrequently, maybe once or twice a year. This relatively slow pace of change means that the administrative and consultation costs of keeping the public or GPs up to date about the thresholds for access to each specialty should be relatively low. Nevertheless, few DHBs have this information on their websites (see paragraph 4.20), and some do not provide GPs with this information (see paragraph 4.16). We consider that up-to-date referral guidelines should include thresholds for access and routinely be made available to GPs.

Telling patients about waiting times for first specialist assessments or treatment

4.20 On 14 May 2010, we visited all DHBs' websites to find out what information they provided about estimated waiting times for FSAs and scheduled treatment. Five DHBs published information about waiting times for FSAs – they were Bay of Plenty, Counties Manukau, MidCentral, Southern, and Taranaki DHBs. Two DHBs published information about waiting times for scheduled surgery – they were Bay of Plenty and Hawke's Bay DHBs.

4.21 Most of the information was intended for GPs' use. As a result, the information was usually in technical language and placed on the web pages for primary care providers. We consider that this is reasonable (see paragraph 4.16).

Ensuring that patients receive specific information about scheduled services

4.22 Under the Strategy, patients are meant to receive information about whether they would receive publicly funded treatment, their maximum waiting time, their likely booking date, the date they would be next assessed or reviewed, their care or treatment options, who to contact if there was a problem, and whether they have joint care plans. We discuss each of these in turn.

4.23 Our comments are based on information from the Ministry and some of the DHBs we visited, but not from every specialty within those DHBs. We have no reason to believe that these specialties and DHBs are significantly different from any others.

4.24 The Ministry has produced and distributed *Generic Requirements for Patient Letters*, to help ensure that communication with patients complies with the Strategy. The *Generic Requirements for Patient Letters* sets out the minimum requirements for letters that are commonly sent to patients seeking or receiving scheduled services. These requirements are not always followed. We encourage DHBs to occasionally check that the standardised letters used in each specialty, and the letters sent to patients, comply with the Ministry's requirements.

Telling individual patients whether their referral has been accepted

4.25 Under the Strategy, patients are meant to know whether their referral has been accepted.

4.26 The Ministry told us that it last audited the letters that DHBs sent to patients in 2006, in part because some patients were told that their referral had been received but not whether it had been accepted. The Ministry considers that DHBs' practices improved after it released the generic requirements. We saw copies of letters that told patients their referral had been accepted.

Giving GPs advice when referrals are declined

4.27 In 2009, the report of a Ministerial Review Group said:

> *New Zealand has for a long time been open with the public and explained when specialist interventional needs cannot be met within existing capacity. This … increase*[s] *the responsibilities of primary care practitioners, who must support those patients who do not meet local access criteria. This is a further opportunity for closer hospital/primary linkages in developing good supportive information*

> *and care pathways for these patients in primary care. Initiatives already exist in this area, but should now be accelerated.*[6]

4.28 DHBs are meant to provide GPs with management guidelines to support them to manage the patient's care and review or reassess their condition as appropriate.[7] We are aware that DHBs return some referrals to GPs without providing advice to the GP about the patient's care. We did not audit the extent to which DHBs do not provide such advice, but our experience suggests that this is likely to occur in most DHBs. The likelihood that referrals will be returned without advice increases when any referral guidelines are not followed.

4.29 The methods that DHBs and specialties use to assess referrals for specialist advice and/or an FSA influence whether referrals are declined without advice (see paragraphs 5.7-5.13).

4.30 Even though advice specific to an individual patient may not be provided, some DHBs may refer GPs to generic or DHB-specific advice about the patient's condition that is provided on a website. For example:

- Healthpoint at www.healthpoint.co.nz (used by Auckland, Capital and Coast, Counties Manukau, Northland, and Waitemata DHBs) has a website for the public's use and a secure website for the DHBs' and GPs' use.
- Health Pathways at www.healthpathways.org.nz is a website specific to Canterbury DHB, which does not have a public component.
- The New Zealand Guidelines Group publishes guidelines on its website (www.nzgg.org.nz) or, if appropriate, on a specific website, such as the Autism Spectrum Disorder website (www.asdguideline.com).

4.31 Methods such as these are replacing the guidelines for managing patients with low-priority common health conditions that were introduced in the early years of the Strategy's implementation. GPs and DHBs told us that the early guidelines were a useful and well-used resource. They are no longer available from the Ministry's website, because the Ministry considers that they may be out of date (see paragraph 5.15). The guidelines were introduced without any process or funding for keeping them up to date. We were told that there are no plans to update them. Partly because of this, the DHBs have to create their own guidance for specialists and GPs to use.

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[6] Ministerial Review Group (31 July 2009), *Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand*, Annex 2, page 11, www.beehive.govt.nz.

[7] Ministry of Health (2010), *2010/11 Operational Policy Framework*, page 69, paragraph 4.20.2.c, www.nsfl.health.govt.nz.

Knowing whether GPs have asked for specialist advice or an FSA

4.32 We expected that patients would not be scheduled for an FSA unless it was necessary. Sometimes, patients are scheduled for an FSA by mistake because it was not clear to the DHB that a GP meant to ask only for specialist advice or a virtual FSA. Unclear requests can delay matters for that individual patient but can also prevent other patients from accessing scheduled services.[8]

4.33 Northland DHB told other DHBs that it addressed this problem by introducing an electronic generic referral form for GPs to use. The new form makes GPs choose between referral for an FSA and referral for advice. Before the form was introduced, 75% of referrals had no clear reason for the referral. Half of the referrals did not include the results of diagnostic tests that would have influenced the decision to offer the patient an FSA. The DHB says that the new form has reduced the length of time it takes to accept or book patients for an FSA.

4.34 Northland DHB reported that the GPs using the system were pleased with it. It is easy to use, and the GPs are now able to send a much higher proportion of referrals to the DHB during the business day instead of after hours. By March 2011, 90% of GP referrals were electronic. The DHB considers that this high rate has been achieved because the health professionals who use the system were involved in its planning and development.

4.35 When access to health services is rationed, the systems that DHBs use to identify which referrals need a virtual FSA, an FSA, or other specialist advice must be effective and efficient. We understand that about 20% of the DHBs have, or are introducing, systems to identify the purpose of a referral so that it can be dealt with effectively and efficiently. (Northland's system was based on Hutt Valley DHB's earlier experience. Canterbury DHB started phasing in a separate electronic referral management system during 2010.) GPs told us they are pleased that virtual FSAs have improved access to specialist advice that might not otherwise have been available.

4.36 The benefits of a generic electronic referral form (or forms, if needed) do not appear to be in dispute. This approach can improve scheduled services' effectiveness and efficiency because it reduces the amount of wasted time and the likelihood that patients will be incorrectly denied access to scheduled services.

4.37 Given the obvious benefits reported by Northland DHB (and Hutt Valley DHB before it), we expect all DHBs to take steps to introduce such a system. These systems should be DHB-wide – that is, when DHBs have more than one hospital, the system should receive and respond to referrals using the same processes and

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[8] The elements of a good referral and booking process are set out in *Making Our Hospitals Safer: Serious and Sentinel Events 2009/2010* (November 2010), which was published by the Health Quality and Safety Commission New Zealand.

criteria so that decisions about access are consistent throughout the DHB. This has not always been the case, and we know that one DHB is consolidating its booking systems.

4.38 Staff from other DHBs told us that they would like to introduce such a system. But they were daunted because they perceived that each DHB needed to separately prepare a business case and buy a suitable system.

4.39 We are concerned at the potential for unnecessarily duplicating the costs of creating and operating these systems. To reduce the total cost to the country, we expect most – if not all – of the DHBs to agree to jointly procure such a system and implement it within their districts.

Ensuring that individual patients with priority are given a commitment to treatment

4.40 Some patients' priority scores meet or exceed the DHBs' thresholds for treatment, but – for whatever reason – they are not given a commitment to treatment within six months. All patients with priority scores that meet or exceed the threshold are meant to be given a commitment to treatment. ESPI 3 monitors the number of these patients for surgical specialties only. We suggest that a more complete assessment would include medical patients.

4.41 Figure 2 shows results for ESPI 3 for the year ending 30 June 2010. All the DHBs had some patients awaiting treatment who should have been given a commitment to treatment within six months but were not.

Figure 2
DHBs' performance in giving certainty of treatment to patients who meet the threshold, for 2009/10

Patient-flow Indicator	Variation allowed	Results for 2009/10
ESPI 3 [Surgical] patients waiting without a commitment to treatment whose priorities are higher than the [DHB's minimum] treatment threshold.	The goal is to have no patients in this category. A small variation of 5% is allowed before a financial penalty is imposed.	All of the DHBs were within the compliance standard, but only two DHBs achieved the goal of having no patients waiting for a commitment. West Coast DHB achieved it in 11 months of the year and Tairawhiti in seven months. DHBs met the goal of no patients waiting without a commitment to treatment on 34 of 252 occasions (21 DHBs x 12 months), which is about 14% of the time. At the end of each month, the number of patients waiting without commitment to treatment ranged from 662 to 1093, and the average was 843.

Data extracted from the National Booking and Reporting System on 2 August 2010.

4.42 We are concerned that patients given priority scores high enough to qualify for treatment were not given a commitment to treatment within six months. We do not know whether these patients were told that they had qualified for treatment. We do not know how DHBs deal with these patients or why commitments were not given.

4.43 In our view, it is not fair – or in keeping with the Strategy – for DHBs to treat patients who have the same priority scores differently by offering to treat some and not others.

Telling patients about maximum waiting times for FSAs and treatment

4.44 DHBs are meant to tell patients that the maximum time they will wait for an FSA or for treatment is six months. We found that this routinely occurs.

Giving patients a likely date for an FSA or treatment

4.45 The Strategy intended that patients should be given information about a likely date for an FSA or treatment. DHBs have this information because they need it to manage their booking systems. We did not see any letters giving this information.

4.46 Some DHBs told patients who had been offered scheduled services but were not yet booked that surgery was available at a private hospital at a cost to the patient. The DHB asked the patient to tell the DHB if they chose to have surgery privately, so that their name could be removed from the DHB's treatment list. It is appropriate that DHBs tell patients that surgery may be available in the private sector. However, we are concerned that DHBs provided this information without also indicating when the DHB was likely to provide treatment.

Arranging a booking date for an FSA or treatment

4.47 A fundamental element of the Strategy is that patients will be booked for FSAs and treatment – and that this occurs, even when patients are booked at short notice.

4.48 When booking FSAs, instead of sending patients a date and time of the DHB's choosing, some services in some DHBs invite patients to book appointments for days and times that suit them. The problems that Hutt Valley DHB overcame by introducing such a system are documented in *Targeting More Elective Operations*.[9] Other DHBs have had similar success. We consider that all DHBs should adopt or adapt these initiatives to make the best use of out-patient clinic sessions.

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[9] The Ministry released this publication in March 2011. It is available from www.moh.govt.nz.

Telling untreated patients when they will be reassessed and who to contact if there are problems

4.49 Patients in active review (see Appendix 7) are to have their health status and priority score reassessed every six months. These patients could be assessed more frequently, but this is seldom necessary. We found that there was confusion about how active review should be used. This has resulted, in some instances, in the Strategy's principles and objectives being undermined. We discuss these issues in more detail in Appendix 7.

4.50 We found that patients were told who to contact if their condition worsened before their next assessment or appointment, or if there was a problem with their appointment for an FSA and/or treatment. Patients were also told who was responsible for their care while they were waiting for an FSA or treatment. This was usually their GP.

Preparing joint hospital and community care plans for patients

4.51 Under the Strategy, information given to patients is meant to be part of a clear, patient-centred care plan, which community and hospital providers will jointly maintain. The Strategy did not define a care plan, although it is clear that the premise was that a GP and specialist would work in a co-ordinated way to care for a patient.

4.52 We consider that information and responsibility for a patient's care is exchanged between community and hospital providers in a similar way to how a baton is passed between relay runners; two parties are involved, but only one is in charge at a time. As in a relay race, risk (in this case, to the patient's continuity of care) increases when the baton is passed from one party to the next.

4.53 In our view, effective co-ordination is more likely when community and hospital staff (in one or more DHBs) can care for patients using agreed care pathways or protocols and a single clinical record that can be shared – at least at a summary level – by all health professionals involved in caring for a patient.

4.54 One DHB told us that it was concerned about inconsistent sharing of information between multiple providers. We understand that other DHBs have this concern.

4.55 We have not recommended introducing integrated clinical records, because it is not within the scope of this report. Nevertheless, we want to register our concern that patient information is fragmented within DHBs and between DHBs. We consider that this situation unnecessarily increases the risk to patients' safety because relevant information is not always easily available.

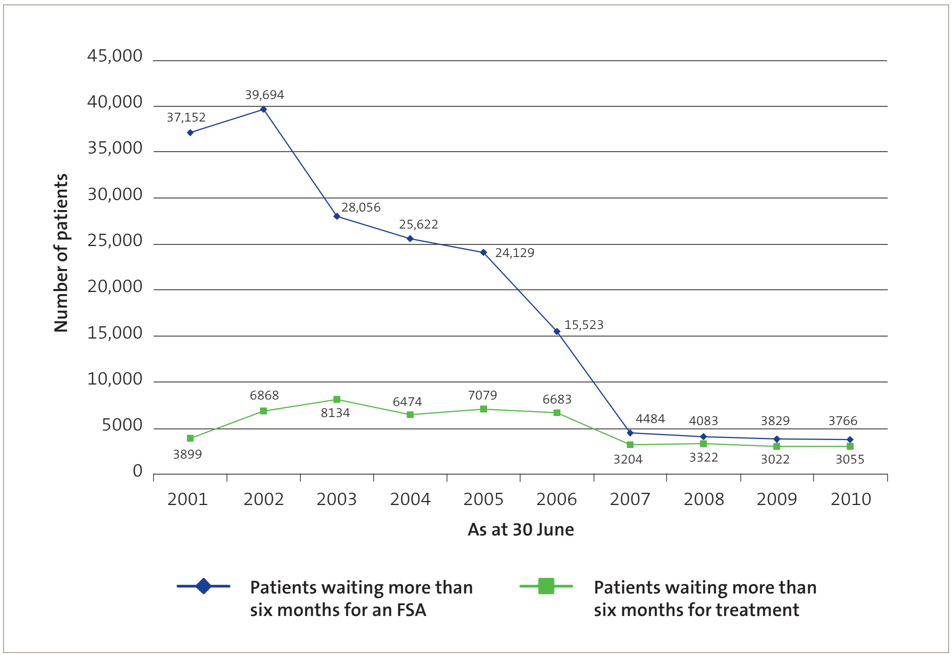
The number of patients who do not receive a first specialist assessment or treatment within six months

4.56 From 2000, DHBs were to ensure that patients did not wait more than six months for an FSA or treatment. DHBs were to achieve this by introducing prioritisation and improving their planning.

4.57 The Ministry provided us with trend data about the numbers of patients who had waited longer than six months for treatment and FSAs from 2001 to 2010. The data is for 30 June each year.

4.58 Figure 3 shows that DHBs made good progress in reducing the numbers of patients waiting longer than six months for an FSA up to 30 June 2007. During this period, DHBs reduced or eliminated their residual waiting lists (see paragraph 6.5, which explains what these lists were). Initially, the numbers of patients waiting longer than six months for treatment increased because more patients were seen at an FSA, which increased the demand for treatment. Since 2007, the rate of improvement in providing treatment within six months has slowed.

Figure 3
Patients waiting more than six months for a first specialist assessment or surgery, at 30 June, from 2001 to 2010



All data is from the National Booking and Reporting System. The Ministry does not know whether the data is accurate because it is supplied as a summary.

4.59 There is little doubt that the Ministry's insistence on compliance with the ESPIs is partly responsible for the relatively sharp decrease in the numbers of patients waiting longer than six months between 2006 and 2007. These numbers have not grown even though DHBs increased the scheduled services provided from 2007 to 2010 (see Figure 17). But it is also clear that, despite improvements in ESPI compliance, further improvements have proved difficult.

4.60 We examined the ESPI results for 2009/10. Figure 4 reports these results and compares them with trends for June over five years. There is more variation from month to month than an annual snapshot shows. At the end of each month:

- 3500 to 5500 patients did not get their FSA within six months (compared with 3462 at 30 June 2010); and
- 2700 to 3600 patients were not treated within six months (compared with 3520 at 30 June 2010).

4.61 At the end of each month, 6200 to 9100 patients had waited longer than six months for a service that they were told to expect within six months. We discuss how long patients wait for treatment in paragraphs 4.63-4.66.

Figure 4
DHBs' performance each month against maximum waiting times, for 2009/10

Patient-flow Indicator	Percentage of patients who are made to wait more than six months	Results for 2009/10
ESPI 1 DHB services that appropriately acknowledge and process all patient referrals within 10 working days.	All DHBs must fully comply with this indicator. However, a small variation is allowed before DHBs attract a financial penalty.	All DHBs complied, except: • Hawke's Bay DHB in July 2009, when five of its 17 services did not comply; and • Southland DHB in June 2010, when one of its 26 services did not comply.
ESPI 2 Patients waiting longer than six months for their first specialist assessment.	From the August 2010 ESPI results, DHBs are allowed to keep up to 1.5% of patients waiting for an FSA waiting more than six months before attracting a financial penalty.* This means that smaller DHBs are allowed fewer patients waiting more than six months than larger DHBs. As DHBs' contracted number of FSAs increases, the number of patients making up the 1.5% also increases.	No DHB ensured that all patients saw a specialist within six months. The total number of patients not seen on time each month ranged from 5542 to 3462. The level of acceptable variation was exceeded nine times by seven DHBs: • Auckland, Capital and Coast, Lakes, Southland, and Waitemata once each; and • Tairawhiti and Wairarapa twice each.

Patient-flow Indicator	Percentage of patients who are made to wait more than six months	Results for 2009/10
ESPI 5 Patients given a commitment to treatment but not treated within six months.	From the August 2010 ESPI results, DHBs are allowed to keep up to 4% of patients waiting for treatment waiting more than six months before attracting a financial penalty.** This means that smaller DHBs are allowed to have fewer patients waiting than larger DHBs. As DHBs' targets for the number of patients to be treated increase, the number of patients who make up the 4% also increases.	None of the DHBs ensured that all patients were treated within six months. The total number of patients not seen on time each month ranged from 2763 to 3662. South Canterbury DHB exceeded the level of acceptable variation in two months.
ESPI 6 Patients in active review who have not received a clinical assessment within the last six months.	A larger variation (up to 15% of all patients in active review) is allowed before DHBs could attract a financial penalty.	Of the DHBs using active review, none of them ensured that all patients were assessed on time. The total number of patients not seen on time each month ranged from 177 to 297 and the average was about 216. The level of acceptable variation was exceeded in nine months by MidCentral Health DHB and in one month by Hutt Valley DHB.

Data is from the National Booking and Reporting System as at 31 July 2010.

* The calculation is "patients waiting more than six months" divided by "patients seen (from National Booking and Reporting System) in the previous 12 months".

** The calculation is "patients waiting more than six months" divided by "patients exited treated (from National Booking and Reporting System) in the previous 12 months".

4.62 The ESPIs are "patient flow" indicators, but they do not report patients' actual waiting times. Information about waiting times is collected but not publicly reported.

How long patients wait for a first specialist assessment

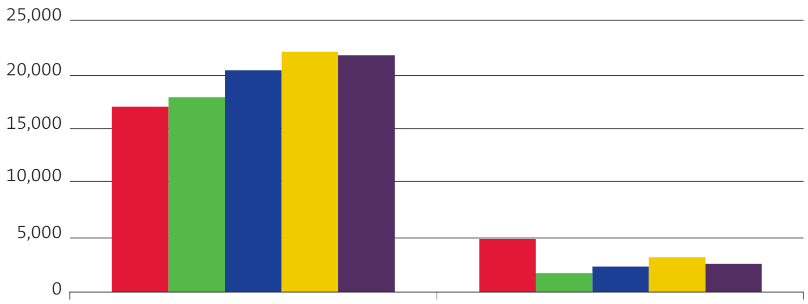
4.63 The Ministry's information about waiting times for an FSA is confined to whether FSAs are provided before or after six months. (More detailed data was collected from August 2000 to 1 July 2006. However, DHBs took different approaches to what they reported, which meant that the data could not be compared. The data is no longer collected.)

4.64 We report on a snapshot of DHBs' performance for the month of June from 2006 to 2010 in Figures 5 and 6. In June each year, most patients who attended an FSA received it within six months:

- In 2006, the proportion of patients seen in June who were seen within six months was 78% for surgical patients and 82% for medical patients.
- In 2010, the proportion of patients seen in June who were seen within six months was 89% for surgical patients and 93% for medical patients.
- Since 2007, performance has stabilised at 87%-91% for surgical patients and 90%-93% for medical patients.

