Sporadic outsourcing of healthcare activity from the public to the private sector – a surgical perspective

Summary

As leads of the National Clinical Programme in Surgery we wish to highlight the issues around the outsourcing of outpatient and inpatient long waiters from the public to the private system. Whilst acknowledging that an acute response is needed to the unacceptable lengths and numbers of waiters, waiting list initiatives have, of late, become a tool that is used reactively and irregularly. As such we have reviewed the impact of recent, but previous, initiatives in addition to reviewing our interpretation of the present initiative together with up to date data. While recognising that solutions are not easy we strongly urge that a more consistent approach to waiting lists and their management be adopted in the future.

Introduction

In January 2015, the Minister for Health, Mr Leo Varadkar, announced a number of Priority Areas, Actions and Deliverables for the period 2015-2017. One of the deliverables specifically relates to patient waiting lists; "To develop and implement a plan to address waiting lists, with a focus on very long waiters such that by mid-year, nobody will wait longer than 18 months for inpatient and day case treatment or an outpatient appointment, with a further reduction thereafter to no greater than 15 months by end year"

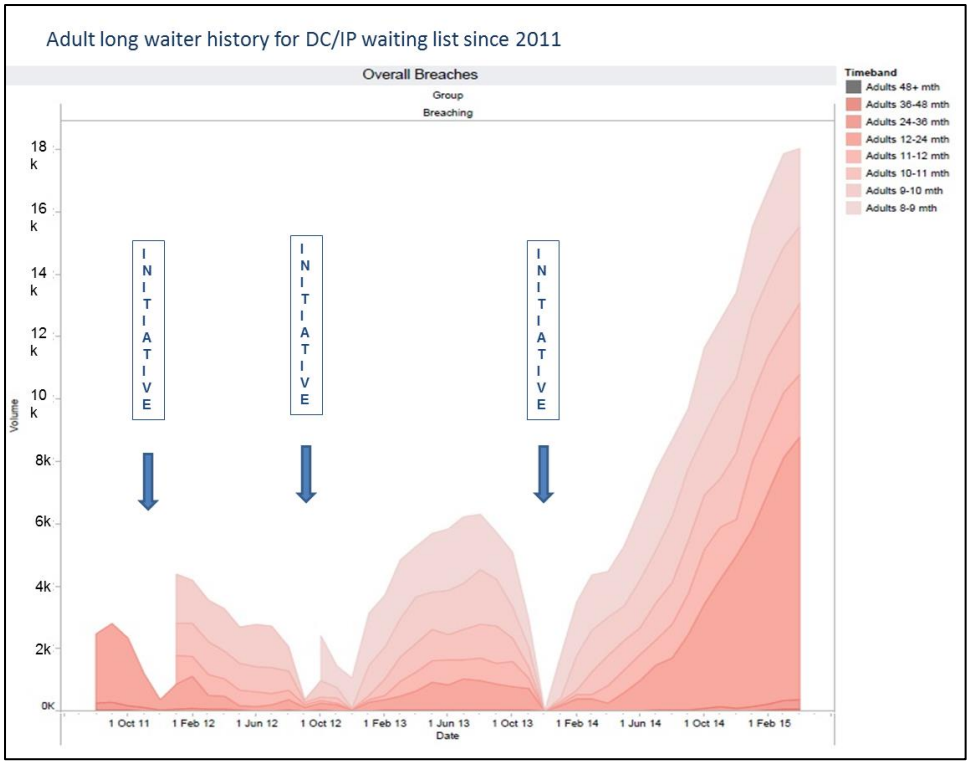
Waiting lists in hospitals are divided into Outpatient, those awaiting outpatient consultation, and Inpatient, those that have been seen (mostly) and are now awaiting an Inpatient or Day Case admission or procedure. On 4th June 2015 there were nationally 415,109 on the Outpatient waiting lists of which 228,247 (55%) were surgical and 83,228 on the Inpatient waiting lists of which 59,407 (71.4%) were surgical. The flow of patients from waiting lists is profoundly affected by the process and practice of surgical activity.

The HSE received an average of 60,360 new referrals per month across the first quarter of 2015. Outpatient services currently see an average of 74,899 new patients and 195,418 review patients per month (2015 YTD average) including obstetrics and trauma patients which are not counted as 'referrals'. Activity has increased year on year, despite ongoing 'cut backs' (7% increase 2013 to 2014, 1% increase 2015 YTD). This results in approximately 3.2 million outpatient attendances per year.

As Leads of the National Clinical Programme in Surgery we would like to register our concerns about the sporadic and repeated Government initiatives related to the outsourcing of outpatient and inpatients appointments to the private sector, how they are executed and their risks and downsides. We believe that these exercises create cynicism within the healthcare workforce, strip resource and capacity from the public system as well as having a negative impact on training. But it is the lack of a coherent strategy to sustain improvement that most concerns us and it is on this that we focus at the end of the document.

