

Reduced Waiting Times
for Public Hospital
Elective Services

GOVERNMENT STRATEGY - MARCH 2000

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Reduced Waiting Times for Elective Services

EXECUTIVE SUMMARY

The Government is committed to reduced waiting times for elective services, and improved national consistency of access.

Elective services are important for improving peoples' independence and ability to participate in the activities of daily living. Reasonable access to elective services is also essential to ensure public confidence in the public health system as a whole.

The Government intends to build forward on the significant progress that has been made, particularly over the last year, in improving access to elective services. Much more needs to be done. Patients in some parts of the country are still waiting too long in a state of significant ill health for access to hospital elective services.

This paper outlines the Government's four key objectives and seven strategies for reducing waiting times and improving access to elective services progressively over the next three years. The four key objectives are to ensure:

- all patients with a level of need which can be met within the resources (funding) available are provided with **surgery within six months of assessment**
- delivery of a level of publicly funded service which is sufficient to ensure **access to elective surgery before patients reach a state of unreasonable distress, ill health, and/or incapacity**
- national equity of access to electives - so that **patients have similar access to elective services, regardless of where they live**
- **a maximum waiting time of six months for first specialist assessment.**

The seven strategies for achieving these objectives are:

1. Nationally consistent clinical assessment
2. Increase the supply of elective services
3. Give patients certainty
4. Improve the capability of public hospitals
5. Better liaison between primary and secondary sectors
6. Actively manage sector performance
7. Build public confidence

BACKGROUND

Waiting Lists - A Long Standing Problem

In New Zealand, as with most publicly-funded health care systems, there has long been a difference between the public resources allocated to non-emergency surgical, medical and diagnostic services (elective services) and the demand for those services. The consequent waiting lists which have been used to manage this supply gap have been a long standing concern.

The National Advisory Committee on Core Health and Disability Services considered the issues surrounding waiting lists shortly after its formation. Based on the findings of a commissioned report (Fraser, Alley & Morris 1993) and consultation with the community, the Committee noted some particular concerns which included:

- unfair selection of patients for treatment as their position on a waiting list did not reflect either their true level of need or their ability to benefit from the treatment
- increasing (or at least static) waiting lists in some specialties, despite increasing rates of surgery
- the relative ineffectiveness of some interventions being provided on a publicly-funded basis
- inconsistency of access to elective services across the country
- a lack of explicit communication to patients about the circumstances under which services were available on a publicly-funded basis and when they would get treatment.

A further concern related to the deficit of information available from waiting lists and waiting times. It was difficult to make meaningful assessments (based merely on the length of a waiting list) of, for example:

- the level of access to services in each region
- the level of unmet need in the community, and
- the likely effects of proposed funding and policy decisions on that level of unmet need in the community.

It was in response to such concerns that the Committee proposed the replacement of waiting lists with booking systems as a much more effective method of managing patients' access to elective services.

The Government of the day, the Ministry of Health and the Regional Health Authorities accepted the Committee's advice. Since that time, Hospital and Health Services have also accepted these concepts as practical approaches which are delivering improvements in service.

Elective Services Policy

There are a range of approaches that are all integral to a well managed system which can significantly improve access to elective surgery:

- nationally consistent prioritisation of patients
- accountability against quality and timeliness performance standards
- improved equity of access through better targeting of funding
- focus on delivery against contracted volumes of elective services
- providing information so that the patients and the public know what services are provided under what circumstances
- greater and more meaningful involvement of general practitioners.

These are all important aspects in the effective management of public hospital elective care so that public confidence is improved and extra resources deliver tangible improvements in waiting times.

Although there has been significant progress toward these goals, particularly over the last twelve months, much more needs to be done. We now have better information and that shows us that the current situation is still unacceptable from a patient access and public confidence point of view. The greatest concerns are that:

- a significant number of patients in need of help most are not receiving their procedure within six months
- in some urban areas (notably Auckland) the level of publicly funded service is not sufficient to ensure reasonable access to electives - consequently patients are in a state of significant distress, ill health, or incapacity before being provided with the procedure
- 30 percent of patients are waiting longer than six months for a first specialist assessment
- the public has considerable anxiety about the public health system in general due to uncertainty about the availability public hospital elective services
- large numbers of patients are in preventable distress because they do not know when they will receive their procedure or operation.

