Addressing the elective surgery backlog

2023

AMA

CLEAR THE HOSPITAL LOGJAM

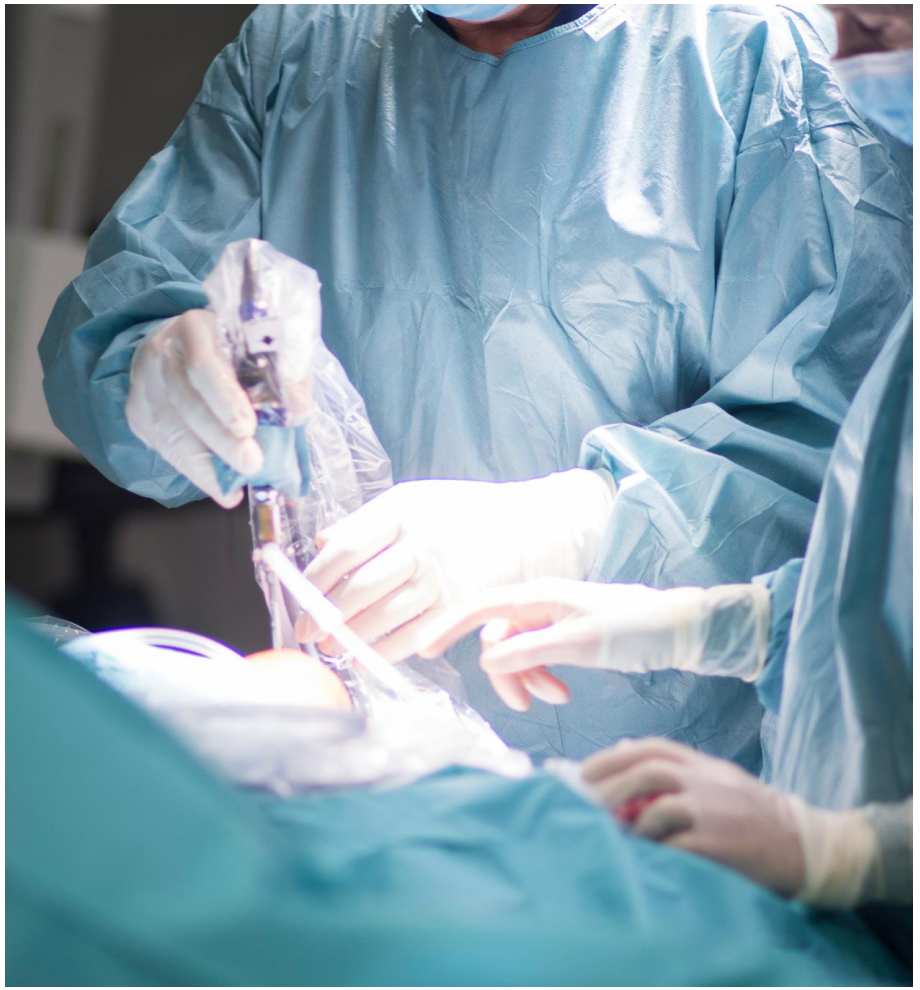
OVERVIEW

When a patient requires surgery, they can choose to receive their surgery through either the public or the private health system. While surgery provided in public hospitals is funded by the government, patients will often wait several months or even years on the waiting list. The alternative is to receive surgery in the private system, where insufficient compensation from health insurers often results in patients incurring out-of-pocket expenses.

Before the COVID-19 pandemic, patients were waiting longer than the clinically recommended time for elective surgery in public hospitals, which indicates there was already unmet need for surgical care (also referred to as a backlog of care) before the pandemic.[1] Elective surgeries were then postponed several times during the COVID-19 pandemic to prevent public hospitals being overwhelmed by surges in COVID-19 cases.[2] This was considered a necessary step initially as our public hospitals were not equipped with sufficient medications, medical equipment, and appropriate personal protective equipment and protocols, and they did not have the capacity to scale up and meet increased demand created by the pandemic.

