

Waiting times for elective surgery in Australia 1999–00

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Foreword

Data on elective surgery waiting times are always of interest but interpretation can be difficult and comparability of data can be subject to a wide range of influences. Over the last few months the Institute has been working with the States and Territories through the Australian Health Minister's Advisory Council and the National Health Information Management Group to revise methods of presenting elective surgery waiting times data, that will mean that the data are easier to interpret and more comparable. Hence, the focus of this report is the number of days waited by patients regardless of their clinical urgency category.

Elective surgery waiting times data are still in need of improvement, therefore the Institute is currently undertaking a review of several national elective surgery waiting times data definitions, with funding provided by the Australian Health Ministers' Advisory Council. This review is likely to lead to further standardisation and improvements in the data definitions from July 2003. Work will also be undertaken on improving methods for estimating coverage of the National Elective Surgery Waiting Times Collection.

National Elective Surgery Waiting Times data will be reported as part of Australian Hospital Statistics for 2000-01 and in the future. This will enable the data to be presented along with a range of other data on hospital activity and performance.

Richard Madden
Director
January 2002

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At the Institute, the report was prepared by Narelle Grayson, Jenny Hargreaves and Ruth Penm; Alannah Smith helped with formatting and Amanda Nobbs managed the publication process.

1 Introduction

Waiting lists for elective surgery, and the associated waiting times, are often used to evaluate the status of health services within a community, particularly the ability of public hospitals to provide access to their services, that is, to provide timely care according to need. The States and Territories have been developing data on waiting times for some years and, since 1995, have agreed to provide these data to the Australian Institute of Health and Welfare as part of the National Minimum Data Set for Elective Surgery Waiting Times.

The data on elective surgery waiting times have undergone considerable improvement over recent years. There remain, however, differences among the States and Territories and between years in collection arrangements, in the hospitals included and, as noted below, in the assignment of clinical urgency categories. Hence, comparisons between jurisdictions and between 1999–00 and other reporting periods should be made with reference to the notes on the variations in coverage and use of definitions.

This report

This report presents summary data on 1999–00 elective surgery waiting times collected by State and Territory health authorities and provided to the National Elective Surgery Waiting Times Data Collection at the Institute. Earlier data on elective surgery waiting times have been reported for January to June in 1995 (Moon 1996), for the two years 1995–96 and 1996–97 (AIHW 2000b), for 1997–98 (AIHW 2000c) and for 1998–99 (AIHW 2001a).

The focus of this report is waiting times rather than waiting lists because, without knowledge of the rate of turnover of patients on a waiting list, the list's size is not a reliable indicator of access to the hospital system or of the amount of time a patient would be likely to have to wait, or to have waited, before surgery.

The waiting times data presented in this report are for patients admitted for their elective surgery during 1999–00. Waiting times for patients admitted during a particular period are generally used as the main summary measure of elective surgery waiting times, although they provide measures of waiting times only for patients who complete their wait and are admitted. Most patients are admitted after waiting, however, 10% to 20% of patients are removed from waiting lists for other reasons, for example, they were admitted as an emergency patient for the awaited procedure; or they could not be contacted, had died, had been treated elsewhere or had declined the surgery.

In previous reports, data on the time waited by patients on waiting lists on particular census dates (for example, 30 June 1999) have also been presented. Although census data encompass both patients who are eventually admitted for their surgery and those who are not (unlike the admissions data presented in this report), they do not represent the completed waiting time experience of patients, and can be difficult to interpret. Census data have not been included in this report.

Also in previous reports, analysis of elective surgery waiting times data focused on patients admitted from elective surgery waiting lists who had extended waits for admission, defined according to the clinical urgency category of the patient. However, there is uncertainty about the uniformity of assignment of clinical urgency categories among the States and Territories, so the main focus of this report is times waited for admission for elective surgery for all patients, regardless of clinical urgency category.

State and Territory overview, specialty of surgeon and indicator procedures

- The main body of this report contains three sections. Chapter 2 provides a State and Territory overview, and chapters 3 and 4 provide data by the specialty of the surgeon who was to perform the elective surgery and by indicator procedure, respectively. Each section in the report includes the following data.
- The distribution of days waited by patients admitted from waiting lists for elective surgery, by hospital peer group and State and Territory.
- The proportion of patients admitted from waiting lists who waited more than 12 months for elective surgery.
- Information on the number of admissions for elective surgery.
- In addition, chapter 2 includes the number of patients added to waiting lists and the number of patients removed from waiting lists for admission or another reason. This provides information about the movement of patients onto and off waiting lists. Data on the reasons for removal (elective admission or another reason) are also presented.

