

Acute Hospital Waiting Lists: Analysis, Evaluation and Recommendations¹



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INTRODUCTION

The purpose of this article is to provide an insight into the nature of the waiting list problem, its socially regressive consequences and the extent to which it is an embedded feature in the Acute A & E sector which these new policy initiatives are intended to address.

The government published its health strategy equality and fairness report in 2001. This was the genesis of a variety of strategies and reports – over 140 – culminating in the Health Reform Programme of June 2003. This programme set out a wide range of institutional changes in the healthcare service, including the establishment of a Health Service Executive, among whose responsibilities will be a National Hospitals Office. The programme also contains extensive provisions dealing with performance measurement, increased accountability and strengthening in the governance of greatly reduced boards and agencies.

More specifically, in the acute sector, the report of the national task force on medical staffing (the Hanley Report) published in October 2003 contains fundamental changes both in staffing and funding of A & E departments, aimed at providing a consultant-delivered service as well as the establishment of a major network of acute hospitals providing A & E services. The impact of the new arrangements on waiting lists will be the touchstone for evaluation by the public whether or not these arrangements are successful. Waiting lists, or more specifically the time that individuals spend waiting for admissions to the acute hospital sector, are a key issue in the management of the health sector.

They raise fundamental issues of equity in terms of, for example, buying elective treatment and the effective use of scarce healthcare resources. Over the last decade, successive governments have undertaken initiatives designed to reduce both the numbers on waiting lists and the amount of time patients spend waiting for access to treatment. In spite of expenditure of some £130 million under the Waiting List Initiative (WLI) and recent initiatives by government and some health boards, the average numbers on waiting lists remains more or less the same at 30,000.

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Nephrology	68								68
Neurology	178						6		184
Neurosurgery	401								401
Oncology	1								1
Ophthalmology	1,742		369		92	262	230	194	2,889
Orthopaedics	1,935	397	171	325	194	275	517	424	4,238
Paediatrics	5								5
Pain	464					20		3	487
Plastic Surgery	1,442	0					138	593	2,173
Psychiatry	7								7
Radiology	3								3
Respiratory	162								162
Rheumatology	62						2		64
Surgery	1,831	112	151	219	212	362	57	175	3,119
Urology	954	42	1	139	31	10	49	227	1,453
Vascular	1,079	65	13	236	59	160	358	173	2,143
All Specialties	15,755	1,621	999	1,271	920	1,623	1,830	2,419	26,438

Source: DOHC

Table 8.1 shows that the distribution of waiting lists is totally skewed towards the Eastern Region. Taking the waiting lists for all specialities, some 70 per cent relates to individuals from within the Eastern Region. It is clearly the case that waiting lists will reflect the lop-sided distribution of population in Ireland. Most national specialisms are located within the Eastern Region. While government policy is to encourage self-sufficiency within the different health boards, the reality is that many people still wish to travel to Dublin. Thus, patients from the ERHA may be "crowded-out" simply because of the volume of patients from outside of the region. This emphasises the importance of more even distribution of facilities, including medical manpower, across the country. This imbalance undermines the rationale behind the present number of health boards. Devolution to, and development of, regional and local hospitals as well as a new generation of well-resourced "group clinics" would allow the outsourcing of a wide range of procedures which overly clog up the acute sector – and could therefore complement a significant reduction in the present health board structure. Much closer integration of systems across health board regions – as well as access to the MIS by patients and GPs – is needed in order to even out such imbalances.

Table 8.2 shows the corresponding quarterly figures for each year since the Waiting List Initiative (WLI) began in 1993, together with yearly expenditure under the WLI.

Table 8.2: Waiting Lists, 1993–2000

Year	Amount (£m)	March	June	September	December
1993	20.0	39,423	40,130	25,165	25,373
1994	10.0	27,576	24,778	27,633	23,835
1995	8.0	27,475	27,696	27,004	27,752
1996	12.0	28,865	30,447	31,519	25,959
1997	8.0	29,069	30,453	32,252	32,206
1998	12.0	33,847	34,331	35,405	36,883
1999	20.0	34,996	33,924	33,555	36,855
2000	34.57	34,370	31,851	29,657	27,857
Total					
1993–2000: £124.57m					

Source: DOHC

It is clear that the numbers on the list vary significantly across each year. Equally, while the *average* number for 2000 (30.9) shows a significant reduction over the last three years, it was much the same as the 1997 figure. However, there has been a reduction in the waiting list for a number of specialties since 2000, reflecting the substantial commitment of government in this regard.⁴

Table 8.3: Waiting Lists for Top-Ten Specialties, March 2001

Specialism	Number (000)
ENT	5,188
Orthopaedics	4,238
Surgery	3,119
Ophthalmology	2,889
Vascular	2,143
Plastic Surgery	2,117
Urology	1,453
Cardiac	1,388*
Gynaecology	1,206
Pain	486
ALL SPECIALTIES	24,227

Source: Based on DOHC

* Includes Cardiac Surgery and Cardiology

Finally, Table 8.3 shows the waiting list in respect of the top-ten specialties, as at December 2000. It highlights the different “capacity needs” to deal with each of these specialties and helps identify how at least some of these could be

shifted either across health board areas (depending on whether the necessary facilities existed in a major regional hospital) or from the public to the private system. We return to these points later.

There is a major ethical dimension to waiting lists: people believe – and they are correct (see below) – that private health insurance (PHI) facilitates quicker access to acute care. However, the affordability of PHI means that a large swathe of people simply cannot afford it. The larger the waiting lists, the more disadvantaged and marginalised are those individuals caught within the present system.

The statistical evidence of the recent BUPA Ireland/ESRI national survey⁵ – the largest ever carried out – on these points is compelling:

- 90 per cent of people believe that hospital care can be obtained more quickly in the private system compared with the public system;
- levels of educational attainment and social groupings are closely correlated to PHI coverage. Some 60 per cent of those with third-level education have PHI coverage compared with, for example, 37 per cent of those who have the equivalent of the Junior Certificate. Equally, whereas 68 per cent of those in professional/management categories have PHI coverage, less than 40 per cent of skilled manual and 18 per cent of unskilled manual workers are covered.

That is why waiting lists are not simply an expression of “excess” demand or a crude rationing device to accommodate demand within the finite resources available to government. They are an ethical issue, with a very direct impact upon the social cohesion of the country.

Developments in Policy

In the less benign economic environment of the late 1980s and early 1990s, waiting lists were perceived as an, albeit unfair, rationing device. Progressively, beginning with the WLI in 1993, policy has moved away from the crude and counterproductive cuts in beds/wards. Since 1997, waiting lists have emerged as a highly potent symbol of failings in the acute system. The difficulties inherent in managing what is an especially complex issue, one which far transcends the question of funding, is reflected in the input of a whole series of policy reviews.