OBJECTIVES FOR REDUCED WAITING TIMES

The Government's four key objectives for reduced waiting times and more equitable access to elective services are to ensure:

- all patients with a level of need which can be met within the resources (funding) available are provided with **surgery within six months of assessment**
- delivery of a level of publicly funded service which is sufficient to ensure **access to elective surgery before patients reach a state of unreasonable distress, ill health, and/or incapacity**
- national equity of access to electives - so that **patients have similar access to elective services, regardless of where they live**
- **a maximum waiting time of six months for first specialist assessment.**

To achieve these objectives, the seven strategies outlined below provide a way forward which addresses the key issues associated with reducing waiting times for elective services.

The strategies build on the best of current waiting times initiatives, including the promising elements of the previous booking systems policy. The intention is to build forward on these positive aspects, while implementing new initiatives to address problem areas. Many of these strategies are already in train, and will continue to be led from the Ministry of Health, HFA, HHSs and general practice.

The Ministry, HFA, and HHSs are confident that implementation of these strategies over the next three years will deliver both the Government's commitment to reduce waiting times and the wider goal of restoring public confidence in the health system.

STRATEGY 1: NATIONALLY CONSISTENT CLINICAL ASSESSMENT

In order to support clinicians in making consistent decisions about a patients' priority for services, assessment tools and guidelines should be continuously developed within all specialties. The tools provide a framework for clinicians to assess a patient's need priority by considering a range of medical and social factors. Such guidelines help ensure that:

- consistent patient care decisions are made by clinicians
- patients in need of help most are seen first
- futile or only marginally beneficial elective procedures are not provided
- extra funding translates into tangibly improved services for patients
- accurate interregional comparisons of access can be made and used to inform funding decisions which improve national consistency of access.

Clinical Confidence

The intent of the assessment tools has been misinterpreted by some clinicians and managers in the past. The tools do not provide a formula for reaching a "score" which then determines the care or treatment decision. Rather, they should act as a guide to assist in clinical decision-making processes. In the final analysis, clinicians must use their clinical judgement in reaching treatment and care decisions - they are in the best position to exercise discretion in the case of individual patients.

Ongoing development and improvement of assessment tools is also important in improving widespread clinical confidence. This can be achieved through an on-going programme of formal and informal evaluation, and by having regular reviews of the tools in place to identify possible improvements.

For example, the Schools of Medicine or Health Research Council could be involved in a research and development programme around improving the validity of the tools. An initial emphasis should be placed on the elective services with the highest volume/cost of procedures, and where tools are the least developed.

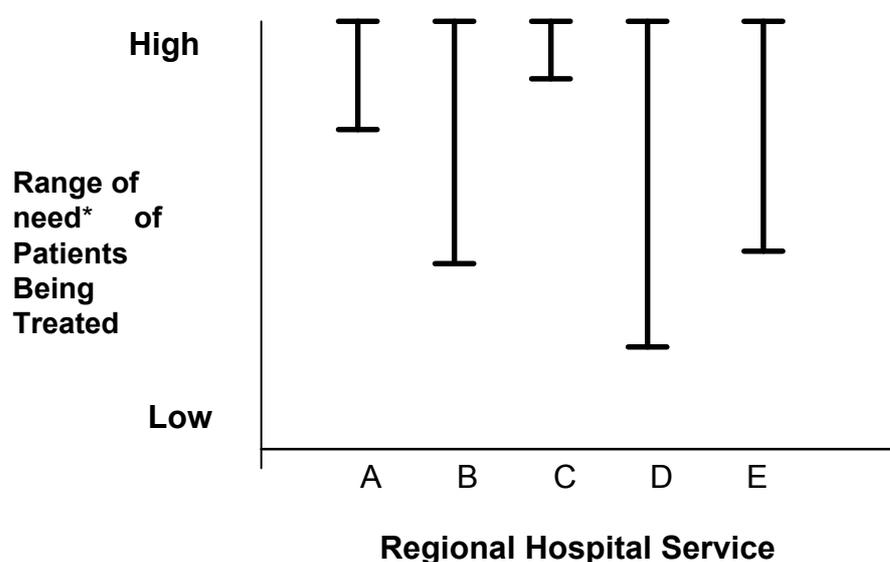
Communicating that assessment tools are intended only as guidelines, and will be subject to clinician led ongoing development and improvement, is key to increasing clinical support and ownership of assessment guidelines by both GPs and specialists.