Figure 5

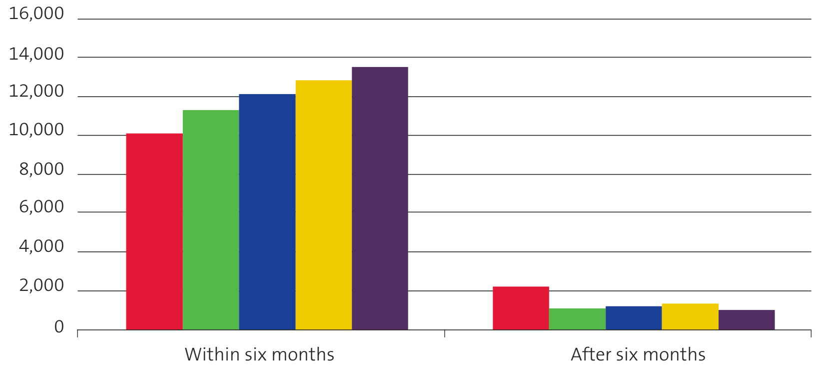
Number of patients receiving a surgical first specialist assessment within and after six months, for June, from 2006 to 2010



	Within six months	After six months
🟥 **Jun-06**	17,063	4873
🟩 **Jun-07**	17,920	1742
🟦 **Jun-08**	20,377	2367
🟨 **Jun-09**	22,111	3206
🟪 **Jun-10**	21,761	2615

Data extracted from the National Booking and Reporting System on 29 March 2011. All patients had been given a commitment to services. We selected trend data for one month to ensure consistency from year to year. The pattern of service delivery changes throughout the year. However, whichever month is chosen, we expect the trends to be similar.

Figure 6
Number of patients receiving a medical first specialist assessment within and after six months, for June, from 2006 to 2010



	Within six months	After six months
🟥 **Jun-06**	10,107	2237
🟩 **Jun-07**	11,313	1108
🟦 **Jun-08**	12,143	1215
🟨 **Jun-09**	12,840	1351
🟪 **Jun-10**	13,526	1037

Data extracted from the National Booking and Reporting System on 29 March 2011. All patients had been given a commitment to services. We selected trend data for one month to ensure consistency from year to year. The pattern of service delivery changes throughout the year. However, whichever month is chosen, we expect the trends to be similar.

How long patients wait for treatment

4.65 Information about actual waiting times for treatment is collected but not publicly reported. In Figures 7 and 8, we report on a snapshot of DHBs' performance for the month of June from 2006 to 2010. The number of patients who were treated increased during this period, and most patients were treated within four to six months:

- From 2008 to 2010, 89% or 90% of surgical patients were treated within six months.
- From June 2008, 95% or 96% of medical patients were treated within six months.[10]

4.66 The total number of patients who had waited longer than six months for treatment did not significantly change. However, the pattern of when patients were treated did change. By 2010, fewer patients had waited longer than nine

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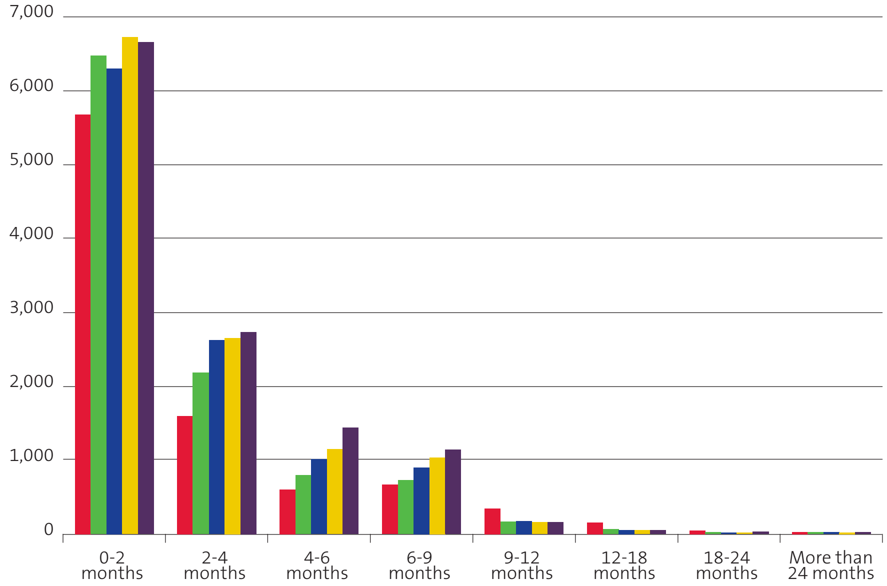
[10] The data may overstate DHBs' performance because some patients whose treatment is postponed after they have been admitted to hospital may be re-entered into the National Booking and Reporting System as a new patient. By December 2010, all DHBs had made changes to prevent this occurring.

months. An increasing number of surgical patients were treated in six to nine months, which DHBs need to address.

Figure 7

Time taken for all DHBs to treat patients waiting for surgery, for June, from 2006 to 2010

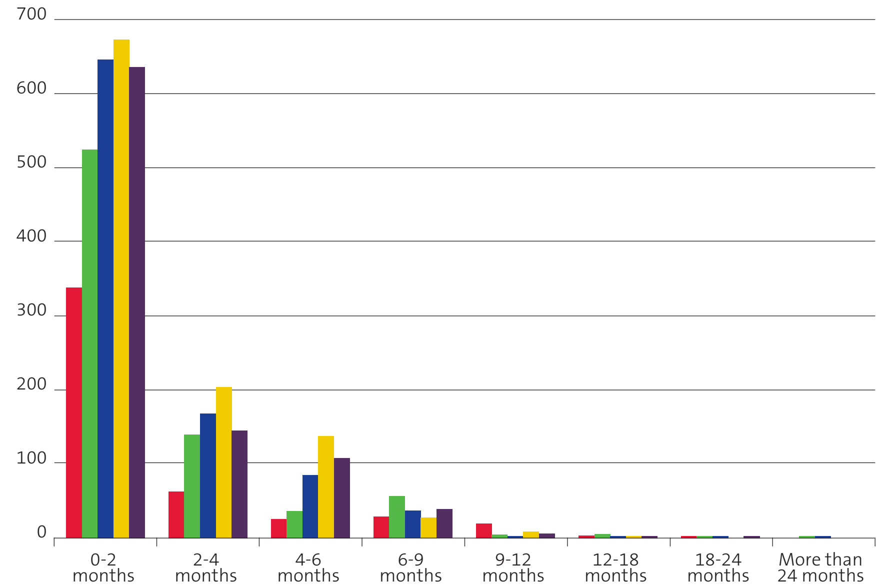


	0-2 months	2-4 months	4-6 months	6-9 months	9-12 months	12-18 months	18-24 months	More than 24 months
🟥 **Jun-06**	5677	1598	605	669	349	160	49	30
🟩 **Jun-07**	6472	2186	797	730	172	65	11	8
🟦 **Jun-08**	6298	2621	1016	901	180	56	15	4
🟨 **Jun-09**	6720	2653	1153	1037	162	53	19	5
🟪 **Jun-10**	6655	2736	1441	1142	167	53	12	4

Data extracted from the National Booking and Reporting System on 31 July 2010. All patients had been given a commitment to treatment. We selected trend data for one month to ensure consistency from year to year. The pattern of service delivery changes throughout the year – for example, less surgery is generally done in January. However, whichever month is chosen, we expect the trends to be similar.

Figure 8

Time taken for all DHBs to treat patients waiting for medical procedures, for June, from 2006 to 2010



	0-2 months	2-4 months	4-6 months	6-9 months	9-12 months	12-18 months	18-24 months	More than 24 months
🟥 **Jun-06**	338	63	26	29	20	2	1	0
🟩 **Jun-07**	524	139	36	56	4	5	2	2
🟦 **Jun-08**	646	168	85	37	3	3	1	1
🟨 **Jun-09**	673	204	138	28	9	3	0	0
🟪 **Jun-10**	636	145	108	39	6	3	1	0

Data extracted from the National Booking and Reporting System on 31 July 2010. All patients had been given a commitment to treatment. We selected trend data for one month to ensure consistency from year to year. The pattern of service delivery changes throughout the year – for example, less surgery is generally done in January. However, whichever month is chosen, we expect the trends to be similar.

Improving waiting times for first specialist assessments and treatment

4.67 In March and July 2010, the Ministry wrote to DHBs asking them to reduce the number of people waiting more than six months for FSAs and treatment. From August 2010, the accepted maximum deviation from the commitment to provide scheduled services within six months was reduced from 2% to 1.5% for FSAs and from 5% to 4% for treatment. DHBs were not to comply with the new thresholds by removing patients from waiting lists after they had been offered scheduled services. The Ministry also told DHBs that further reductions could occur.

4.68 The Ministry made the change to manage the fact that, as the quantity of scheduled services increases, so too will the number of individual patients "allowed" to wait longer than six months. For example, if 110,000 patients were treated in a year and the maximum deviation was 5%, the number of patients "allowed" to wait longer than six months would be 5500. However, if the number of patients treated in a year increased to 140,000 and the maximum deviation remained at 5%, the number of patients "allowed" to wait longer than six months would be 6500.

Publishing reports about actual waiting times

4.69 ESPIs for patients waiting more than six months for an FSA or treatment are relatively easy to report in consolidated statistical tables for the 20 DHBs. The benefit of these reports is that they readily allow comparison between DHBs, which helps the Ministry to monitor an individual DHB's performance and to examine long-term trends. However, we consider that the ESPI tables have limited value in clearly communicating DHBs' overall performance to patients, GPs, and the public.

4.70 In paragraph 4.13, we commented that people seemed to distrust their DHB's performance. In our view, Figures 5-8 give a richer understanding of how well the DHBs are doing, despite giving trends for only one month of each year. We consider that the public's perception of DHBs' performance would improve if such reports were available. The reports give credit where it is due and also show where further improvement is needed.

4.71 Some DHBs and the Ministry have told us that they consider that they have done well to restrict the numbers of patients waiting longer than six months for scheduled services at the same time as increasing the quantity of scheduled services provided. Extra funding and the threat of financial penalties for non-compliance with ESPI requirements have helped with this.

4.72 We do not underestimate the efforts that DHBs have made in the last 10 years to remove the backlog of patients waiting for scheduled services (see Part 5) and to introduce and improve their booking systems. Nevertheless, six months – and not any longer period – is the maximum length of time that patients are meant to wait for scheduled services that they have been offered. Patients with high health needs and ability to benefit from treatment should not wait that long. They should be treated much more quickly.

4.73 Looking ahead to the next 10 years, we encourage the Ministry and DHBs to consider introducing methods of reporting on the total time taken for patients to progress through care pathways, instead of using only the "snapshot" approach of waiting times for specific events, such as an FSA and treatment. We anticipate that reports of this type would be confined to selected “key marker” pathways, such as pathways that all DHBs commonly provide or where there is concern about waiting times.

Do hidden waiting lists exist?

4.74 We sometimes discussed with DHBs and others whether DHBs have “hidden” waiting lists. This term is not defined, but we have heard it used when someone considers that the number of patients waiting more than six months for treatment may be larger than is reported to the Ministry in the National Booking and Reporting System. We did not find any evidence of “hidden” waiting lists.

Reducing transaction costs in the scheduled services system

4.75 Increased confidence in the booking system was expected to reduce transaction costs. The intention was that GPs would make just-in-time referrals rather than using multiple referrals, letters, and telephone calls to get patients timely access to scheduled services.

4.76 We consider that transaction costs for a patient who has a straightforward passage through the scheduled services system are less than they would have been under the former waiting list and booking systems.

4.77 However, we consider that transaction costs are unlikely to have reduced where:

- DHBs have not released clear referral guidelines;
- DHBs have not prepared and introduced care pathways that cross community and hospital boundaries; and
- specialists and GPs are not frank with patients about the likelihood of the patient getting access to publicly funded treatment.

Part 5

Achieving nationally consistent clinical assessment

5.1 In this Part, we discuss the Ministry's and DHBs' progress in carrying out actions relevant to the sub-strategy "introducing nationally consistent clinical assessment" and related matters. The actions to implement the sub-strategy are to introduce nationally consistent assessment tools developed by the specialists who will use them. The tools are to be continuously improved using research. Data collected through the tools is to be used to improve national equity of access to scheduled surgery by targeting funding to patients with the highest needs.

5.2 In assessing progress on these matters, we discuss:

- the purpose of nationally consistent clinical assessment;
- the methods used to select patients for an FSA;
- whether patients are selected consistently;
- prioritisation tools and how they should work;
- whether patients are consistently prioritised for treatment;
- whether patients are treated in priority order;
- auditing selection decisions and priority scores;
- DHBs' and specialists' commitment to, and management of, prioritisation tools to achieve equity; and
- setting minimum service levels for access to scheduled services.

The purpose of nationally consistent clinical assessment

5.3 Nationally consistent clinical assessment is needed to ensure national equity of access to scheduled services. "National equity of access" means that patients with a similar level of need and ability to benefit from treatment will have similar access to scheduled services, regardless of where they live.

5.4 Certain conditions need to exist for this to be achieved. These are that:

- all patients referred to scheduled services are selected and prioritised for treatment using suitable national tools;
- clinically appropriate minimum thresholds for access to scheduled services are set so that patients do not reach a state of unreasonable distress, ill health, and/or incapacity before they receive scheduled services; and
- prioritisation decisions are regularly audited to check that they are consistent.

5.5 Two sets of national tools are needed – one set to select patients for FSAs and the other set to prioritise patients for treatment. These tools would help to ensure that:

- specialists make consistent decisions about patient care;
- patients most in need of services receive them first;
- futile or marginally beneficial scheduled procedures are not provided;

- any extra funding translates into tangibly improved scheduled services for patients; and
- accurate comparisons of access to scheduled services by district can be made and used to inform funding decisions that improve the national consistency of access.

5.6 For the sake of simplicity, in this Part, we discuss only how patients are selected for FSA and prioritised for treatment (even though, under the Strategy, access to specialist advice – not only access to FSAs – was to be increased). Virtual FSAs and specialist advice provided by other means, such as "same day" clinics[11] or out-reach services, may also increase patients' and GPs' access to specialist advice.

Methods used to select patients for a first specialist assessment

5.7 We asked specialists how they selected patients for an FSA, and they told us about three main methods. To aid their decision-making, specialists may use any referral guidelines that the DHB has issued, which may or may not have been prepared jointly with health professionals working in hospital and community care settings (see paragraph 4.16).

5.8 The first method involves a single individual, such as a GP liaison[12] or semi-retired surgeon, who assesses all referrals received by a specialty. This individual accepts or declines patients for an FSA based on any criteria that have been agreed. They might use a specific selection tool. The individual might telephone the GP to find out more information about the patient and discuss care or treatment options available in the hospital or the community. If this individual declines a referral, they might tell the GP when the hospital would accept any new referral for that particular patient and/or similar patients.

5.9 The second method is more commonly used when the number of referrals to a department is small. The specialists discuss all the referrals at a weekly meeting. They might use selection tools. The specialists jointly decide which patients they will accept, how quickly they will see each patient, and which specialist will care for the patient. Alternatively, the specialists may agree that one of them will discuss the patient with the GP before deciding how to proceed.

5.10 These first two methods offer similar benefits and disadvantages. Both methods are likely to promote consistent selection even if a selection tool is not used. They also create opportunities to:

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[11] Some DHBs operate clinics where GPs can send a patient to the hospital for a same-day assessment without sending the patient through the emergency department. These patients may be returned to the GP's care or admitted to hospital.

[12] A GP liaison is a GP who works part-time for a DHB to improve the way that DHBs and GPs work together, and part-time as a GP. Their roles vary considerably; some are mainly to provide a channel for the DHB to distribute information to GPs, and others are more deeply involved in changing the way that scheduled services are delivered.

- clarify or change any GP referral guidelines;
- provide general information or advice to GPs about managing conditions in primary care; or
- improve the effectiveness and efficiency of the scheduled services system by, for example, identifying circumstances when it would be useful to GPs to order diagnostic tests without involving the specialist.

5.11 However, if decisions about patient care are not recorded using a selection tool, data is not collected that can later be analysed to:

- help improve access to scheduled services;
- inform proposals to reduce scheduled services; or
- compare access to scheduled services between DHBs.

5.12 The third method involves hospital departments allocating the responsibility for selection referrals to the "on-call" specialist, who may or may not use selection tools. On-call specialists generally fit this selection work around their other duties, such as out-patients' clinics, ward rounds, operating theatre sessions, or assessing patients in the emergency department. On-call specialists do not usually set aside specific time to deal with GPs' referrals.

5.13 We found that this method was more commonly used by surgeons and less often by physicians. These surgeons were confident that they and their colleagues selected patients consistently, even when they were not using selection tools. We were not convinced. Because the specialists do not have dedicated time for considering the referrals, we consider that they may be less likely to contact the GP to discuss the patient and provide advice. If the specialists are selecting referrals in the evenings, GPs are less likely to be available to discuss the patients. We consider that this is likely to mean that patients may unnecessarily be accepted for FSAs because surgeons will be cautious about declining referrals, based only on a written referral.

Are patients selected consistently for first specialist assessment?

5.14 Even though different methods are used to select which patients will have an FSA, in our view, consistent access to scheduled services by specialty could be promoted if credible national tools were available. Analysing the data collected would help specialists to know whether consistent access was being achieved throughout the country and what needed to occur to improve consistency, such as refining the tool.

5.15 National tools for selecting patients for an FSA used to be publicly available. They were called "Access Criteria for First Specialist Assessment" and were available from the Ministry's website. The Ministry has:

> *... removed the guidelines for Primary Care Management; Patient Referral and Management; and Access Criteria for First Specialist Assessment from* [its] *website. These guidelines have not been reviewed for a number of years and are considered to be potentially out of date.*[13]

5.16 To the best of our knowledge, there are currently no up-to-date selection tools that all DHBs use. Some DHBs told us that they had to create and use their own tools because the national ones were out of date. We consider that it is unlikely that patients are consistently selected for FSAs throughout the country. This means that one of the fundamental aspects of the Strategy is not in place. We consider that the Ministry and DHBs need to decide how they will address this matter with the relevant professional groups.

5.17 Some DHBs told us that they consider that all of the relevant tools (selection, prioritisation, and referral forms) should be available online and be easy to use. We are aware that some DHBs have started doing this. However, progress is not uniform throughout the country, and few of the DHBs are working with other DHBs to produce regional or national tools. We are concerned that this is another area where haphazard implementation may produce unnecessary variation for patients and where unnecessary duplication may increase costs for DHBs.

What are prioritisation tools for treatment, and how should they work?

5.18 At an appropriate time in a patient's care pathway, specialists assess a patient's need and ability to benefit from treatment. They are meant to do this using national prioritisation tools.[14] The Ministry's contracts with the DHBs require that the systems to assign priorities are evidence-based, transparent, systematic, and procedurally fair.

5.19 Currently, three sets of prioritisation tools are used – older national tools, more recent national tools, and local (DHB-level) tools. Some prioritisation tools address a single procedure, such as varicose veins, and other tools are used for all patients seen by a specialty, such as the tool for General (internal) Medicine.

5.20 DHBs have to create their own prioritisation tool when one does not exist or the existing national prioritisation tools are out of date. However, DHBs are unable to use local prioritisation tools or processes to comply with ESPI 8 until the Ministry

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[13] As at 12 April 2011, www.electiveservices.govt.nz.

[14] These are called Clinical Priority Assessment Criteria (CPAC) or Clinical Prioritisation System (CPS) tools. The terms are interchangeable.

has agreed that they can be used for this purpose. DHBs must convince the Ministry that a proposed local variation to a national prioritisation tool improves outcomes for patients.

5.21 Any improvements at the local level do not lead to an automatic update and reissue of the national prioritisation tool to all DHBs, because the Ministry does not consider this to be practical. The Ministry says that a consensus of experts is needed to update a national tool. This can also involve re-weighting the criteria in each tool. Instead, the Ministry considers changes to a national tool when it is reviewed.

5.22 We consider that it would make more sense for the relevant professional groups to be responsible for the "life cycle" of national tools, including proposed changes to the tools, rather than the Ministry. The professional groups could recommend to the Ministry that it agree to allow DHBs to use a particular tool to comply with ESPI 8. (We discuss commitment to prioritisation in more detail in paragraphs 5.56-5.65.)

5.23 Local tools can take different approaches to assigning scores to patients with similar needs and ability to benefit from treatment, which means that scores cannot be used to compare access throughout the country. For example, some scores have a scale of one to 100, and others have a scale from one to five. In different DHBs, patients with a score of 70 may not have a similar need for, and ability to benefit from, scheduled services (in the same specialty or across specialties). This means that the data that the Ministry holds about patients' priority scores cannot be used to monitor progress towards national equity.

5.24 Specialists exercise their professional judgement in applying the prioritisation tools. They can override the priority score to consider circumstances particular to an individual patient. Because they are using their clinical judgement, specialists can apply tools differently. Research to examine how specialists make these decisions is under way.[15] Nonetheless, the idea behind national prioritisation tools is that they will produce better consistency for patients than if each DHB used a different local prioritisation tool or no tool at all.

5.25 Prioritisation tools should contain standardised medical and social criteria that are systematically applied to give each patient a priority score that reflects their level of health need and ability to benefit from treatment. Although the details of each tool will differ, the tools' criteria should deal with such matters as:

- the severity of a patient's condition or disability,
- a patient's ability to benefit from treatment; and
- any consequences from delaying treatment.

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[15] More information is available from the Health Services Research Centre, Victoria University of Wellington, at www.victoria.ac.nz/hsrc.

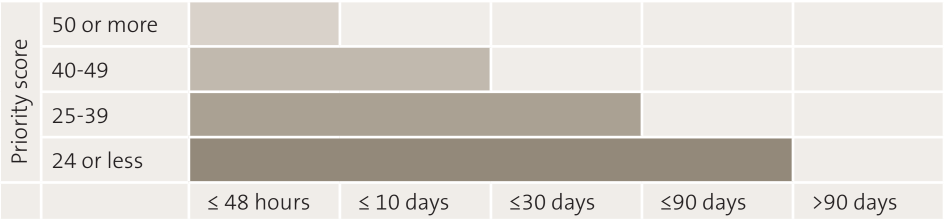
5.26 Ideally, the priority scores would relate to a "clinically appropriate treatment period" so that patients are treated in priority order and are not in unreasonable distress by the time they receive treatment. A clinically appropriate treatment period can be set by considering the latest medical evidence. It can also reflect practical decisions that are necessary to meet policy requirements set by the Government, such as the requirement to treat patients within six months, and thresholds for access to scheduled services. (For example, some patients could wait nine months for surgery without undue distress, but current policy requires that scheduled services that have been offered are delivered within six months.) We acknowledge that it can be difficult to achieve universal agreement among specialists about a clinically appropriate treatment period (partly because, under the Strategy, resources have a role in setting the level of access to scheduled services). We do not consider that this is a reason not to try to promote national equity of access.

