Article

Booking Systems, Waiting Lists and Patients

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In 1993 a report was published which proposed a new method for prioritising access to non-acute surgery in New Zealand.[1] This proposal was supported by the then Core Services Committee and formally introduced by the Ministry of Health, with the intention that all public hospitals and health purchasing authorities would be using the new method, which is known as the booking system, by 1 July 1998. The booking system is complex and many health professionals, patients and public are unclear about its structure and functioning. This article begins with a brief discussion of how the booking system was intended to function and highlights some differences between the booking system and the waiting list system. The structure and operation of the booking system stimulate ethical interest at several levels. For example, at the wider societal level the booking system was designed to prioritise access to surgery in a 'fairer' manner than the waiting list system had done – determining what is fair and how best to allocate resources between competing claims are issues of ethical concern.[2] At the patient and health professional level the booking system may change the nature of relationships. These relationships, originating in the experience of illness, are 'shot through with complex moral dimensions'[3], the meanings of which we need to try to understand. This article considers some issues raised by the impact of the new system upon the patients presenting for surgical assessment and treatment in New Zealand.

When the booking system was introduced it was intended that all hospitals throughout New Zealand would quickly establish the system in a consistent manner. Patients would begin their journey through the booking system by being referred to a specialist's clinic at a public hospital, once the referring GP had read the appropriate referral guidelines and ascertained that the patient met the criteria for referral. The letters of referral would then be evaluated by hospital staff using Access Criteria for First Assessment (ACA), and patients would be prioritised for outpatient appointments according to their score or profile on the ACA. For example, an orthopaedic outpatient department would provide an appointment within two weeks to someone with a suspected malignancy or to children in acute pain, whereas someone with functional impairment may have to wait the maximum acceptable time of two months to see a specialist. When the patients meet the specialist their condition may be diagnosed as one which may benefit from surgery and they would be prioritised for surgery using Clinical Priority Assessment Criteria (CPAC). Continuing with the orthopaedic example, someone presenting for possible hip or knee joint replacement would usually be scored with CPAC which include sections evaluating pain, activity, range of movement and pain on examination, and other factors including the ability to work, care for dependents or to live independently.

It was also intended that a clinical threshold would be set at the CPAC score where specialists agree there would be a benefit in providing surgery to people. Patients with a score equal to, or above, this clinical threshold would be prioritised so that someone with 100 points would gain surgery before someone with 50 points. However, the amount of money from Vote: Health allocated to non-acute surgery is determined via the contracting process between the HFA and the hospitals. Consequently each CPAC also has a financial threshold which is equal to or higher than the clinical threshold. The financial threshold is calculated from variables such as the usual rate of referral, the case complexity and the amount of funding provided. Such thresholds would remain reasonably stable over time and become known as the financially sustainable threshold. All people with a CPAC score equal to, or above, the financial threshold would be prioritised to receive a booked appointment for surgery within six months of their outpatient assessment. They would be informed of this date within two weeks of their outpatient appointment. People scoring below the financial threshold are referred back to their original health care provider for ongoing care and treatment. If their condition worsens they can be re-referred, reassessed and rescored using the CPAC.

Several differences are immediately apparent between the booking system and waiting lists. The first area of difference is in the use of specific referral guidelines, ACA and CPAC, to prioritise patients for both outpatient clinics and surgery itself. Prior to the implementation of the booking system formal scoring criteria were not generally used for scheduling outpatient appointments. Yet prioritisation did occur, and people with suspected malignancies would still have received appointments with specialists ahead of people with functional difficulties alone. Specialists generally prioritised people for non-acute surgery according to urgent (A), semi-urgent (B) and non-urgent/routine categories (C). This process was left largely to the individual specialist's clinical judgement, and waiting lists were criticised for failing to accurately and transparently prioritise the people in greatest need for surgery. By contrast, it is argued that the use of booking system CPAC to prioritise people for surgery provides consistency, an indication of the level of need, and that data can be generated about the numbers of people gaining access or denied access to surgery and the types of symptoms they are experiencing.

Under the waiting list system people prioritised as 'urgent' would usually have received their surgery within a few months, but there were no strict guidelines specifying the time people who were routine or semi-urgent could expect to wait for surgery. This lack of certainty about when surgery could be anticipated was one of the main criticisms levelled at waiting lists. People did not know if they would be called in for surgery next week or in three years time. The booking system, by contrast, in theory provides certainty to all people assessed for surgery. Those reaching the finan-

cial threshold are given a date for surgery within six months. People below the financial threshold are told that they are not eligible for surgery at their public hospital and are able to seek alternative means of coping with their condition, such as paying to have surgery privately, if they can afford to.

Another problem associated with waiting lists was the ever-increasing number of New Zealanders waiting for lengthy periods of time, and the difficulty in targeting funding to those patients on waiting lists who were in the greatest need for surgery. The booking system was introduced with financial support from the Ministry of Health in the form of the Waiting Times Fund[4] ($280 million over four years). This money was to purchase surgery over and above the usual baseline elective surgery levels, and was to be dedicated to removing the 'backlog' of people waiting for surgery under the old waiting list system, so that a point would be reached where the number of new referrals to the system would equal the numbers of people either receiving surgery or being told they were not eligible for surgery in a public hospital.