Despite most hospitals recommencing elective surgery in 2021–22,[3] the latest Australian Institute of Health and Welfare (AIHW) data shows public hospitals continue to find it challenging to meet demand and have not been able to return to pre-pandemic service volumes. These surgeries — commonly referred to as *elective surgeries* — are not optional procedures that a patient elects to have. They are essential surgeries that are often performed to address life-threatening conditions that prevent a patient from living a normal life due to severe pain or disability. Common elective surgeries for adults include joint replacements to support mobility or cataract extractions to improve vision, whereas common procedures for children include insertion of gromets and cleft lip repair, both of which are essential for speech development.

We are now at a critical point where access to timely elective surgery is out of reach for many Australians. A national plan is urgently needed to address the growing and increasingly critical backlog of elective surgeries. This plan needs to be funded by both states and territories and the federal government, backed by long-term funding commitments that deliver permanent expanded capacity in our public hospital system.



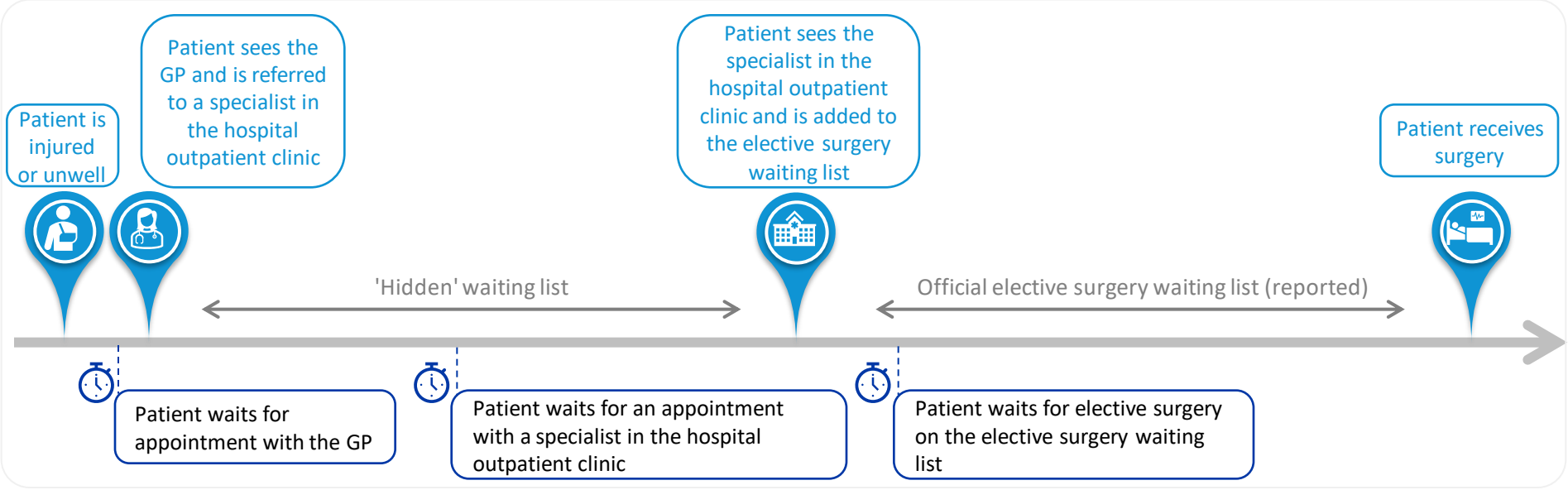
THE WAITING LISTS FOR SURGERY

When a patient requires surgery in a public hospital, they are placed on a waiting list — commonly referred to as the public hospital elective surgery waiting list. Before being added to the elective surgery waiting list, a patient requires a consultation with a specialist to determine urgency for surgery. There are three urgency categories for elective surgery:[4]

- **urgent (Category 1):** needing treatment within **30 days** (for example: limb amputation, biopsies, removal of malignant skin cancers, removal of kidney stones)
- **semi-urgent (Category 2):** needing treatment within **90 days** (for example: removal of ovarian cysts, treatment of a brain aneurysm, heart valve replacement)
- **non-urgent (Category 3):** needing treatment within **365 days** (for example: reconstructive surgery, cleft lip and palate repair, joint reconstructions, tonsillectomy).