Data are not presented for the Australian Capital Territory. Data for only one hospital were available (see below), so that jurisdiction has not been included in any part of this report. Data for the Australian Capital Territory are also not included in the totals for Australia.

Appendixes for each State and Territory

An appendix is presented for each State and Territory. For each, included is a commentary on the management of elective surgery and waiting lists in the jurisdiction, which provides contextual information relevant to interpretation of the data.

For Queensland, Western Australia, South Australia, Tasmania and the Northern Territory, the appendixes also include information on patients admitted from waiting lists after extended waits, by clinical urgency category. Separate appendixes for these jurisdictions are included because apparent differences in the assignment of patients to clinical urgency categories among the States and Territories mean that these State and Territory data should not be regarded as comparable. For example, the proportion of patients assigned to clinical urgency category 1 ranged from 24% in South Australia to 44% in Tasmania (Tables A5.1 and A6.1).

The data presented by clinical urgency category are:

- The proportion of patients admitted from waiting lists following extended waits by hospital peer group. These data are also presented by the specialty of the surgeon who was to perform the surgery and by indicator procedure.
- Information on the number of admissions for elective surgery.

New South Wales and Victoria did not agree to their clinical urgency category data being included in this report.

50th and 90th percentiles

The number of days waited by patients is reported at the 50th and the 90th percentiles. The 50th percentile (the median or the middle value in a group of data arranged from lowest to highest) represents the number of days within which 50% of patients were admitted; half the waiting times will have been shorter and half the waiting times will have been longer than the median. The 90th percentile data represent the number of days within which 90% of

patients were admitted. The 50th and 90th percentiles were calculated using SAS version 8 and rounded to the nearest whole number of days.

Hospital peer groups

- The hospital peer group classification was developed by the Institute for analysis of costs per casemix-adjusted separation. It groups hospitals into broadly similar categories in terms of their volume of admitted patient activity and their geographical location. This classification has been adapted for use with elective surgery waiting times data (see Appendix 9 for further details).

Data validation

The States and Territories provide the Institute with elective surgery waiting times data at the patient level. These data are generally individual records of the amount of time waited by each patient admitted from a waiting list during the year, along with other details such as their clinical urgency category, the specialty of the surgeon who was to perform the surgery, and whether the patient was waiting for a particular indicator procedure.

The Institute works with the States and Territories to validate the data. Detailed checking of the data is undertaken, including ensuring that the data provided are internally consistent. Any apparently anomalous data are queried with the providing State or Territory and are not considered final until all anomalies are resolved.

Other notes on data presentation

- Where the number of hospitals reported in a peer group category was one, data on the distribution of days waited were not published. Similarly, in the appendixes, data on the proportion of patients with extended waits were not published.
- Where denominator counts of patients were less than 10, data on the proportion of patients who waited more than 12 months were not published. Similarly, in the appendixes, data on the proportion of patients admitted from waiting lists with an extended wait were not published.

State and Territory data coverage

The National Elective Surgery Waiting Times Data Collection relates to public acute care hospitals. Private hospitals were not included, except for two hospitals in New South Wales that were funded by the New South Wales Health Department to provide services for public patients. Some public patients treated under contract in private hospitals in Victoria and Tasmania were also included.

In the Northern Territory all public acute care hospitals were included in the data collection. In the other States all public hospitals that undertake elective surgery were generally included, although data were not collected for some smaller public hospitals. South Australian and Queensland admissions data were derived from a database linked with the South Australian and Queensland data in the National Hospital Morbidity Database (see AIHW 2001b), respectively. For South Australia, a total of 89% of waiting list admission records were linked, so about 11% of records were not included in the admissions data. As noted above, data are not presented for the Australian Capital Territory because data were not available for one of the two public hospitals.

Table 2.1 includes information on the numbers of hospitals within each peer group and overall that were included in the State and Territory elective surgery waiting times data collections. Comparing the number of hospitals reporting to the National Elective Surgery Waiting Times Data Collection with the number of hospitals in peer groups provides some information on coverage. All but one Queensland hospital in the peer group 'Principal referral and women's and children's' are included in the Collection. Progressively higher proportions of the 'Large' and 'Medium' hospitals are not included in the Collection. However, hospitals that were not included may not have had waiting lists at all. Alternatively, they may have had waiting lists, but with different characteristics compared with waiting lists of the reporting hospitals.