- Medical Manpower Forum;
- Report on Working Candidates/Junior Doctors;
- Commission on Nursing;
- Strategic Assessment (jointly with the Department of Finance in consultation with the Social Partners of Bed Capacity);
- Review of Primary Care Services;
- Strategic/Consultative Review on the Health System;
- National Development Plan 2000–2006, which provides for an investment

of £1 billion to improve the capacity of acute hospital facilities to partly meet the prospective increase in demand.⁶

However, the most focussed evaluation of waiting lists was undertaken by the Review Group established in 1998. This merits a special mention because it established a very specific reference point, not least in regard to its recommendations.

(i) Report of the Waiting List Review Group

In 1998, the government established a task force to address the problem of waiting lists. The terms of reference were:

To examine the underlying factors giving rise to waiting lists and waiting times and to make recommendations on the most appropriate means of addressing the underlying causes of substantial waiting lists and waiting times.

The review should have particular regard to:

- The net effect of the current WLI on waiting lists and waiting times;
- Any incentive effects of the WLI on participating hospitals in relation to their activity and treatment schedules;
- The extent to which hospitals can consistently and accurately validate their waiting lists; and
- The adequacy of existing information systems to permit routine evaluation of the WLI.

Source: *Task Force on Waiting Lists, DOHC*

In setting out a proposed approach to the issue, the Group proposed a series of short-, long- and medium-term initiatives. Taken together, these stand as a "strategic checklist".

Over and above the necessary input from the highly informed healthcare professionals that constituted the Review Group, there was a need to draw on "Best of World" insights and practices across a wider range of management and technological competencies. At the heart of the waiting-list problem are issues, not just of resource allocation, but also of the technical efficiency and cost-effectiveness of processes – and these are not unique to healthcare. Indeed, those in the manufacturing and service sectors who have built sustainable excellence in a highly demanding and competitive marketplace through process innovation have important insights to bring to the process management of the waiting-list issue.

It is a pity that the Terms of Reference precluded the Group from developing a number of more radical scenarios which questioned the logic of existing arrangements and the constraints they impose on developing more innovative approaches to reducing waiting lists.

(ii) Recent Factors

We now turn to the present situation in respect of waiting lists. Summarised below are recent factors impacting on acute hospitals' capacity to deal with waiting lists. These include:

- Increased A & E admissions (particularly the elderly);
- Cancellation of five- and seven-day planned work because of the above;
- Inability to deal with existing hospital waiting lists;
- Lack of nursing staff particularly in HDU, intensive care/coronary care, A & E and theatre;
- Difficulties in the placement of patients requiring non-hospital care who have finished the acute phase of treatment (age >65, <65 years);
- Chronic difficulties in staff recruitment and retention – nursing, clerical and catering and housekeeping;
- The lack of a national, highly integrated programme of investment in high technology diagnostic systems;
- A lack of adequate pre-treatment facilities and the kind of “step-down” facilities that would lessen candidate strain – at the point of discharge. These have been referred to in successive reports – but have not been systematically put in place across the acute public system.⁷

RESEARCH APPROACH

In evaluating alternative approaches to the underlying causes of the waiting-list issue, three main perspectives were used. The primary methodology used was the Harvard Case Study approach, which involved some 50 senior and middle management drawn from manufacturing and service industry. The second method used was process mapping. Essentially, this involved tracking the steps involved, from the initial contact with the GP, through referral, into and then out of the acute hospital setting. Here, the impact of factors such as thru-put of the OPD, constraints in bed capacity, staffing level, facilities as well as the impact of the lack of acute medical and A & E admissions all impact on waiting lists and times.

The third component of the approach involved a review of waiting-list data. In particular, the lack of standardisation in relation to issues such as inclusion of day cases and validation is highlighted, as well as the impact of confidentiality requirements, in respect of private patients, on the robustness and relevance of the published waiting-list data. The objective is to focus attention on the need for a “clean” data set and to evaluate the contribution which such a standardised “clean” data set would make to materially reducing the size of the waiting list. Clearly, this raises an issue of accountability. Whose responsibility is it to ensure a person receives their surgery? The consultant? The speciality within the hospital? The hospital management? The Department of Health and Children? This is obviously a fundamental concern; you can only manage that which you can measure and for which you are accountable.

There is a second issue: to the extent that a consultant's waiting list comes

within the domain of their personal practice, it is impossible to compile a robust national picture of the size of the waiting list and to compile a transparent list (using identical protocols/severity criteria) across both public and private sectors.

ANALYSIS

(i) The Harvard/Stakeholder Approach

We begin by looking at the perspectives of each of the different stakeholders involved in the “waiting list” process: the GP, the hospital manager, the consultant, the nursing staff, the admissions officer, the Department of Health and Children and, most importantly, the patient. The perspectives of each of these concerning the management of waiting lists are set out in Figure 8.1. The value of this approach is this: the existence, scale, impact and management of waiting lists must be seen in a *holistic* perspective. Managing the waiting-list issue requires reconciling and accommodating the different perspectives of each of these stakeholders.

What quickly becomes apparent is that each, in isolation, sees the problem from their own unique perspective. Also apparent is the interaction – the jostling – of these different perspectives in pursuit of what is, in fact, a common goal.

Figure 8.1: Systems Issues in Waiting List Management

GP Stage	<ul style="list-style-type: none"> • Gatekeepers of the system. • Refer, on average, 7% of patients onto acute system. • Role is constrained by lack of information feedback from hospitals and MIS development. 	<ul style="list-style-type: none"> • GPs concerned that patients get lost in hospital system and are not referred back to the community for ongoing management. Direct access to hospital diagnostics. • Adjustment in GP referrals towards a "best practise" would have major impact on acute sector.
Consultant Private Patients	<ul style="list-style-type: none"> • Those with PMI, or who are self-funded, may attend outpatient department (OPD) or meet with their consultants in their private practice. • Surgery, if appropriate, is arranged once diagnosis is made. • Choice of location and time. 	<ul style="list-style-type: none"> • Significantly less waiting time compared with public patients; depending on classification, patient is given a date (which may be some months ahead). • Surgery arranged in a private hospital or in a private bed in a public hospital. • There are now some waiting lists for private patients in public hospitals.
Outpatient Department	<ul style="list-style-type: none"> • First encounter by patient with the acute system unless admitted through A & E. • May be long waiting lists for new patients seeking an initial appointment: this information is not formally 	<ul style="list-style-type: none"> • Many problems with patients returning on an ongoing basis to the OPD – failure to move these patients out of the system means new patients cannot be seen. • Lack of capacity in OPD a concern in many hospitals.