While some patients will see a specialist in their private practice, many will see a specialist in a public hospital outpatient clinic. While there is no national reporting on public hospital outpatient waiting times (which is why it is often referred to as the 'hidden waiting list'), state and territory reporting reveals that patients will wait months or even years for an appointment[5] (further detailed in the AMA report *Shining a light on the elective surgery hidden waiting list*). This means that by the time a patient is added to the elective surgery waiting list, they have already waited for an appointment with the specialist in the outpatient clinic to be assessed, and may have also waited for diagnostic tests to determine urgency and the type of surgery required (depicted in Figure 1).

Figure 1: Overview of patient journey to receive elective surgery

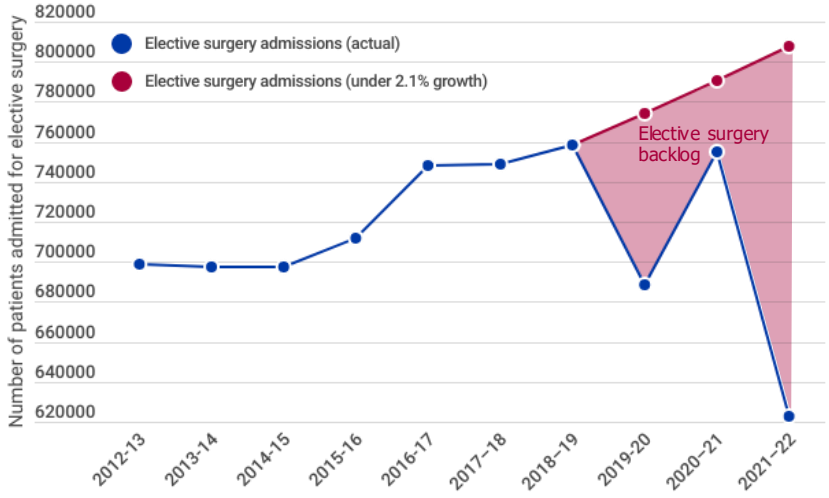


ESTIMATING THE BACKLOG

Public hospitals were struggling to meet community demand even before the COVID-19 pandemic,[6] however the pandemic has had a significant impact on the number of elective surgeries performed in the last few years (Figure 2). In 2021–22, 622,988 patients were admitted for elective surgery in public hospitals, the lowest number of admissions over the last decade.[7] This represents a 17.4 per cent decrease from 2020–21,[8] a 17.8 per cent decrease from 2018–19 (the last reporting period before the COVID-19 pandemic).[9]

Assuming that elective surgery admissions should be growing by 2.1 per cent each year,[i] by the end of 2021–22 there was an estimated **elective surgery backlog of 306,281 patients nationally**. This represents a backlog of almost five months, with Figure 2 demonstrating that most of this backlog has come from the last financial year (2021–22).

Figure 2: Public hospital elective surgery admissions, 2012–13 to 2021–22[10,11]