5.27 Cardiac surgeons and cardiologists have recently achieved universal agreement on their prioritisation tool for cardiac surgery (part of which is reproduced in Figure 9). These specialists have agreed that all patients who are offered valve surgery or coronary artery bypass grafts should receive their surgery within 90 days, which is well within the maximum period of six months. They use this tool for all patients being considered for cardiac surgery, not only those patients who could be offered scheduled treatment.

5.28 The patient's priority score determines the period in which the patient should or could be treated:

- Patients with a score of 50 or more should be treated as an unscheduled patient in 48 hours or less.
- Patients with scores of 40-49 could be treated as unscheduled or scheduled patients, but should receive their treatment in 10 days or less.
- Patients with scores of 25-39 could be treated in 30 days or less.
- Patients with scores of 24 or less could be treated at any time during the 90-day period.

Figure 9
Part of the prioritisation tool for cardiac surgery



The prioritisation tool that this chart is part of was endorsed for use in May 2010 for patients needing valve surgery or coronary artery bypass grafts. This tool was prepared by cardiac surgeons and cardiologists representing the New Zealand National Cardiac Surgery Clinical Network and the New Zealand Branch of the Cardiac Society of Australia and New Zealand. The Ministry provided specialist expertise to these groups.

5.29 Such a tool enables DHBs to schedule patients for treatment in priority order. The tool clearly demonstrates that there is no problem with treating patients with lower scores quickly as long as patients with higher scores are treated within the relevant period. Patients with lower scores often need treatment that takes less time to perform. Operating theatre sessions can be more efficiently used if patients needing shorter operations "fill up" any time that is left after longer operations.

5.30 Patients are entitled to certainty, so a patient should be told when a DHB cannot offer publicly funded treatment within the clinically appropriate treatment period. The Strategy assumes that the whole public health system is responsible for achieving its objectives, even though DHBs' legislative responsibilities are somewhat narrower. When one DHB cannot provide treatment within a clinically appropriate treatment period, it may be possible for another DHB to do so.

5.31 In practice, we expect that any offer of this sort would mainly be confined to patients with high priority scores who are at risk of suffering irreversible consequences of delayed treatment and who could be safely transferred to a Treating DHB (or a private hospital). Effective and efficient regional collaboration and planning would be needed to ensure that this works well for patients.

Whether prioritisation tools produce scores that have a matching treatment period

5.32 We examined each of the 30 currently available national prioritisation tools to assess whether they could produce a score that had a matching clinically appropriate treatment period. Figure 10 presents the results. Six tools produced both a score and a clinically appropriate treatment period. Another 16 tools produced scores, but did not have matching clinically appropriate treatment periods. Eight tools have a matching clinically appropriate treatment period but do not produce scores. Instead, patients are assigned to a category, such as urgent, semi-urgent, or routine.

Figure 10
List of currently available national prioritisation tools

Specialty	Prioritisation tool	Tool number	Produces a priority score	Has a matching clinically appropriate treatment period	Assigns patients to a category	Tools in the implementation phase/live in NBRS*
Cardiac surgery	1. Aortic regurgitation	9074	✓	✓	-	-
Cardiac surgery	2. Aortic stenosis	9072	✓	✓	-	-
Cardiac surgery	3. Mitral regurgitation	9075	✓	✓	-	-
Cardiac surgery	4. Mitral stenosis	9073	✓	✓	-	-
Cardiac surgery	5. Coronary artery bypass graft	9076	✓	-	-	-
Cardiac surgery	Universal coronary artery bypass graft and valve	**	✓	✓	-	Will be available in NBRS during 2011/12
Cardiology	6. Cardiac catheterisation	9082	✓	-	-	-
Cardiology	7. Percutaneous coronary revascularisation	9081	✓	-	-	-
Gastroenterology	8. Colonoscopy	9162	-	-	✓	-
Gastroenterology	9. ERCP (endoscopic retrograde cholangio-pancreatography)	9163	-	-	✓	-
Gastroenterology	10. Gastroscopy	9161	-	-	✓	-
General (internal) medicine	11. All conditions	9170	-	-	✓	-
General surgery	12. Varicose veins	9131	✓	-	-	Was live in NBRS during 2007/08
Gynaecology	13. Infertility	9063	✓	-	-	-
Gynaecology	14. Sterilisation	9062	✓	–	-	-
Gynaecology	15. All other conditions	9065	✓	–	-	Was live in NBRS during 2007/08

Specialty	Prioritisation tool	Tool number	Produces a priority score	Has a matching clinically appropriate treatment period	Assigns patients to a category	Tools in the implementation phase/live in NBRS*
Hospital dentistry and oral maxillo-facial surgery	16. All conditions	9100	✓	-	-	-
Neurosurgery	17. Spinal	9111	✓	-	-	-
Neurosurgery	18. All other conditions	9110	-	-	✓	-
Ophthalmology	19. Cataract	9041	✓	-	-	Was live in NBRS during 2007/08
Ophthalmology	20. All other conditions	9040	✓	✓	-	-
Orthopaedics	21. Hip or knee joint replacement surgery	9011	✓	-	-	Was live in NBRS during 2007/08
Orthopaedics	22. All other conditions	9010	✓	-	-	-
Otolaryngology (ear, nose, and throat)	23. All conditions	9030	✓	-	-	-
Paediatric medicine	24. All conditions	9220	-	-	✓	-
Paediatric surgery	25. All conditions	9120	✓	✓	-	-
Plastic and reconstructive surgery	26. Skin lesion	9051	✓	-	-	Was live in NBRS during 2008/09
Plastic and reconstructive surgery	27. All other conditions	9050	✓	-	-	-
Respiratory medicine	28. All conditions	9240	-	-	✓	-
Thoracic surgery	29. All conditions	9260	-	-	✓	-
Urology	30. Prostatectomy	9090	✓	-	-	-

Some of the tools are “integrated” or “general” tools. For the sake of consistency, we renamed these tools “all conditions” or “all other conditions” as appropriate.

* NBRS means the National Booking and Reporting System.

** A number will be allocated when the tool is live in NBRS.

5.33 When a tool does not produce a specific score, specialists can allocate standard scores to patients in each category. (Less sophisticated tools can also produce only a few standard scores.) For example, a specialty in a DHB organises the referrals that it accepts into urgent, semi-urgent A, and semi-urgent B groups. (It was not accepting routine referrals at the time of our audit fieldwork.) The booking clerks were instructed to allocate scores to patients in each group as follows:

- Urgent patients were given a score of 90 points.
- Semi-urgent A patients were given a score of 80 points.
- Semi-urgent B patients were given a score of 70 points.

5.34 We understand that this practice is commonplace. However, allocating scores in this way defeats the purpose of prioritisation because it means that specialists allocate scores for largely administrative, instead of clinical, purposes. They allocate a score simply because a score must be entered for each patient in the National Booking and Reporting System. We acknowledge that specialists may have taken pragmatic steps to compensate for deficits in the tools that some of their colleagues were involved in producing. However, when scores are allocated according to categories, it is not possible to:

- further prioritise patients within these categories;
- compare the scores with those of other DHBs (because the other DHBs might assign different values for each category); or
- use the scores to consider whether to alter the threshold for treatment.

5.35 Prioritisation tools that are not fit for the purpose they are used for are not likely to produce a good result. This means that:

- patients with a greater health need and ability to benefit from treatment could be given too low a score relative to other patients and potentially be denied access to scheduled services that they should have access to; and
- patients with a lesser health need and ability to benefit from treatment could be given too high a score relative to other patients and access scheduled services sooner than they should.

Are patients consistently prioritised for treatment?

5.36 Under the Strategy, DHBs are meant to use national prioritisation tools to assess each patient’s level of health need and ability to benefit from treatment consistently throughout the country and to ensure that patients who most need services receive them soonest. Figure 10 lists the 30 currently available national prioritisation tools. The tools listed in Figure 10 do not cover all patients who are prioritised for scheduled services – for example, general surgery has a tool only for varicose veins[16] – and some of the tools are not of good quality. The DHBs' local tools do not necessarily produce priority scores that reflect a similar level of need and ability to benefit from treatment for similar patients. This means that access cannot be fairly compared between DHBs. Therefore, it is not possible to determine whether patients are consistently prioritised for treatment.

Are patients treated in priority order?

5.37 Under the Strategy, patients needing scheduled services are meant to be treated in priority order. This is reinforced in the Ministry's contractual requirements with DHBs. In July 2010, the Ministry wrote to DHBs and emphasised that patients must be assigned an appropriate priority score and treated in priority order.

5.38 We asked the Ministry for information about selected procedures to check whether DHBs are treating patients in priority order. We chose to report on waiting times by priority score for adult cardiac surgery,[17] general gynaecology surgery,[18] and hip and knee replacement surgery.[19] Because DHBs prioritise patients differently and have different treatment thresholds, we decided to use data from only one DHB, which we have not named. We chose to use one DHB on the assumption that practices are consistent within each specialty, which may not be the case. We have also included only those patients who were scored using a national prioritisation tool.[20]

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[16] General surgery deals with conditions such as common gallbladder conditions and hernia repairs. We expect that access to surgery for these and other conditions would be assessed using one or more national prioritisation tools. General surgeons increasingly focus in sub-specialty areas, such as upper intestinal surgery, lower intestinal surgery, breast surgery, and vascular surgery. It may be practical to have a national prioritisation tool for each of these sub-specialties.

[17] Access to cardiac surgery (heart valve procedures and coronary artery bypass grafting) is an area of concern to the public, and delays in receiving treatment can be life-threatening. Five of the 20 DHBs provide this surgery. The Clinical Cardiac Network was established to help improve services to cardiac patients.

[18] General gynaecology surgery was not the focus of a national initiative to increase the number of operations performed. All DHBs provide this surgery.

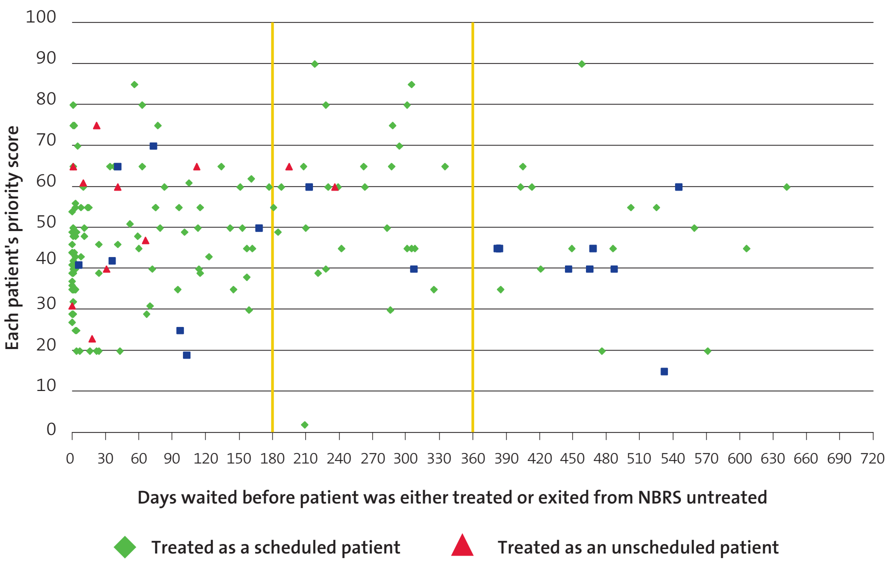
[19] Hip and knee replacement surgery was the focus of a special initiative to increase the number of operations performed. As part of the initiative, DHBs had to agree a plan with time frames with the Ministry, such as complying with ESPI 7 and ESPI 8, before each DHB could access any additional funding. All DHBs provide this surgery.

[20] DHBs may find this technical information useful. Data is for "normal" patients only, which means that patients identified as staged, planned, and surveillance were excluded. Because the exit categories changed substantially between 2005/06 and 2009/10, the Ministry sorted the data as shown in our graphs. For 2005/06 data, patients coded as "treated other hospital" are included in "Treated as a scheduled patient", and patients coded as "treated privately" are included in "Exited from NBRS untreated".

5.39 Figures 11-16 are scatter graphs that compare changes in performance from 2005/06 to 2009/10. If more than one patient has the same score and waited the same length of time to get treatment, it will show up as one diamond, triangle, or square on the graphs. Also, the thresholds for treatment sometimes changed during both years. For these reasons, the scatter graphs cannot stand alone. We report some statistical information about the data used to produce these graphs after each pair of graphs. We discuss the implications of the findings from all of the scatter graphs in paragraphs 5.46-5.51.

Figure 11

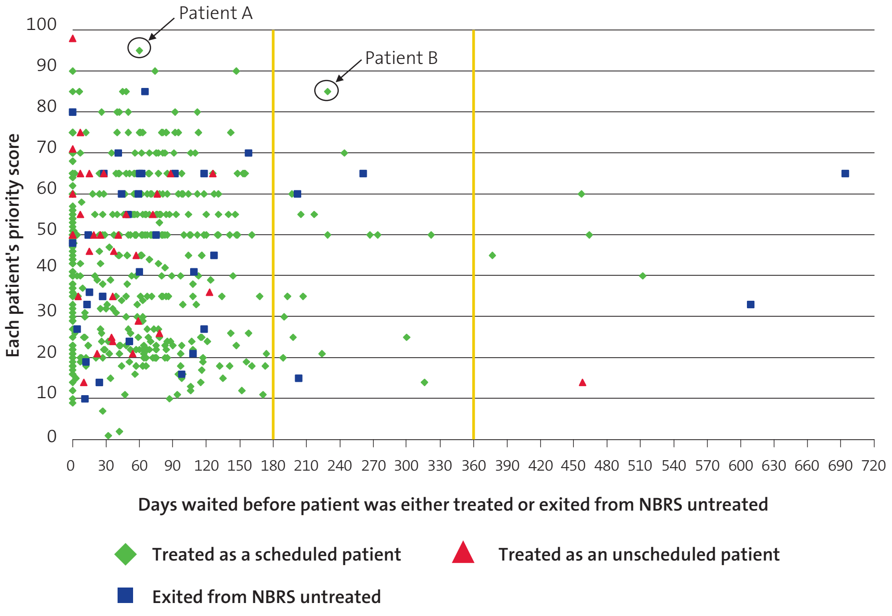
Days waited for treatment by patient priority score (adult cardiac surgery), at one DHB during 2005/06



Data was extracted from the National Booking and Reporting System on 14 October 2010 and reports each patient's latest priority score. Patients were scored using the national tools for cardiac surgery, which were *CABG (9071), Aortic Stenosis (9072), Mitral Stenosis (9073), Aortic Valve (9074), Mitral Valve (9075),* and the *National Tool Cardiac Surgery – CABG – Cardiac Society of Australia and New Zealand Clinical Priority Score 2005 (Revised July 2005) (9076).*

Figure 12

Days waited for treatment by patient priority score (adult cardiac surgery), at one DHB during 2009/10



Data was extracted from the National Booking and Reporting System on 14 October 2010 and reports each patient's latest priority score. Patients were scored using the national tools for cardiac surgery, which were *Aortic Stenosis (9072), Mitral Stenosis (9073), Aortic Valve (9074), Mitral Valve (9075),* and the *National Tool Cardiac Surgery – CABG – Cardiac Society of Australia and New Zealand Clinical Priority Score 2005 (Revised July 2005) (9076).*

5.40 In Figure 12, Patient A had a score of 95 and had their surgery in 60 days. Patient B had a score of 85 and had their surgery after waiting 229 days (about seven and a half months). The data for cardiac surgery also shows that in 2009/10:

- seven out of 18 patients (39%) with scores of 80 or higher were treated in 30 days or less, compared with one out of eight patients (13%) in 2005/06;
- 14 out of the 18 patients (78%) with scores of 80 or higher were treated in 90 days or less, compared with three out of eight patients (38%) in 2005/06; and
- 30 out of the 35 patients (86%) who exited the booking system without treatment exited within 180 days (about six months), compared with seven out of 20 (35%) in 2005/06.

5.41 The problems in ensuring that patients waiting for coronary artery bypass graft are treated in priority order are longstanding. In 2006, an article in *The New Zealand Medical Journal* reported on patients waiting for coronary artery bypass grafts who were assigned a priority score from June 2002 to September 2004. It stated:

> *Some patients with low* [priority] *scores were assigned an emergency category, while others with much higher [priority] scores were sent home to wait. These findings are similar to previous studies in this area.*[21]

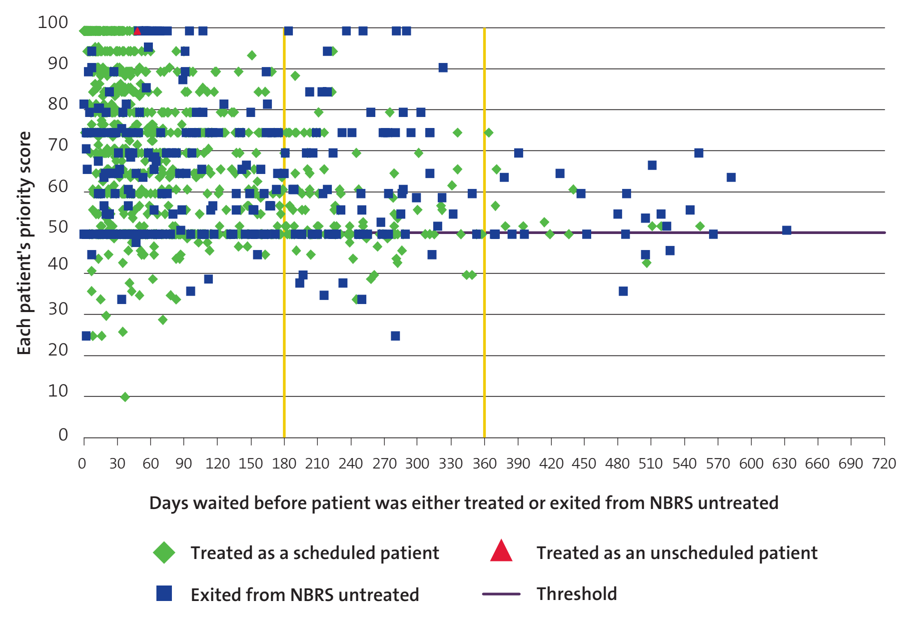
5.42 In 2008, the Cardiac Surgery Service Development Working Group reported that:

> *… there is little correlation between assigned priority and time to treatment. … Provision of surgery in accordance with assigned priority will require resolution of a number of factors which currently make this difficult.*[22]

5.43 We expect the updated "cardiac surgery urgency score by urgency time frame" shown in Figure 9 to rapidly result in observable improvements for patients. Given the longstanding nature of this problem, we plan to report on it when we monitor the Ministry's and DHBs' progress in responding to our recommendation.

Figure 13

Days waited for treatment by patient priority score (general gynaecology surgery), at one DHB during 2005/06



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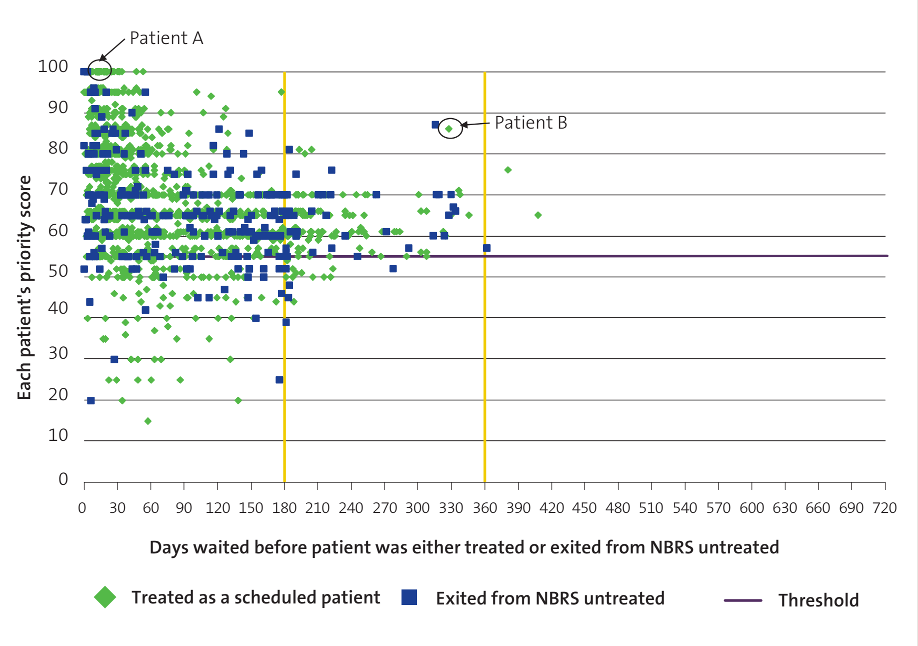
21 Seddon, M et al (March 2006), "Coronary artery bypass graft surgery in New Zealand's Auckland region: a comparison between the clinical priority assessment criteria score and the actual clinical priority assigned", *The New Zealand Medical Journal*, www.nzma.org.nz/journal/119-1230/1881/.