	<p>recorded. Some waiting lists for OPD may be closed.</p> <ul style="list-style-type: none"> • Presence of senior staff extremely important – they are the decision makers who determine whether, and when, a patient gets put on a waiting list and under which severity category the patient is placed, i.e. "Soon", "Urgent", "Routine". 	<ul style="list-style-type: none"> • Lack of protocols regarding new attendees. • Lack of consistence/agreement as to which patients go on a waiting list and under which severity category. • Ideally, there is a need for chronic conditions (e.g. diabetes) to be managed in the community rather than having people continually attending the OPD in hospitals.
Waiting Lists	<ul style="list-style-type: none"> • Severity determined by senior doctors in OPD. • Admissions office informed; list kept by speciality, by consultant and by severity category. • Patients listed as "Routine" or even "Soon" can be on lists for surgery for years: not usually reviewed in OPD as a matter of course unless patient requests reassessment. 	<ul style="list-style-type: none"> • System open to accusation of inequity and lack of transparency. • Need for national approach to waiting list management and evaluation of pilot programmes and studies currently underway nationally. • Validation and prioritisation of waiting-lists is a key issue – some patients may be on several lists – there is a need to balance confidentiality with effective management, possibly through a unique ID number. • Patient must be on a list for three months before they are officially regarded as being on a waiting list by DOHC. • Lack of rigorous and equitable protocols to judge criteria for admission onto a list and allocation to the appropriate severity classification.
Hospital Issues	<ul style="list-style-type: none"> • Capacity: major concern particularly for hospitals with A & E facilities. • "Bed Blockers", inappropriate admissions, poor discharge planning, lack of sufficient staff to ensure effective admission/discharges as well as lack of "step-down" and rehabilitation beds all compound the problem. • Increasing demand for surgery and increasing numbers of older patients in the system exacerbate the capacity issue. • Trauma and medical admissions will overflow into elective beds. 	<ul style="list-style-type: none"> • Delicate balance: need to cater for those requiring emergency admissions while reducing waiting lists. The patient on a trolley in A & E is competing with the person on a waiting list for years for the same bed! • Bed management is becoming increasingly important. • Equity and management issues around admitting patients well in advance of surgery in order to "book the bed". • Ring-fenced beds ensure treatment to those on waiting lists for the speciality.

Theatre	<ul style="list-style-type: none"> • Limited theatre time per consultant. • Recruitment and retention of sufficient staff is a key constraint. • Need for 24-hour, 7-day process arrangement approach as well as additional capacity. 	<ul style="list-style-type: none"> • Need for objective utilisation study. • Management of theatre capacity and time a priority. • Scope for more flexible capacity management (e.g. all weekend use) which is a feature of private hospitals.
WLI Funding	<ul style="list-style-type: none"> • DOHC view this is as supplementary income but the view of some hospital managers is that it is part of annual income. • DOHC allows the hospital/health board to use the WLI funding as it sees fit in the treatment of patients on lists. 	<ul style="list-style-type: none"> • Funding can be diverted to cover general hospital expenditure, which dilutes the impact of WLI. • Increasing controls and closer monitoring of waiting-list activity and funding, with hospital returns now submitted more frequently. • Phase II activity commissioned with agencies on a basis of capacity and tendering. • Negotiations with and outsourcing of numbers in selected specialities to selected private institutions is an emerging trend.
Bigger Picture	<ul style="list-style-type: none"> • Waiting lists are only one element in total hospital activity. • Medical manpower: recruitment and retention of staff, in particular nurses, is central to capacity. • Inadequate number of consultant posts despite recent increases – government initiative may resolve this. • Need for stronger management: much of existing practice, both managerial and medical, continues on a historic basis. • Role of PMI has had a very genuine influence on practice and management. • Need for more pre-assessment facilities. 	<ul style="list-style-type: none"> • Need for clinical audit and involvement of physicians in management. • There is a need for a thorough review of work practices including process mapping throughout hospitals, i.e. basic workplace study groups and more medical education/career development. • Need to promote evidence-based practice and use of protocols. • Need for more pre-assessment clinic.

The Positive Side	<ul style="list-style-type: none"> • Of central importance is the fact that many thousands of procedures are successfully carried out each year in our acute system. Commendable as it is, it is not the focus of this paper, though is still worth emphasising. • Several initiatives underway throughout the country. • Scope for public/private partnerships especially in relation to waiting-list reduction. Steps have been taken in this regard within some health boards. • Strong commitment to alleviate the problem – prioritised by politicians, hospital and Health Boards. • Major review of bed capacity, which will see more beds opened completed by government. • Active initiatives to recruit and retain staff (especially nurses). 	<ul style="list-style-type: none"> • Need to promote same-day admissions for elective surgery and pre-assessment clinics. • Increased role for bed managers; consider the role of a National Bed Bureau. • Information systems for "real time" information on status of <i>each</i> bed in <i>each</i> hospital.
Issues for Thought...	<ul style="list-style-type: none"> • UK's NHS/private 'concordat' to reduce waiting lists. • Hospital consolidation vs regional/local devolution – availability of adequate oncology service. • Number of health boards excessive: duplication and makes policy/strategy more difficult. • Separation of public funding for hospital entitlement from the delivery (via public acute hospitals) of such services. • North/south co-operations in acute hospital sector. • Most elective work (including OPD sessions) is done in regular working hours, i.e. from Monday to Friday between 9 am and 5 pm, with facilities lying idle outside of these hours. 	

The GP is the de-facto "gate keeper" to the hospital system. Referral rates for GPs differ significantly. This is an important anomaly in the system that can be addressed. Even a small reduction in referral rates by GPs will have a disproportionate impact on congestion within the acute hospital system.

The hospital manager is accountable for the effective use of resources and, in this context, for the delivering on specific commitments to the DOHC in respect of waiting lists. The nursing staff, for their part, are at the "cutting edge" of the intake of patients through casualty and for the provision of care during the stay of patients in the system.

The perspectives of each of these stakeholders set out were gleaned from in-depth interviews at a large Dublin teaching hospital. It is important to point out that while the views expressed do not claim to be valid for all stakeholders in a particular category, they are reasonably representative. *Taken as a whole*, they provide a foundation for achieving goal congruence and for capturing and reconciling very different but equally informed perspectives on efficient, cost-effective waiting-list management. Moreover, they provide an indispensable backdrop to the second part of our analysis – process management – to which we now turn.

(ii) Process Management

What is presented in Figures 8.2 to 8.6 is a process flow chart which the Case Study Group⁸ developed and which explains the processes by which patients get onto a waiting list and why it takes such an amount of time for them to get their surgery, as well as the impact of the many external factors influencing the elective workload of a hospital. While there may be some variation between hospitals, the process, as set out in Figures 8.2 to 8.6, is representative across the acute hospital sector as a whole.