Former Initiatives

We appreciate that patients being left on waiting lists for unreasonable lengths of times is both unfair and dangerous and we also recognise that figures for inpatient and outpatient waits have reached unacceptable levels. However, there is good evidence that repeated outsourcing initiatives of the present kind are not solving the underlying problem within the public hospital and health service. Not alone is valuable resource and time taken out of the public system, the problem appears to be compounded as can be seen when examining the effect of initiatives on Inpatient and Day Case waiting lists after each initiative since 2011:



At the end of 2013 under an initiative run by the then Acute Hospitals National Director, thousands of patients (no-one knows the real figure) were outsourced from the public to the private sector for a one off OPD appointment. Those patients who required a follow up appointment or procedure then had to go through another process to be seen again by the original consultant to whom they were referred. Tens of thousands of patients had to be then re-processed. These patients have subsequently become 'orphaned' in the system.

The lessons learned from these initiatives include the following:

1. Patients were put in an invidious position; they needed their outpatient appointment, but by accepting one in the private sector, their status as a public patient became unclear in terms of who is ultimately responsible for their care pathway.
2. Once the patients 'full package of care' is complete, i.e., initial outpatient appointment, inpatient/daycase procedure and follow up outpatient appointment have been complete it was not clear how and where they could re-enter the public system. It was not clear when an episode of care was complete. If they required ongoing treatment it was unclear how and where do they were to re-enter the system.
3. Meanwhile patients who were on the waiting list for an inpatient or day case procedure were 'skipped' as those patients selected for an outpatient appointment would then proceed immediately to their inpatient or day case procedure without waiting. This is clearly inequitable.
4. The models of care designed by the National Clinical Programme in Surgery (e.g., the Model of Care for Elective Surgery and the Model of Care for Pre-Admission) are not replicated or even implemented in the private sector. There is anecdotal evidence (from the 2013 outsourcing initiative) that the conversion rate to surgery in the private outpatient setting was higher than in the public sector.
5. Preparing the notes and liaising with the private provider necessarily required a significant amount of administrative time. This time would have been better spent actively managing the waiting lists internally (for example, by doing clinical and clerical validation).
6. A significant part of this success of initiatives has not been the removal of true waiters but simply a process of validation, removal of DNAs (did not attends) etc. Long waiting lists of themselves compound inappropriate entries. There are huge variations in practice around the country particularly in regard to the New to the Review ratios.
7. Outpatients are taken off the waiting lists once they have an outsourced appointment and not, perhaps as they should be, when they have been seen.

8. The good will and commitment to performance improvement measures from consultants and NCHD's is in danger of becoming eroded as there is or has been no determination made with regard to rewarding excellent performance of genuine high volume specialities that are poorly resourced.
9. Contractual differences between consultants have created differing and unfair incentives for participating in initiatives.
10. The externalisation of the waiting list 'problem' perversely rewards poor performance.
11. Outsourcing ignores the issue of sustainable change

The present initiative

Many of the concerns stated above pertain to the present initiative. But there are differences and other issues.

There are two types of Waiting patients - those that are being actively pursued as part of the initiative and another cohort who are not part of the initiative.

Those that are part of the initiative include

Outpatients

Those awaiting 1st consultations (public patients) both those that are not scheduled and those that are scheduled (have been given an appointment date)

The plan is to take long waiters (over 15 months) off the list by the end of the year (nine months from today). Patients will be covered to have a consultation in the private sector and if a procedure is required the procedure will be covered in the private system together with one follow-up appointment. It is unclear whether the outpatient visit or subsequent treatment will have to be completed by the end of the year. The Minister has suggested that the subsequent treatment may not have to be completed by the end of the year to be covered.

Inpatients and Day Cases

Those requiring a procedure and those not yet scheduled (not yet given an appointment date)

The plan is to try to complete as much of this within current HSE capacity. If there is insufficient capacity then treatment will be outsourced to the private sector. The treatment should be completed by the end of the year but it is unclear whether a follow up will be covered in the private sector.

There are also a considerable number of patients on waiting lists that have not been included in the initiative. These include:

Outpatients

Those requiring follow-up appointments (not currently captured), those awaiting nurse led clinics (not currently captured), those suspended and those awaiting private consultations.

Inpatients and Day Cases

Those patients who have been given a date for their admission, those suspended and those requiring a follow on Inpatient admission and procedure

Waiting list and funding concerns

In the current initiative, on 4th June 2015 there were a total of 228,247 patients on the surgical outpatient waiting list. In the 4 weeks to 30th June 2015 12,043 surgical patients were taken off the outpatient waiting list and 680 from the inpatient waiting lists. Meanwhile the total inpatient waiters remain virtually static at 83,120 versus 83,228.

We have analysed the 2013 HIPE data (AvLOS by procedure) data to assess impact of the long waiter, Inpatient/Day Case clearance initiative. Using the HPO pricing tables (average Activity-based Funding by procedure) and the Inpatient/Day

Case waiting lists by procedure at 30th June 2015 we have projected the Activity Based Funding required and bed day usage in order to achieve no waiters greater than 15 months at the end of the year and no endoscopy greater than 91 days. The data for those included in the present initiative is shown below:

Included in the present initiative			Inpat BDU at occupancy			ABF modelled payments		
Waiters grouped by procedure & admitting specialty	Day Cases	Inpat's	90%	95%	85%	Day Cases	Inpat's	Total
Surgical procedures required	5,740	3,958	15,596	14,776	16,514	€6,937,494	€27,309,952	€34,247,447
Surgery admit for non surgery	2,585	886	4,186	3,966	4,432	€2,287,526	€6,041,018	€8,328,544
Surgical total	8,325	4,844	19,783	18,741	20,946	€9,225,020	€33,350,971	€42,575,990
Medicine et. al. admit total	1,571	493	1,453	1,376	1,538	€1,161,857	€1,818,399	€2,980,257
Endoscope Surgical admit	7,108	75	242	229	256	€3,531,917	€318,598	€3,850,515
Endoscope Medicine et. al. admit	8,795	9	75	71	80	€4,120,150	€44,499	€4,164,649
Endoscopes total	15,903	84	318	301	336	€7,652,067	€363,096	€8,015,164
Combined surgical and medicine et. al. total	25,799	5,421	21,553	20,419	22,821	€18,038,944	€35,532,467	€53,571,411

If one includes all waiters, initiative or not the data is as follows:

All known long waiters (initiative and non-iniative)			Inpat BDU at occupancy			ABF modelled payments		
Waiters grouped by procedure & admitting specialty	Day Cases	Inpat's	90%	95%	85%	Day Cases	Inpat's	Total
Surgical procedures required	8,964	5,435	22,433	21,253	23,753	€10,176,485	€38,874,596	€49,051,081
Surgery admit for non surgery	4,190	1,379	6,430	6,091	6,808	€3,500,093	€9,075,361	€12,575,453
Surgical total	13,154	6,814	28,863	27,344	30,561	€13,676,578	€47,949,956	€61,626,534
Medicine et. al. admit total	2,709	607	1,806	1,711	1,913	€1,960,327	€2,240,182	€4,200,510
Endoscope Surgical admit	20,542	418	1,350	1,279	1,429	€10,207,180	€1,775,652	€11,982,833
Endoscope Medicine et. al. admit	21,172	94	788	747	834	€9,918,342	€464,763	€10,383,105
Endoscopes total	41,714	512	2,138	2,025	2,264	€20,125,523	€2,240,415	€22,365,938
Combined surgical and medicine et. al. total	57,577	7,933	32,808	31,081	34,737	€35,762,428	€52,430,554	€88,192,982

This shows a substantial increase in numbers as compared to those who are just part of the initiative. Perhaps this is the hidden side of the problem.

Another issue is that Activity-Based Funding inlier pricing pays the same amount for acute inpatient as for elective inpatients, however an acute case for identical procedures stay 50% to 80% longer than elective cases. If a portion of the elective work load is taken from the HSE hospitals and their ratio of acute activity increases there will be a funding short fall relative to bed days used in those hospitals.

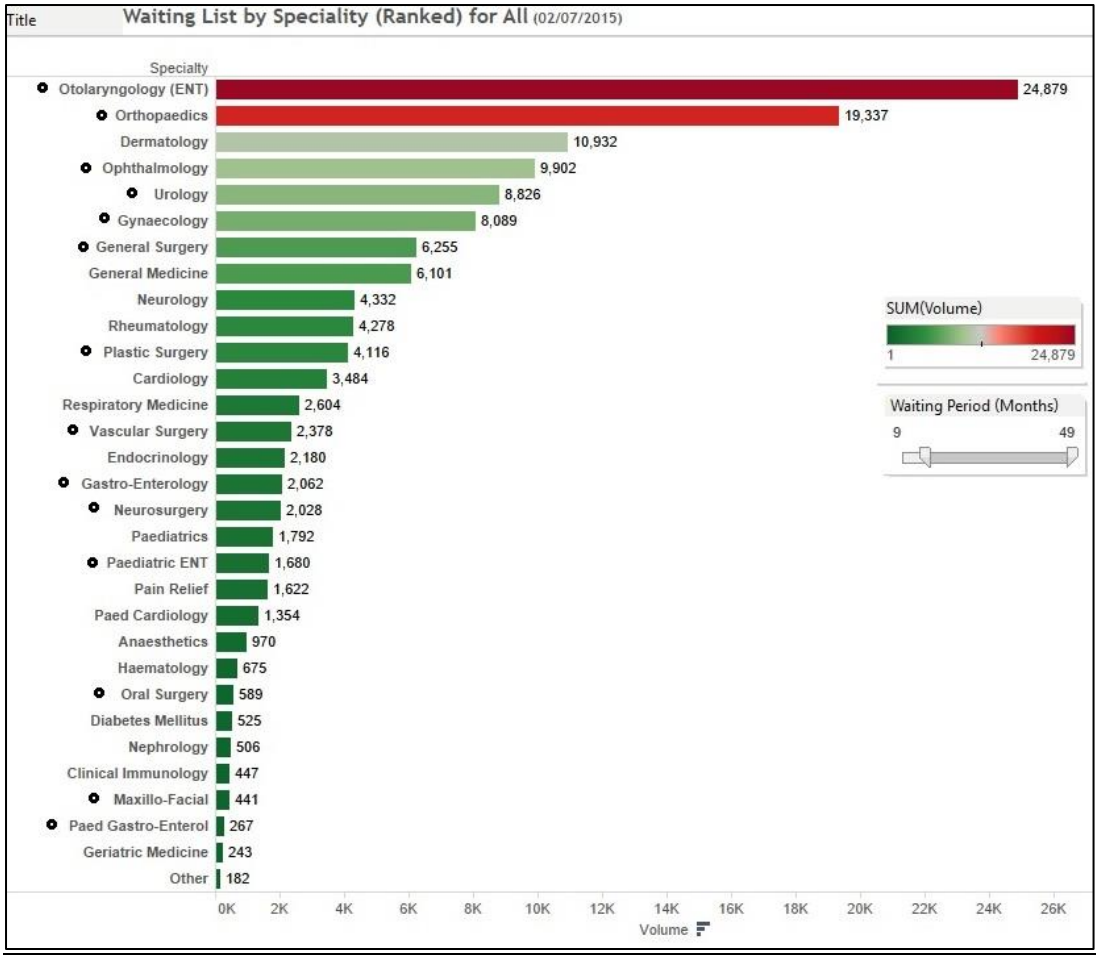
More importantly is the funding required to achieve this goal. For surgery alone, managing those who are part of the initiative using this funding model will cost over €42 million. This is before tackling the medical waiters and does not include the cost of tackling all the Outpatient waiters.