22 Cardiac Surgery Service Development Working Group (September 2008), *Cardiac Surgery Services in New Zealand*, www.moh.govt.nz.

Data was extracted from the National Booking and Reporting System on 14 October 2010 and reports each patient's latest priority score. The data excludes patients treated for infertility or who were sterilised. Patients were scored using the *National Tool Gynaecology – General (9065)*.

Figure 14
Days waited for treatment by patient priority score (general gynaecology surgery), at one DHB during 2009/10



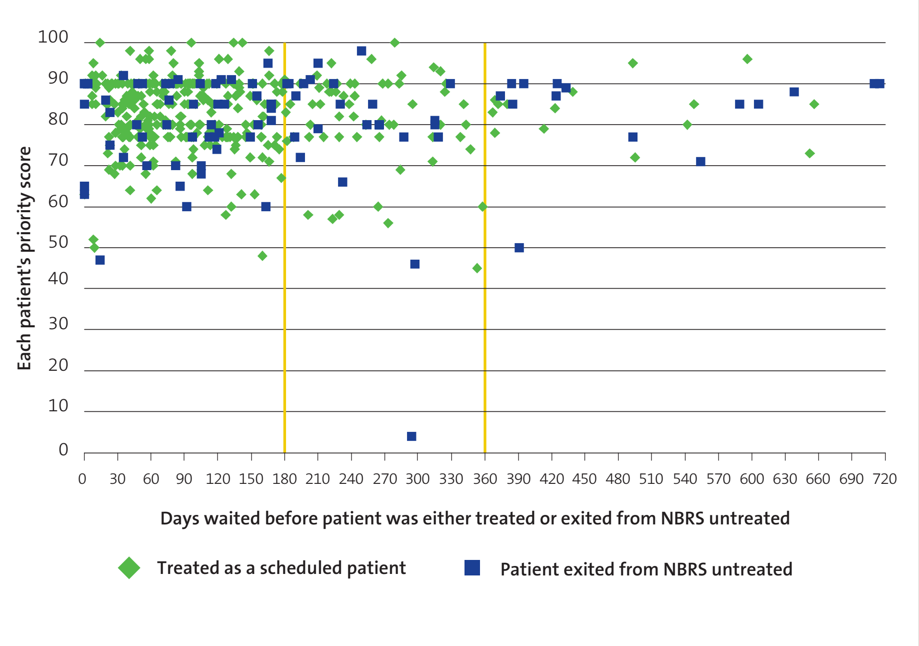
Data was extracted from the National Booking and Reporting System on 14 October 2010 and reports each patient's latest priority score. The data excludes patients treated for infertility or who were sterilised. Patients were scored using the *National Tool Gynaecology – General (9065)*.

5.44 In Figure 14, Patient A had a score of 100 and had their surgery in 11 days. Patient B had a score of 86 and had their surgery after waiting 327 days (about 11 months). The data for general gynaecology surgery also shows that in 2009/10:

- 322 out 434 patients (74%) with scores of 80 or higher were treated in 30 days or less, compared with 319 out of 484 patients (66%) in 2005/06;
- 418 out of 434 patients (96%) with scores of 80 or higher were treated in 90 days or less, compared with 454 out of 484 patients (94%) in 2005/06; and
- 216 out of 258 patients (84%) who exited the booking system without treatment exited within 180 days (about six months), compared with 181 patients out of 271 (67%) in 2005/06.

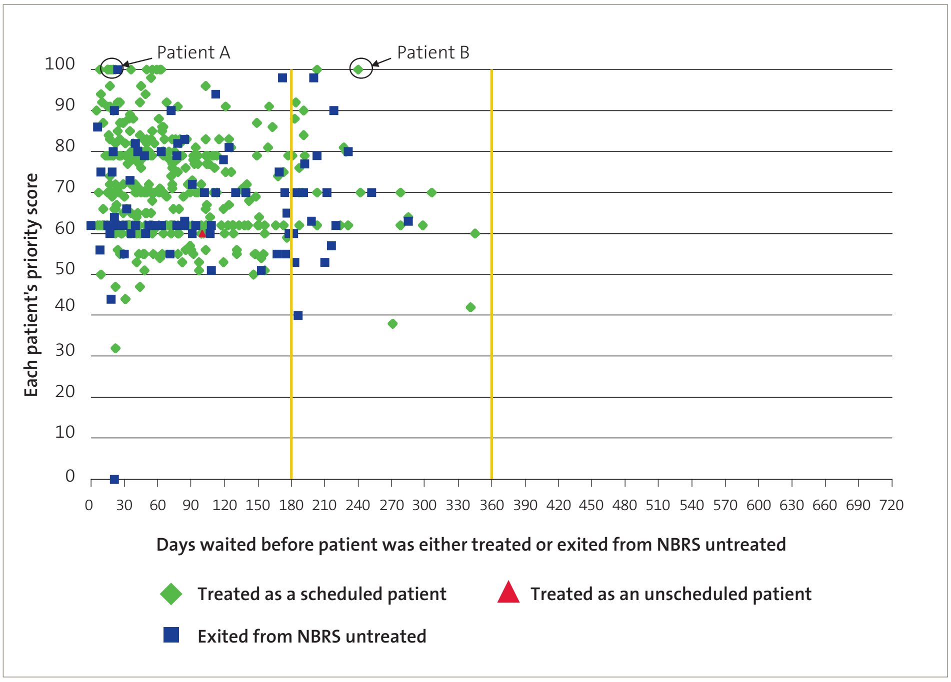
Figure 15

Days waited for treatment by patient priority score (hip and knee replacement surgery), at one DHB during 2005/06



Data was extracted from the National Booking and Reporting System on 14 October 2010 and reports each patient's latest priority score. Patients were scored using the *National Tool Orthopaedics (9010)*.

Figure 16
Days waited for treatment by patient priority score (hip and knee replacement surgery), at one DHB during 2009/10



Data was extracted from the National Booking and Reporting System on 14 October 2010 and reports each patient's latest priority score. All except five patients were scored using the *New Zealand Orthopaedics Association Hip/Knee Replacement/Revision Clinical Priority System 2006 (9011)*. The other five patients were scored using the earlier tool – *National Tool Orthopaedics (9010)*.

5.45 In Figure 16, Patient A had a score of 100 and had their hip replacement surgery in 16 days. Patient B had a score of 100 and had their hip replacement surgery after waiting 240 days (eight months). The data for hip and knee replacement surgery also shows that in 2009/10:

- 29 out 99 patients (29%) with scores of 80 or higher were treated in 30 days or less, compared with 33 out of 272 patients (12%) in 2005/06;
- 80 out of 99 patients (81%) with scores of 80 or higher were treated in 90 days or less, compared with 134 out of 272 patients (49%) in 2005/06; and
- 58 out of 75 patients (77%) who exited the booking system without treatment exited within 180 days (about six months), compared with 51 patients out of 76 (53%) in 2005/06.

Some overall conclusions about these graphs

5.46 It is clear from the scatter graphs that more patients were treated overall and that more of them were treated within six months in 2009/10 than in 2005/06. These graphs support the information that we report in Parts 4 and 6. In this Part, we focus on whether patients were treated in priority order.

5.47 We expected the scatter graphs to show the pattern of treatment set out in Figure 9 – that is, that the high priority patients cluster in the top left-hand side of the graph and the other patients spread out in "steps" that increase in width as the priority scores decrease. The scatter graph that comes closest to this is the one for general gynaecology surgery in 2009/10 (Figure 14), which has not been the focus of a national initiative.

5.48 We have taken a fairly blunt approach to assessing whether patients have been treated in priority order. We chose to analyse how many patients with scores of 80 or more were treated within 90 days and 180 days.

5.49 We consider it reasonable to expect that all patients with a score of 80 or more will receive treatment within three months and that none of these patients will wait longer than six months. (The new cardiac surgery tool requires all patients with a score of 50 or more to be treated within 48 hours, not 90 days.) The example DHB treated most patients within these periods, but not all patients were treated in priority order.

5.50 We have no reason to believe that these results cannot be generalised to other specialties in our example DHB or to all specialties in all the DHBs.

5.51 In our view, the scatter graphs provide rich information about whether DHBs are treating patients in priority order. We suggest that DHBs publish this information for selected specialties or procedures to tell their communities about any improvements that they make. We consider that the Ministry should regularly report on this aspect of DHBs' performance, which might involve introducing an ESPI.

5.52 The Ministry periodically provides each DHB with scatter graphs about their untreated patients who have been given a commitment to treatment within six months. The DHBs are meant to use these graphs to treat patients in priority order.

Auditing selection decisions and priority scores

5.53 The Ministry expects DHBs to evaluate the effectiveness of their prioritisation processes and systems, and to improve their quality where required. This includes audits. We were told that audits of selection decisions and priority scores for treatment are not part of the routine management of scheduled services within a DHB or between DHBs.

5.54 DHBs occasionally complete one-off audits. This is usually in response to a complaint or because a new manager or clinical director wants to examine whether changes to a service are needed. A DHB's management of a waiting list can also be externally audited, which results in a published report, such as *Report on Patients Awaiting Cardiac Surgery: Capital and Coast District Health Board* (1 October 2008). The report is available from www.moh.govt.nz.

5.55 In our view, DHBs should have continuous quality assurance and improvement programmes for their scheduled services, and those programmes should use a range of methods. National prioritisation tools should be audited to validate the prioritisation of access to treatment, because such audits are fundamental to good clinical practice. We also consider that the Ministry and DHBs need to share the information produced and update the national prioritisation tools as needed.

DHBs' and specialists' commitment to, and management of, prioritisation tools to achieve equity

5.56 Many DHBs told us that improving equity within their DHB (by this, they mean that the resources made available for each specialty closely matches the needs of patients in their district) and throughout the country is important to them. They also want to be able to measure and acknowledge the level of unmet need in the population. Effective prioritisation can help with this. DHBs consider that national prioritisation tools enable decisions to accept or decline patients for scheduled services to be transparent and make it possible to compare the scheduled services offered by each DHB.

5.57 Half of the DHBs told us that progress towards achieving national equity had been slow and needed to improve. One DHB said that achieving equity of access objectives remains less than ideal, largely because of the need to further mature the prioritisation tools and their acceptance. Another DHB considered that there is a clear difference in views between nonspecialists and specialists about using nationally consistent prioritisation tools. This DHB considered that the nonspecialists' view is that it is unclear whether there is a commitment to using the tools nationally because they are not being used by all services. The specialists' view is that the usefulness of the tools is limited – the tools become either too complex to be embraced by specialists or too simple to provide enough stratification of priority.

5.58 We are not surprised that there are a wide range of views, given that there is not a full suite of national prioritisation tools (or processes if tools are not practical) that properly meet all of the Strategy's objectives. We understand that none of the national prioritisation tools have been audited to verify that they produce the results that were intended. Until this is done, the information that the tools produce cannot be used to assess whether the thresholds for access to scheduled treatment are appropriate. The survey responses we received from DHBs are consistent with our conclusion.

5.59 We also consider that no-one is clearly responsible for controlling the tools and their use. In our view, this has weakened the incentives to prepare and introduce national tools and use them effectively.

5.60 Prioritisation is always a specialist medical judgement. The resulting priority score determines whether the patient meets the DHB's threshold for access to scheduled services within six months. The specialist is responsible for overriding a patient's score, as needed, to respond to a patient's circumstances. (Audits would soon discover if this responsibility had been abused or whether the tool has a "blind spot" that disadvantages certain types of patients.) We expect specialists and DHBs to decide about access together.

5.61 The New Zealand Medical Association's Code of Ethics (2008) sets out doctors' wider role in prioritising care. One of the four clauses on this topic (clause 65) states that:

> *Patients must be able to trust their doctor to deal with their needs fairly and honestly. Doctors should, within reason, provide adequate information to their patients about their assessment and available treatments, including those not readily available.*

5.62 We understand that, in earlier years, the professional groups did not formally lead the preparation of the tools, but individual members were involved. Professional groups are increasingly taking on a formal leadership role, which is appropriate. We consider that these groups should be responsible for the "life cycle" of each national prioritisation tool. They could:

- lead the preparation and testing of each tool;
- design and implement a change management process to effectively communicate a new or updated tool to the relevant health professionals and managers at each DHB, so that they are correctly used;
- apply to the Ministry recommending that a tool be used to comply with ESPI 8;

- review the tools regularly;
- consider how best to collect patients' views about the benefits of the treatment compared to their pre-treatment expectations; and
- audit the use of the tools to check whether patients were dealt with consistently.

5.63 In our view, the DHB's role is to provide the administrative and operational systems and resources to provide scheduled services within the time limits determined by the patient's priority score and the Government's maximum time limits.

5.64 The Ministry's role may be more flexible. At a minimum, it should set the operational policy parameters for the DHBs and professional groups to work within, to ensure that the tools created meet the Strategy's objectives and to share lessons learned by the professional groups. The Ministry could be responsible for the processes used to approve the use of the tools to comply with ESPI 8. Other than that, we consider that its role in preparing and introducing tools may be to provide support – such as funding, co-ordination, and expertise – to the professional groups.

5.65 We consider that a full suite of tools needs to be prepared, introduced, and used to improve the national consistency of clinical assessment and prioritisation for treatment. Once they are introduced, we expect the Ministry to withdraw its agreement for specialists and DHBs to use local tools to comply with ESPI 8. We consider that there should be as few national prioritisation tools as practicable within a specialty, so that:

- a DHB can ensure equitable access to treatment within a specialty;
- access to treatment can be more easily compared throughout the country;
- the effect of proposed increases or decreases in funding allocated to a specialty or procedure can be assessed more easily;
- the tools are used with enough patients to collect enough data to improve the tool and/or services; and
- the cost of preparing and updating the tools is minimised.

Setting minimum service levels for access to scheduled services

5.66 The Strategy anticipated that methods for funding scheduled services could shift from payments made for activities (such as an FSA or treatment) to funding DHBs based on their meeting an agreed service level for the population, measured in clinical and human terms. The Strategy gave two examples:

- Ophthalmology – all patients clinically assessed as requiring a cataract operation to keep their driver licence will be provided with cataract surgery within six months of assessment (about X operations per 1000 population).
- Orthopaedics – all patients clinically assessed as requiring a hip replacement to comfortably walk a flight of stairs will be provided with hip replacement surgery within six months of assessment (about X operations per 1000 population).

5.67 We understand that no moves have been made to introduce such methods. Instead, the minimum service levels have been set or managed in two main ways. The first is that DHBs take more patients into the system than they have the resources to deliver scheduled services to within six months, as long as they comply with the ESPIs. Secondly, the Ministry has recently introduced target intervention rates for each DHB's population and for certain operations.[23] The intervention rates are one way to substitute for consistent national data about priority scores. Because the rates are standardised, they also address changes in the size of the population and changes in demographic profile. The rates also ensure that DHBs increasingly make a proportional contribution to meeting the Health Target (see paragraph 6.10).

5.68 Managers and funders of scheduled services need to be mindful that minimum service levels for scheduled services or for a specific operation should not be set in isolation from other services that DHBs deliver or provide access to. One DHB told us:

> *Horizontal equity/prioritisation issues are not well addressed – that is, as a nation or region how do we decide whether greater resources should be targeted into a surgical specialty at the expense of another* [hospital or service] *because* [Quality Adjusted Life Years], *or some other outcome measure, would be greater?*

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[23] In 2010/11, the target rate for each DHB is to treat 292 patients for every 10,000 population. From 2009/10, target rates have been set for cataract, hip and knee replacement, and cardiac surgery. DHBs need to explain to the Ministry if they cannot meet the targets.

Part 6
Increasing the supply of scheduled services

6.1 In this Part, we discuss the Ministry's and DHBs' progress in increasing the supply of scheduled services. We discuss:

- increased funding for scheduled services and how it was used;
- changes in the number of patients receiving scheduled surgery;
- improvements in efficiency; and
- of the effect on unmet need of providing more treatment.

6.2 According to the Strategy, the backlog of patients waiting for an FSA and treatment had been substantially reduced by 2000. Therefore, any increases in sustainable funding would be used to ensure improved levels of service for newly presenting patients – that is, the level of unmet need would be reduced.

Increased funding for scheduled services

6.3 In the first few years, DHBs used the increases in devolved funding for scheduled services to implement the Strategy. In general terms, they used the extra funding to further reduce the backlogs of patients waiting for an FSA and treatment. DHBs also used it to improve their systems for managing, delivering, and reporting on scheduled services, which also included working more effectively with GPs. At the same time, DHBs were to ensure that patients did not wait more than six months for an FSA or treatment.

6.4 DHBs used two main methods to reduce their backlog of patients. Patients were returned to their GP for reassessment and re-referral as needed, or the DHB held extra out-patient clinics for FSAs and extra operating theatre sessions.

6.5 "Residual waiting list" was the term specifically used to describe the backlog of patients waiting for treatment. Once the Strategy was introduced, DHBs were not allowed to add new patients to these lists. ESPI 4 reports on this. DHBs made good progress in decreasing the number of patients on residual waiting lists. At 30 June 2000, there were about 39,000 patients on the lists. By 30 September 2006, there were only 44 patients on lists nationally. The Ministry regularly reported these improvements in its published annual reports.[24]

6.6 From 2006/07, a central pool of extra funding for scheduled services was set up within the Ministry. The extra funds paid to DHBs (excluding GST) were about:

- $141 million in 2007/08;
- $197 million in 2008/09;

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[24] There are several reports that the Ministry is statutorily required to publish each year on behalf of the Ministry, the Director-General of Health, and the Minister of Health. Information about scheduled services was contained in more than one of these reports in most years.

- $203 million in 2009/10; and
- $220 million in 2010/11 (the budgeted amount).

6.7 These funds were (or will be) used to increase the total number of patients receiving scheduled surgery. Some of the funds were (or will be) used to specifically increase the number of patients receiving cardiac surgery, cataract surgery, and hip and knee replacement surgery. Hutt Valley DHB was allocated funds to provide breast reconstructive surgery for eligible women living in the Capital and Coast, Hawke's Bay, MidCentral, Nelson Marlborough, Wairarapa, and Whanganui DHBs' districts. (DHBs in the rest of the country provide this surgery using their devolved funding.)

6.8 The DHBs had to agree to deliver more treatment services for any extra funds they were allocated in a year. If a DHB delivered more treatment than was agreed, it may have been able to get a top-up from the Ministry to cover its costs. This often depended on whether other DHBs had delivered fewer services than planned, which meant that the Ministry could shift funding between DHBs.

6.9 Because a particular year was chosen as the "baseline" year against which to measure improvements (most recently 2005/06), DHBs were providing different levels of access. This is called "historical inter-regional inequity". DHBs providing comparatively poorer access in 2005/06 were able to use less of their own funding for scheduled services and use proportionally more funding from the Ministry's central pool than other DHBs. The Ministry can also require DHBs to use devolved funding to increase scheduled services before they can access funding from the central pool.

6.10 Each year, DHBs are to provide an agreed minimum quantity of scheduled services. The previous year's treatment levels are the baseline for the current year. However, the quantity of treatment can be increased to make more progress towards correcting historical inter-regional inequity and to meet the applicable Health Target, which requires DHBs to jointly increase the number of surgical operations each year by an average 4000 surgical operations nationally.[25] They are to do this and comply with the ESPIs.

6.11 The Ministry is managing this process to achieve a total of 190,000 scheduled operations in 2025/26. In that year, DHBs will need to provide 56,819 more operations than they did in 2009/10 (see Figure 17). Each DHB is expected to eventually deliver an equitable share. The Ministry tells us that 12 DHBs will need to provide between 25% and 90% more operations than they plan to provide during 2010/11.

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[25] Patients receiving scheduled medical procedures do not count towards the Health Target.

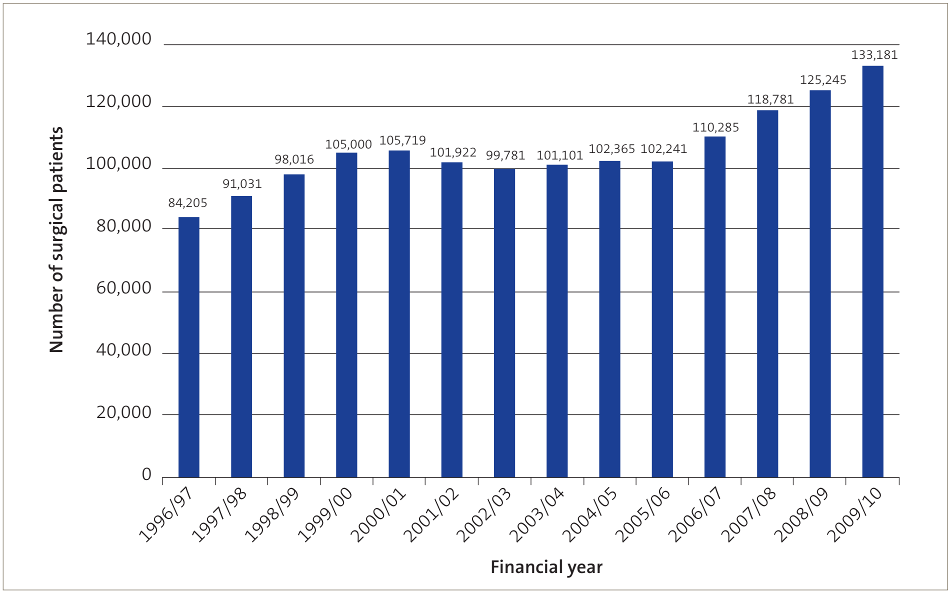
6.12 Since 2008/09, part of the Ministry's central fund for scheduled services has been allocated to increasing the number of FSAs and procedures provided in out-patient settings to reduce waiting times for patients. The number of FSAs was not publicly reported until 2010/11. This information is provided in the Ministry's caseload monitoring reports on its website. We consider that the number of FSAs is not particularly meaningful. In our view, the number of FSAs does not necessarily reflect the efficiency of the service. In some circumstances, fewer FSAs could indicate an effective care pathway. For example, the need for FSAs can be reduced when GPs are able to order diagnostic tests for their patients.