Getting into the System

The first point of contact for the patient is their GP. Following assessment, the GP will decide whether to refer the patient to a specialist. While on average, GPs only refer some 6 per cent of their patients on for further tests or management, a minor variation in GP referral will have a major impact on the hospital system. It is for this reason that GPs are regarded as the "gate keepers" to the system. One of the shortcomings in the current system is that GPs may be unaware of the waiting lists for the first appointment for the *individual* consultant to whom the patient is referred.

There is increasing demand overall for acute hospital services, with patients automatically expecting referrals to specialists. Patients are increasingly well educated and often arrive at a GP surgery armed with the latest medical developments from the Internet. This, and increasing litigation, will influence referrals to acute hospitals.

There is also a very strong link between what happens in OPD and the

Figure 8.2: Overall Process Flow

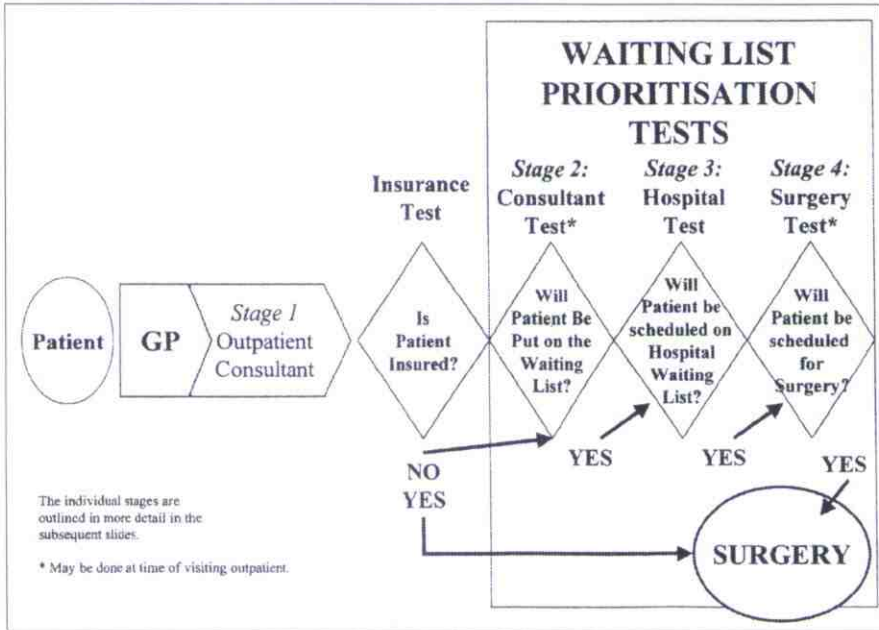


Figure 8.3: Stage 1: Out Patient

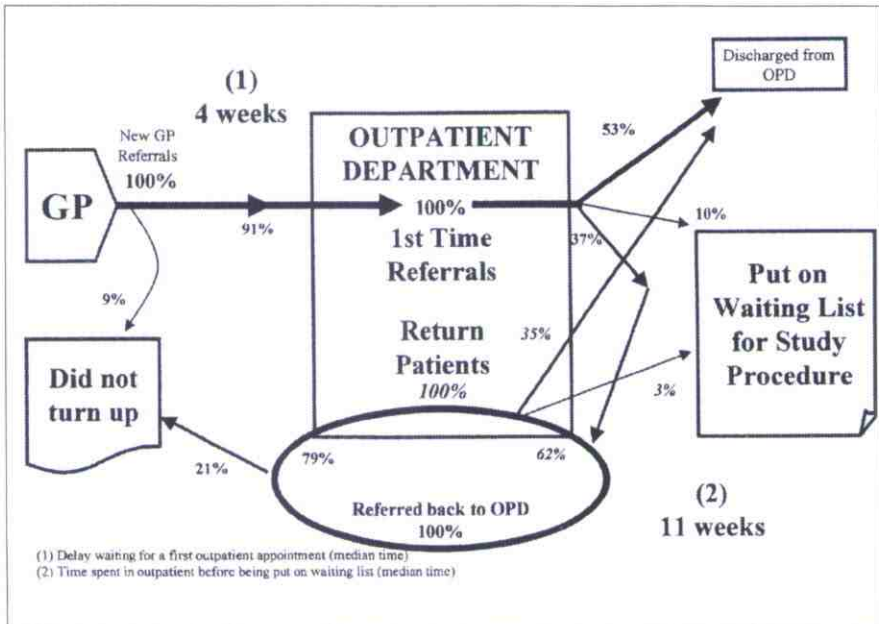


Figure 8.4: Stage 2: Consultant Test

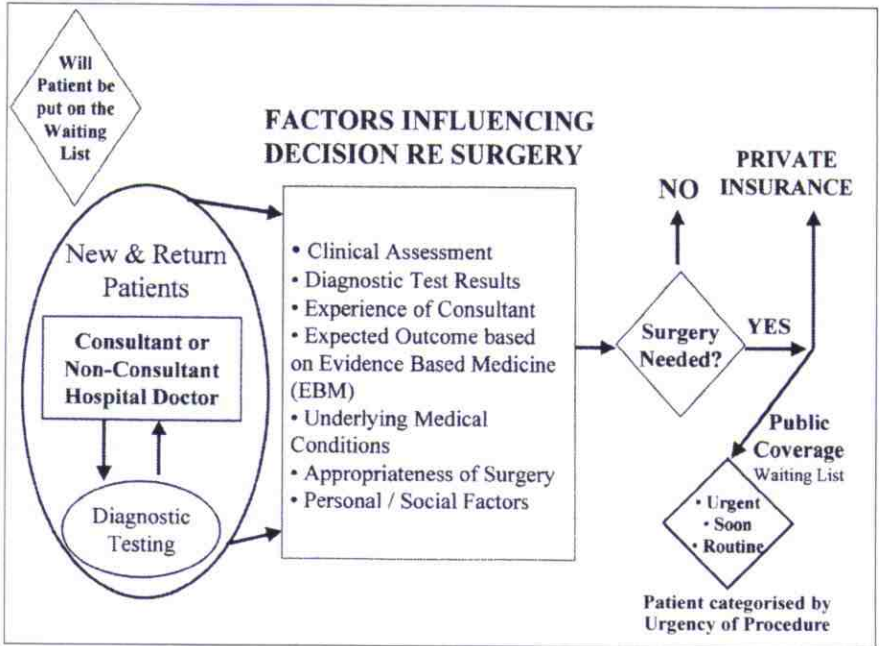


Figure 8.5: Stage 3: Hospital Test

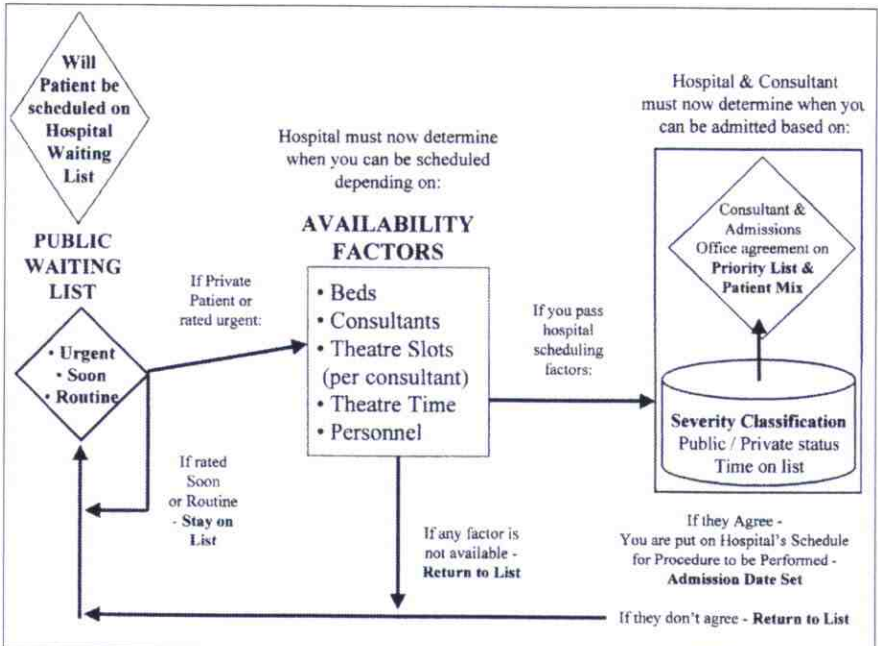
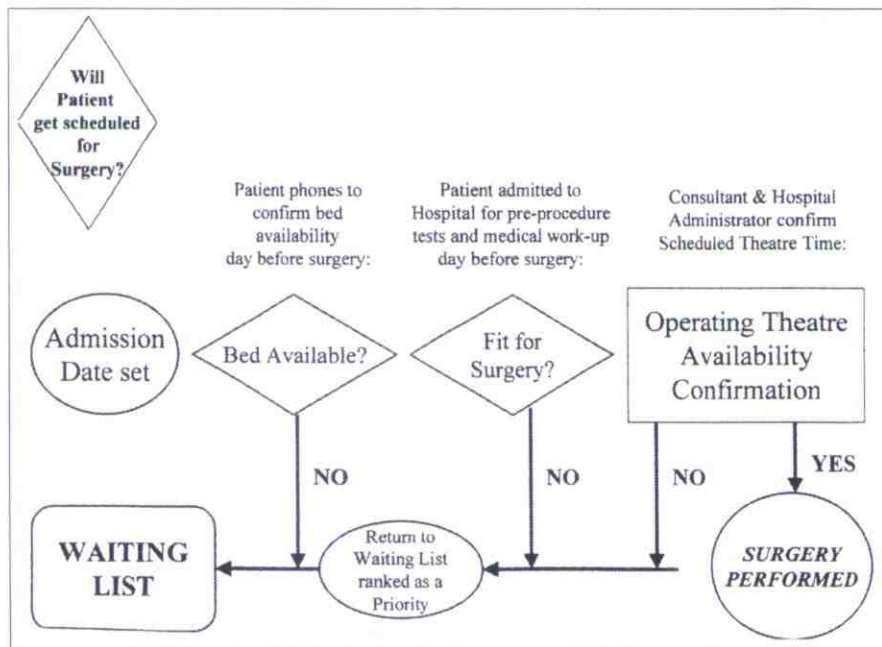


Figure 8.6: Stage 4: Surgery Test



effective management of waiting lists. While OPD could be regarded as meriting a case study in itself, it is important to refer to it in the overall context of the present study.

Outpatients

OPD is the first point of contact for most people to the acute hospital system. It is the area where many of the key decisions are made in relation to patient management. OPD is often attended by both public and private patients and it is only after their OPD assessment that those with PMI opt to use it to expedite their date of surgery, compared with public patients. This raises major issues of equity and of equality of access.

Current practice is for a GP to send a letter of referral to the OPD office. However, there are no protocols or guidelines concerning patient profiles that GPs send to the hospital. This is a significant deficiency, since often the patient may be inappropriate or could just as well be treated within a GP clinic. The introduction of guidelines on types of patients to be referred would make an impact on the increasing numbers being referred to OPD.

Prof. Leslie Daly's (UCD) authoritative study provides a clear overview of how the OPD system works, with a mix of new and "return" patients. Prof. Daly reviewed several clinics and the results clearly highlight the impact of poor

management of OPD, the need for strict protocols and the importance of senior medical decision makers in OPD ensuring appropriate care and prudent management. Lack of senior staff in OPD leads to increased rates of return patients. Prof. Daly's study clearly demonstrates the negative effect of "return" patients in clogging up the system.