National Consistency of Access

Assessment tools are key to improving consistency of access to elective services across the country.

By examining the relative level of need of patients who are being treated at current funding levels, it is possible to make meaningful comparisons of access to elective services on a regional basis. A fictional example of this type of comparison is shown in diagram form below:

Figure 1. Use of Assessment Tools in Achieving National Consistency



* eg Level of pain, disability, or reduced quality of life amenable to surgery

Under the above scenario, hospital service “C” has the poorest access to elective services and, consequently, elective patients in this area would be in the greatest state of need before receiving surgery. By contrast, many patients in hospital service “D” would be in a lesser state of pain and reduced independence when receiving their treatment.

Using such information in conjunction with other data such as overall intervention rates, it will be possible to effectively allocate the additional elective services funding to the highest need areas and services thereby improving access in these services to more nationally equitable levels. Some significant improvements in equity of access across regions have already been made using this type of information.

The introduction of national assessment tools will also aid consistency of access. At present different assessment tools are in use in different regions across the country. This makes interregional comparisons of access more difficult (though it is still possible to some degree) and creates a public perception of greater disparities of access than may actually exist. This has been the case with South Island heart surgery, for example.

Consistent Assessment and Improved Maori Health Outcomes

Allocation of operations and other elective services on the basis of the level of need of patients ensures that the highest priority patients are treated first. As Maori (and Pacific people) have greater health needs than the general population, they will benefit significantly from access to elective hospital care on the basis of their medical assessment. This will improve Maori health outcomes and reduce health status disparities.

However, other initiatives are required to address wider health service access issues for Maori. For example, Maori generally have poorer access to primary care and this contributes to Maori being underrepresented in hospital treatment statistics relative to their level of clinical need.

The New Zealand Health Strategy is currently being developed and it will provide a framework for addressing wider access issues and improving health and disability outcomes.

Once Maori do access hospital services, nationally consistent assessment will ensure that the clinical facts are the major determinant of access which is a significant improvement over access based on date of referral to a waiting list.

Actions:

Nationally Consistent Clinical Assessment

- Introduce nationally consistent assessment tools. The development of these tools must be led by clinicians who retain responsibility for making appropriate treatment decisions on the basis of their assessment.
- Ensure that national assessment tools are subject to continuous improvement through research and development of the tools on an on-going basis.
- Use data collected through the use of assessment tools and patient care decisions to improve national equity of access to elective surgery by targeting funding to hospital services with the highest need patients, so that they can build capacity to deliver more preventative and treatment services.