Changes in the number of patients receiving scheduled surgery

6.13 It took time for DHBs to establish systems to enable an even flow of patients from an FSA to surgery. This meant that, from about 2005/06 to 2007/08, DHBs were not able to use all the extra funding for scheduled services that was available to them.

6.14 Figure 17 shows changes in the number of patients who received scheduled surgery from 1996/97 to 2009/10. The numbers of patients treated decreased after the Strategy was introduced and averaged about 101,400 from 2002/03 to 2005/06. It is apparent from Figure 17 that increased funding from 2006/07 led to increased service provision.

Figure 17
Number of patients receiving scheduled surgery, from 1996/97 to 2009/10



The data in this graph has been adjusted to retrospectively apply changes made to the way surgery was coded. This provides a comparison across years, although some changes may slightly influence the results. The figures differ, substantially in some cases, from earlier data that the Ministry has published. This is because the data is retrospectively adjusted when coding practices change.

Improvements in efficiency

6.15 Evidence of improvements in efficiency tends to be anecdotal. By this, we mean that there are case studies about changes made in one DHB that:

- increased the number of patients seen and/or treated;
- decreased waiting times for patients;
- improved the effectiveness of the working relationship between the hospital and GPs; or
- saved money, which was used to see more patients.

6.16 The projects to make these improvements were usually started because a specialty had long waiting times or were (or were at risk of) turning away referrals for patients who should rightly see a specialist. The projects were successful in ensuring that more patients received scheduled services and received them more quickly.

6.17 We were repeatedly told about the same handful of case studies. This reinforced our impression that a culture of willingness to learn from the experience of others is not widespread throughout the DHBs. When we discussed improvements we had learned about in one DHB with other DHBs, we were often told “But that wouldn’t work here.” Sometimes, we were told this by another service in the same DHB where a project had been successful.

6.18 Few of the reasons we were given to justify a lack of action seemed to be significant enough to prevent an attempt to achieve similar improvements.

6.19 We consider that every DHB and every specialty providing scheduled services can increase the efficiency of its delivery. Improvements would enable patients and GPs to get more and faster access to specialist advice, reduce waiting times for an FSA and treatment, and reduce the total time for patients to complete their care pathways. DHBs need to ensure that the methods they use to fund scheduled services encourage innovation instead of inhibiting it.

Day-of-surgery admission and day-case treatment

6.20 DHBs have more widely improved the use of day-of-surgery admission (DOSA) and day-case treatment.

6.21 Most specialties and DHBs admit patients on the day of surgery to maximise the use of their in-patient beds. For DOSA to work effectively, DHBs must select appropriate patients and have efficient systems for sending them home on time so that a new patient can use the same bed or chair later in the day. Patients are relied on to begin preparing for surgery at home the night before or on the morning of their procedure.

6.22 Some patients do not need to stay in hospital overnight for treatment. These patients are brought into hospital for the day and go home at night. One DHB told us that it had encouraged each of its hospital's surgical specialties to meet the national and international benchmarks for day-case rates. This has helped the DHB increase its day-case rate for surgery.

The effect on unmet need of providing more treatment

6.23 The Strategy holds several objectives in balance. When more resources are available, DHBs are expected to offer scheduled services to patients with the highest needs and ability to benefit from treatment relative to other patients. Effective prioritisation is needed to identify these patients. DHBs are also expected to offer scheduled services only to patients they can treat within mandated time limits. It is assumed that DHBs will make the best use of the resources available by continuously improving their practices.

6.24 Baseline information about the amount of unmet need in a population is needed for DHBs to know whether increased resources have reduced unmet need. Otherwise, it is difficult to know whether increased service provision has done more than keep pace with population growth or changes in the population's demographic profile. DHBs told us that they need to do more work on this (see paragraph 5.56-5.57), and we agree.

6.25 In 1993/94, the Ministry considered that the national level of access to publicly funded surgery was roughly comparable to that in similar countries for which data was available. The Ministry reached its conclusion after analysing data for "key marker" cases, which were hip and knee replacements, coronary artery bypass grafts, angioplasty, cataract operations, and prostatectomy operations.

6.26 In late 2003, the Ministry started a project to assess whether orthopaedic patients in five DHBs were receiving similar access to scheduled services. This led to the Orthopaedics Initiative in 2004. A Cataract Initiative started in 2005. Part of each initiative involved increased funding to increase the number of operations for hip and knee replacements and cataract surgery. Targets were set that were largely achieved and/or exceeded.

6.27 The national initiatives were intended to correct perceived failures of DHB-level prioritisation. The patients who received these operations benefited from them. However, a review of the initiatives found that the increased level of service for these patients had generated inequities of access for conditions not covered by the initiatives. This was of particular concern for the care of patients with chronic conditions that can cause permanent, irreversible loss of vision in patients of working age.[26] Vision loss from cataracts is reversible.

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[26] Gandar, Philip (7 July 2008), *A review of the elective services orthopaedic major joint and ophthalmology cataract initiatives: report prepared for the Ministry of Health*, www.moh.govt.nz, page 4.

6.28 Prioritisation tools that are consistently used and continuously audited and updated will gradually produce enough good quality data to better inform the debate about where funding should be allocated and why (see paragraph 5.68).

Appendix 1
Our methodology

We analysed quantitative and qualitative information published or provided to us by the Ministry, DHBs, professional groups, researchers and academics, and international organisations such as the Organisation for Economic Co-operation and Development.

We talked with, and received written comments and documents from, various organisations and individuals, such as people managing and working in private hospitals, representatives from health professional groups, the Office of the Health and Disability Commissioner, DHBs, primary health organisations, individual general practitioners, the Ministry (past and present employees), the New Zealand Guidelines Group, and members of the public.

We asked many of the people we contacted to recommend other people for us to speak to before we wrote our report. We carried out as many of their suggestions as we could. For several reasons, we did not contact patients who had:

- received scheduled services;
- were waiting for scheduled services; or
- not been offered scheduled services by DHBs or ACC.

News media articles provided some insights, as did some of the Health and Disability Commissioner's published case studies. These articles and case studies tended to be complaints rather than compliments.

We visited Auckland, Canterbury, Capital and Coast, Nelson Marlborough, and Wairarapa DHBs. We visited the Canterbury Charity Hospital in Christchurch. We were shown around the operating theatres at Auckland and Green Lane Hospitals and were told how they were used. Clinical administration staff in two DHBs showed us how they book patients for specialists' appointments and add patients to the waiting list for surgery.

We asked DHBs and others about the progress they thought they had made towards achieving the Strategy's objectives. We asked them to consider the last 10 years and tell us:

- what they thought was working well in the system to provide scheduled services;
- what further improvements in the system, if any, they thought the public could reasonably expect by the end of 2013;
- what the first improvement they would make to the system was and why, if they were free to make that improvement;
- what their biggest frustration was and why; and

- what outcomes they thought a scheduled services system should deliver and whether they thought these were being achieved.

We thank everyone who told us what they thought and all those who met with us. We asked representatives from the Ministry, ACC, and DHBs to comment on our draft report. We carefully considered their comments and the information they gave us. As we expected, there were areas where people held relatively similar opinions and areas where there was a range of views.

Appendix 2

The Accident Compensation Corporation's approach to scheduled services

The *Reduced Waiting Times for Public Hospital Elective Services: Government Strategy* (the Strategy) does not apply to ACC. ACC's methods for managing scheduled services differ from those of the Ministry and DHBs because it has a different and specific role. Its role is to purchase treatment for people who have been injured by an accident covered by the Accident Compensation Act 2001 (the Act).

ACC's role is set out in the Act and supporting regulations. This Appendix gives general and summarised information about ACC's approach to scheduled services. The information that ACC provides to patients and health care providers uses terms that have a specific meaning. For ease of reading, we may use these terms differently or omit certain information. Patients and their health professionals should rely on information provided by ACC about their care and treatment.

Patients with injuries from accidents can be cared for by a GP, physiotherapist, specialist, or a public hospital when an injury is first sustained. Services are funded separately from scheduled services. ACC pays for more scheduled orthopaedic surgery than other types of surgery because it is commonly needed after an accident. ACC has started to introduce rehabilitation pathways for common types of injuries. These are equivalent to the care pathways that some DHBs use.

At an appropriate time, the specialist and patient may agree that scheduled surgery is in the patient's best interest and will apply to ACC to approve funding for a treatment plan using an application form devised for that purpose. ACC will approve the request for surgery, based on the information supplied, when:

- the treating surgeon can demonstrate a causal link between the injury and need for the proposed treatment;
- the treating surgeon is listed with ACC as accredited to work in the hospital where the surgery will occur; and
- the treating surgeon is approved to carry out the treatment.

After ACC has approved funding for a request for surgery, the surgeon is expected to provide treatment within the time frame that they proposed to ACC. Nearly all surgery is completed within three to nine months of its approval.

ACC has a review process[27] that patients can use after it has declined to fund a request for surgery. A private hospital or DHB may complete the patient's surgery before a review has been concluded. If directed by the review authority, ACC will retrospectively fund the surgery if the patient's appeal is successful. If

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[27] In May 2011, the Minister for ACC announced changes to the status of ACC's review body, Dispute Resolution Services Limited. It is to become an independent Crown entity on 1 July 2011.

unsuccessful, the DHB or patient has to fund the surgery. The patient can use their private health insurance and/or their own funds.

Surgeons can support a patient's appeal to ACC so that the patient can access entitlements they might be missing out on or that their insurance might not cover.

How ACC pays DHBs for scheduled surgery

DHBs choose whether to contract with ACC. DHBs have contracts with ACC and manage to an agreed budget for a financial year, and some DHBs sub-contract some of the ACC-funded and/or DHB-funded surgery to private hospitals. Some DHBs provide the surgery in private premises – they hire the facility and equipment but use their staff to perform the surgery.

Expenditure is relatively stable from year to year and relatively insignificant compared to Vote: Health funding. From 2006/07 to 2008/09, about half to two-thirds (11-14) of the then 21 DHBs had contracts with ACC, which were all worth less than $1 million annually.

DHBs can access "Regulation 18 funding" if they want to do more surgery for ACC.[28] DHBs may want to do more surgery because they want to earn more revenue. The amount of Regulation 18 funding that ACC paid to DHBs was about:

- $0.7 million in 2006/07;
- $0.6 million in 2007/08;
- $1.0 million in 2008/09; and
- $1.4 million in 2009/10.

The increase in the use of Regulation 18 funding in the last two years might be because some DHBs have improved their ability to identify which of their patients are eligible to have their surgery funded by ACC instead of Vote: Health.

Receiving surgery in public and private settings

Depending on where they live and the type of surgery they need, patients may be able to have their surgery at their Home DHB or at a private hospital.

Most surgery is completed in a private hospital because there is a high likelihood that the surgery will be completed in the preferred time frame. DHBs' ability to offer guaranteed admission and theatre time can be affected by higher than expected unscheduled admissions, workforce shortages, or industrial action, which do not trouble private hospitals to the same degree. Another factor

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[28] Regulation 18 of the Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

influencing patients' decisions is that DHBs are seldom specific about how long patients will wait for surgery when an offer of treatment is first made.

Some DHBs work closely with the surgeons in their district to treat ACC-funded patients locally. This helps to ensure that there are enough surgeons to make a particular service clinically and financially viable for the DHB and the private hospital. An example is Wairarapa DHB, which works closely with the local small private hospital to help recruit and retain a skilled workforce, particularly for complicated shoulder surgery. This means that patients do not need to travel out of the district for surgery. Whanganui DHB manages a joint contract with its local private hospital for ACC-funded elective surgery. Patients can be treated in either hospital, depending on their individual risk factors or the availability of beds.

ACC's focus is to ensure access to a quality service, which is appropriate for the patient's clinical priority for treatment and effective rehabilitation. ACC does not direct in which facility the treatment is to be provided.

Appendix 3

Changes in health care and society that increase demand for scheduled services

Expecting all new treatments to be available throughout the country may place a strain on publicly funded health services. When they are first introduced, new treatments and techniques commonly cost more than the treatments they replace. Sometimes, more staff are needed to deliver the new treatment and maintain new equipment.

Some procedures and surgery can become cheaper when performed as day-cases instead of bringing patients into hospital to stay overnight. These opportunities tend to be taken up cautiously because of fears that the quality of care could decrease. By the time the cost to treat an individual patient is reduced, more people want the treatment, which means that the total cost to the public health system may not decrease.

Figure 18 gives examples of improvements in health care that increased the demand for, and cost of, scheduled services and improved people's quality of life and/or the length of their life.

Figure 18
Examples of advances in health care that have increased the demand for scheduled services

Health condition	Brief description of changes
Heart disease	Since the 1960s, a range of new treatments has been introduced to care for patients with heart disease, such as angioplasty and heart valve surgery. Over time, when the whole-of-life costs and benefits are considered, the techniques have become more effective and more cost-effective compared to traditional conservative techniques. The overall cost of treatment has risen as the population ages and expects more aggressive management of heart disease with better outcomes.
Gallbladder disease	These days, surgeons commonly remove gallbladders using a laparoscopic (or keyhole) technique instead of traditional abdominal surgery. The patient recovers more quickly from the laparoscopic technique (which has fewer adverse side effects, such as infection) and is discharged from hospital sooner. However, more expensive equipment (with cameras and screens) is needed to perform laparoscopic procedures. Sometimes, operating theatres may need to be larger to accommodate the extra equipment used in this and other laparoscopic procedures, so that staff can work safely. Nevertheless, this is another example where there are better patient outcomes and reduced overall costs. This means that more people can safely have this surgery instead of having their condition managed conservatively.

Health condition	Brief description of changes
Wet macular degeneration	Wet macular degeneration is an eye condition caused by the growth of abnormal blood vessels, which can leak. The leaks cause the retina to lift away from the eye wall, causing swelling and decreased central vision. Until recently, there was no treatment for this condition, which affects relatively few people. A treatment is now available, and success depends on prompt intervention. A drug can be injected into the back of the eye, and these injections are delivered six-weekly in an operating theatre and involve follow-up visits to hospital after each treatment. Although fewer people are affected, providing this treatment reduces costs elsewhere in the health and disability system, the non-government organisation sector, and the welfare system that would be incurred if the patient lost their sight.

How changes in health care affect how scheduled services are accounted for

As medical knowledge becomes more reliable and codified, the places where scheduled services are provided can change because it is possible for a wider group of health professionals to provide high quality and safe scheduled services. Some scheduled services move from hospital to primary care, but the reverse can also occur if high-cost technology is needed to treat conditions that were previously untreatable. New methods of caring for patients can increase timely access to scheduled services, but can cause problems in accounting for this care.

Traditionally, health services have accounted for improvements by counting the number of patients:

- seen at a first specialist assessment rather than the number of patients who got access to specialist advice; and
- operated on rather than the number of patients who did not need surgery because effective non-surgical care had been provided.

These statistics can be used to produce standardised intervention rates for different population sizes. Intervention rates can be used to assess whether access to scheduled services is adequate. However, the intervention rate will be low for conditions that have been prevented by good public health and primary health care, or are well managed in primary health care. Therefore, a comprehensive knowledge of a DHB's population is needed before assuming that a low intervention rate indicates poor access to scheduled services. Also, the smaller the size of the population, the less likely it is that the standardised intervention rate will be reliable because the number of patients in each age group will be too small to produce statistically reliable results.

Sometimes, an assumption exists that the number of patients who are seen and treated should automatically keep up with population growth. Whether this is a useful measure depends on whether treatment methods have changed and whether the demographics of the population have changed. In this situation, a national standardised intervention rate would be more useful.

In contrast to most other countries, New Zealand's booking system could produce good information about whether the supply of scheduled services is meeting the needs of the population. This is because there is the potential to quantify the level of unmet need by measuring the gap – if any – between the threshold at which most people consider that patients should be treated and the threshold at which most patients receive publicly funded treatment.

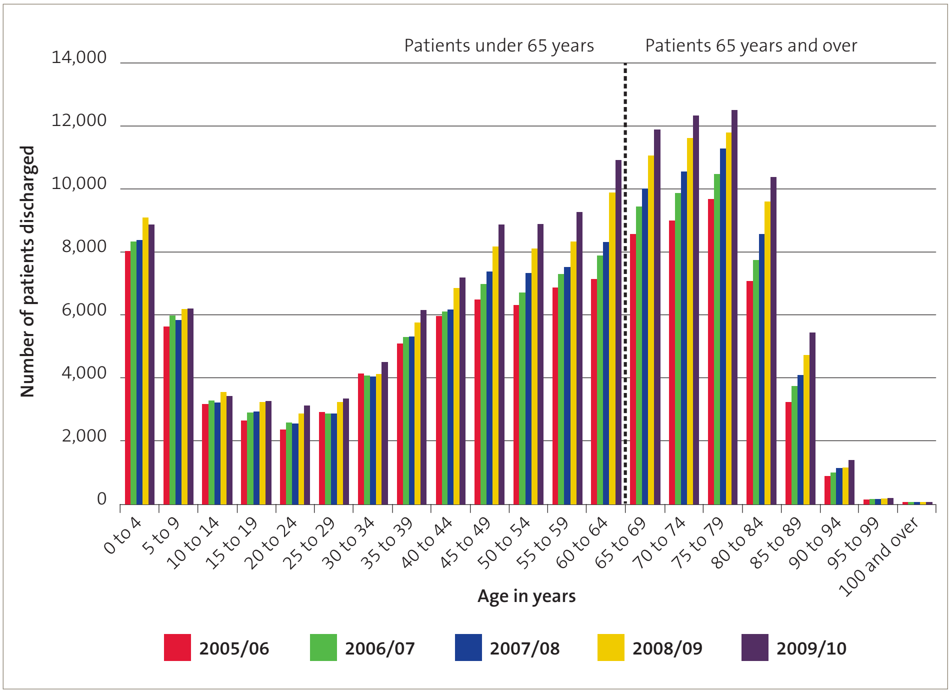
The age profile of patients receiving scheduled services

In the past, a patient's older age might have restricted their access to surgery. Nowadays, a patient's frailty has more bearing on the assessment of their ability to benefit from treatment than their age.

We asked the Ministry to produce a report for us to show the ages of patients receiving scheduled surgery from 2005/06 to 2009/10. Figure 19 shows the ages of patients who received scheduled surgery in five-year age groups in each of these years. The data shows that the number of patients receiving surgery were stable or increased in most age groups and, from the age of 60 years, the number of patients receiving surgery increased faster than in younger age groups.

Figure 19

Number of patients receiving scheduled surgery, in five-year age bands, from 2005/06 to 2009/10



Data was extracted from the National Minimum Data Set on 31 August 2010. This is a dynamic data set, which means that the same information request may produce different results when data is extracted on different days. The data does not include patients who received scheduled medical or dental services or patients whose care was funded by ACC.

The effect of better management of long-term conditions

There is a view that better management of long-term conditions will lead to lower levels of unscheduled use of services and that this will release resources for scheduled services.

Others consider that this is not necessarily the case. They say that increased investment in primary health care and prevention may:

- alter the purpose and timing of specialist assessment for a patient's condition;
- delay, rather than prevent, a patient's need for scheduled surgery, which means that the person is older when they are treated; and
- mean that patients live to an older age, which means that they live long enough to experience other health problems and may then need scheduled services.

Information and communication technologies

Improvements in information and communication technologies offer benefits for health care, but these projects can be difficult to introduce effectively and efficiently. They also need capital investment at the beginning, training for staff, and ongoing maintenance. Nevertheless, some DHBs have successfully introduced such technologies to improve the management of scheduled services.

Making faster progress in areas such as introducing telemedicine, electronic referrals from GPs to specialists or between specialists, and electronic clinical records has been complicated in most countries. In our country, factors complicating progress are the DHBs independently choosing products that may not easily communicate with each other, DHBs' priorities and financial position, and privacy concerns.

Appendix 4

Where patients were treated, from 2005/06 to 2009/10

Patients are not always treated by their own DHB. Each DHB:

- treats its own patients where feasible;
- refers its patients to be treated by another DHB; and
- treats patients who are the responsibility of other DHBs.

We have graphed the number of patients discharged in each category for each DHB from 2005/06 to 2009/10. We comment on some of the graphs, but not all of them.