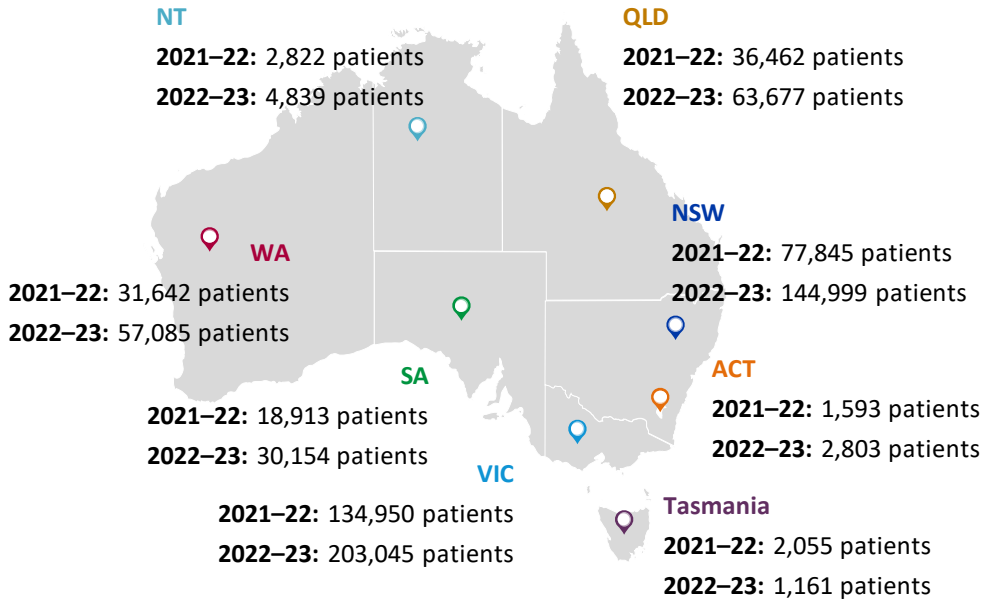


[i]The annual growth rate for elective surgery admissions of 2.1 per cent was determined by calculating the average annual growth rate between 2014–15 and 2018–19, as this represents the growth in elective surgery admissions prior to the COVID-19 pandemic.[12,13] The backlog was calculated by subtracting the actual elective surgery admissions from the estimated elective surgery admissions under an assumed annual growth rate of 2.1 per cent.

If hospitals do not expand their capacity to address this backlog, there will be an estimated backlog of **507,764 patients by the end of this financial year** (2022–23) — a backlog of eight months (when compared to pre-pandemic 2018–19).

Analysis of elective surgery admissions in each state and territory reveals that the estimated backlog is greatest in Victoria (134,950 patients, or 44 per cent of the backlog) and New South Wales (77,845 patients, or 25 per cent of the backlog), with Queensland and Western Australia accounting for around 10 per cent of the backlog each.

Figure 3: Estimated elective surgery backlog in each state and territory for 2021–22, and projected backlog for 2022–23[14,15]



Note: Tasmania was the only state where the number of elective surgery admissions increased between 2020–21 and 2021–22, which is why the 2022–23 projection is lower than the estimated backlog for 2021–22.

THE CAUSE OF THE BACKLOG

There are three key categories of patients that make up the elective surgery backlog:

- patients who have deferred care and require a referral to a specialist
- patients who have been referred to a specialist and are waiting for an appointment to be assessed for surgery (the elective surgery hidden waiting list)
- patients waiting longer than the clinically recommended time for surgery on the elective surgery waiting list.

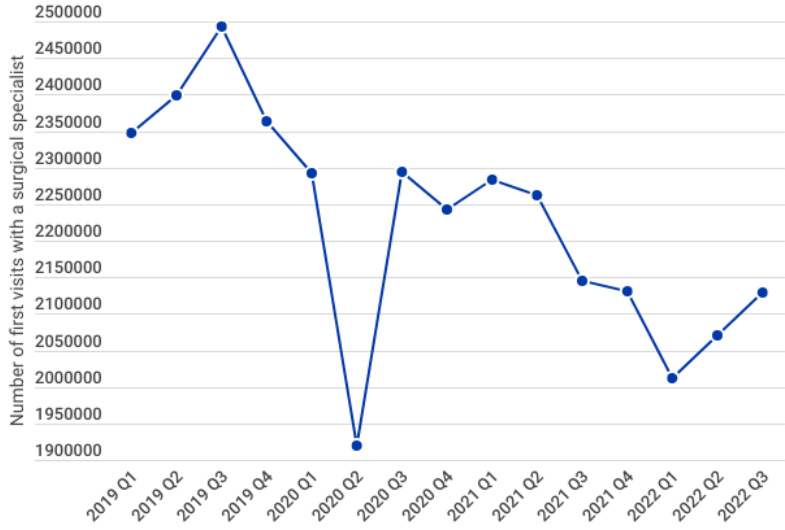
While some of the elective surgery backlog is due to patients waiting longer on the elective surgery waiting list (for example, of the 622,988 patients who were admitted for their surgery in 2021–22, 121,489 patients (around 20 per cent) did not receive their surgery within the clinically recommended timeframe),[16] analysis of the number of additions to the waiting list reveals that most of the backlog is from patients waiting to be added to the elective surgery waiting list. In 2021–22 there were 783,715 patients added onto the public hospital elective surgery waiting list.[17] This represents a 12.3 per cent decrease from 2020–21, and a 12.2 per cent decrease from 2018-19 (pre-COVID-19 pandemic).[18] Assuming that admissions to the elective surgery waiting list should be growing by 2.5 per cent each year,[ii] by the end of 2021–22 there was an estimated 299,407 patients that should have been added to the elective surgery waiting list but were not.