What can be done to sustain improvement?

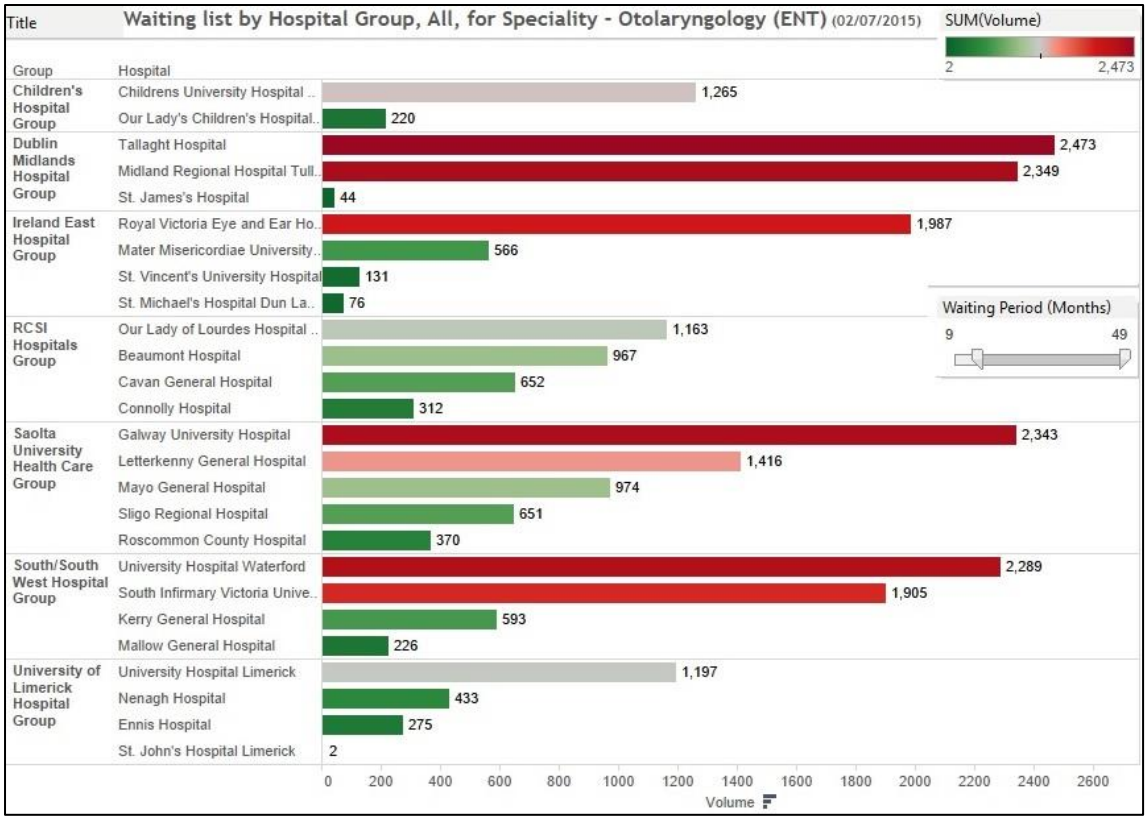
Creating sustained change is both hugely important and hugely challenging. Tackling the problem could be undertaken under two headings. First, by targeting the problematic areas and secondly, by addressing the difficult, general but highly important health service issues.