Table 2.1 also includes estimates of the proportions of elective surgery admissions that were covered by the National Elective Surgery Waiting Times Data Collection. The Institute derived these estimates from data provided by the States and Territories for the National Hospital Morbidity Database (AIHW 2001). The estimates were derived as:

- the number of separations with a surgical procedure for public hospitals reporting to the National Elective Surgery Waiting Times Data Collection as a proportion of the number of separations with a surgical procedure for all public hospitals.

Separations for cosmetic surgery were excluded. The definition of 'surgical procedure' used for these estimates is detailed in the glossary and based on the definition of Elective surgery in the *National Health Data Dictionary* (see glossary). It should be noted that, since these estimates are based on all admissions, rather than on elective admissions only, they provide an indication of coverage, but are not actual measures of coverage.

Based on this measure, overall coverage of the National Elective Surgery Waiting Times Data Collection (excluding the Australian Capital Territory) was about 85%, and ranged from 100% in the New South Wales, Tasmania and the Northern Territory, to about 67% in South Australia. Coverage was highest for the peer group 'Principal referral and women's and children's hospitals' at about 100%, and progressively lower for the 'Large hospitals' and 'Medium hospitals' groups.

The coverage in previous years was not necessarily the same in each State and Territory as in 1999–00. For previous reports, estimates of coverage were provided by the States and Territories and estimation methods may have varied. This should be taken into consideration in any comparison of 1999–00 data with data from previous years.

Admissions other than for elective surgery

There was some variation in the patients included in the data on admissions from the waiting lists. Most States and Territories provided data separately for patients admitted for the awaited procedure on an elective basis and for patients admitted as an emergency patient for the awaited procedure. In this case, only the data on admissions that were elective have been included in this report, because patients who were admitted as emergency patients for the awaited procedure can no longer be regarded as having had 'elective surgery'.

However, small numbers of records for emergency admissions could not be excluded from the data supplied to the Institute by Tasmania and the Northern Territory. This may have had the effect of lowering the reported waiting times for these jurisdictions relative to others.

Definitions

National Health Data Dictionary definitions (NHDC 1999) are the basis of the National Elective Surgery Waiting Times Data Collection and are summarised in the glossary. However, some of the definitions used varied slightly among the States and Territories in 1999–00 and in comparison with previous reporting periods. Comparisons between jurisdictions and between 1999–00 and previous reporting periods should therefore be made with reference to the notes on the definitions used.

Clinical urgency and extended waits

Data presented in the State and Territory specific appendixes are presented by clinical urgency category.

Patients waiting for elective surgery are classified according to their clinical urgency into three categories:

- category 1 – admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency;
- category 2 – admission within 90 days desirable for a condition causing some pain, dysfunction or disability but that is not likely to deteriorate quickly or become an emergency;
- category 3 – admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

‘Extended waits’ are defined as waits longer than 30 days for clinical urgency category 1, waits longer than 90 days for clinical urgency category 2, and waits longer than 12 months for clinical urgency category 3. Patients in clinical urgency categories 1 and 2 who have extended waits are referred to as ‘overdue’.

Calculation of waiting times

Waiting times are generally calculated by comparing the date on which a patient was added to a waiting list with the date that they were admitted. Days on which the patient was ‘not ready for care’ are excluded.

There was some variation in the method the States and Territories used to calculate waiting times for patients who changed clinical urgency category while they were on the waiting list, and for patients who were transferred from a waiting list managed by one hospital to that managed by another.

Changed clinical urgency category

For patients who changed clinical urgency category, three methods were used:

- (a) counting the time waited in the most recent urgency category plus any time waited in more urgent categories, e.g. time waited in category 2, plus time spent previously in category 1 (this is the agreed national standard for counting);
- (b) counting the time waited in all urgency categories;
- (c) counting the time waited in the most recent urgency category only.

New South Wales, Queensland and Tasmania counted the time waited in the most recent urgency category plus the time waited in previous urgency categories if the previous

urgency categories were of higher urgency (a). The Northern Territory counted total waiting time in all urgency categories (b). Victoria, Western Australia and South Australia counted only the time waited in the most recent urgency category (c). Western Australia has indicated that the national standard for counting will be able to be used for all future reporting periods. As discussed, data are not available for the Australian Capital Territory for 1999–00.