OPD is, therefore, one area where there could be an immediate impact if information on waiting times could be made accessible to GPs, ideally on a website. This would enable GPs to inform patients as to the expected length of waiting and allow the public waiting list to be more effectively managed. At present, five Dublin hospitals are responsible for the majority of waiting lists: this small number would facilitate such process throughput management.

Managing Admissions through the OPD

The key decisions regarding admission are made in the OPD. There are a number of dimensions to this. Firstly, there is the management of the patient: decision on admittance is made on the basis of clinical assessment, result of diagnostic tests, age, expected outcome, underlying medical condition as well as personal factors. At the heart of the patient-management process at this point is this: does the patient have PHI? If they do, they are usually given a date to come in for surgery (TCI) often at a convenient time and/or at the location of their choice. If not, they may – depending on their categorisation – get locked into the public waiting-list system.

A decision is made to categorise the patient into one of three categories – "Urgent", "Routine" and "Soon" – based on the view of the admitting doctor. Clearly, a person diagnosed as being "urgently" in need of surgery will have a better chance of getting an early date, as opposed to someone categorised as "Routine". For the latter, while hospitals do endeavour to take those from the end of their list, the patient can, in practice, wait indefinitely without a realistic expectation of treatment.

A different set of decisions arises in the case of patients without PHI. To begin with, once a person on the public list is referred for surgery, they are not generally routinely contacted again until they are called for surgery. However, some people/families will continually contact the admissions office. While the office cannot change a person's priority status, it can refer the patient back to OPD, where they may be given a higher priority rating but keep their initial date of referral for surgery, thus increasing their chances of being called at an earlier date. In effect, those who shout the loudest may gain faster access, while the less vocal may be disadvantaged.

The list does not differentiate between those who are actually waiting for surgery and those who while they need surgery, are not ready for it. The UK has overcome this particular situation through the establishment of a so-called "suspended" waiting list. For example, a person who has unstable angina (chest pain) may be on waiting list for a hip replacement but in reality, that person cannot be considered a candidate for surgery as long as they are medically unstable.

