From: [redacted]
To: Office of the Secretary Mailbox; Our Healthcare Future
Cc: [redacted]
Subject: RE: Our Healthcare Future – Extension to Consultation Period
Date: Friday, 12 February 2021 10:13:02 AM
Attachments: image001.png
image005.png

Dear Health Planning Unit,

Many thanks for all of your efforts towards improving our health care system. Aspiring to provide "*the right care in the right place at the right time*" is undoubtedly appropriate and – in my opinion – a good catchphrase in terms of reminding us of what we are aiming for when improving our systems.

Briefly I would like to contribute an answer to "*How can we improve integration across all parts of our health system and its key interfaces (e.g. primary health, mental health, disability services, aged care and acute care)? What should be our priorities for integration?*" and "*How do we provide clear pathways into our health system so that patients are accessing the most appropriate care for them?*" by simply mentioning the Tasmanian Health Pathways project. Also to the question "*How can we target our current investment as well as future investments in health to ensure a sustainable and balanced mix of services are delivered across the whole of the health system to provide right care in the right place at the right time?*" the 'Choosing Wisely' campaign. Both of these endeavours should be fully adopted and integrated into the THS.

As a surgeon working at the RHH the systemic issue that dominates our experience is the deficiency of our capacity to provide services compared to the ever-increasing demand. While there are many consequences of this, the one that dominates is extremely large elective surgery waiting lists. Of course this offers only a very narrow, numerical perspective on what are actually multiple complex and overlapping issues, but it is also self-evident that a health system that delivers care "at the right time" would have waiting lists that are not just smaller, but a small fraction of their current size.

In addressing the issue of access to surgical services (particularly procedural services but also outpatient and others) we are contributing answers to many of the Reform Initiatives Consultation questions, and indeed many of the solutions to those questions should have consequences that improve access to, and utilisation of, our surgical services.

Why should this be prioritised ahead of so many other potential initiatives (in the context of Reform Initiative 1)? Of course the additional suffering of patients, the inability to provide (for both patients and trainees) the full range of services / procedures that are worthwhile but not time-critical, and the negative impact on staff morale are all real and important issues that we constantly face; but these apply in many areas of health provision area that would benefit from additional resources.

I believe the key factor here is that a tremendous amount of our healthcare resources are currently wasted because of the excess time patients spend waiting for procedures. There are a myriad of contributing factors to this drain on our resources. In the elective setting some of the major ones include:

- Patients on waiting lists being admitted through the ED due to their surgical problem instead of electively; leading to admissions that are far more complex and resource intensive than the elective admission would be.
- Additional outpatient clinic and GP consultations, adding to clinic waiting lists and the difficulties people have accessing primary care.
- Additional medications; these are often required to treat symptoms or avoid complications of the problem awaiting surgical treatment and can be both expensive and the cause of side-effects or other problems.
- Investigations (both pathology and imaging) to monitor progress or assess complications that can occur due to progression of the condition awaiting surgical treatment.
- Additional complexity / magnitude / risk of the surgery when it finally occurs.
- A huge amount of additional time spent by both administrative and clinical staff managing the waiting lists (triaging and re-triaging, shuffling bookings, dealing with complaints, etc).

While not directly impacting the THS budget, we should not forget the additional economic cost to our community when their untreated condition means that patients cannot perform their usual functions (work or domestic).

In the emergency setting patients are frequently spending multiple additional days in hospital waiting for operations because we simply do not have the resources to deal with the number of patients needing urgent procedures. This adds to their length of stay and exacerbates the problem of access block across the hospital and beyond.

As with any goal it is essential that is explicit and measurable; so what exactly should we be aiming for?

When we book a patient for surgery (or endoscopy) the procedure is allocated a category: 1 for potentially life-threatening conditions or those that pose a significant risk (generally cancers or those that are causing – or could cause – serious harm), 2 for conditions that are distressing and/or impair quality of life but are not a major threat in the short term, and 3 for conditions that require resolution but not likely to cause harm soon or are preventative. As stated on our booking forms Category 1 procedures are supposed to be performed within 30 days, Category 2 within 90 days, and Category 3 within 365 days. When patients wait longer than the allocated time period they are considered to be "over boundary".

Surely most Tasmanians would agree that there will be reasons this is occasionally not possible, but that our health system should provide care "at the right time" in the vast majority of cases, and that therefore the number of over boundary cases should be a very small minority. We – the THS – should specify a target, and it should undoubtedly be a single digit percentage (in the absence of a detailed economic analysis I would suggest 5%, but there may be ways to estimate an optimal level). That target should apply not just for the entire THS but to each hospital and department individually. Currently the percentage of over boundary cases varies widely, but tragically many of us deal with waiting lists where the majority of patients have already waited longer than those time frames, many for literally years.

Having set our targets, and understanding why we should achieve them, the biggest challenge of course is making it happen. Fortunately some of this work necessary for this is already happening, and we must continue to increase those initiatives. The infrastructure and capital redevelopments and governance changes mentioned in the "*Our Healthcare Future*" document are critical, and efforts to increase staffing even more so (as per Reform Initiatives 3a and 3b). We are aware of some ways to improve efficiency, and the ICT reforms and improved consultation and planning processes should contribute to this.

Beyond this, and in order to ensure the gains made are not lost, it seems necessary that the processes by which decisions regarding resource allocation are made be reviewed and changed fundamentally. Like other clinical staff with whom I have discussed it, I was shocked to learn that the number of elective cases our hospitals provide is dictated to them by a process that is neither transparent nor predictable. It is no exaggeration to say that I have sat in meetings where senior clinical staff were dumbfounded when informed that the allocated number of elective procedures was going to be reduced despite the ongoing increase of both our waiting lists and demand. Of course there needs to be control of the budget and expenditure, and I acknowledge that I am a clinician and not an economist, but surely there is a way we can manage funding that minimises the tremendous waste mentioned above, and also avoids the additional inefficiencies produced by rapid and unanticipated changes in targets.

Is there a valid alternative to fully committing to providing "*the right care in the right place at the right time*" with the inevitable consequence of solving the perennial waiting list problems?

It would be unethical to choose to continue as previously; promising a quality health system with surgery within acceptable time frames when we know that for most that won't happen (note that I am confident that the quality of care we provide is indeed high quality; it is access to this care that is the problem). My fear is that this is what will continue to occur, not deliberately but as a result of ongoing neglect of these issues.

We as a society could decide to place limits on what is provided, and as long as this is explicit and justifiable from a health economic and ethical perspective any amount of reduction in expenditure could be achieved. However I find it hard to imagine any government being willing or able to deliver such a reform.

There really is no choice but to choose to solve this problem in a definitive way, the real question is how soon and how well can we achieve this.

Please contact me if that would be useful at all, I would be grateful for the opportunity to discuss these and/or other issues further.

Kind regards,

Luke.

Mr Luke Rayner
Endocrine, Breast, and General Surgeon
Head of Department - General Surgery
[redacted]