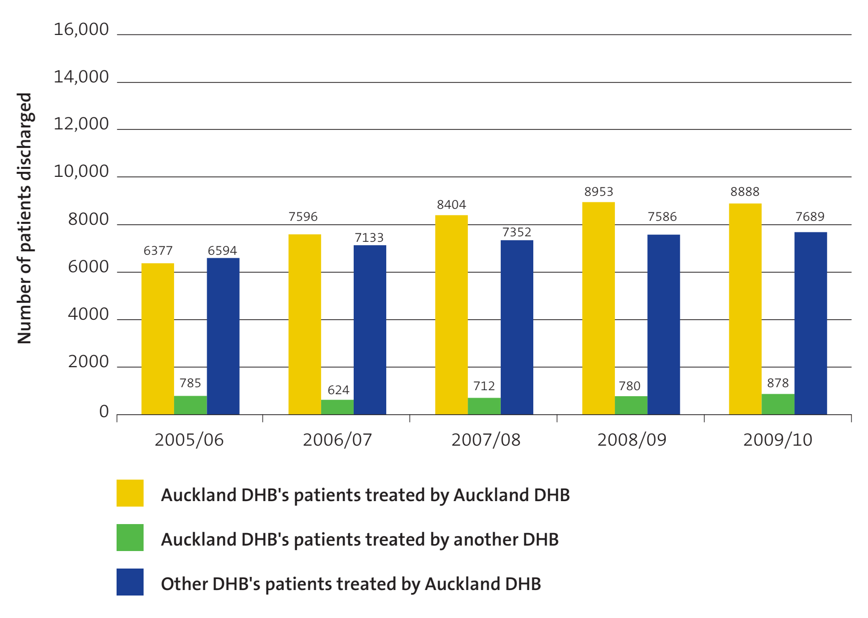
The data includes day-case surgical patients if they were assigned a case weight, and surgical patients treated by private providers contracted to provide the surgery on the DHB's behalf.

The data reported does not include:

- scheduled medical patients;
- scheduled surgical patients from overseas who were treated by DHBs; and
- scheduled surgical patients treated by non-DHB providers. These patients were treated by a charity hospital or independently sought and paid for treatment in a private hospital.

Auckland DHB

Publicly funded scheduled surgical patients treated by Auckland DHB and publicly funded scheduled surgical patients from Auckland DHB treated by other DHBs, from 2005/06 to 2009/10

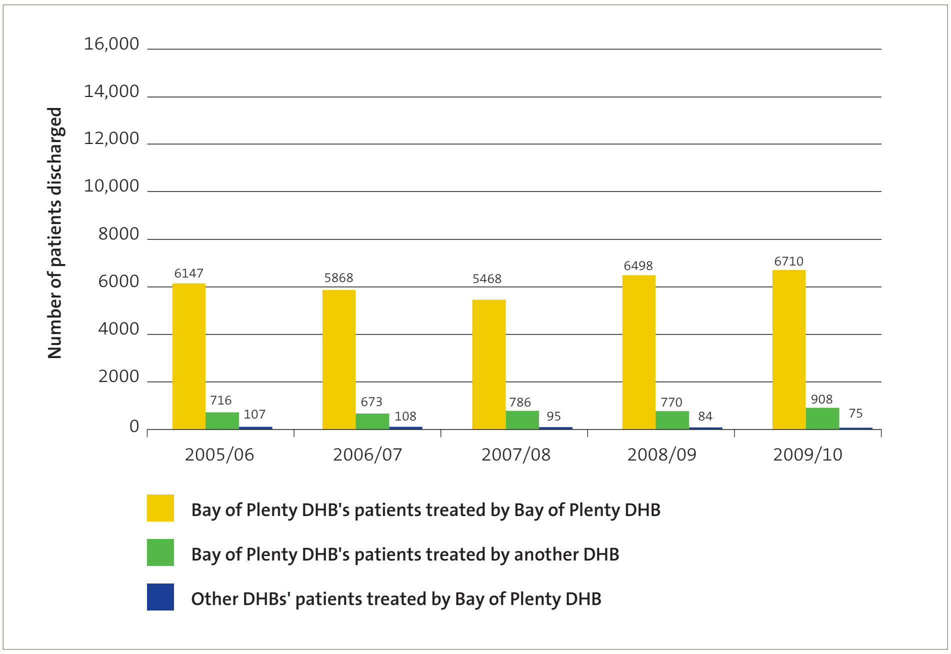


Data extracted from the National Minimum Data Set on 16 August 2010.

🟨	During these five years, the proportion of its own patients treated by Auckland DHB increased from 49% to 54%.
🟩	In 2009/10, of Auckland DHB's patients who were treated by another DHB: • Counties Manukau DHB treated 91%; and • Waitemata DHB treated 7%.
🟦	In 2009/10, of all the patients from other DHBs who Auckland DHB treated: • 56% were from Waitemata DHB; • 27% were from Counties Manukau DHB; and • 17% were from outside the Greater Auckland region.

Bay of Plenty DHB

Publicly funded scheduled surgical patients treated by Bay of Plenty DHB and publicly funded scheduled surgical patients from Bay of Plenty DHB treated by other DHBs, from 2005/06 to 2009/10



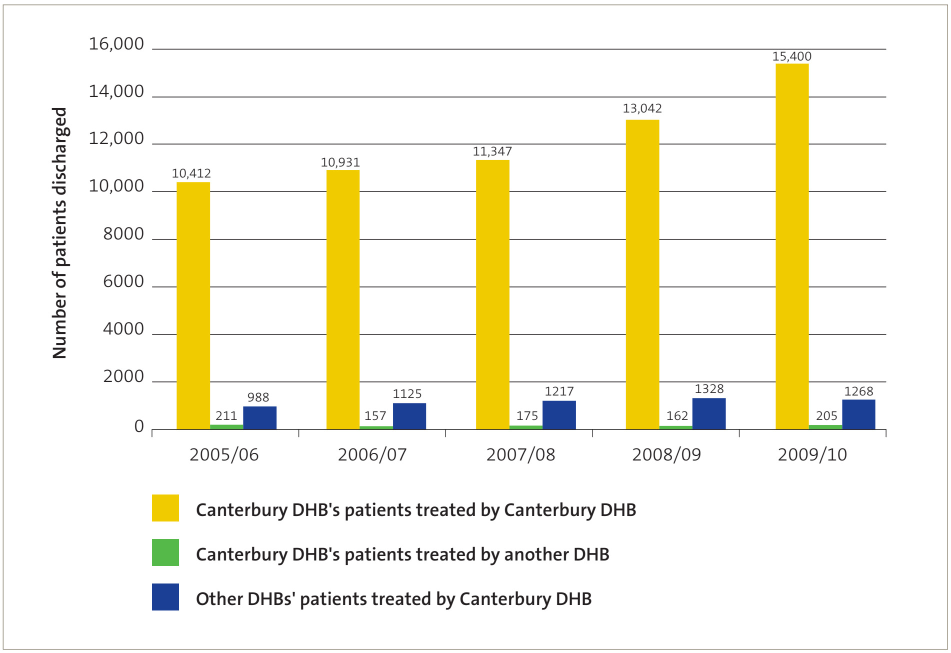
Data extracted from the National Minimum Data Set on 16 August 2010.

🟩 In 2009/10, of all Bay of Plenty DHB’s patients who were treated by another DHB:

- Waikato DHB treated 61%;
- Lakes DHB treated 23%; and
- Auckland DHB treated 13%.

Canterbury DHB

Publicly funded scheduled surgical patients treated by Canterbury DHB and publicly funded scheduled surgical patients from Canterbury DHB treated by other DHBs, from 2005/06 to 2009/10

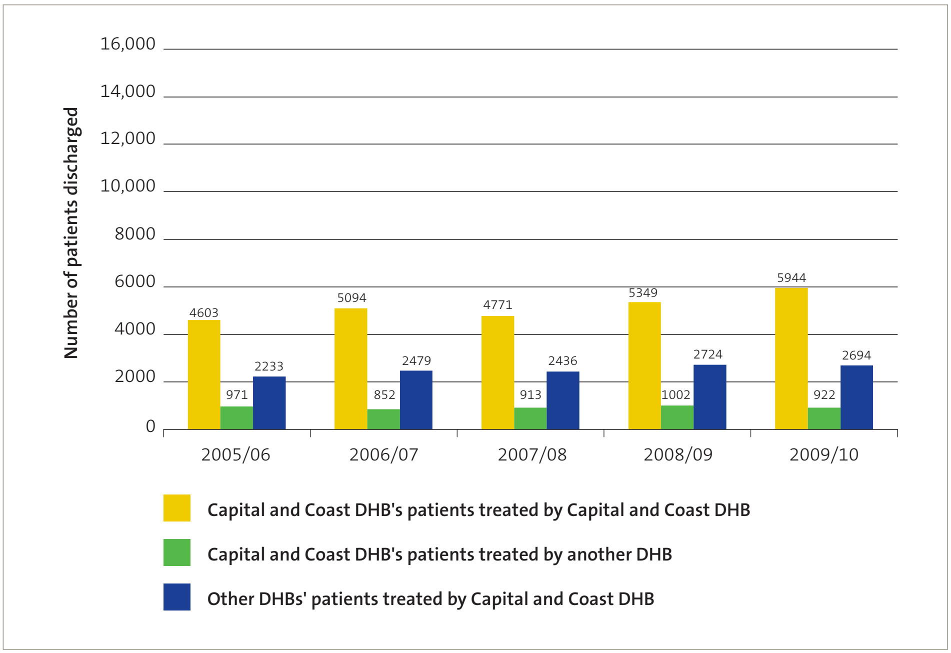


Data extracted from the National Minimum Data Set on 16 August 2010.

🟨	During these five years, the number of its own patients who Canterbury DHB treated increased by 48%.
🟦	In 2009/10, of all the other DHBs' patients who Canterbury DHB treated, 98% were from other South Island DHBs.

Capital and Coast DHB

Publicly funded scheduled surgical patients treated by Capital and Coast DHB and publicly funded scheduled surgical patients from Capital and Coast DHB treated by other DHBs, from 2005/06 to 2009/10

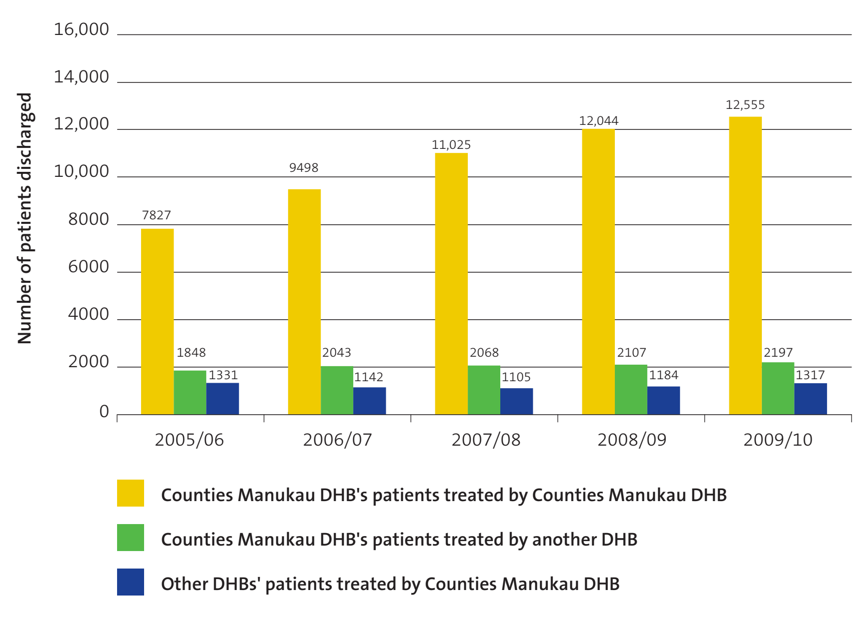


Data extracted from the National Minimum Data Set on 16 August 2010.

🟩	In 2009/10, of all Capital and Coast DHB's patients who were treated by another DHB, Hutt Valley DHB treated 94%.
🟦	In 2009/10, 31% of the patients who Capital and Coast DHB treated came from other DHBs. Of this group: • 53% were from Hutt Valley DHB; • 9% were from Hawke's Bay DHB; • 9% were from Wairarapa DHB; and • 3% were from MidCentral DHB.

Counties Manukau DHB

Publicly funded scheduled surgical patients treated by Counties Manukau DHB and publicly funded scheduled surgical patients from Counties Manukau DHB treated by other DHBs, from 2005/06 to 2009/10

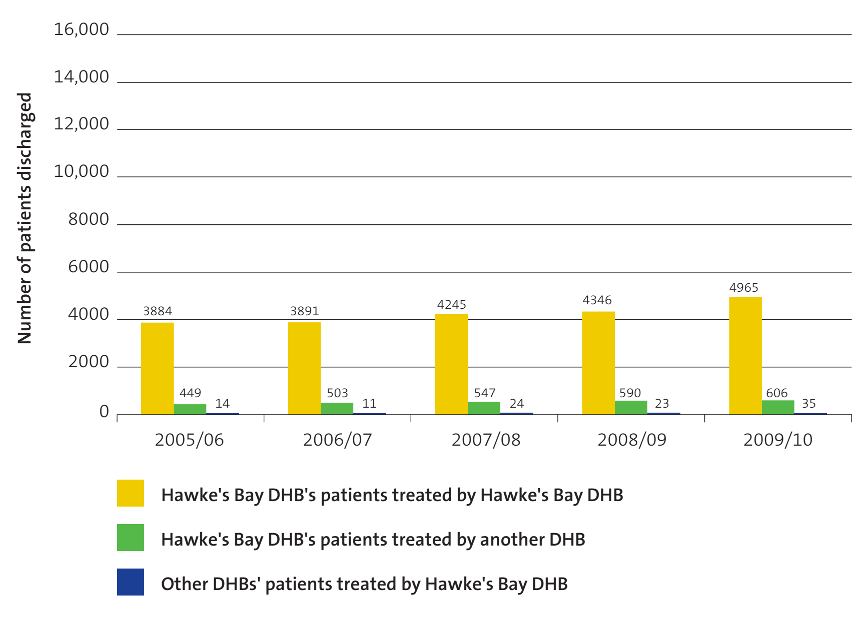


Data extracted from the National Minimum Data Set on 16 August 2010.

🟨	During these five years, the number of its own patients who Counties Manukau DHB treated increased by 60%.
🟩	In 2009/10, of all Counties Manukau DHB's patients who were treated by another DHB, Auckland DHB treated 96%.

Hawke's Bay DHB

Publicly funded scheduled surgical patients treated by Hawke's Bay DHB and publicly funded scheduled surgical patients from Hawke's Bay DHB treated by other DHBs, from 2005/06 to 2009/10



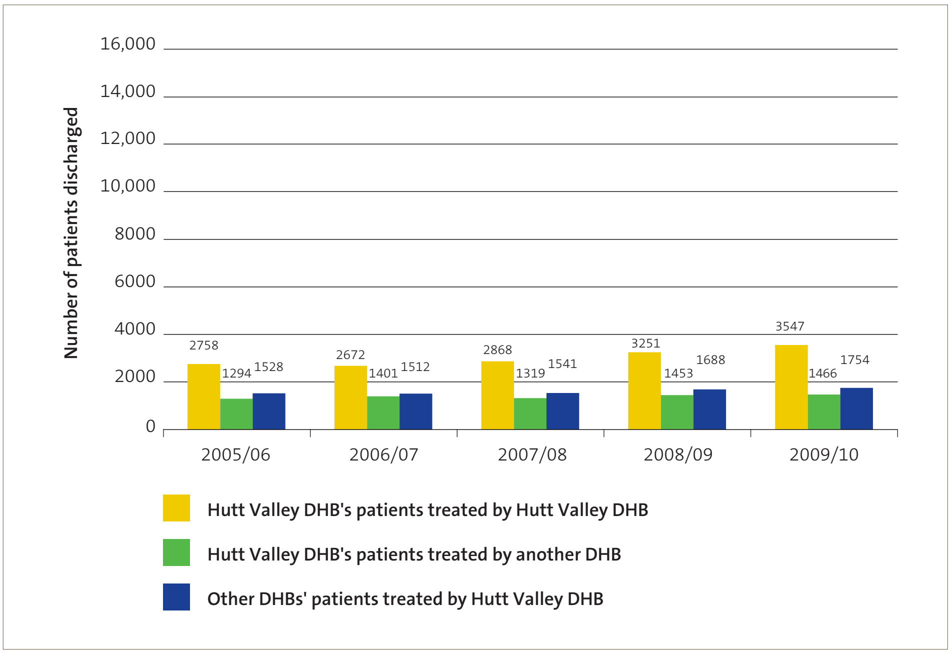
Data extracted from the National Minimum Data Set on 16 August 2010.

🟩 In 2009/10, of all Hawke's Bay DHB's patients who were treated by another DHB:

- Capital and Coast DHB treated 41%; and
- Hutt Valley DHB treated 35%.

Hutt Valley DHB

Publicly funded scheduled surgical patients treated by Hutt Valley DHB and publicly funded scheduled surgical patients from Hutt Valley DHB treated by other DHBs, from 2005/06 to 2009/10

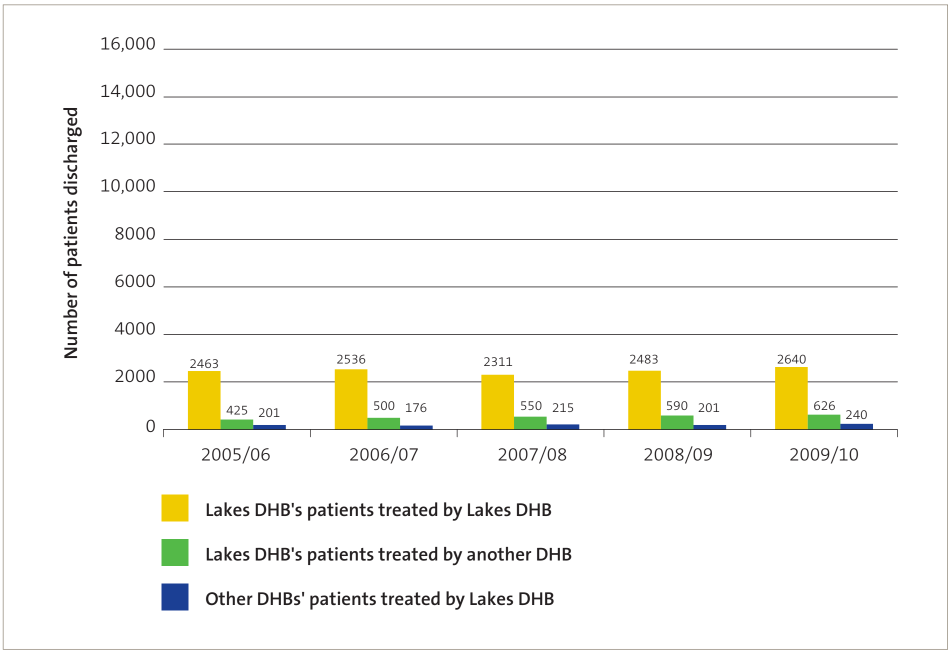


Data extracted from the National Minimum Data Set on 16 August 2010.

🟨	During these five years, the number of its own patients who Hutt Valley DHB treated increased by 29%.
🟩	In 2009/10, 29% of Hutt Valley DHB's patients were treated by another DHB. Of this group, Capital and Coast DHB treated 98%.
🟦	During these five years, the number of other DHBs' patients who Hutt Valley DHB treated increased by 15%. In 2009/10, 33% of patients treated by Hutt Valley DHB were from other DHBs. Of this group: • 49% were from Capital and Coast DHB; • 13% were from MidCentral DHB; • 13% were from Wairarapa DHB; and • 12% were from Hawke's Bay DHB.

Lakes DHB

Publicly funded scheduled surgical patients treated by Lakes DHB and publicly funded scheduled surgical patients from Lakes DHB treated by other DHBs, from 2005/06 to 2009/10

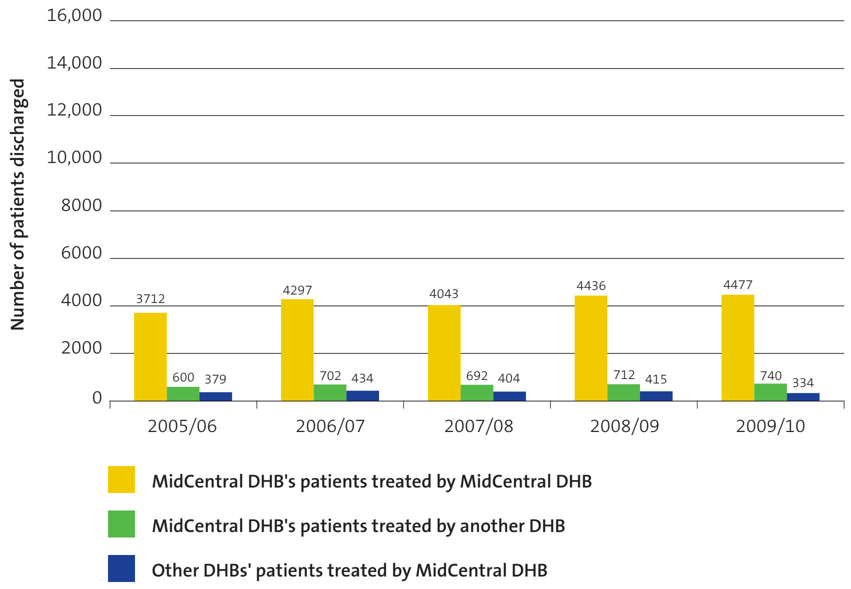


Data extracted from the National Minimum Data Set on 16 August 2010.

🟨	During these five years, the number of its own patients who Lakes DHB treated remained stable.
🟩	During these five years, the number of Lakes DHB's patients who were treated by other DHBs increased by 47%: • In 2005/06, 15% of Lakes DHB's patients were treated by another DHB. • In 2009/10, 19% of Lakes DHB's patients were treated by another DHB. Of this group, 84% were treated by Waikato DHB.
🟦	In 2009/10, of all the other patients who Lakes DHB treated, 86% were from Bay of Plenty DHB.