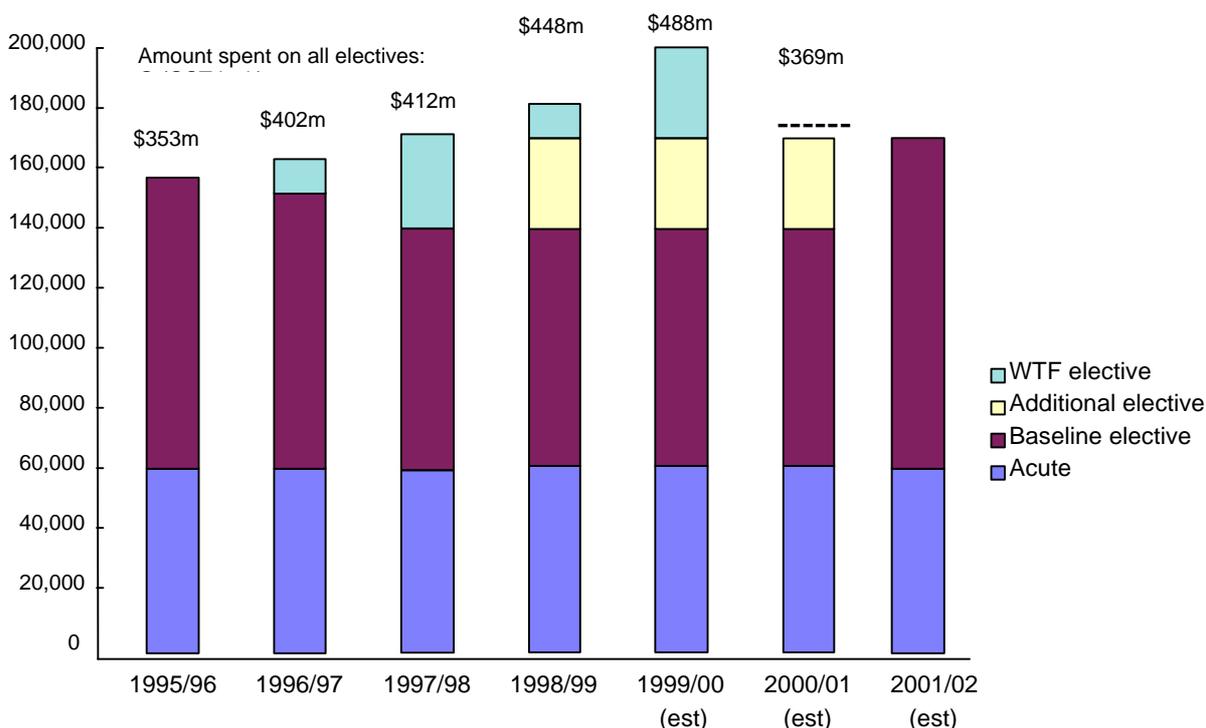
STRATEGY 2: INCREASE THE SUPPLY OF ELECTIVE SERVICES

Increasing the supply of elective services, particularly surgery, is integral to reducing waiting times. To ensure achievement of the waiting times objectives, Ministers will consider an increase to Vote: Health from 2000/01 as part of the up coming budget process.

Any additional elective service funding will replace the one-off Waiting Times Fund (WTF)¹ (now in its final year) with sustainable funding. The WTF has been directed to reducing backlogs of patients waiting for surgery. These backlogs will be substantially reduced by 30 June 2000.

Figure 2 shows the number of surgical discharges, and sources of funding for surgical discharges, since 1995/96. Due to the substantial clearance of backlogs through the WTF, any increase in sustainable elective funding above the dotted line indicated in Figure 2 below would ensure improved levels of service for newly presenting patients.

Figure 2: Surgical discharges and funding (GST incl) for elective surgery (1995/96 - 2001/02)



Any new funding which increases surgical volumes above the dotted line indicated in Figure 2 will be directed to the areas of highest need to improve waiting times, and ensure a more equitable level of service.

¹ The Waiting Times Fund (WTF) is a one off, multi-year appropriation established by Cabinet [CAB (96) M 16/10 refers] on 1 July 1996, in order to assist the former regional health authorities to clear the backlogs of waiting list patients as at 7 May 1996.

Actions:

- seek an additional on-going budget allocation from Cabinet for 2000/01 onwards for a sustained improvement in the level of service
- allocate this funding, in the first instance, through existing HFA contractual mechanisms - giving priority to hospital services with the most inequitable levels of service.

STRATEGY 3: GIVE PATIENTS CERTAINTY

One of the most critical failings of traditional waiting list management was the failure to provide basic information to patients, for example, expected waiting time, options for care, or even who was responsible for their care at the various stages of the process. This lack of information contributed significantly to the perception of poor service from the public health system.

Developing minimum patient information requirements will improve this situation. On assessment all patients should receive, as a minimum, their probable diagnosis, clear information about their eligibility for surgery, their maximum waiting time and likely booking date, the date that they will next be reviewed/assessed, and who to contact if there is a problem.

Consistent care decisions should be made as a result of consistent assessment processes. The following patient care categories are suggested:

Level of Need for Surgery	Undertakings to Patient / Care Category			
HIGH	<table border="1"> <tr> <td data-bbox="587 1115 1098 1238">Scheduled for Surgery</td> </tr> <tr> <td data-bbox="587 1238 1098 1361">Certainty of Treatment Within Six Months</td> </tr> <tr> <td data-bbox="587 1361 1098 1429">Active Care and Review</td> </tr> </table>	Scheduled for Surgery	Certainty of Treatment Within Six Months	Active Care and Review
Scheduled for Surgery				
Certainty of Treatment Within Six Months				
Active Care and Review				
LOW				

As seen above, depending on the patient's priority, they will either be scheduled for treatment (*booked*), or given a firm assurance that they will receive the procedure with the next six months (*certainty*).

Where treatment cannot be provided in the next six months, a plan of care is developed jointly between the specialist and GP outlining for the patient review dates, contact persons, and care strategies available (*active care and review*).