We know that the booking system has not yet been able to function as originally envisaged. National consistency, in terms of both the CPAC instruments used and the financial thresholds determining access, remains elusive.[5,6] Also, methods of CPAC administration differ, and concerns have been raised about the reliability and validity of the CPAC instruments and the linear method of scoring used.[7,8,9,10] There are large numbers of people waiting much longer than the recommended two months to see a specialist for their first specialist assessment, and people presenting for reassessment after failing to meet the financial threshold make these delays even longer. Because of the numbers of patients falling into the gaps between the clinical thresholds and the financial thresholds the HFA has decided these patients should be placed on Residual Waiting Lists, rather than simply being referred back to their GPs, as originally intended. These patients are informed that: 'Your level of urgency is less than that currently being treated, but you will be reconsidered for treatment during the next 12 months. During that period you may be offered treatment, however, there is no guarantee'.[11] When and how patients hear about whether or not they have met the access threshold varies, and the provision of surgery within six months to all those meeting the financial threshold is still problematic. Far from increasing the levels of non-acute surgery provided in New Zealand there has actually been a decline in the baseline levels provided, and some of the money from the Waiting Times Fund has been diverted away from non-acute surgery to support other demand-driven health services, such as pharmaceuticals and acute care.[12] Staff from the HFA (in particular the National Waiting Times Project Team) and the hospitals are seeking to remedy these problems. One day soon the booking system may approximate the original design – where the CPAC instruments reliably prioritise people for surgery, where everyone referred by GPs to hospital specialists is seen in a timely fashion, where people have access to a credible level of non-urgent surgery based on need and ability to benefit, and where no-one slips through the cracks and is left with a serious condition undiagnosed in the community. Yet when these problems have been resolved, will the new system provide a definite improvement for patients as compared with the former waiting list system?

David Mechanic suggests that explicit rationing, as is intended with the booking system, is often preferred by people who feel strongly about equality and solidarity and who see inequalities in health care status 'as inherently unfair and believe that medical care should be allocated solely on the basis of need and the capacity to benefit'.[13] These critics of implicit rationing may also see medical decision-making as allowing too much latitude for the social and clinical preferences of physicians rather than being evidence-based. In New Zealand these reasons were presented to support moving from waiting lists to booking systems. Yet Mechanic describes five potential pitfalls associated with explicit rationing which merit attention. Firstly, he suggests that once rigid criteria for prioritisation are developed and implemented they can become fixed and resistant to change – guidelines, ACA and CPAC may be difficult to modify despite apparent problems with their design and scoring mechanisms. Secondly, he argues that medical care is about a process of decision-making which depends on a relationship of trust between the doctor and patient, which is more than 'the application of technical means'. Thirdly, patients are not uniform. They have different needs, preferences, tolerances and values, and 'measured values are often meaningless to individuals'.[13] The booking system may be reducing the opportunity for the patients to be involved in decisions concerning their health care. Should the patient with 75 points and an ambivalent attitude towards major surgery receive their operation ahead of someone with 45 points who desperately wants surgery? Should the patient with 65 points who is happy to wait 12 months for surgery receive their operation before someone with 60 points who would like it next week? The sensible answers to both questions should be 'No'. There should be room to take patients' preferences into account, as long as patients have been adequately informed of the actual risks and benefits of surgery. And the ability to voice preferences depends on patients feeling worthy enough to ask something of the system.

A fourth potential pitfall for explicit rationing is a lack of flexibility in terms of allowing for 'other contingencies' such as comorbidities and life situations. Although there was considerable discussion of the use of CPAC as 'guidelines' and of the opportunities for clinical discretion to override the CPAC points, we do not know how frequently this occurs or under what circumstances. Specialists may be encouraged by managers not to override the CPAC scores except in unusual circumstances[14] because this may result in spending beyond the contract. Of course we do not yet know the extent to which doctors and patients have allowed the explicit nature of the CPAC to determine access to surgery. We may find that as the financial thresholds increase the numbers of patients scored to meet that threshold also increases, in the absence of any increase in the prevalence of severe symptoms in the community. Mechanic's fifth criticism is that explicit rationing can fall victim to political manipulation and result in a destabilising of the health system, with never ending calls for more funding to meet the 'measured need'. This may be one criticism of explicit rationing that potentially serves to benefit New Zealand patients waiting for non-acute surgery. As mentioned previously there has actually been a decline in the baseline level of non-acute surgery

provided. The booking system enables this decline to be tracked and related to the level of need, as measured by the CPAC. In America, where Mechanic is based, the health sector consumes a far greater proportion of GDP than it does in New Zealand. The explicit booking system may well result in extra funding for non-acute surgery, but whether it will result in an increase in the overall proportion of taxpayers' money going to health (as desired by the thousands who marched for health last year) is uncertain.

There is of course a need to consider the ramifications of the booking system on the community rather than just on the individual patients. Gavin Mooney writes that '... the nature of the health care system in a society can convey something more than desire to treat sick people. It is a "performance indicator" of the nature of concerns for equity and caring in a society'.[15] The introduction of the explicit booking system has probably affected how the public in general view the health system, and it would be timely to explore this societal impact. It may be that for some in the community the introduction of explicit prioritisation has been seen as the application of rules to govern rather than a system to serve those who need non-urgent surgery. If this is how the system is perceived within the community it would then influence the expectations and experiences of those individuals from the community who develop an illness which may benefit from surgery, and the expectations and interactions of the health professionals providing that treatment. There needs to be an ongoing dialogue extending beyond the bounds of the patient to the patient embedded in relationships with health professionals and the wider community. The patient perspective is the sensible place to commence such a dialogue because patients are uniquely able to comprehend their illness and the impact of the booking system upon their lives. Well in excess of one hundred thousand New Zealanders have been affected and continue to be affected by this new system. What does the booking system mean for these people, how could it be improved, and how has it altered their perceptions of the health system and the society they live in? No system is perfect, and the previous method of prioritising by waiting lists certainly had its problems.[16] We simply do not yet know enough about the impact of the booking system to say that it is better or worse than waiting lists. However, the potential pitfalls in terms of the impact on patients and their communities needs exploring sooner rather than later.

Notes

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