There may be real advantages in integrating the concept of a suspended list, with the deferment of pre-admission facilities (as in Canada). In the latter, patients are admitted for a complete check several weeks prior to admission for a scheduled procedure. Any unknown conditions that might delay scheduled treatment once admitted (leading to extensive bed usage) could be identified and addressed in good time. This makes for the best possible use of the acute bed capacity.

Comparative Perspectives

Many international projects have been undertaken to make the requirements for surgery more open and transparent, the two most notable being the New Zealand Project and an initiative currently ongoing in Salisbury in the UK. In Ireland, a recent study undertaken in the Mid-Western Health Board focused on the value of giving orthopaedic patients awaiting treatment a "needs-based" assessment. The objective was to identify those who were most in need. This process improved transparency, efficiency and service quality by reassessing patients and clarifying their needs, on the basis of an internationally recognised, objective classification system. This enabled the patients most disabled by arthritis to be prioritised for treatment within the acute sector.

Getting from the List to a Bed

The process of getting a patient from the list to a bed is a joint effort involving the medical staff, admissions office and bed managers in balancing the requirement of groups of surgeons and their patients within the existing resources. The admissions staff usually try to fill the beds allocated to the speciality. However, within this blend, there is a need to accommodate both public and private patients, the varying levels of acuity (i.e. major/minor procedures) as well day cases and inpatients for all surgeons.

The single most important limiting factor is bed availability. Many hospitals, particularly in the winter months, have full occupancy; frequently, surgical beds will be occupied by medical emergency cases, thus preventing the surgeon admitting an elective patient. Those hospitals with A & E departments are at particular risk of having all beds filled with emergency patients.

In general, elective patients are given a provisional TCI date that is four weeks in advance of their surgery. All admissions have to ring to confirm bed availability the day before their surgery. If the bed is unavailable, the patient returns to the waiting list with their initial date of assessment. Lack of bed availability is the single most common reason why people have their provisional date for admission cancelled. A key issue throughout the Dublin hospitals is the large numbers of beds closed due to lack of staff, particularly nursing staff.

If there is a bed for the patient, the person is normally admitted one to two days before their date. The patient is "medically worked up", i.e. assessed for fitness for surgery. Patients may have deteriorated since their assessment date. During the time spent getting on the list and subsequently waiting on the list, they may require additional/unforeseen medical treatment prior to surgery,

which can delay the surgical date or require the patient be returned home until they are medically fit.

This system can be improved. The patient could be admitted the day of their surgery, as is the case in the US and Canada, *if* patients undergo/attend a pre-admission unit. These “day areas” conduct all necessary, routine tests up to three weeks in advance of surgery, thus freeing up beds, discovering any abnormalities in advance of admission and, for example, allowing a move to a suspended list where it is necessary.

Finally, once the patient, the staff, the theatre and the bed are arranged, surgery will occur.

List Management

In terms of proactively managing waiting lists, there are a number of points that need to be addressed. The first is the *reliability* of the existing data, in terms of coverage and an effective definition of what is being measured. A second point relates to the ongoing *validation* of waiting lists: for example, some patients may remain on the list even after surgery. A third point relates to the possible adoption in Ireland of the suspended-list procedure referred to above.

The political dimension of waiting lists cannot be overestimated. Often when an audit of names on waiting lists is undertaken, the reduction in numbers is misconstrued as a “fudging” of figures for political gain, even though this is manifestly not the case.

In theory, a person has to wait for three months before their name is put onto a waiting list. Therefore, a person who has been waiting for two and a half months and is then called for surgery will not be registered as having undergone surgery from the waiting list. In addition, in some specialities (notably cardiac), patients require immediate surgery and, as such, never appear on waiting lists. “Ownership” of lists and the question of the possible transferability of patients also merit consideration.

In their report, the Review Group recommend allocating money on the basis of appropriate business plans, whereby those who had proven efficient in dealing with waiting lists and who had adequate staffing and capacity would be entitled to more money. Without doubt, there is a need to focus on *commissioning* work rather than arbitrarily giving money in the hope that it will make some impact.

(iii) Data Evaluation and Information Management

The third component of the analysis relates to the waiting-list data – the logical starting point for any national strategy to manage waiting lists. At present:

- The data gives no indication of waiting times, either for specialists – which would be an important advance – or for procedures.
- It relates to inpatients. In some instances, for individuals awaiting an appointment for day care treatment the effects can be equally distressing and costly and should, therefore, be encompassed in the data.

- The data relates only to public/voluntary hospitals. Under present arrangements, encompassing private sector data is not possible. This "reporting" gap means that a true national picture of waiting lists is not available.
- Turning to the data, there are widely acknowledged constraints. For example, from a hospital perspective, patients waiting for less than three months are, in effect, not resourced to be treated within the public system.
- More generally, the validity of comparisons in waiting lists over an eight-year period is questionable, given the changes in procedures, for example the significant move to day care surgery as well as changes in bed capacity.
- Some institutions focus on inpatient procedures only, while others include day cases in their quarterly returns to the DOHC/health board. This issue itself potentially raises difficult issues for hospital managers: for example, a decision by a major hospital to include day cases may significantly increase the size of their waiting list, thereby targeting them for unwarranted criticism. It raises the issue of the importance of holistic waiting-list systems that are properly integrated with other relevant activities within hospitals.
- The compilation of quarterly returns at the level of the individual hospital gives rise to difficulties.

The most important point that arises from this review is the need to extend the waiting-list data – to develop a single national waiting list – while, at the same time, making it more accessible to all stakeholders.

At the institutional level, the DOHC should require the mandatory adoption, within a specified period, by all hospitals of the "Best of Breed" reporting systems currently in use in a small number of major hospitals. Equally, responsibility for the waiting-list reporting template, statistical processing and reporting software could be transferred directly to the CSO. This would mean that individual hospitals would report directly to the CSO and that the validation of waiting lists would be the sole responsibility of the CSO. Specifically, this would have the following advantages:

1. It would involve the hospitals directly inputting waiting-list data to the CSO; at present, this is done through the eight Health Boards.
2. It would ensure that the analysis and evaluation of waiting-list data was configured to better management of waiting lists at a national level. For example, having the CSO validate a single set of waiting-list data would allow for better access, through new MIS, by GPs and the public. There are also obvious synergies between waiting-list data and other socio-demographic statistical series that the CSO presently publish.

The underlying premise is quite simple: the business of Health Boards is service planning and the operation of facilities. Equally, the business of the DOHC is policy development including strategic planning. The business of the CSO is

the implementation of “Best of World” statistical methodologies. It is precisely because waiting lists are so problematic at present that the system needs to become more transparent and less politicised and, more importantly, be presented in the most robust and flexible form.