There are some procedures and operations which carry some benefit to patients but are not a priority for public resources and are therefore are not provided in the public health system. This has always been the case and occurs where a procedure is likely to be only marginally beneficial to the particular patient and is therefore a low priority for public resources (for example, largely cosmetic varicose vein procedures).

Actions:

- Communicate a clear set of performance expectations that patients should expect when entering the public health system (a “pledge card” of straightforward statements, e.g. “you will be provided access to specialist assistance within 6 months”).
- Provide information to patients on their eligibility for public funded treatment, their maximum waiting time, likely booking date, date they will be next assessed/reviewed, care or treatment options, and who to contact if there is a problem.
- Formalise and integrate this type of information from each stage of the process into a clear, patient centred “plan of care” maintained jointly by primary and secondary elective health providers in discussion with the patient.

STRATEGY 4: IMPROVE THE CAPABILITY OF PUBLIC HOSPITALS

The focus of public hospitals over the last few years has been on cost containment and efficiency. However, as levels of elective service have increased, along with a greater emphasis on effective waiting time management practices, some hospital services have not had the capability to supply:

- the desired level of elective services
- desired levels of quality and timeliness performance standards, for example, few hospitals are providing a high percentage of patients with certainty of treatment within the next six months.

Delivery of the Required Level of Elective Services

Capacity constraints can result due to insufficient staff, equipment, theatre space or unplanned increases in demand for surgical services. The largest problems are associated with Waiting Times Fund contracts where one off funds have strained hospital capacity in the short term without the security of on-going sustainable funding.

As elective service levels are raised and performance standards tightened, capacity management becomes crucial to achieving and maintaining performance levels. This requires:

- clear information and understanding of medium to long term service level requirements (i.e., the level of patient need that will be met in future)
- effective production planning of surgical volumes in each HHS so that commitments (for example, booking dates) can be made in advance to patients
- the ability to analyse capacity constraints, and to invest in redesigning existing processes to relieve those constraints
- cooperation between services, hospitals, and other health providers to provide the capacity and resiliency required to consistently manage waiting times.

Facilitating the development of public hospital capability to meet and maintain longer term elective care service levels is critical to the sustainable reduction of waiting times in the highest need areas. In the shorter term, it is important that other strategies are used to ensure that patients receive needed services.

In particular, allowing sub-contracting of services to other public and private providers will ensure that appropriate service levels are achieved in high need regions.

However, in order to ensure that patients receive a coordinated service, and to ensure the maximum contribution to public hospital overhead costs, there are two principles which should be followed in subcontracting:

- available public capacity (including capacity in other centres where this is practicable) should be absorbed before arrangements with private providers are made
- public disclosure of the contracts and arrangements made with private providers, so that there is openness about the reasons for using private facilities.

Following these principles will encourage cooperation between public providers and ensure that the intentions of public hospitals who contract with private providers are not misinterpreted by other hospitals or the public.

Delivery of Performance Standards

Effectively managing waiting times requires appropriate administrative and support staffing for the purposes of:

- production planning, including modelling of likely supply and demand trends over the short and intermediate term
- monitoring and analysing trends in the in-flow of patients and their relative need
- effective liaison with GPs and other primary care groups so that communication channels are kept open and joint projects are successful
- ensuring patients seeking surgery are tracked, cared for, and reviewed in appropriate timeframes.

If these initiatives are supported then the maximum number of patients will be given firm commitments about when they will receive treatment or have their condition reviewed. It is also more likely that accurate data on the level of service in each region will be made available, and variations in access to services throughout the year will be reduced.

At present many hospital services do not have these capabilities, and as a result fewer patients are booked for surgery in advance, many lists contain patients that no longer require surgery (which distorts production planning), and general practitioners commonly feel uninformed about their patients and access to secondary services in general.

It is important that hospitals build the capacity to meet minimum performance standards and expectations, so that patients and patient access are managed more effectively with improved communication and monitoring.

Actions:

- provide a more stable environment for production planning through fewer non-sustainable “one-off” funding streams, and better definition of expected service levels
- facilitate the development of best practice waiting time management across hospitals and primary care
- improve the capacity of public hospitals in high need areas, to enable them to deliver higher levels of service
- allow some flexibility in the delivery of publicly funded services through private facilities as an interim measure to reduce backlogs of patients, and to manage peak demand periods
- improve the capacity of public hospitals to meet defined performance standards in terms of patient information, tracking and review.