The elective surgery backlog (as outlined previously, an estimated 306,281 patients in 2021–22) can therefore be largely explained by a reduction in the number of patients added to the elective surgery waiting list in the first place. While some of the reduction in admissions may be due to patients receiving surgery through the private health system, this is unlikely to be a significant contributor as the benefits paid by insurers has not been growing enough to account for this reduction.[19]

[ii]The annual growth rate for elective surgery additions of 2.5 per cent was determined by calculating the average annual growth rate between 2014–15 and 2018–19, as this represents the growth in additions to the elective surgery waiting list prior to the COVID-19 pandemic.[20,21] The backlog in additions was calculated by subtracting the actual elective surgery additions from the estimated elective surgery additions under an assumed annual growth rate of 2.5 per cent.

Additionally, while mortality rates were higher in 2021–22 compared to previous financial years, this is also unlikely to explain the reduction in patients added to the waiting list.[22] As there has been an overall reduction in first visits with a surgical specialist (Figure 4), it is more likely that these patients have either deferred care and require a referral to a specialist, or have been referred to a specialist but are waiting for the appointment (i.e. on the elective surgery hidden waiting list).

Figure 4: Number of first visits with a surgical specialist, 2019 to 2022 [23]



While postponing elective surgery during the COVID-19 pandemic is one of the key drivers for this backlog, the reduction in additions to the waiting list suggests that this is unlikely to be the only cause. Additionally, public hospital performance has been deteriorating for several years, even before the pandemic.[24] It is therefore likely that other factors are contributing to this backlog, including long waits for hospital outpatient appointments (the elective surgery waiting list), workforce shortages and furloughing of staff due to COVID-19, and hospitals simply not being able to expand their capacity to meet demand.

PLAN TO ADDRESS THE BACKLOG

The significance of the elective surgery backlog indicates that access to timely healthcare is now out of reach for many Australians. Alarmingly, there is no evidence that the pressure on public hospitals has eased, with reports that hospitals are continuing to face workforce shortages, increased ambulance ramping, emergency departments at capacity, and exit block. It is therefore unlikely that public hospitals will be able to expand their capacity to address this backlog if there is no intervention.

Costs associated with delayed elective surgeries go beyond the health system. Every delayed surgery has an impact on the patient, as it leads to further deterioration of health and impacts quality of life. This in turn has a significant economic cost due to loss of workforce participation and productivity. For example, a patient waiting for a procedure to address chronic pain may be unable to work and will often require prescription medication to manage their pain. This will incur costs to the health system through more consults with their general practitioner, more medicine subsidised by the Pharmaceutical Benefits Scheme (PBS), and through income support from the government due to an inability to work. This could also lead to further health issues for the patient, including mental health issues, due to limited ability to participate in work, physical exercise, and social activities.