It should be noted that methods (a) and (c) are equivalent for patients in urgency category 1 (the most urgent category), who cannot have spent time in a more urgent category. Method (b) would have had the effect of increasing the apparent waiting time (and thus the proportion of patients with extended waits) for category 1 patients admitted in the Northern Territory compared with other jurisdictions.

For urgency categories 2 and 3, the variation in counting method could have the effect of increasing the reported waiting times for admissions in the Northern Territory compared with all other jurisdictions and in New South Wales, Queensland and Tasmania compared with Victoria, Western Australia and South Australia.

Transfers between waiting lists

For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is not generally included in the waiting time reported to the National Elective Surgery Waiting Times Data Collection. Therefore, the number of days waited reflects the waiting time on the list managed by the reporting hospital only. This would have the effect of shortening the reported waiting time compared with the time actually waited for these patients.

Victoria and Western Australia were able to report the total time waited on all waiting lists. This could have the effect of increasing the reported waiting time for admissions in Victoria and Western Australia compared with other jurisdictions. South Australia has indicated that it is uncommon for patients to be transferred from a waiting list managed by one public hospital to that managed by another in that jurisdiction.

Indicator procedures

It is possible that the procedures included for each indicator procedure may have varied between jurisdictions. This is because some jurisdictions identify indicator procedures according to the descriptive list of procedures provided in the *National Health Data Dictionary* (NHDC 1999) and other jurisdictions use the codes from the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM)* (National Centre for Classification in Health 1998), which are also provided in the *National Health Data Dictionary*.

2 State and Territory overview

This section provides data, by State and Territory, on the distribution of days waited by patients admitted from elective surgery waiting lists (Table 2.1) and on the number of additions to and removals from (for admission or another reason) waiting lists during the collection period (Table 2.2).

Distribution of waiting times

Table 2.1 presents data on the number of days waited at the 50th and 90th percentiles for patients admitted from waiting lists for elective surgery. These data are presented by State and Territory and by hospital peer group. The number of admissions from waiting lists reported to the National Elective Surgery Waiting Times Data Collection and the proportion of patients who waited more than 12 months for admission are also presented.

Information is also included about the number of hospitals in each peer group and the number of hospitals reporting to the Collection in each peer group. Differences between the number of hospitals included in the peer group and the number reporting elective surgery waiting times may provide some indication of the coverage of the data collection. For example, there are hospitals missing in Western Australia and South Australia in some peer group categories because the collection does not cover them in those States. Hospitals that were not included may not actually undertake elective surgery, may not have had waiting lists, or may have had different waiting list characteristics compared with reporting hospitals.

The table also includes estimates of the coverage of the Collection based on information provided to the National Hospital Morbidity Database on the number of surgery separations for the hospitals included in the Collection as a proportion of the number of surgery separations in all public hospitals (see chapter 1 for further details). These estimates broadly reflect the numbers of hospitals in the peer groups included in the Collection.

Hospitals in the 'Principal referral and women's and children's' peer group accounted for 66.2% of admissions from elective surgery waiting lists. Another 18.2% were reported for hospitals in the 'Large hospitals' peer group and 14.0% of admissions from waiting lists were reported for hospitals in the 'Medium hospitals' peer group. Waiting times for patients admitted from waiting lists in hospitals not included in these peer group categories are included in the total.

Overall, the median waiting time for patients who were admitted from waiting lists was 27 days, ranging from 22 days in Queensland to 36 days in Tasmania. Ninety percent of patients were admitted within 175 days, ranging from 134 days in Queensland to 292 days in Tasmania.

The shortest median waiting time was for patients admitted from waiting lists in hospitals in the 'Principal referral and women's and children's' peer group. The longest median waiting time was for patients admitted from waiting lists in hospitals in the 'Large hospitals' peer group.