STRATEGY 5: IMPROVED PRIMARY AND SECONDARY LIAISON

The separation of (and lack of communication between) general practitioners (GPs) and hospitals is contributing to poor patient care in the community while GPs and patients wait for specialist assistance - which could often be managed by a simple phone call.

Current practice is dominated by the activity of outpatient clinic assessments. As there are a limited number of specialists available, this inflexible approach contributes to the backlog of patients.

Providing patients and GP's with more flexibility in accessing hospital services will significantly reduce waiting times. This situation can be achieved through the establishment of joint primary/secondary working groups to develop appropriate and speedy GP/patient access to specialist assistance. Examples of such initiatives include:

- general practitioners working within hospital clinics to improve referral quality through providing feedback, reduce load on consultants; ensure referrals are directed to the most appropriate access/assessment option
- development of management plans for common conditions, (an extension of the referral guidelines concept)
- development of general practitioner skills through education and a certification process to enable a better level of assessment and management to be undertaken in primary care - in some instances enabling patients to be booked for treatment without the intermediate step of specialist assessment
- enhanced general practitioner direct access to allied health and diagnostic services such as ultrasound
- a greater role for certified general practitioners in follow-up assessment activities
- an increased role for general practice provider groups in profiling general practitioner referral behaviour and improving referral practice.

Through these initiatives, other process improvements can be made, for example, more consistent joint patient care decisions and open communication about the results of reviews of patients' conditions.

The main benefit of better primary/secondary integration will be to provide services more tuned to these needs, providing better care, more flexibility and significantly reduced waiting times. To date 17 hospitals have elective care integration projects underway.

Actions:

- Shift the focus from the activity of first specialist assessment clinics to the goal of “timely and appropriate access to specialist assistance and certainty of patients subsequent plan of care”
- Establish joint primary/secondary projects to develop a mix of solutions to provide appropriate access to specialist assistance.
- Implement these solutions in conjunction with primary care to reassess patients, facilitated by resource from both waiting time and sustainable funding.
- Apply this mix of solutions to sustainably manage inflows and apply a consistent approach to residual waiting lists.

STRATEGY 6: ACTIVELY MANAGE SECTOR PERFORMANCE

The Ministry and HFA's experience is that effectively implementing waiting times initiatives requires:

- **a facilitative approach** which encourages best practice through collaboration and information sharing
- **clear performance expectations** and minimum standards, including tight accountability arrangements and effective monitoring
- **accountability arrangements** and contracts which are focused on the desired outcomes (for example, timely service) rather than outputs (for example, raw numbers of specialist assessments).

Facilitation of Sector Change

The factors influencing elective surgery waiting times are numerous and spread across a large number of organisations and individuals.

Thorough understandings among the many parties are required to secure commitment to shared goals. This requires a nation-wide programme of facilitation which defines and clarifies key expectations and benchmarks best practice. Examples of such facilitation activities are:

- provide nation-wide forums for ideas and expertise to be shared amongst participants
- establish multi-party projects to redesign existing processes (for example, the GP referral process discussed under primary - secondary liaison)
- clinical audit followed by meetings on a hospital service level to discuss key issues, put people in touch with others, and improve clinical and management practice.

To date, this type of sector facilitation has not occurred by itself except in an ad hoc way. A systematic and active, rather than passive, approach is necessary to secure significant gains in waiting times.

Performance Expectations

Improving or changing sector behaviour in the management of elective surgery requires:

- clearly defined and communicated performance expectations
- measurement and monitoring of progress against those expectations
- incentives and sanctions for achieving the performance expectations.

Accountability documents which include minimum standards and performance expectations are central to this approach. Regardless of the nature of the document (contract, funding agreement, etc.), the same principles apply. Accountability documents should clearly document:

- the relevant standards and performance measures and who is responsible for achieving those standards
- the likely benefits of achievement of performance expectations
- the escalation pathway if the standards are not achieved.

Minimum standards and performance measures for elective services can be developed to cover the seven strategies outlined in this paper. To be most effective, performance measures should be few and strategically chosen to leverage substantial patterns of patient care, for example:

- percentage of patients waiting less than six months for surgery from the time of the decision to treat
- the percentage of patients who have a care plan which details their diagnosis, next actions planned, and who to contact if there is a problem
- the percentage of patients operated on who were booked or given certainty of treatment at the time of assessment
- the hospital's level and quality of data collection, analysis and feedback, to improve clinical practice (for example in assessing the relative need of patients).