Looking to the future, significant investment will be required to restore the capacity of public hospitals and provide access to all those who require it within the clinically recommended timeframes. To achieve this, Australia will need a national recovery plan that factors in improving wait times for outpatient appointments and elective surgeries and establishing enough capacity to meet the population demand while factoring in repeat waves of COVID-19 infections into the future.

While the current funding agreement — the 2020–25 National Health Reform Agreement — does not finish until 2025, a solution is urgently needed now to address the growing and increasingly critical backlog of elective surgeries. The AMA is proposing that an agreement be established between the Commonwealth Government and state/territory governments that:

- is funded by both the Commonwealth and state/territory governments, backed by long-term funding commitments that deliver permanent capacity in our public hospital system
- includes an upfront advance payment provided by the Commonwealth to support state/territory governments to expand their capacity (in particular workforce)
- reduces the backlog of hospital outpatient appointments (the hidden waiting list) by providing funding to state/territory governments and/or direct to health services to assist in expanding the number of outpatient specialist appointments
- reviews the current backlog to identify where alternative care pathways may be appropriate
- includes a robust and regular reporting framework that reports on the number of patients on the waiting list (including the hidden waiting list), and demonstrates the increase in activity directly from the funding, with feedback to the relevant National Cabinet/subcommittees. Reporting should be made publicly available where appropriate.

The AMA's broader solution for public hospital reform proposes a new hospital funding agreement be established between the Commonwealth Government and state and territory governments that:

1. Improves performance by reintroducing funding for performance improvement.
2. Expands capacity for public hospitals through additional funding for extra beds and staff.
3. Addresses demand for out-of-hospital alternatives, prioritising programs that work with general practitioners throughout design and implementation to address avoidable admissions and readmissions
4. Increases the Commonwealth Government's contribution to 50 per cent for activity, with removal of the 6.5 per cent cap on funding growth. State and territory governments would reinvest the five per cent of 'freed-up' funds to improve performance capacity.

Key considerations

Key to the success of clearing the elective surgery backlog will be ensuring we have enough healthcare workers with the appropriate training to support the additional surgeries required. Consideration should be given to the recommendations outlined in the National Medical Workforce Strategy, as well as other relevant workforce strategies, on what will be required both in the short term and the medium-long term to support our health workforce to address this backlog, as well as improve performance into the future. Consideration must also be given to patients in regional, rural and remote areas, as many of these patients must travel long distances to receive the care they need due to workforce shortages in these areas.

The private sector will continue to play a key role in helping address the public hospital elective surgery backlog in the short term where they have additional capacity, noting that many areas of the private sector are also now experiencing longer waiting lists due to increased demand and workforce shortages. Utilisation of the private sector to address the elective surgery backlog will need to be done in a way that does not undermine the value of private health insurance or prevent private patients from accessing care. There must also be no impact on the training of specialist trainees.

Additionally, while national emergency surgery data is not publicly reported, studies show that emergency surgeries are often delayed until after hours to prioritise scheduled elective surgeries, which can have a significant impact on patient outcomes. Efforts to address the elective surgery backlog must not undermine emergency surgeries, particularly as studies show that emergency surgery in Australia also requires significant reform.

Efforts to address the elective surgery backlog will need to be continuously monitored and reviewed to ensure there are no negative impacts on the private sector, healthcare workers, or patients, and that the new agreement is effective. While this short-term funding agreement will be essential to address the elective surgery backlog, it does not replace the need for long-term reform and investment to increase capacity, improve performance and outcomes, and reduce wait times in our public hospital system.

The risk of doing nothing

Elective surgeries are not optional. They are surgeries that address life-threatening conditions as well as conditions that impact quality of life. The current backlog of elective surgeries is therefore devastating for many patients, and may result in a patient's condition deteriorating and requiring emergency surgery. Delays in diagnostic and screening procedures can also mean that the opportunity for early intervention is missed, resulting in patients presenting with more advanced illness and poorer prognosis. This ultimately results in worse health outcomes for Australians, higher healthcare costs, and increased burden on the economy.

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