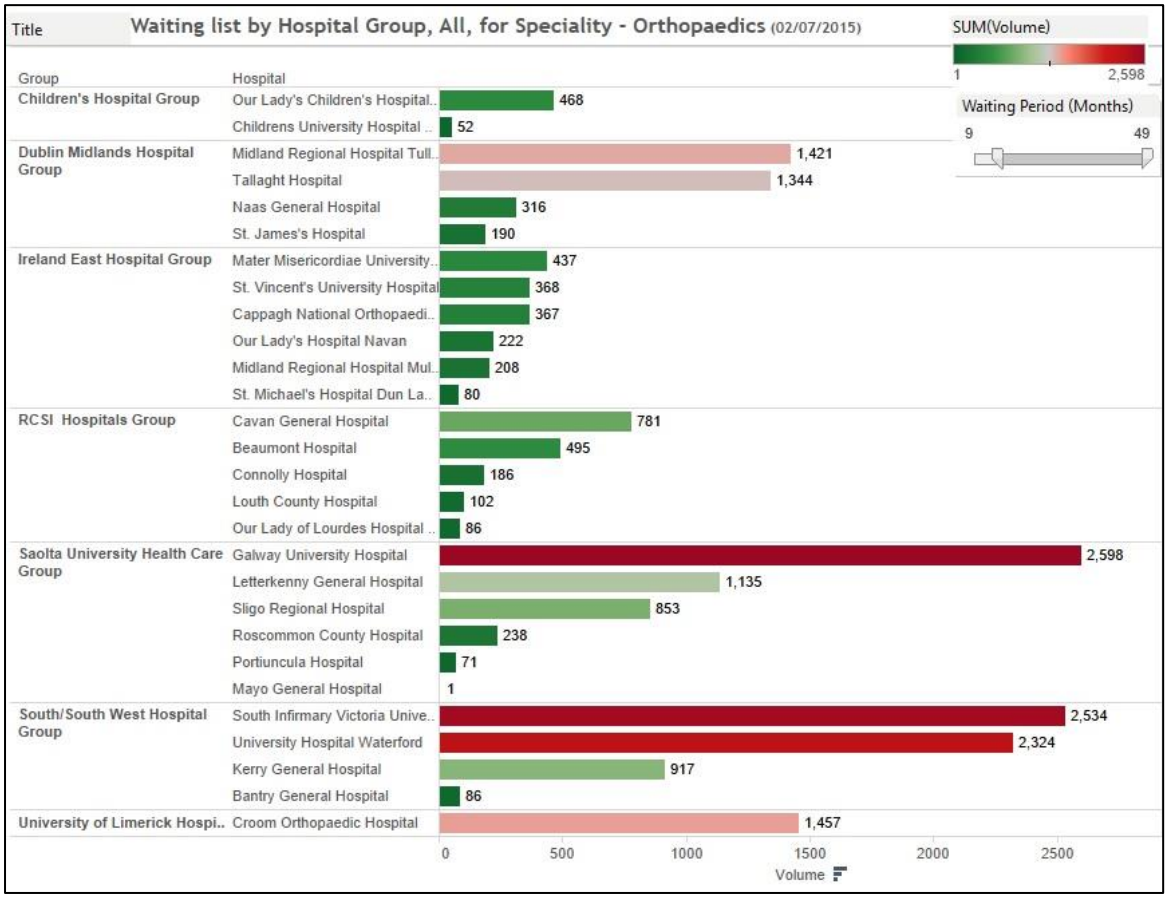
Tackling the problematic areas

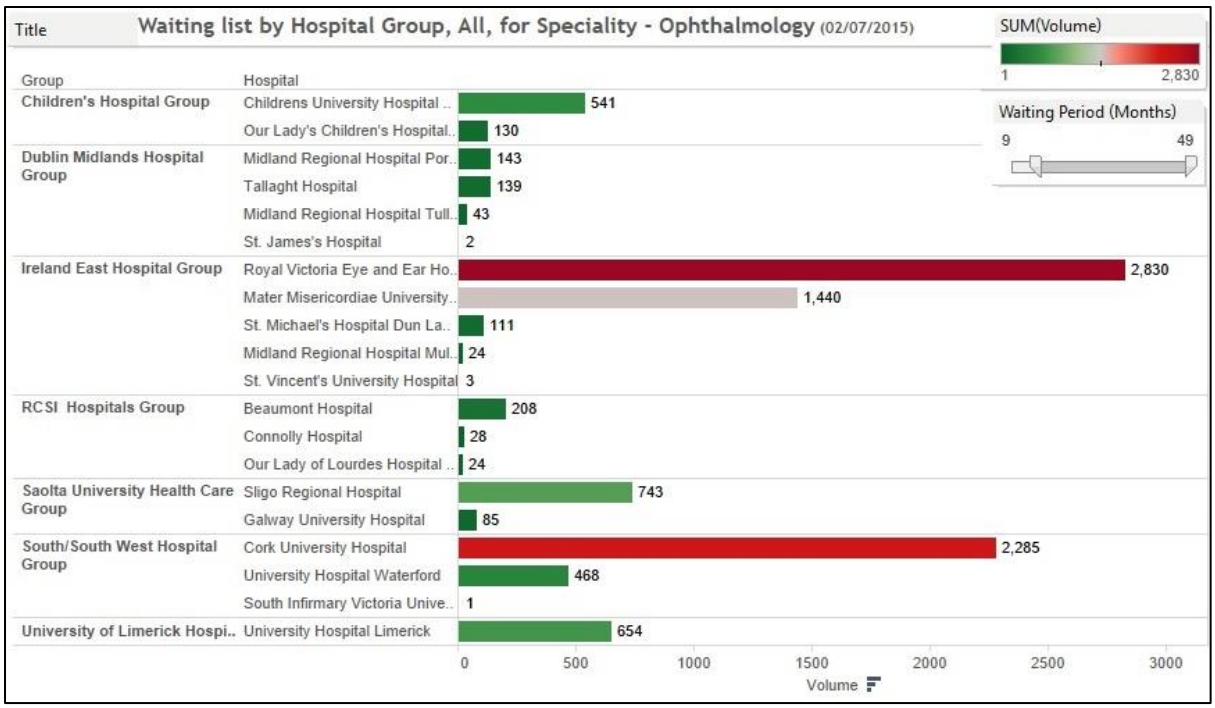
The leading surgical specialties with particular waiting-list problems include otolaryngology, orthopaedics, ophthalmology, urology, gynaecology and surgery:

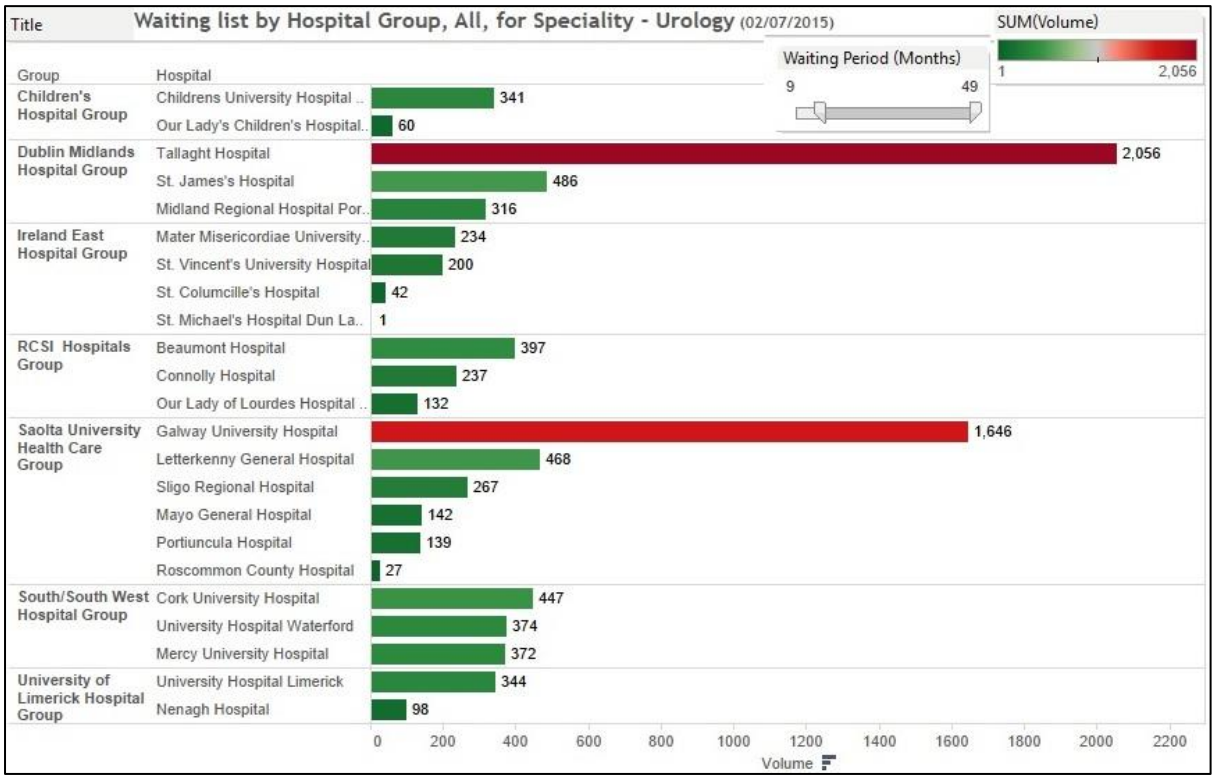


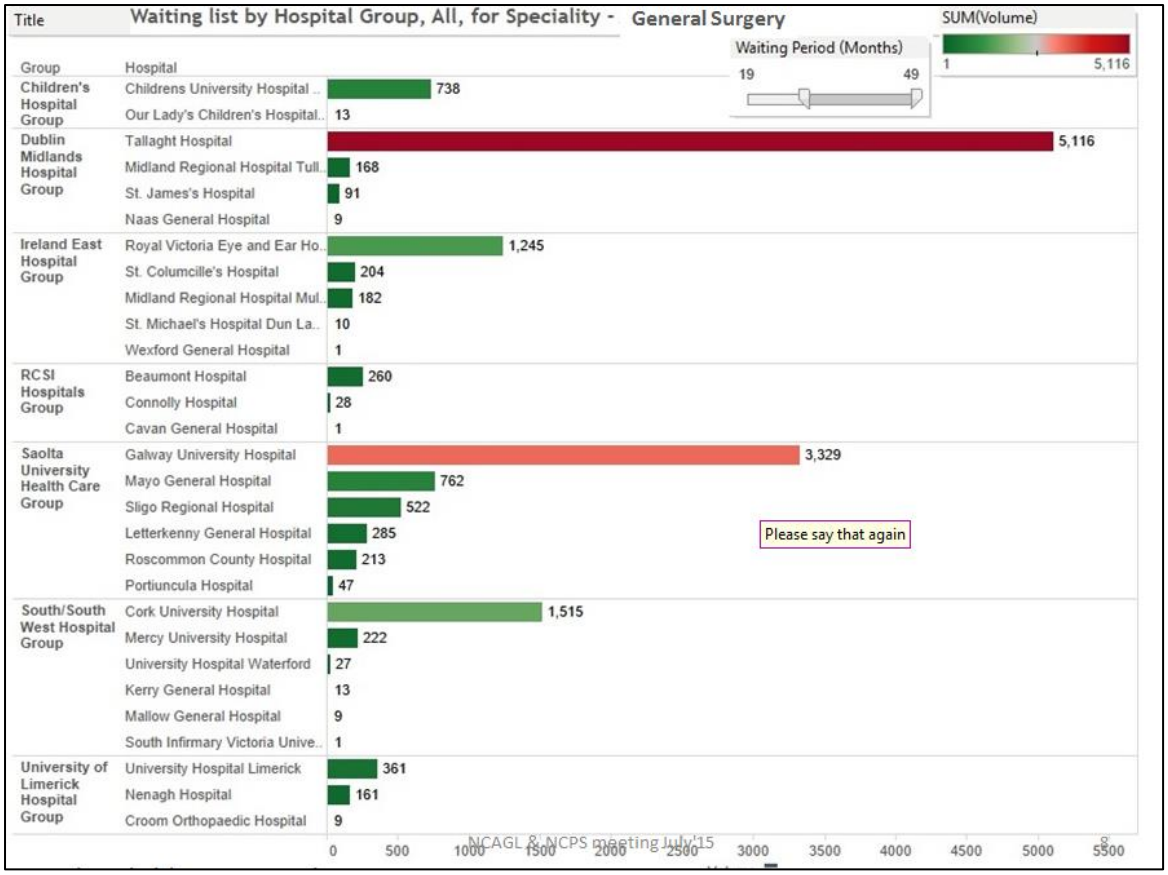
The hospitals with problems with regard to the problematic surgical specialties are shown below:


Title
Waiting list by Hospital Group, All, for Speciality - Otolaryngology (ENT) (02/07/2015)
SUM(Volume)
2
2,473
Group
Hospital
Children's Hospital Group
Childrens University Hospital ..
1,265
Our Lady's Children's Hospital..
220
Dublin Midlands Hospital Group
Tallaght Hospital
2,473
Midland Regional Hospital Tull..
2,349
St. James's Hospital
44
Ireland East Hospital Group
Royal Victoria Eye and Ear Ho..
1,987
Mater Misericordiae University..
566
St. Vincent's University Hospital
131
St. Michael's Hospital Dun La..
76
Waiting Period (Months)
9
49
RCSI Hospitals Group
Our Lady of Lourdes Hospital ..
1,163
Beaumont Hospital
967
Cavan General Hospital
652
Connolly Hospital
312
Saolta University Health Care Group
Galway University Hospital
2,343
Letterkenny General Hospital
1,416
Mayo General Hospital
974
Sligo Regional Hospital
651
Roscommon County Hospital
370
South/South West Hospital Group
University Hospital Waterford
2,289
South Infirmary Victoria Unive..
1,905
Kerry General Hospital
593
Mallow General Hospital
226
University of Limerick Hospital Group
University Hospital Limerick
1,197
Nenagh Hospital
433
Ennis Hospital
275
St. John's Hospital Limerick
2
0
200
400
600
800
1000
1200
1400
1600
1800
2000
2200
2400
2600
Volume


Title
Waiting list by Hospital Group, All, for Speciality - Orthopaedics (02/07/2015)
SUM(Volume)
1
2,598
Group
Hospital
Children's Hospital Group
Our Lady's Children's Hospital..
468
Childrens University Hospital ..
52
Waiting Period (Months)
9
49
Dublin Midlands Hospital Group
Midland Regional Hospital Tull..
1,421
Tallaght Hospital
1,344
Naas General Hospital
316
St. James's Hospital
190
Ireland East Hospital Group
Mater Misericordiae University..
437
St. Vincent's University Hospital
368
Cappagh National Orthopaedi..
367
Our Lady's Hospital Navan
222
Midland Regional Hospital Mul..
208
St. Michael's Hospital Dun La..
80
RCSI Hospitals Group
Cavan General Hospital
781
Beaumont Hospital
495
Connolly Hospital
186
Louth County Hospital
102
Our Lady of Lourdes Hospital ..
86
Saolta University Health Care Group
Galway University Hospital
2,598
Letterkenny General Hospital
1,135
Sligo Regional Hospital
853
Roscommon County Hospital
238
Portiuncula Hospital
71
Mayo General Hospital
1
South/South West Hospital Group
South Infirmary Victoria Unive..
2,534
University Hospital Waterford
2,324
Kerry General Hospital
917
Bantry General Hospital
86
University of Limerick Hospi..
Croom Orthopaedic Hospital
1,457
0
500
1000
1500
2000
2500
Volume


Title
Waiting list by Hospital Group, All, for Speciality - Ophthalmology (02/07/2015)
SUM(Volume)
1
2,830
Waiting Period (Months)
9
49
Group
Hospital
Children's Hospital Group
Childrens University Hospital .. 541
Our Lady's Children's Hospital.. 130
Dublin Midlands Hospital Group
Midland Regional Hospital Por.. 143
Tallaght Hospital 139
Midland Regional Hospital Tull.. 43
St. James's Hospital 2
Ireland East Hospital Group
Royal Victoria Eye and Ear Ho.. 2,830
Mater Misericordiae University.. 1,440
St. Michael's Hospital Dun La.. 111
Midland Regional Hospital Mul.. 24
St. Vincent's University Hospital 3
RCSI Hospitals Group
Beaumont Hospital 208
Connolly Hospital 28
Our Lady of Lourdes Hospital .. 24
Saolta University Health Care Group
Sligo Regional Hospital 743
Galway University Hospital 85
South/South West Hospital Group
Cork University Hospital 2,285
University Hospital Waterford 468
South Infirmary Victoria Unive.. 1
University of Limerick Hospi..
University Hospital Limerick 654
0
500
1000
1500
2000
2500
3000
Volume


