Submission No 7

INQUIRY INTO THE MANAGEMENT OF HEALTH CARE DELIVERY IN NSW

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CPSA COMBINED PENSIONERS & SUPERANNUANTS ASSOCIATION OF NSW INC

Submission to the Public Accounts Committee of the NSW Legislative Assembly

Inquiry into the Management of Health Care Delivery

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CPSA is a non-profit, non-party-political membership association founded in 1931 which serves pensioners of all ages, superannuants and low-income retirees. CPSA has 108 branches and affiliated organisations with a combined membership of over 24,000 people living throughout NSW. CPSA's aim is to improve the standard of living and well-being of its members and constituents.

Recommendations:

Elective surgery

CPSA recommends that an elective surgery waiting list covering the period between referral by a GP and diagnosis by a specialist doctor be created.

CPSA recommends that elective surgery performance reporting reflect the loss of quality of life while particularly elderly patients await diagnosis and treatment.

Oral health

CPSA recommends that patient information relating to public oral health services in NSW be upfront about the system's severe limitations in coping with demand. CPSA recommends this be done by the publication of actual waiting times between initial contact and the conclusion of treatment.

CPSA recommends that patients of the NSW public oral health system should be clearly advised and reminded that they can be re-assessed and assigned a higher Priority Code.

CPSA recommends that NSW Health should publish explanations of oral health Priority Codes and the oral health conditions they cover in plain English and major community languages.

Introduction

CPSA welcomes the opportunity to make a submission to the Public Accounts Committee of the NSW Legislative Assembly's *Inquiry into the Management of Health Care Delivery*. CPSA's submission will be confined to a discussion of 'waiting lists' for elective surgery and public oral health services, i.e. the time it takes from referral (or self-referral in the case of oral health) to the start of therapy, under the term of reference of the adequacy of the provision of timely, accurate and transparent performance information to patients, clients, health providers and health system managers.

The NSW Ageing Strategy 2016-2020 commits the NSW Government to "plan our health services and infrastructure in light of our ageing population" and "focus our own efforts on people who are ageing in NSW who may need further or more targeted support – such as those on low incomes, carers, Aboriginal people, and people with mental health issues or dementia". The first step in achieving these aims is to collect information about access to health services by people over 50. That group includes nursing home residents, who anecdotal evidence suggests, may have poor access to medical and oral health care.

The quality of currently publically available data on waiting lists in the NSW public health system is variable and this limits the capacity to use data in the development of policy and allocation of health funding. It also means that patients, carers, advocates, practitioners, health managers and the general public do not have access to timely, accurate and transparent information about the performance of publically funded health services.

Elective surgery

From the point of view of patients on a low income and without private health cover and therefore wholly dependent on the NSW public health system, it is important to know that they will receive the health care they need when they need it. That need should not be defined solely from a clinical point of view, but also from the point of view of quality of life.

For example, from a clinical perspective, cataract surgery performed within a period of 365 days of diagnosis set by the Recommended Clinical Priority Category may be

acceptable, but from the perspective of the patient requiring cataract surgery it will likely not be.[1]

The example of cataract extraction waiting times gives rise to the question whether clinically acceptable waiting times are set with reference to public relations convenience. In the fourth quarter of 2016, on-time cataract extraction scored 99.1 per cent[2], but how many patients, who for years may have been unable to do everyday things such as reading, food preparation, driving, supervising their grandchildren at play, or watching TV would agree that this is an impressive result? Yet, to a casual observer that 99.1 per cent score looks good.

CPSA's concern is that elective surgery performance information creates the impression patients are treated in a timely manner. This concern is amplified by the fact that no attempt is made to measure the time it takes for a public patient to be seen by a specialist doctor, i.e. the time between referral by a GP and diagnosis by a specialist doctor. Anecdotal evidence suggests the time between referral and diagnosis of cataract conditions can easily be another 365 days.

It is very concerning that elective surgery waiting lists promote the idea that elderly people, i.e. people with a life expectancy of, say, ten years or less should accept that they have to wait for their cataract extractions for 20 per cent or more of the time they have left on this earth. The loss of independence and social isolation such unreasonable delays can cause as well unnecessary entry into nursing homes of people who would otherwise be able to function at home must be reflected in the performance reporting for surgeries in the NSW public health system. The impact of waiting times on elderly patients should cover cataract extractions as well as other types of surgery with significant quality-of-life implications, such as arthroscopy, shoulder-, hip- and knee replacements and the removal of ingrown toenails, all of which are procedures which are to be treated within 365 days of diagnosis on current priority settings. Waiting times for these types of surgery for elderly patients should be significantly shorter than 365 days between diagnosis by a specialist doctor and actual surgery.

CPSA recommends that an elective surgery waiting list covering the period between referral by a GP and diagnosis by a specialist doctor be created.

[1] NSW Health, Advice for Referring and Treating Doctors – Waiting Time and Elective Surgery Policy [IB2012_004]. Available online: http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2012_004.pdf
[2] NSW Bureau of Health Information, Quarterly Performance Results for Elective Surgery: Oct – Dec 2016.

CPSA recommends that elective surgery performance reporting reflect the loss of quality of life while particularly elderly patients await diagnosis and treatment.