Collecting verifiable information (according to agreed data definitions) at a nation-wide level is necessary to measure progress against such performance expectations. When used in conjunction with more subjective information (for example, the results of hospital audits), an accurate impression of the quality and timeliness of hospital services can be gained.

Comparisons of hospital performance (for example, through widely available league tables and benchmarks) can then be used to recognise high performers and provide leadership for others to improve their performance.

High performers should be progressively given greater flexibility and less process monitoring in their waiting time management activities. In the case of substandard performance, it is important to work with the hospital service to agree recovery plans. Escalating performance issues to Board level may sometimes be necessary to gain the required engagement of the hospital service.

Outcome Focused Accountability Arrangements

At present most hospital services have relatively simplistic contracts which specify a volume of elective services for a given price. While this arrangement may be effective in incentivising efficient output (for example, through reduced length of stay in hospital for an operation), it does not assure one of the most desired outcomes - nationally equitable access to a reasonable level of elective service. Similarly, such contracts do not foster enhanced production design that extends beyond the purchased outputs.

In the longer term, it may be possible to move to accountability arrangements with high performing hospitals that do not require price/volume contracts for the delivery of elective services. Rather, funding could be allocated on the basis of meeting an agreed service level for the population, measured in clinical and human terms. Two illustrative examples are:

- ophthalmology - all patients clinically assessed as requiring a cataract operation in order to keep their driver's licence will be provided with cataract surgery within six months of assessment (approximately x operations per 1000 people in the region)
- 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 (approximately y operations per 1000 people in the region).

These service levels can then be monitored through national data collection systems and clinical audits.

It will be important to proceed carefully when implementing this type of accountability arrangement in order to ensure that financial and service risks are managed effectively.

Provision of specialist assistance (including, but not confined to, specialist assessment) is an early candidate to be contracted in this way:

- very well developed standards and performance measures
- relatively low cost
- strategically important in fostering innovative approaches and improving 1°/2° integration
- block funding trialled in 99/00

Such flexible (but tightly focused and monitored) accountability arrangements will be particularly useful as we move to a District Health Board (DHB) structure.

Allocating funding to DHB's on the basis of a population based funding formula without a requirement to ensure adequate elective service levels would likely lead to unacceptable inequities in access to elective services across the country.

However, if minimum service levels are defined in the accountability arrangements with DHBs, they will retain a level of flexibility in deciding the range and mix of health services in their districts while the public retains confidence of equitable access to electives. The infrastructure for such arrangements needs to be laid now.

Actions:

- implement a facilitative approach to waiting times management, through national forums, multi-party projects, and clinical audits
- establish accountability arrangements which detail national minimum standards, and performance expectations and measures
- establish national information collection on waiting times, care decisions, and performance indicators
- lay the infrastructure, and continue trialing, flexible funding and accountability arrangements which define a minimum level of service for the population.

STRATEGY 7: BUILD PUBLIC CONFIDENCE

Public confidence can be considered the ultimate goal of an effective elective surgery system. There are significant gains associated with improved confidence which directly impact on waiting times and even health outcomes. Confidence reduces transaction costs, for example, GPs and patients are more likely to use “just in time” referral, rather than using multiple referrals, letter writing, and constant phone calls etc. to try to ensure the service is provided in a timely way.

In order to build public confidence it is important to ensure early adherence to minimum timeliness standards. It is also necessary to make the intent of elective surgery policy widely known to the public by providing information on the elective services that **are** provided through public hospitals. This can be achieved through publications which outline what patients can expect when seeking publicly funded elective care.

Actions:

- communicate which services are provided in the public system
- adhere to minimum timeliness and patient information standards
- communicate the intent of elective services policy to the public
- publish a patient brochure outlining what they can expect from the public health system when seeking elective care.

IMPLEMENTATION OF THE STRATEGIES

The Minister of Health has approved these key objectives and high level strategies. The Ministry of Health and HFA are now working with the sector to implement the strategies.

Although challenging, significant advancements are being made quickly in the area of elective care management and reduced waiting times. Further progress requires a facilitative approach with input from across the sector.