RECOMMENDATIONS

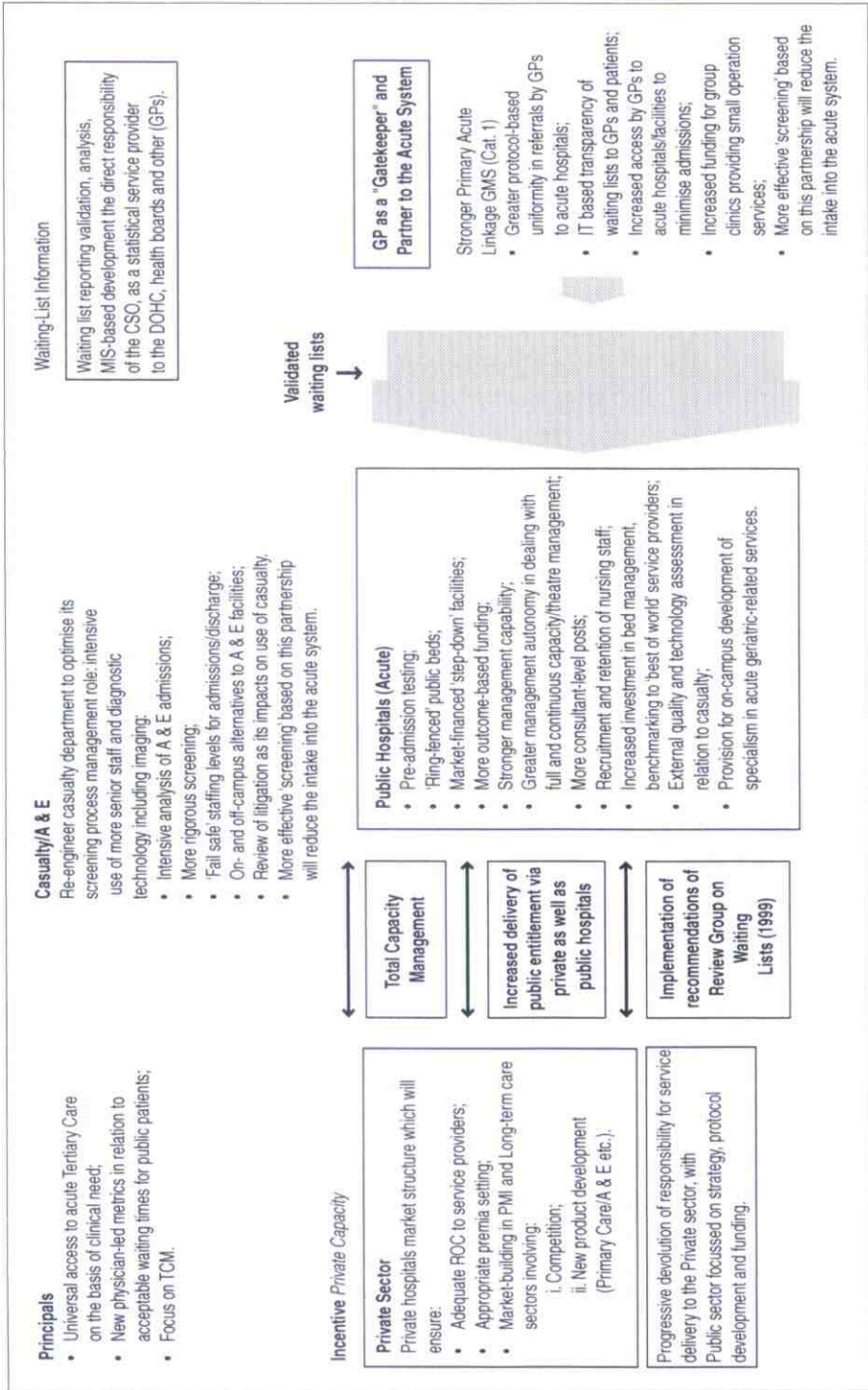
The main elements of an integrated national waiting-list strategy are set out in Figure 8.7. The recommendations have their foundation in four key components:

1. Recognition of the ethical responsibility of government to ensure timely universal access to the acute system on the basis of clinical need. Targets – for example no more than three/six/twelve months – are indicative, arbitrary and lack any substantive clinical meaning. The recent experience of the UK is that an inappropriate or badly directed obsession with waiting lists *per se* can, in some circumstances, be inequitable, clinically misguided and impose serious pressures on clinicians and hospital management.
2. The efficiency of the GP as a gatekeeper to the acute system. Reduction towards “best case” referral rates is the key to improving this efficiency. The greater the degree of this convergence, the greater the efficiency benefit to the acute system.
Referral rates could be significantly reduced through encouraging a new generation of group clinics, with a sufficiently large capacity, to which a wide range of treatments which presently “clog up” the acute system could, in effect, be outsourced.
3. In terms of comprehensively addressing the waiting-list issue, there is a need to focus on the total capacity (that is, public *and* private). In addition, there is a need to develop waiting lists by procedure to facilitate more effective management of clinical resources throughout the country.
4. Finally, there needs to be a rebalancing of the public/private mix within the health sector and a move towards greater reliance on the private sector in delivering innovative service outcomes in the best interests of all citizens.

The evidence suggests that it would be more efficient for the Exchequer, for society and in terms of individual patient outcomes if the “universal” entitlement were delivered to a progressively greater extent through the private sector.

The National Review Group estimates that approximately 5,000 beds are needed over the ten-year period up to 2011. The fully costed requirements for servicing each bed implies a total expenditure in excess of £2bn, with significant ongoing costs to be borne by the Exchequer. The BUPA Ireland/ESRI National Study clearly indicates that the public, across a range of factors, perceive there to

Figure 8.7: Key Elements of an Integrated Waiting-List Strategy



be better outcomes within the private sector. This raises the question of why the Exchequer should assume the burden of wholly funding and delivering, via the public system, this quantity of additional acute services, when it could be more cost-effectively delivered through private capacity, with the State delivering and monitoring clinical outcomes in terms of easier access, equality and sustainability.

Addressing the waiting-list issue cannot occur in isolation. Increasing waiting lists are manifestations of a multi-system problem and addressing surgical lists in isolation will have little impact upon this problem. For a significant improvement there needs to be a radical overhaul of the system.

- The total capacity of what is, as noted, really one system should be deployed to reduce waiting lists.
- There is a need to follow up with the recommendations from the 1999 Waiting List Review Group, particularly those related to the development of on-campus facilities to reduce pressure on A & E, as well as step-down facilities and long-term care.
- There is a need for the use of pre-admission units, which would facilitate same-day admission for elective patients and would ensure patients are fit, upon admission, to undergo surgery.
- There is a need for a more substantial presence of senior decision makers (admission/discharge) in casualty and in the system generally. There is undoubtedly an issue with competing demands upon consultants' time – teaching, administrative and private patient commitments limit consultants' availability for public elective work.