In the 'Principal referral and women's and children's' peer group, 3.4% of patients were admitted after waiting more than 12 months. In the 'Large hospitals' peer group 2.7% of

Table 2.1: Waiting times statistics for patients admitted from waiting lists, by State and Territory and hospital peer group, 1999–00

Peer group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Principal referral & women's & children's hospitals									
Number of hospitals in peer group	23	16	15	5	4	2	n.p.	1	66
Number of reporting hospitals ^(b)	23	16	14	5	4	2	n.p.	1	65
Estimated coverage (%)	100	100	98	100	100	100	n.p.	100	100
Number of admissions ^(c)	113,346	87,076	85,580	26,042	22,806	10,896	n.p.	3,731	349,477
Days waited at 50th percentile	22	27	21	33	26	36	n.p.	n.p.	24
Days waited at 90th percentile	156	199	132	293	153	282	n.p.	n.p.	177
% waited more than 12 months	2.3	4.0	3.0	7.6	2.3	6.0	n.p.	n.p.	3.4
Large hospitals									
Number of hospitals in peer group	17	14	7	2	3	1	n.p.	1	45
Number of reporting hospitals ^(b)	17	6	7	0	3	1	n.p.	1	35
Estimated coverage (%)	100	52	100	0	100	100	n.p.	100	77
Number of admissions ^(c)	39,800	24,842	17,474	..	9,877	2,702	n.p.	1,409	96,104
Days waited at 50th percentile	31	33	27	..	40	n.p.	n.p.	n.p.	31
Days waited at 90th percentile	201	156	141	..	166	n.p.	n.p.	n.p.	174
% waited more than 12 months	2.8	1.7	3.3	..	1.9	n.p.	n.p.	n.p.	2.7
Medium hospitals									
Number of hospitals in peer group	41	28	16	12	15	0	n.p.	..	112
Number of reporting hospitals ^(b)	41	2	11	6	0	..	n.p.	..	60
Estimated coverage (%)	100	15	92	72	0	..	n.p.	..	58
Number of admissions ^(c)	41,766	4,398	9,201	18,486	..	..	n.p.	..	73,851
Days waited at 50th percentile	28	22	29	29	..	..	n.p.	..	28
Days waited at 90th percentile	155	173	154	184	..	..	n.p.	..	166
% waited more than 12 months	1.9	4.1	2.5	2.9	..	..	n.p.	..	2.4
Total^(a)									
Number of hospitals in peer group	221	144	159	90	80	23	n.p.	5	722
Number of reporting hospitals ^(b)	108	24	33	11	7	3	n.p.	5	191
Estimated coverage (%)	100	71	95	75	67	99	n.p.	100	85
Number of admissions ^(c)	202,281	116,316	112,718	44,528	32,683	13,598	n.p.	5,786	527,910
Admissions per 1,000 population ^(d)	31.5	24.5	31.9	23.8	21.8	28.9	n.p.	29.8	27.8
Days waited at 50th percentile	26	28	22	31	30	36	n.p.	23	27
Days waited at 90th percentile	168	187	134	242	157	292	n.p.	149	175
% waited more than 12 months	2.4	3.6	3.0	5.7	2.2	6.7	n.p.	1.6	3.1

(a) Includes data for hospitals not included in the specified hospital peer groups.

(b) Number of hospitals reporting to the National Elective Surgery Waiting Times Collection.

(c) Number of admissions for elective surgery reported to the National Elective Surgery Waiting Times Collection.

(d) Crude rates.

.. not applicable.

n.p. not published because there was only one hospital in the peer group.

patients waited more than 12 months and in the 'Medium hospitals' peer group, 2.4% of patients waited more than 12 months.

Overall, the proportion of patients admitted after waiting more than twelve months varied among the States and Territories, ranging from 1.6% in the Northern Territory to 6.7% in Tasmania.

There were 27.8 admissions reported for elective surgery per 1,000 population (crude rate) for Australia overall.

Additions and removals from waiting lists

Table 2.2 shows the movement of patients on and off waiting lists in 1999–00. Patients are removed from waiting lists either when they are admitted on an elective basis for the procedure for which they were waiting or for a range of other reasons such as admission as an emergency patient for the procedure for which they were waiting; the surgery not being required; or the patient not being able to be contacted by the hospital, having died, having the surgery elsewhere or declining the surgery (see the glossary for a full description of the categories).

Of total removals (elective admissions and other), elective admissions accounted for the greatest proportion overall (86.6%), ranging from 65.4% in the Northern Territory to 90.0% in South Australia.

Table 2.2: Number of additions to and removals from waiting lists, by State and Territory, 1999–00

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Additions	237,610	138,223	131,568	49,737	39,295	15,925	n.p.	7,243	619,601
Removals^(a)									
Admitted as an elective patient	202,281	116,316	112,718	44,528	32,683	13,598 ^(b)	n.p.	5,786 ^(b)	527,910
Admitted as an emergency patient	1,480	454	n.a.	52	131	n.a.	n.p.	10	2,127
Could not be contacted/died	1,808	1,567	n.a.	280	282	1428	n.p.	228	5,593
Treated elsewhere	8,775	3,980	n.a.	2,613	657	392	n.p.	145	16,562
Surgery not required or declined	12,452	9,637	n.a.	5,412	1613	1046	n.p.	950	31,110
Not reported	..	..	20,049	3,237	964	..	n.p.	1,730	25,980
Total	226,796	131,954	132,767	56,122	36,330	16,464	n.p.	8,849	609,282

(a) See the glossary for a full description of the categories.