Title
Waiting list by Hospital Group, All, for Speciality - Urology (02/07/2015)
SUM(Volume)
1
2,056
Waiting Period (Months)
9
49
Group
Hospital
Children's Hospital Group
Childrens University Hospital .. 341
Our Lady's Children's Hospital.. 60
Dublin Midlands Hospital Group
Tallaght Hospital 2,056
St. James's Hospital 486
Midland Regional Hospital Por.. 316
Ireland East Hospital Group
Mater Misericordiae University.. 234
St. Vincent's University Hospital 200
St. Columcille's Hospital 42
St. Michael's Hospital Dun La.. 1
RCSI Hospitals Group
Beaumont Hospital 397
Connolly Hospital 237
Our Lady of Lourdes Hospital .. 132
Saolta University Health Care Group
Galway University Hospital 1,646
Letterkenny General Hospital 468
Sligo Regional Hospital 267
Mayo General Hospital 142
Portiuncula Hospital 139
Roscommon County Hospital 27
South/South West Hospital Group
Cork University Hospital 447
University Hospital Waterford 374
Mercy University Hospital 372
University of Limerick Hospital Group
University Hospital Limerick 344
Nenagh Hospital 98
0
200
400
600
800
1000
1200
1400
1600
1800
2000
2200
Volume



Tackling the more general problems

We believe that more sustainable solutions will require root and branch changes that are not only designed to address waiting lists but also the perennial problems of Emergency Department overcrowding, trolley waits and intolerable inpatient bed occupancy rates:

1. Critical structural reform of the hospital and community care groups to better align with patient catchment populations as closely as possible; without this integrated systems will continue to fail.
2. Governance structures established within hospital and community care groups clearly set up and aimed primarily at providing better care and patient flow, each for their own population within clearly defined specialties recognising that it is unlikely that in Ireland these groups ever be truly equivalent, independent or set up in competition.
3. An emphasis amongst all governance groups (groups, hospitals, programmes, specialties and even political) for better overall patient care rather than selfish, strategic advocacy and opportunism.
4. Stronger implementation of the principles contained in the surgery Models of Care.
5. Establishing a clear and genuine separation of acute and elective services at the hospital level.
6. Achieving greater penetrance of performance improvement – change is slow
7. Increased patient access to senior decision makers requiring more consultants and work-force remodelling with strategic oversight of consultant appointments based on demographic and epidemiological demand, as opposed to local hospital or group perceived requirements.
8. Greater oversight of internal professional and operational standards
9. Greater consultant administrative engagement and corporate responsibility
10. Addressing the ever burgeoning burden of the Acute Care demand. It is now completely clear that unless this is tackled this will continue to overwhelm any possibility for providing elective capacity. This should be done by:
    i. Setting up of a primary care programme (linked to the main hospital clinical programmes) to specifically address hospital admission avoidance.

ii. Establishing clear Acute Care governance and accountability structures (SOPS) with close, cross specialty co-operation and agreement within the operation of
    a) The acute floor: including triage, EDs and their infrastructures (Resus, RAT, minor injuries, CDUs) AMAUs, SSUs and ASAUs and with a strong emphasis on the development of Ambulatory Pathways.
    b) Early senior decision making matched by appropriate staffing. (including increasing the consultant pool of Acute General Physicians and Surgeons)
    c) In-patient wards including; strong, real time navigational hubs, patient and specialty ward cohorting, mandatory early rounding , greater use of ward performance (with closely adhered to 'home by 11' targets) and patient feedback.
iii. Examining the feasibility of 7-day working.
iv. More active strategies for managing older persons with early risk stratification, ward cohorting, admission avoidance and adequate intermediate care.

11. Addressing and improving Scheduled care performance by:
    i. Establishing clear Scheduled Care governance and accountability structures.
    ii. Centralising OPD referrals and the development/ adoption of guidelines
    iii. Designating protected in-patient and day surgery beds.
    iv. By the effective utilisation of Model 2 hospitals and or the designation of elective hospitals.
    v. Clearly defining Day Surgery patients and separating them from Minor Procedure patients
    vi. By greater use of pre-admission assessment and increasing DOSA rates
    vii. Shifting to appropriate settings - overnight to day stay and day to OPD and/or GP surgery.
    viii. Chronological Scheduling.
    ix. Routine waiting list validation.
    x. Better management of DNA's.
    xi. Application of HIQA HTA standards.
    xii. More effective monitoring of and utilisation of theatre time. Acute and Elective separation with maximisation of use within working hours. Recycling of vacant theatre sessions
    xiii. Urgently addressing the critical shortage of theatre nurses.
12. Continuing increasing resource and development of community care, fair deal, home help etc.
13. Greater emphasis on performance monitoring and improvement with ABF given wider scope to better recognise 'good' performance.
14. Critical IT and infrastructural development

Conclusion

Many people are aware of the issues stated above. Whilst the problems outlined are extremely challenging it is only by analysing what we are doing and what we need to address that we can start to adopt better strategies for putting in place sustainable solutions.

Professor Frank Keane

Mr Ken Mealy

National Clinical Programme in Surgery