The Elephant in the Waiting Room

Are long waits in our public hospitals inevitable while DHB specialists also work in the private sector?

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It is common for doctors in our public hospitals to also work in the private sector, creating a conflict for the doctors involved. The actual experience of 'Jennifer' illustrates how our public and private health sectors interact:

> Jennifer was advised that she would need back surgery. As there was a lot of pain, and a risk of paralysis, the doctor advised that the operation should be performed soon. However, she would have to wait up to 8 months for treatment in the public system.
>
> On the other hand, if she had private health insurance, or could pay about $50,000 from her own pocket, she could receive an operation within 2 weeks in a private hospital.

Long waits for public treatment clearly increase demand in the private sector.

What would happen if we got rid of long waits?

Reducing the public hospital wait for Jennifer to something like the 2-4 weeks on offer privately would mean a large drop in demand in the private sector. As doctors are generally paid a much higher rate when they work in the private sector than they earn in public hospitals, doctors with 'dual practice' would suffer a drop in income.

This conflict has long been recognised in the UK health system, and efforts have been made to address it. Meanwhile the issue barely gets a mention here.

Waiting times in our public hospitals

Operations like hip and knee replacements, the back surgery that Jennifer needs, replacing a heart valve, or cardiac bypass surgery, are included as 'elective'. This doesn't mean 'unnecessary' or 'optional'; it simply means that the service is provided 7 or more days after the decision to proceed with treatment.

The current maximum waiting times for these procedures are:

- 4 months to be assessed by a specialist after a patient is referred by their GP
- a further 4 months to be treated following assessment.

However even these modest targets are proving too difficult for some DHBs. For example, the Ministry of Health's website showed that in February this year:

- Auckland Orthopaedics – 42% of patients had waited longer than 4 months from assessment to treatment
- Hutt Valley Opthalmology – 14% of patients had waited longer than 4 months to be assessed by a specialist and 12% of patients had waited longer than 4 months from assessment to treatment.

Is it a priority?

Whether led by National or Labour, reducing waiting times has been a priority for successive governments for the past 22 years. Before then, we had waiting lists that some people stayed on for years, with many never receiving surgery.

The change from waiting lists to booking systems in the mid-1990s signalled a serious intention to do better for public patients. Waiting times would be reduced and patients would have the certainty of an actual booked appointment time.

Points systems and qualifying thresholds for treatment were introduced to make the system fair and transparent. They would also give governments a sound basis for investing more money to lower the thresholds and get more people treated.

As part of this push, the Government invested $260m to clear the large backlogs of patients on waiting lists. Later, a central pool of funding for **extra** electives (over and above what DHBs were already delivering) was set up. This pool has increased from $132m in 2007/08 to $364m in the current year.

But despite it being a 'priority', and very significant financial investment, we have yet to achieve what was envisaged 22 years ago.

What needs to happen?

Waiting several months for treatment causes an unacceptable level of pain, disability, anxiety and disruption to the lives of the people affected. This situation won't improve without making changes.

To make a start, one of our larger DHBs would take the lead by offering a new contract to doctors in one specialty (e.g. cardiothoracic) to work exclusively in the public sector. The contract would include milestones to cut the current maximum waits in half and provide patients with the earliest possible booked appointment times. Funding would be provided to the DHB to pay more to doctors willing to give up their private practices.

Next, the DHB managers and clinical staff would make the changes they need to run a more efficient service. This could mean greater separation of elective and urgent cases so that fewer electives are 'bumped'. It could also mean nurses and other staff being employed more flexibly (e.g. as surgical assistants) to free-up surgeons to do more operations.

Can we afford it?

The cost of paying more to some doctors needs to be compared with the high costs in the present system – the costs for patients waiting for treatment, the extra money that governments keep investing in electives, costs to people who take out private insurance to avoid long waits, large co-payments for insured people, and costs for those who pay for private treatment out of their own pockets.

With the system under review, the time is right to start talking about the elephant in the waiting room – specialists with dual practice.

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