Oral health

The approach to prioritising patients in public oral health in New South Wales differs from that used for elective surgery in NSW hospitals. While elective surgery prioritises on the basis of medical procedure *after* a diagnosis has been made, oral health prioritises patients on a potentially continuous basis *before and after* a diagnosis has been made. A Priority Code for assessment by a dentist is assigned following a triage-by-telephone. The accuracy of this triage relies heavily on the responses by people who may have low oral health literacy and who may be inclined to play down the seriousness of their symptoms. It is reasonable to assume that in many cases this triage method leads to the assignment of Priority Codes which are too low. As a result, it is likely that in many cases patients are not seen by a dentist to have their oral health problem assessed within a clinically appropriate timeframe. As part of the assessment by a dentist a Priority Code for therapy is assigned.[3]

As Priority Codes are coupled with a Maximum Recommended Waiting Time, oral health patients have a much better idea of how long they will be waiting to receive the treatment they need than elective surgery patients, who must wait for an unspecified period of time before they are assessed/diagnosed by a specialist doctor.

However, oral health patients are only in theory better informed about the time they have to wait, because effectively only patients in the two or three highest Priority Codes in oral health receive treatment. Patients who have been assigned lower Priority Codes tend to receive treatment once their oral health condition deteriorates to the point where they are re-prioritised to one of the two or three highest Priority Codes. As a result, the oral health waiting lists published by NSW Health are largely meaningless as a source of information for patients.

[3] NSW Health, Priority Oral Health Program and List Management Protocols (PD2008_056). CPSA understands that PD2008_056 is about to be superseded, but that the approach to patient prioritisation will not materially change as a result.

The oral health waiting list data published on the NSW Health website gives the impression that public dentistry in NSW covers the full range of oral health services. It suggests that the NSW public oral health system covers the full range of dental procedures, while in reality, the majority of resources are used to do extractions, fillings and dentures.

The Adult Treatment Waitlist by Priority Code at the end of June 2016[4] shows the following priority distribution, with Priority Code A representing the most urgent cases and H the lowest:

Priority Code	A	B	C	D	E	F	G	H	Total
Number waiting	74	377	2,577	12,379	37,341	25,280	48	207	78,283

It is obvious that eligible people with a low oral health need (Priority Codes G and H) by and large do not engage with the NSW public oral health system, while the system deals swiftly with the most urgent cases. Patients assigned Priority Codes D through to F will in the main have to graduate to Codes A, B and C before they receive treatment. CPSA understands that the NSW public oral health system considers just keeping adult numbers down under Codes A and B a job well done. It should be noted that this implies a criticism of the federal and state Governments, not of NSW public oral health system, which is vastly under-resourced.

It should also be noted that the Priority Codes used on the NSW Health website do not correspond with the Codes published in the policy document: NSW Health, Priority Oral Health Program and List Management Protocols (PD2008_056). While CPSA understands publication of a reviewed policy document is imminent, it is strange that information intended for patients should feature Priority Codes which are not explained at all.

What obscures the meaning of the oral health waiting lists further is that a Recommended Maximum Waiting Time is associated with each Priority Code. For example, the Priority Oral Health Program and List Management Protocols (PD2008_056) assigns a 12 month Recommended Maximum Waiting Time to the Priority Code covering “High Oral Health Need”, which is of mid-range urgency within current

[4] http://www.health.nsw.gov.au/oralhealth/Pages/dental-pohp-waitlist.aspx

priority settings. The assignment of the Priority Code “High Oral Health Need” gives the impression that in most cases it will take up to 12 months for a patient with “High Oral Health Need” to be seen. As mentioned before, it is likely that before those 12 months have elapsed such a patient’s oral health will have deteriorated to the point where the next Priority Code up will have been assigned to him or her, which will also have a Recommended Maximum Waiting Time of say 9 months. This process will repeat itself until a Code A, B or C has been assigned and by that time the patient may have been on waiting lists for years. All through these periods of Recommended Maximum Waiting Times the waiting list will give the impression that patients are being treated within required timeframes, when in fact patients are involved in a slow, relentless race to the top Priority Codes assuring urgent treatment of their oral health condition.

The oral health waiting list, then, is misleading. CPSA is regularly contacted by people who would be categorised in the top two priority categories as part of a competently conducted triage, but who are languishing in lower priority categories, unaware that they need to play the waiting lists game, and unaware that a re-assessment can get them to a Priority Code under which they would actually be treated. These people tend to ask about any alternatives to the NSW public oral health system: they have clearly given up on the public oral health system. Meanwhile, these people’s quality of life is often severely compromised due to their oral health condition: they may not be able to eat solids (which has further health implications), they may be in pain or experience embarrassment about their oral health condition, which in turn may restrict their involvement in social activities, education, work or looking for a job.

Performance information published by the NSW public oral health system covers up the catastrophic lack of capacity to treat the vast majority of its patients in a timely fashion. Also, the process does not inform patients about the possibility of re-assessment, which can lead to earlier treatment.

What is also galling is that the NSW Health website, in describing patient eligibility criteria, projects an image of the public oral health system as a system under some stress but altogether working well:

“Approximately 47% of the NSW population is eligible for public oral health services. The NSW criteria of eligibility for public dental services are more generous than most other States and Territories.

"It should be noted that although the broad eligibility criteria may be met, limited resources and available services may result in waiting times to access care."[5]

The management of waiting lists as well as the publication of data related to waiting lists for public oral health services must be improved to ensure greater transparency and in turn accountability around the provision of public dental care. It is critical that prospective patients are able to access meaningful information in order to form realistic expectations about the NSW public oral health system. It is also critical that policy makers have access to useful and relevant data, which can be used as an evidence base for policy and budget decisions to improve access to oral and dental care.

CPSA recommends that patient information relating to public oral health services in NSW be upfront about the system's severe limitations in coping with demand. CPSA recommends this be done by the publication of actual waiting times between initial contact and the conclusion of treatment.

CPSA recommends that patients of the NSW public oral health system should be clearly advised and reminded that they can be re-assessed and assigned a higher Priority Code.

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