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A new Australian citizen asks "Why are public hospitals often associated with long waiting times"?

I have been waiting for what seems like a very long time. Thankfully my wait is almost over. This month I am excited to become a fully-fledged Australian citizen almost 5 years after I arrived here. It is an enormous privilege to become a citizen of a country that my family and I now call home. I have no issue with a long wait in this case – it is important to spend time integrating into the society of a new country before becoming eligible to apply for citizenship. However I soon started thinking about the whole concept of 'waiting'; and particularly how it relates to consultancy work I have been doing with public sector healthcare organisations for more than 15 years. I have been staggered (for example) by the length of time that some outpatients have to wait for appointments at public hospitals in Australia. Maximum clinically recommended waiting times are published (waits within these might be termed 'good waits') but many patients wait significantly longer (conversely these may be termed 'bad waits') and furthermore there are numerous examples of waits in excess of 3 years to see a hospital specialist. This is by no means restricted to Australia – a recent blog from the Kings Fund (read it here) highlights the deteriorating picture in the UK. What can be done?

In this short article, I will focus on outpatient waiting lists but, as I note at the end, many of the techniques I cover are applicable to all areas of the hospital and even outside of healthcare. Solutions to long waiting times are not expensive or difficult to implement and certainly cost less than frequent waiting list initiatives and crisis meetings of senior leaders and clinicians, called at short notice, to solve today's problem. A few organisations in Australia have solved their problem of long waiting times in outpatients and beyond, but much more needs to be done. Below is a high level overview of some concepts and tools that I have used in the past, with trusted colleagues, which are proven to reduce outpatient waiting times in a sustainable way.

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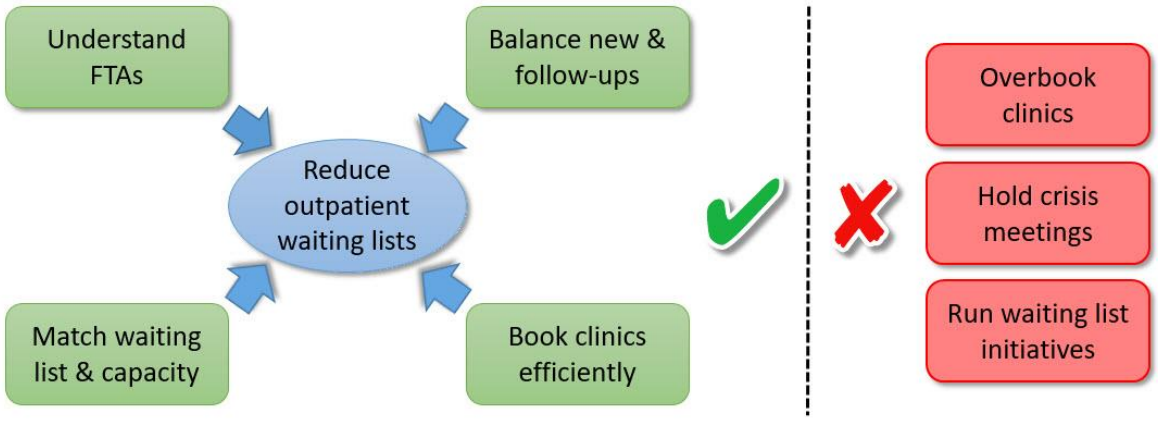

- **Understand why people fail to attend** (FTA) as this is the single biggest loss of capacity in outpatient clinics. It is an administrative problem which wastes significant amounts of senior clinical time. A gold standard is to reduce the FTA rate down below 5%. A high FTA rate is symptomatic of the need for improvement in clinic booking processes and communication with patients. Some organisations attempt to compensate for the symptom (e.g. "*We overbook all our clinics to compensate for FTAs*") rather than tackling the underlying problem. Operating a partial booking system is one of the best ways of reducing FTA rates.
- **Optimise the balance between new outpatient appointments and follow-up outpatient appointments**. In a world where there is limited capacity and seemingly ever increasing demand it is necessary to ask some challenging questions: Do all follow-up outpatient appointments need to occur? Can technology such as video calling be used instead? Are there solutions outside of the hospital (for example in primary care) that can free up capacity within the hospital for those who are more acutely ill and have greater need?
- **Combine information from waiting lists with information about available capacity**, at a subspecialty level (sometimes called the 'Clearance Time' approach). This allows us to think about how many patients we can treat and how effective we are at treating the right ones. It is best to use the cumulative capacity over several weeks in order to iron out variations and it is normal to set aside a proportion of the activity for urgency, clinical discretion and the fact that the world is imperfect to give a more reliable final result. In some cases there is a real capacity constraint to solve, but administrative rather than capacity issues are generally signposted by clearance times being significantly smaller than actual waiting times.
- **Examine closely the efficiency of clinic bookings** and, once clinical exception / priority is considered, operate a strict 'treat in turn' process. There is no point in booking a patient into a slot in advance that will mean they will already breach the clinically recommended timeframe when there is a patient who is well within their clinically recommended timeframe occupying an earlier slot. I have always recommended the use of a 'Patient Tracking List' (PTL) which is a forward looking management tool and is a dynamic list of patients who need to be treated by given dates to achieve a specific waiting time target.

The result of booking clinics in the way described above is that outpatient clinics operate in an 'efficiency range'. Clinics that are overbooked and over utilised will represent peaks in outpatient activity and subsequent peaks in transfers to inpatient waiting lists. Clinics that are not fully booked will represent troughs in activity and wasted resources. It is also important not underestimate the cultural change that may be required, as staff will have to work in different ways to succeed at this challenge.

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But, there is light at the end of the tunnel: there are a small number of organisations in Australia who have already solved the issues of long waits and are now regularly treating patients within clinically recommended times (for outpatients this is 30 days for category 1, 90 days for category 2 and 365 days for category 3). Both the Wide Bay and Gold Coast Hospital and Health Services in QLD have no outpatients waiting beyond the clinically recommended times.

Adrian Pennington (CEO at Wide Bay HHS) notes that, when he first arrived at Wide Bay in 2012, he was completely horrified by a maximum outpatient waiting time of 12.5 years whereas this year they are moving even further than the clinically recommended times towards a completely sustainable maximum wait of only 9 months for category 3 outpatients.

It is completely possible to extend this logic and the tools / techniques in this article to other areas inside the hospital and health space (e.g. emergency department, medical imaging, GP services, allied health, elective surgery and time in a bed waiting for discharge). And it isn't just healthcare is it? 'Bad waits' exist in many others areas, often due to sub-optimal process issues. Examples range from queues at airports, taxi ranks and road junctions to long waits for places at popular child care centres or high schools.

My long wait for Australian citizenship is over – I maintain that this was a 'good wait' providing the time necessary for my family and I to truly be able to call Australia 'home'. I'd love to hear any experiences you have of 'good waits' and 'bad waits', particularly in healthcare, and to start a conversation.

About us www.newhighconsulting.com paul@newhighconsulting.com

New High Consulting is a growing, niche, Sydney based company providing strategic support to healthcare providers and allied companies predominantly in the healthcare strategy and analytics arena. Paul White is the Managing Director and he is a highly experienced executive and management consultant with a deep understanding of the challenges currently facing healthcare based upon 20 years' experience in the sector.