Substantial changes in this area should be scoped and led by the appropriate bodies (colleges) themselves in order to ensure that the system, as a whole, remains physician-led as the best guarantor of retaining its "public good"/patient-focussed ethos.

In addition to shortages of staff and, in particular, specialised nursing staff, there is vast under-utilisation of existing resources. Theoretically, public hospitals are open on a 24-hour basis, 7 days a week, but in reality operate on a Monday to Friday, 8 am to 5 pm basis. This includes hours of operation of theatres. Why should the public system not operate outside of these hours? WLI funding should be made available to pay staff and should be strictly monitored to ensure value for money. The reality is such that the shortage of nurses may restrict this option in the short term.

There should be a mandatory requirement to inform patients as to the length of waiting lists and the option to go elsewhere should be considered. An important innovation in this regard would be to deepen the waiting-list data a further tranche, to encompass procedure-specific monitoring of waiting times. This would enable a much more efficient concentration of resources in the areas that need them the most.

The "engineering" of A & E in terms of "Best Practise" in service industries

needs to be urgently addressed. This should encompass enhanced diagnostics within A & E together with process management benchmarked against "Best of World" (for example airports) flow-through systems.

The current public hospital system operates under very tight specific financial constraints. The idea is to increase activity and thus thru-put of patients, and to undertake more elective work. In its annual service plan, each hospital projects, and therefore budgets for, a specific number of procedures. While increased elective activity will have a positive impact on the waiting list, the hospital cannot allow itself to go over its allocation, since a deficit will over-run into the following year's financial allocation. This has the consequence of disincentivising productivity and, indeed, elective work is frequently cancelled where hospitals/health boards realise they are "over budget". This makes no sense where the capacity to deal with elective patients is there and where such cancellation simply defers procedures, which may affect the individual patient and will ultimately lead to higher costs.

The waiting-list issue will not be resolved as a problem that is, somehow, external to the acute system. Waiting lists are embedded within – and a product of – an acute system that is flawed, inequitable and in need of re-engineering in order to face the challenges of the future.

APPENDIX

Report of the Waiting-List Review Group Short, Medium and Long-Term Recommendations

Short-term Recommendations: 1998

- Further study of hospital capacity is needed as a matter of urgency. Some hospitals have reached full capacity with existing resources in relation to elective work. Where staffing is an issue, these hospitals should be funded for the provision of appropriate temporary staff in target specialities, subject to certain conditions. Where physical capacity is an issue, favourable consideration should be given to developing, in the medium to long term, additional capacity in hospitals that demonstrate that their existing facilities are already appropriately utilised and fully committed.
- Agencies should be asked to review their information systems to ensure that they can maintain accurate and up-to-date WLI data and should be assisted if specific shortfalls are identified. The Department of Health and Children should develop and implement an improved IT system for recording and analysing national WLI data.
- Hospitals should carry out a bulk postal review of patients on their waiting lists where they have not done so in the previous twelve months. There should be an agreed protocol for periodic further reviews on a selective basis following this validation process.
- A set of short-term steps relating to the operation of hospital services should be taken. These include an improved flow of information between primary and hospital care regarding the status of patients on waiting lists; a continued move towards day case work; the appointment of bed managers and bed utilisation committees; agreement under each agency's services plan regarding the mix of public and private patients treated; and a written policy on planning the discharge of older patients and on liaising with community-based services.

Medium-term Recommendations: 1999

- A number of steps should be taken during the course of 1999. These are summarised below:
- WLI funding should focus on a limited number of specialities and take the greatest possible account of health and social gain, the priority set according to clinical judgement and the length of time already waited by patients.

- The present system of allocating WLI funding may act as a disincentive to hospitals to improve their waiting-list performance. The Department of Health and Children should consider introducing positive financial incentives to hospitals to reduce their waiting times. A proportion of total WLI funding could be retained by the Department for distribution to the hospitals that showed the greatest reduction in waiting times in target specialities. The details of any such incentive system should be developed in conjunction with the relevant hospitals.
- Protocols should be developed in all major waiting-list specialities for the validation and prioritisation of cases. This should be done either at national level through protocols devised by the relevant professional bodies, or at local level by individual hospitals.
- A number of measures should be pursued to reduce the pressure from A & E services on acute beds. These include developing rapid diagnostic systems for common emergency presentations; developing effective care guidelines for managing conditions that no longer require admission; further developing treatment/observation areas to allow frequent review of certain cases; and improving access by general practitioner to urgent specialist opinion.

Long-term Recommendations: 1999–2001

- The availability of beds for elective treatments is being restricted due to a number of factors. These include shortfalls in the provision of services for older people (and others who may need long-term care) such as day investigation facilities, rehabilitation facilities, community-based support services and long-term residential care places. The shortfalls in these services result in inappropriate use of acute hospital facilities and thus severely hamper the ability of hospitals to provide treatments to patients on public waiting lists.
- The development of Geriatric Day Hospitals on the site of acute hospitals should be prioritised in the medium to long term. The next priority should be the development of rehabilitation facilities on acute hospital sites where they do not already exist. Both of these developments would significantly increase the appropriate utilisation of scarce acute hospital services.
- Each health board should evaluate the long-term residential care needs of its region. There should then be a planned programme of investment in appropriate facilities for those in need of long-term care.
- For acute patients, the case for providing stand-alone day surgery units on

the site of acute hospitals should be examined closely. Since many patients who are on public waiting lists could be treated on a day care bases, a dedicated day surgery unit could greatly protect them from delays that arise from other hospital pressures.

- The question of providing additional hostel or other short-term accommodation for patients who do not otherwise need to stay overnight in an acute bed should be pursued as a means of reducing unnecessary hospital stays.

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- 1 The genesis of this paper was a Case Study developed for and by the Harvard Association of Ireland. The input of Fidelma McHale, Dermot Berkery and Daniel McGowan was, quite simply, invaluable. The responses, and suggestions, of participants at the Case Study presentation were insightful and far-thinking and were greatly appreciated. The assistance of David Christopher was also much appreciated. The usual caveat applies.
 - 2 The input and advice of Fidelma McHale is gratefully acknowledged.
 - 3 Movements in waiting lists, by speciality, for *each* individual public hospital is also published by the DOHC.
 - 4 See *Dáil Debates* (Written Answers) 22 May 2001 (par. 73) and also Minister's statement in a debate on health services, 22 May 2001, p. 145.
 - 5 J. Williams and D. Watson (2001) "Perceptions of the Quality of Health Care in the Public and Private Sectors in Ireland" (Foreword by Ray Kinsella), *Report to Centre for Insurance Studies*, Dublin, ESRI.
 - 6 St Vincent's Hospital Annual Report, 1999.
 - 7 Based on St Vincent's Hospital Annual Report, 1999.
 - 8 Particular thanks are due to Fidelma McHale and, also, to the work of Prof Leslie Daly in this field.

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