MidCentral DHB

Publicly funded scheduled surgical patients treated by MidCentral DHB and publicly funded scheduled surgical patients from MidCentral DHB treated by other DHBs, from 2005/06 to 2009/10



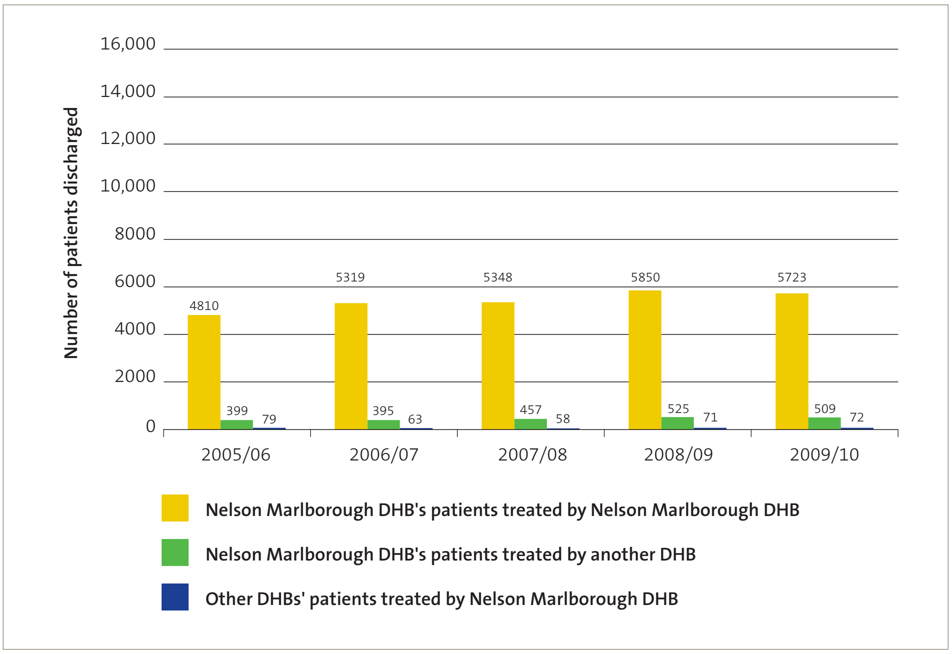
Data extracted from the National Minimum Data Set on 16 August 2010.

In 2009/10, 14% of MidCentral DHB's patients were treated by another DHB. Of this group:

- Capital and Coast DHB treated 49%;
- Hutt Valley DHB treated 31%; and
- Auckland DHB treated 8%.

Nelson Marlborough DHB

Publicly funded scheduled surgical patients treated by Nelson Marlborough DHB and publicly funded scheduled surgical patients from Nelson Marlborough DHB treated by other DHBs, from 2005/06 to 2009/10



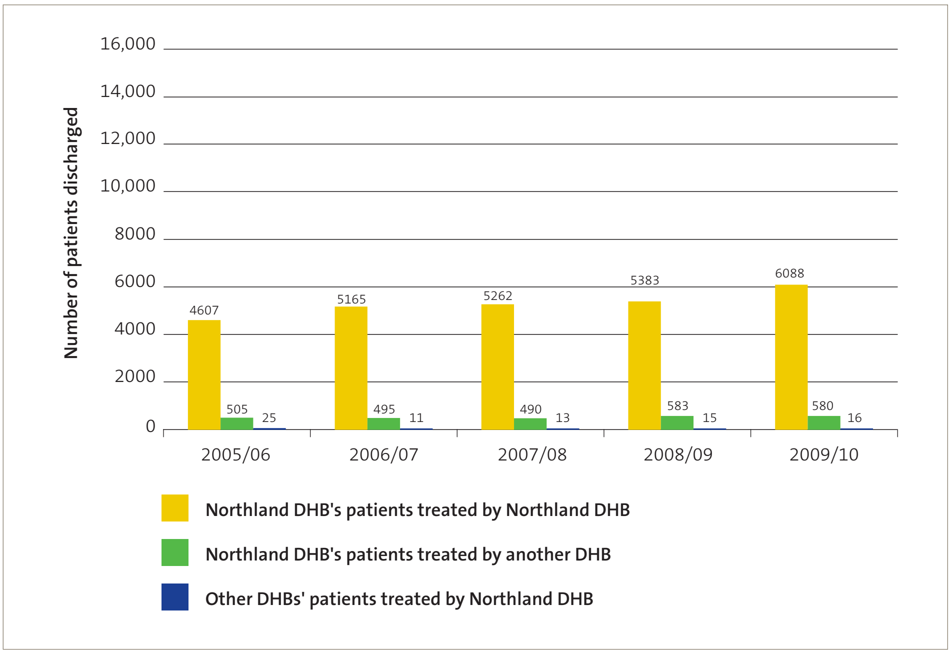
Data extracted from the National Minimum Data Set on 16 August 2010.

🟩 In 2009/10, 8% of Nelson Marlborough DHB’s patients were treated by another DHB. Of this group:

- Canterbury DHB treated 53%;
- Capital and Coast DHB treated 23%; and
- Hutt Valley DHB treated 18%.

Northland DHB

Publicly funded scheduled surgical patients treated by Northland DHB and publicly funded scheduled surgical patients from Northland DHB treated by other DHBs, from 2005/06 to 2009/10

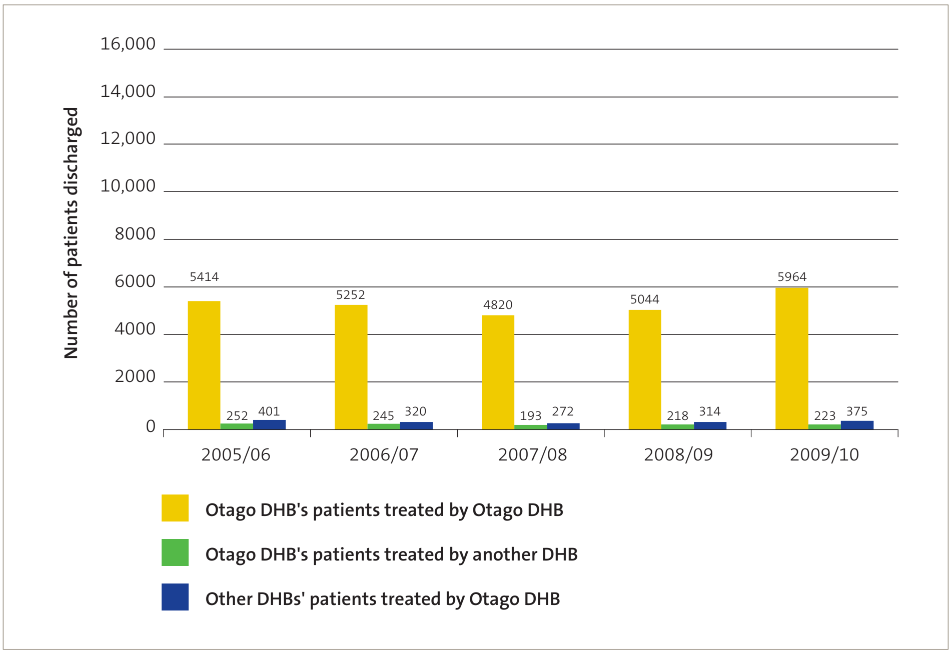


Data extracted from the National Minimum Data Set on 16 August 2010.

🟩 In 2009/10, of all Northland DHB’s patients who were treated by another DHB, Auckland DHB treated 87%.

Otago DHB (now part of Southern DHB)

Publicly funded scheduled surgical patients treated by Otago DHB and publicly funded scheduled surgical patients from Otago DHB treated by other DHBs, from 2005/06 to 2009/10

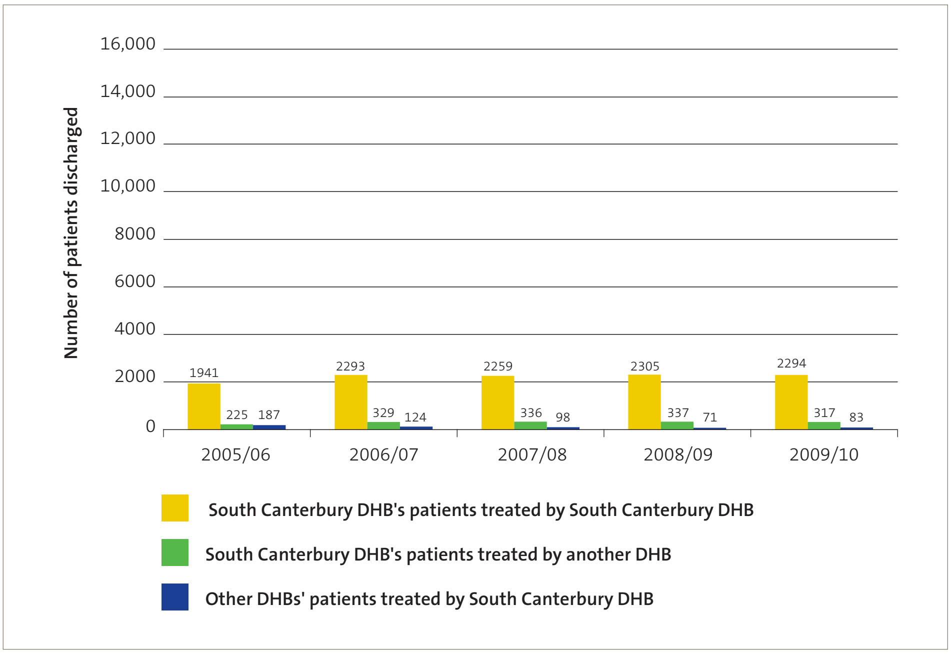


Data extracted from the National Minimum Data Set on 16 August 2010.

The number of its own patients who Otago DHB treated decreased in the years up to 2007/08 and then increased. The same pattern occurred with the other groups of patients.

South Canterbury DHB

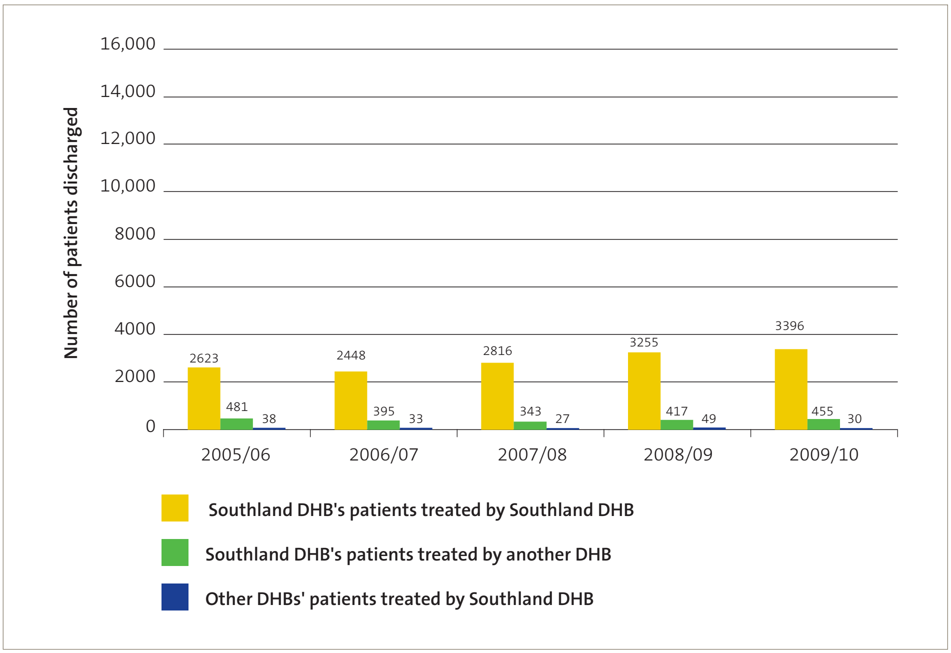
Publicly funded scheduled surgical patients treated by South Canterbury DHB and publicly funded scheduled surgical patients from South Canterbury DHB treated by other DHBs, from 2005/06 to 2009/10



Data extracted from the National Minimum Data Set on 16 August 2010.

Southland DHB (now part of Southern DHB)

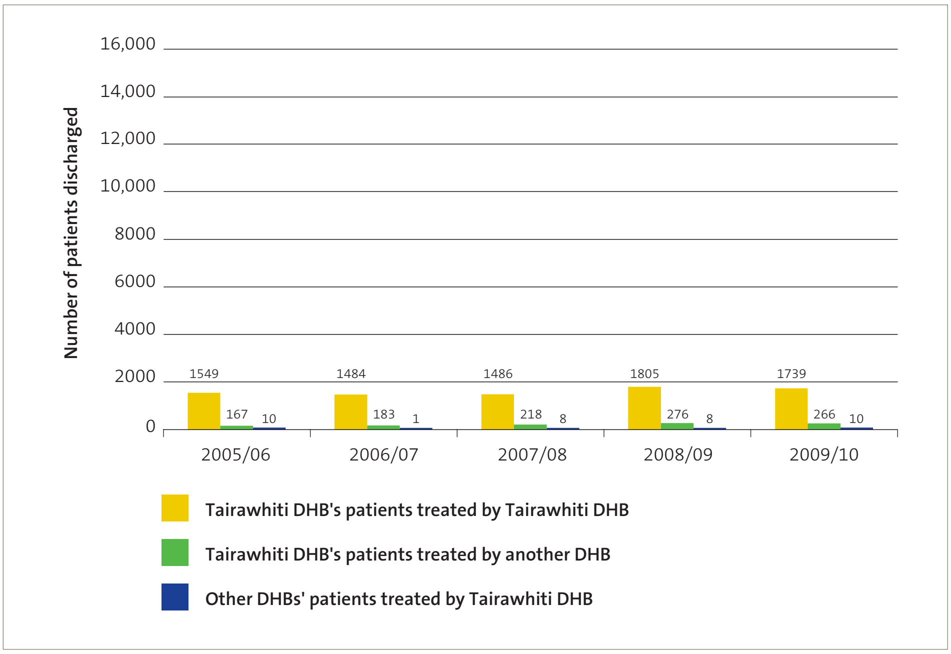
Publicly funded scheduled surgical patients treated by Southland DHB and publicly funded scheduled surgical patients from Southland DHB treated by other DHBs, from 2005/06 to 2009/10



Data extracted from the National Minimum Data Set on 16 August 2010.

Tairawhiti DHB

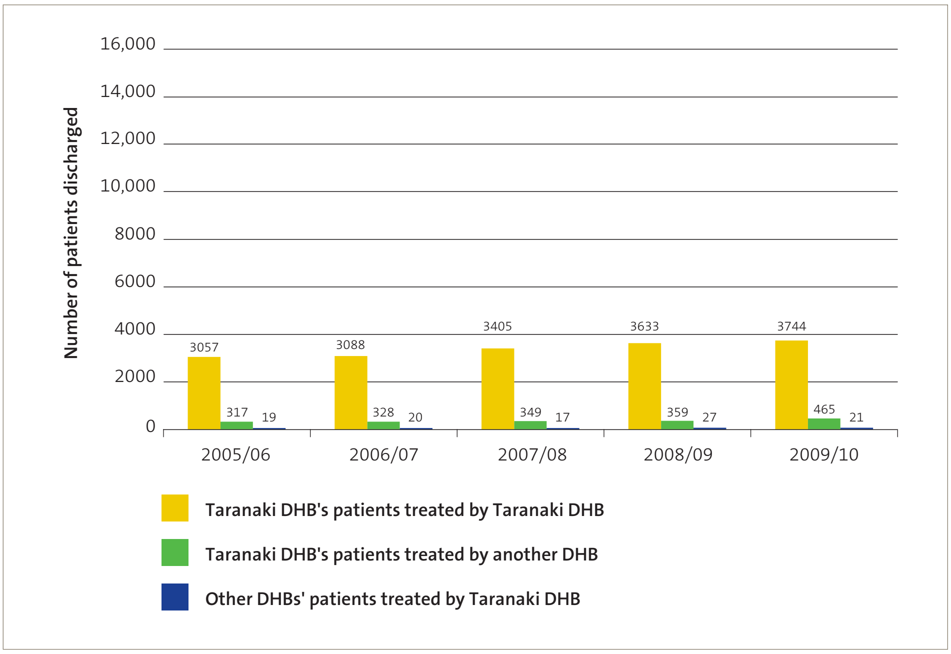
Publicly funded scheduled surgical patients treated by Tairawhiti DHB and publicly funded scheduled surgical patients from Tairawhiti DHB treated by other DHBs, from 2005/06 to 2009/10



Data extracted from the National Minimum Data Set on 16 August 2010.

Taranaki DHB

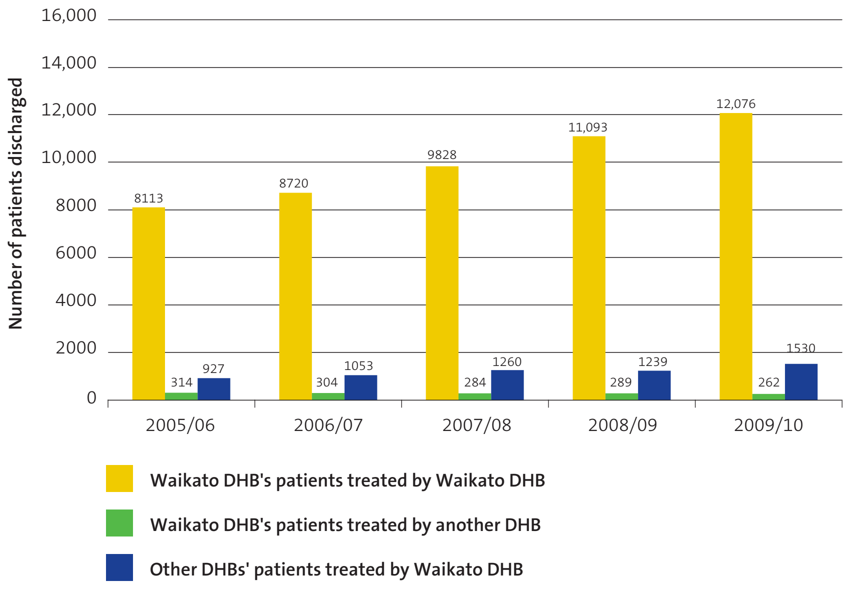
Publicly funded scheduled surgical patients treated by Taranaki DHB and publicly funded scheduled surgical patients from Taranaki DHB treated by other DHBs, from 2005/06 to 2009/10



Data extracted from the National Minimum Data Set on 16 August 2010.

Waikato DHB

Publicly funded scheduled surgical patients treated by Waikato DHB and publicly funded scheduled surgical patients from Waikato DHB treated by other DHBs, from 2005/06 to 2009/10

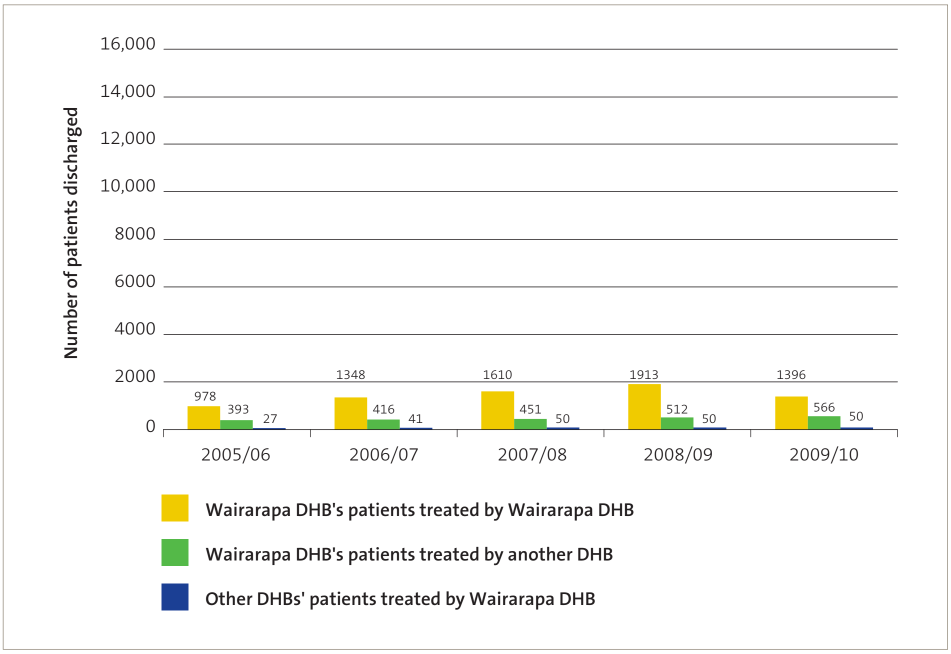


Data extracted from the National Minimum Data Set on 16 August 2010.

🟨	During these five years, the number of its own patients who Waikato DHB treated increased by 49%.
🟦	In 2009/10, 11% of patients treated by Waikato DHB were from other DHBs. Of this group: • 36% were from Bay of Plenty DHB; • 34% were from Lakes DHB; • 11% were from Taranaki DHB; and • 11% were from Tairawhiti DHB.

Wairarapa DHB

Publicly funded scheduled surgical patients treated by Wairarapa DHB and publicly funded scheduled surgical patients from Wairarapa DHB treated by other DHBs, from 2005/06 to 2009/10



Data extracted from the National Minimum Data Set on 16 August 2010.

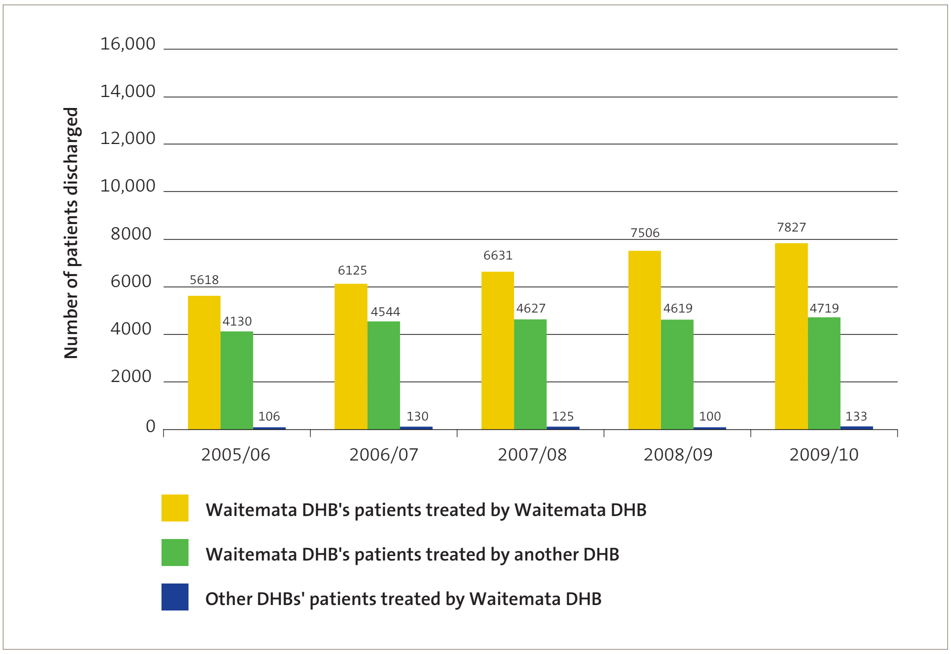
🟩

In 2009/10, 29% of Wairarapa DHB's patients were treated by another DHB. Of the group:

- Capital and Coast DHB treated 44%; and
- Hutt Valley DHB treated 40%.

Waitemata DHB

Publicly funded scheduled surgical patients treated by Waitemata DHB and publicly funded scheduled surgical patients from Waitemata DHB treated by other DHBs, from 2005/06 to 2009/10

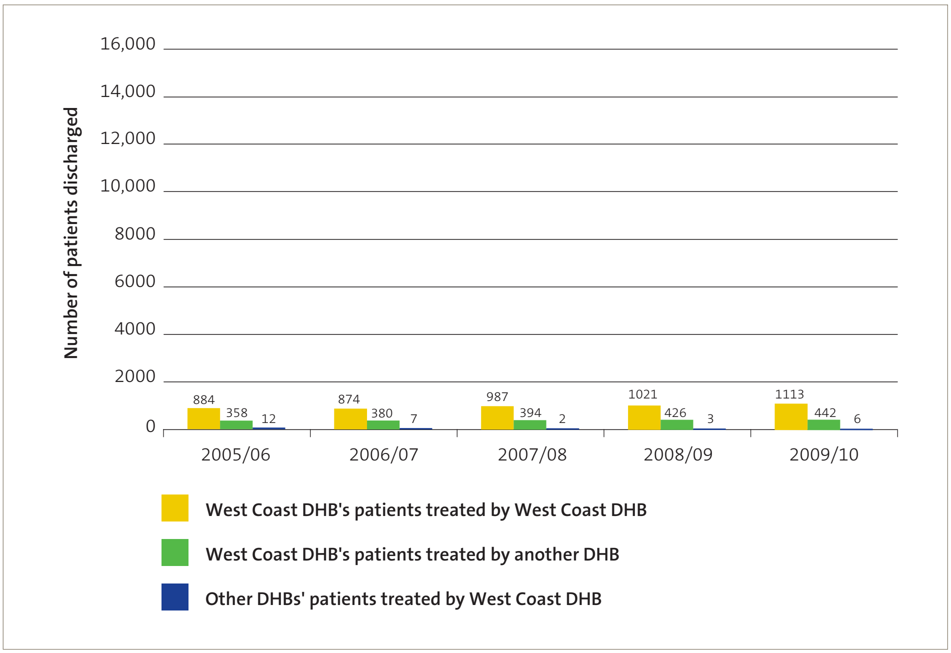


Data extracted from the National Minimum Data Set on 16 August 2010.

🟨	During these five years, the number of its own patients who Waitemata DHB treated increased by 39%.
🟩	During these five years, the number of Waitemata DHB's patients who were treated by other DHBs increased by 14%. In 2009/10, Auckland DHB treated 91% of this group. During these five years, because Waitemata DHB is also treating more of its own patients, the proportion of its patients being treated by other DHBs has decreased from 42% to 38%.

West Coast DHB

Publicly funded scheduled surgical patients treated by West Coast DHB and publicly funded scheduled surgical patients from West Coast DHB treated by other DHBs, from 2005/06 to 2009/10

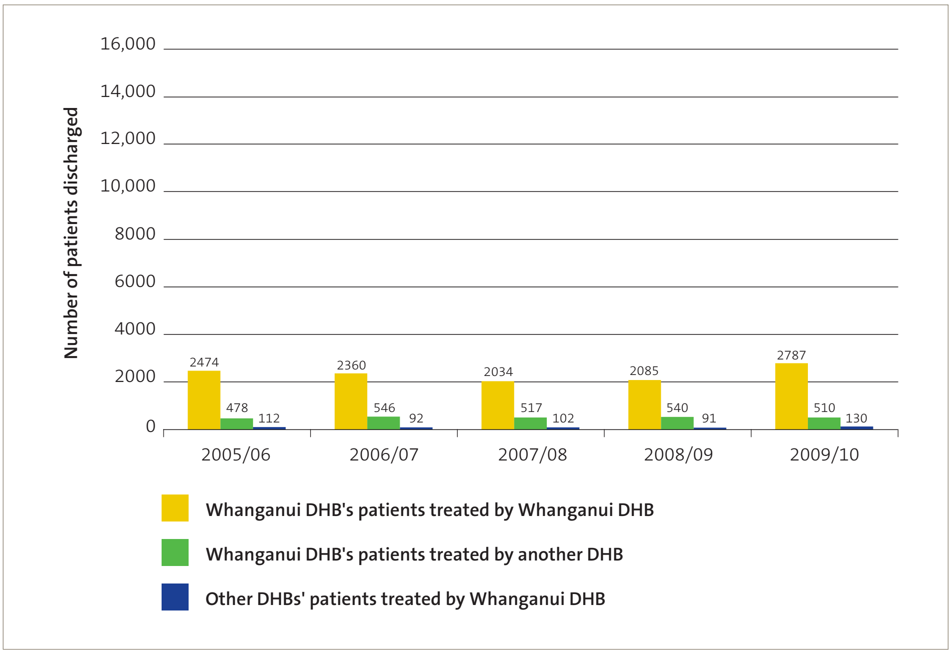


Data extracted from the National Minimum Data Set on 16 August 2010.

🟩 In 2008/09, 28% of West Coast DHB’s patients were treated by another DHB, with 91% of these patients treated by Canterbury DHB.

Whanganui DHB

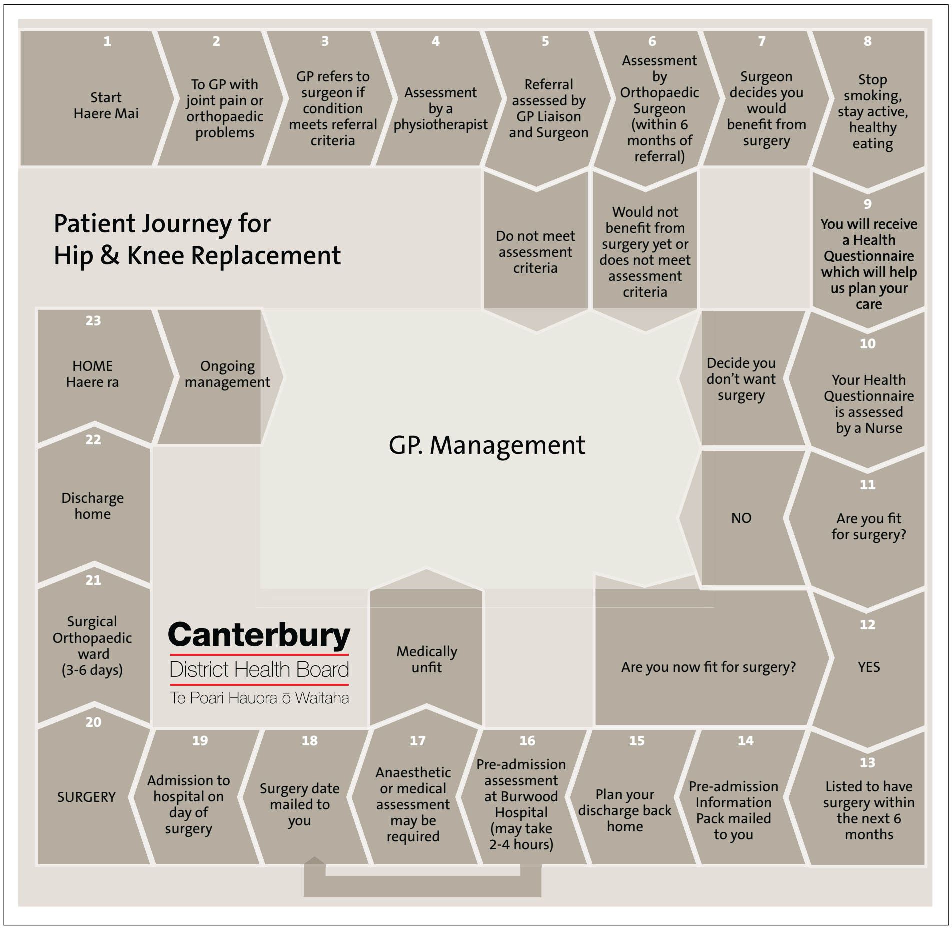
Publicly funded scheduled surgical patients treated by Whanganui DHB and publicly funded scheduled surgical patients from Whanganui DHB treated by other DHBs, from 2005/06 to 2009/10



Data extracted from the National Minimum Data Set on 16 August 2010.

Appendix 5

Example of a care pathway for patients needing a hip or knee replacement



Source: Canterbury District Health Board.

Appendix 6

Performance indicators for scheduled services

The Ministry monitors DHBs' performance in meeting aspects of the Strategy using eight Elective Services Patient-flow Indicators, or ESPIs. Under the Strategy, all patients are meant to be treated within certain periods. In practice, the Ministry allows a certain amount of variation from the ESPI before non-compliance attracts a financial penalty. This information was correct at 15 September 2010.

Number	Elective Services Patient-flow Indicator	What is and is not counted by this ESPI
ESPI 1	DHB services that appropriately acknowledge and process all patient referrals within 10 working days.	All specialties are included.
ESPI 2	Patients waiting longer than six months for their first specialist assessment.	All specialties are included.
ESPI 3	Patients waiting without a commitment to treatment whose priorities are higher than the [DHB's minimum] treatment threshold.	All surgical specialties are included. Some medical specialties are included (see ESPI 5).
ESPI 4	Clarity of treatment status.	Patients on residual waiting lists do not have clarity of treatment status. DHBs are not allowed to put patients on residual waiting lists.
ESPI 5	Patients given a commitment to treatment but not treated within six months.	Increasingly, some DHBs are submitting data for this ESPI for some medical specialties. These are cardiology (11 DHBs), gastroenterology (6 DHBs), respiratory medicine (3 DHBs) and general medicine (3 DHBs).
ESPI 6	Patients in active review who have not received a clinical assessment within the last six months.	All specialties are included.
ESPI 7	Patients who have not been managed according to their assigned status and who should have received treated.	All surgical specialties are included. Some medical specialties are included (see ESPI 5).
ESPI 8	The proportion of patients treated who were prioritised using nationally recognised processes or tools.	All surgical specialties are included. Some medical specialties are included (see ESPI 5).

As a group, medical specialties are less likely to provide procedures that need scheduling in the same way that surgery is scheduled. In most instances, patients' care is managed at out-patient visits and with pharmaceuticals. The main medical specialties that offer medical procedures that require scheduling are cardiology (which carries out procedures such as angioplasty) and gastroenterology (which provides procedures such as colonoscopy and gastroscopy).

All ESPIs exclude patients who are identified with a “planned”, “staged”, or “surveillance” tag. These are patients who will receive a scheduled procedure, but who receive the procedure outside the six-month time limit because it is in their best interest. Examples are patients who need implants removed about a year after they were inserted to stabilise a fracture, children who need a series of operations as they grow, or patients who have temporary ostomies reversed at a specific interval.

Appendix 7

Different understandings about active review

“Active review” is a category of patients within the National Booking and Reporting System. Patients in active review do not have enough priority to receive a commitment from the DHB for treatment, but there is a realistic probability that their condition will worsen to reach the threshold for treatment within two years. These are the patients who would next receive treatment if DHBs’ capacity increased, which would mean that the threshold for treatment would be lowered.

We have found that DHBs – and specialties or service groups within DHBs – are not using active review as they are meant to. We consider that there is confusion about how active review should be used. In some instances, this has undermined the Strategy’s principles and objectives.

Given the Ministry’s definition of active review, in our view, it follows that there would always be a small number of patients in active review. However, some DHBs do not use active review. In other DHBs, only some specialties use active review.

Preventing misuse of active review

Some DHBs said that they wanted to prevent active review from being misused, so they have banned its use rather than manage its use responsibly. We consider that this may disadvantage some patients who may be more effectively and efficiently cared for specialists than GPs.

Lack of capacity in secondary care

Sometimes a DHB does not have the capacity to regularly review patients, so active review is not used in some specialties. Instead, the patient is returned to GP care and potential re-referral at a later date.

Shifting costs from secondary care to primary care

To manage their budgets and scheduled services effectively, some hospital managers prefer to shift the cost of reviewing patients to their (or the referring) DHB’s primary care budget. Patients are returned to GP care and potential re-referral at a later date. When we asked, these managers did not know whether this practice was more or less effective or efficient for the patient or for the DHB overall.

When patients can be adequately managed in the community, they should be, and this is consistent with the Strategy’s objectives. However, the main motivation for having GPs manage patients should not be to shift costs between different parts of a DHB’s budget.

Managing compliance with Elective Services Patient-flow Indicators

Some DHBs put patients into active review even though they have no intention of reviewing them in six months – instead, they intend to treat them within six months. Putting patients in active review – when they should be given certainty of treatment within six months – gives the DHB up to 12 months to treat the patient instead of six months.

The logic behind this practice is that DHBs risk financial penalties when they exceed the Ministry's limits on the number of patients they are allowed to keep waiting for more than six months. One method of reducing this risk is to commit to treat only those patients who the DHB can treat within five or five-and-a-half months, instead of six. The DHB may hold the additional month's or half-month's worth of patients in active review as insurance against interruptions to service delivery that could affect compliance with ESPI 5. To some degree, the Ministry can use ESPI 3 to monitor whether DHBs are doing this. This practice clearly benefits the DHBs that use it. However, it does not meet the Strategy's requirement that patients be given certainty of treatment.

There are different perspectives on this practice. Some people consider that DHBs are manipulating the system, and others consider that DHBs' actions are a reasonable response to reduce financial risk. One DHB considers that active review was created for just this purpose, which surprised us. The DHB told us that one of the improvements in the last 10 years has been "the active review buffer [that] actively manages patients ... [with the greatest need] and also offers booking flexibility". Patients with the greatest need should not be in active review – they should be treated as soon as possible and within six months.

Patients who are not medically ready for treatment

Some DHBs use active review to hold patients who are not yet ready for surgery – because they need to lose weight, bring their blood pressure under better control, or have a dental check before cardiac surgery. This is not the purpose of active review. DHBs need to use other methods to manage these patients.

Patients with no realistic chance of receiving publicly funded treatment

Active review is also used to hold patients who have no realistic chance of receiving publicly funded treatment within the next year. The extent to which this occurs has reduced since 2000 for various reasons, but we have been told that it still occurs.

Some specialists may wrongly put patients into active review instead of referring them back to their GPs because they hope that the DHB will be able to offer them treatment within six months by the time the patient is next reviewed. We consider that this is unlikely unless more resources become available or the DHB creates opportunities to treat more patients within the resources available by making significant efficiencies in the way that it delivers scheduled services. It is more likely that patients will be returned to their GPs' care after they have had the maximum three reviews that they are allowed.

Specialists who place patients in active review for the wrong reasons are more likely to be deferring the day when the patient is told that scheduled services are not available to them. The public health system needs patients to be responsible for their own health. A paternalistic approach, which may be kindly meant, is not helpful (even in the short term). It is not consistent with the Strategy's focus on providing patients with clarity and certainty.

It is also not in keeping with many patients' expectations that they will be dealt with fairly. The reluctance to give patients certainty denies patients the opportunity to make timely decisions about their own needs, means, and requirements for care. The specialist who incorrectly leads a patient to believe that they will receive publicly funded treatment by being in active review potentially stops the patient from actively seeking other available care. The specialist – and maybe the DHB – may also be at risk of breaching patients' rights, which are set out in the *Code of Health and Disability Services Consumers' Rights*.[29]

The New Zealand Medical Association's Code of Ethics (2008) sets out the role of doctors in prioritising care. One of the four clauses on this topic (clause 65) states that:

> *Patients must be able to trust their doctor to deal with their needs fairly and honestly. Doctors should, within reason, provide adequate information to their patients about their assessment and available treatments, including those not readily available.*

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[29] Health and Disability Commissioner, *The Code of Health and Disability Services Consumers' Rights*, www.hdc.org.nz.

Glossary

To help the reader, we have simplified some of the terms that the Ministry of Health and district health boards use. Fuller definitions about scheduled services are available on the Ministry's website. Where we have replaced the Ministry's term with one of our own, we explain the difference. We do not explain the medical terms used in our report because some of the terms are in general use or information about them is widely available from reputable medical websites and other sources.

A **care pathway** describes what happens to patients with certain conditions or groups of symptoms from the time a patient raises a concern with a doctor to after any treatment is completed. Many pathways cross the traditional boundaries between hospital and community care. In this way, care pathways help to implement new knowledge, clinical guidelines, and protocols.

Diagnostic tests are tests (such as colonoscopies, biopsies, X-rays, and CT and MRI scans) that are recommended or needed to help establish a diagnosis, to discover the extent of a disease, or evaluate the effectiveness of treatment.

Elective services – see scheduled services.

Elective Services Patient-flow Indicators (ESPIs) are a set of eight performance indicators used to monitor some aspects of DHBs' performance in managing patients' progress through the scheduled services system. The Ministry can impose financial penalties if DHBs do not comply with the ESPIs. The ESPIs are listed in Appendix 6.

First specialist assessment (FSA) refers to a patient's first visit to a specialist for advice about a health condition after referral from a GP or other health professional. A written plan of care must be produced for a specialist's advice to be considered an FSA or virtual FSA.

General practitioners (GPs) are medical practitioners registered with the Medical Council of New Zealand who specialise in general practice. For the sake of simplicity, we use the term to represent all health professionals who may refer patients for scheduled services, such as nurse practitioners, dentists, optometrists, and others.

Home DHB is the DHB responsible for people living in a certain geographical district. The Ministry and DHBs call this the DHB of domicile.

The **National Booking and Reporting System** (NBRS) is a national database that contains information about patients seeking and receiving scheduled services.

Scheduled services are medical and surgical services to provide FSAs, virtual FSAs, or treatment that can be delayed because they do not need to be provided urgently. We use this term to refer to all services that are known as elective or non-urgent services. They are services that are provided more than seven days after the need for treatment is recommended. Scheduled services do not include access to diagnostic tests or services such as disability support, maternity, mental health, oncology, primary health, or public health services.

Specialists are medical practitioners registered with the Medical Council of New Zealand who specialise in a particular vocational area. They have appropriate qualifications, training, and specialist experience, and are competent to practise independently. Other health professionals may also provide scheduled services, but for the sake of simplicity we use the term specialists to refer to all the relevant professionals.

The **Strategy** is a document called *Reduced Waiting Times for Public Hospital Elective Services: Government Strategy* that was published by the Ministry in March 2000 and is available from www.moh.govt.nz.

The **Treating DHB** is the DHB delivering scheduled services to a patient who lives outside a certain geographical district. In this report, the Treating DHB is never the Home DHB. The Ministry uses "DHB of service" to describe the DHB that provides an FSA or treatment, which means that the DHB of service and DHB of domicile could be the same.

Treatment can include medical procedures, pharmaceuticals, surgery, and other therapies (such as physiotherapy) to relieve or treat a patient's health condition.

Unscheduled services are services for patients provided within seven days after treatment is recommended. We use this term to refer to all services that are known as emergency, urgent, and acute health services.

Virtual FSAs do not require the patient to attend an appointment with a specialist. However, the specialist may telephone the patient or speak with the GP as part of providing their advice. Doctors in training to be specialists, nurse practitioners, and GPs who are employed to decide which patients will be offered scheduled services may also provide virtual FSAs. A written plan of care must be produced for a specialist's advice to be considered an FSA or virtual FSA.

Publications by the Auditor-General

Other publications issued by the Auditor-General recently have been:

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- Review of the Northland Events Centre
- Public entities' progress in implementing the Auditor-General's recommendations
- Ministry of Social Development: Managing the recovery of debt
- Local government: Results of the 2009/10 audits
- The Auditor-General's Auditing Standards
- Central government: Results of the 2009/10 audits (Volume 2)
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- District health boards: Learning from 2010–13 Statements of Intent
- Central government: Case studies in reporting forecast performance information
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- Central government: Results of the 2009/10 audits (Volume 1)
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- Department of Internal Affairs: Administration of two grant schemes
- Inquiry into payments to chief executives of dissolving local authorities in Auckland
- Guidance for members of local authorities about the Local Authorities (Members' Interests) Act 1968
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