(b) For Tasmania and the Northern Territory, small numbers of emergency admissions were included with the elective admissions.

n.a. not available.

n.p. not published.

.. not applicable.

Information on the reason for removal other than elective admission for the awaited procedure was not available for Queensland. For the other States and Territories, 'Surgery not required or declined' was the reason for removal with the greatest proportion of removals (6.5%, 31,110 patients) following admissions as elective patients. A further 0.4% of patients (2,127) were admitted as emergency patients, 1.2% (5,593) could not be contacted and 3.5% (16,562) were treated elsewhere. The reason for removal was not reported for 1.2% (5,931) of patients who were removed from waiting lists.

3 Specialty of surgeon

In this chapter data are reported by the specialty of the surgeon who was to perform the elective surgery and by State and Territory.

Distribution of waiting times

Table 3.1 shows the distribution of days waited by patients admitted from waiting lists, by the specialty of the surgeon who was to perform the surgery and by State and Territory.

Orthopaedic surgery and ophthalmology were the surgical specialties with the longest median waiting times (53 and 54 days respectively). All other surgical specialties except ear, nose and throat surgery had median waiting times of less than 30 days; cardio-thoracic surgery had the shortest median waiting time (11 days).

The median waiting time varied markedly among the States and Territories for orthopaedic surgery, with 50% of patients being admitted within 22 days in Queensland and within 146 days in Tasmania. For plastic surgery, variation in the median waiting time was less marked, ranging from 14 days in the Northern Territory to 29 days in Tasmania and Western Australia, respectively.

Table 3.1: Days waited by patients admitted from waiting lists, by specialty of surgeon and State and Territory, percentiles, 1999–00

Surgical specialty	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Cardio-thoracic									
Days waited at 50th percentile	12	8	12	13	6	24	n.p.	..	11
Days waited at 90th percentile	66	55	84	53	76	135	n.p.	..	65
Ear, nose & throat surgery									
Days waited at 50th percentile	51	35	32	56	36	49	n.p.	45	44
Days waited at 90th percentile	308	284	286	348	228	371	n.p.	329	301
General surgery									
Days waited at 50th percentile	21	24	20	26	29	36	n.p.	34	23
Days waited at 90th percentile	125	162	112	158	126	308	n.p.	162	142
Gynaecology									
Days waited at 50th percentile	21	28	27	21	25	31	n.p.	7	23
Days waited at 90th percentile	108	156	94	71	111	118	n.p.	62	112
Neurosurgery									
Days waited at 50th percentile	13	14	7	19	13	25	n.p.	..	14
Days waited at 90th percentile	58	128	78.5	139	68	172	n.p.	..	84
Ophthalmology									
Days waited at 50th percentile	63	40	26	86	35	56	n.p.	64	54
Days waited at 90th percentile	315	165	358	301	224	500	n.p.	217	268

(continued)

Table 3.1 (continued): Days waited by patients admitted from waiting lists, by specialty of surgeon and State and Territory, percentiles, 1999–00

Surgical specialty	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Orthopaedic surgery									
Days waited at 50th percentile	43	54	22	101	58	146	n.p.	37	53
Days waited at 90th percentile	274	304	174	520	252	406	n.p.	216	315
Plastic surgery									
Days waited at 50th percentile	23	21	21	29	27	29	n.p.	14	24
Days waited at 90th percentile	100	159	107	240	134	159	n.p.	119	153
Urology									
Days waited at 50th percentile	25	25	23	18	29	34	n.p.	33	25
Days waited at 90th percentile	111	146	119	91	138	363	n.p.	89	126
Vascular surgery									
Days waited at 50th percentile	12	15	12	20	8	29	n.p.	..	13
Days waited at 90th percentile	78	141	94	165	43	208	n.p.	..	94
Other									
Days waited at 50th percentile	6	30	15	17	2	5	n.p.	14	14
Days waited at 90th percentile	63	126	89	291	28	27	n.p.	56	104
Total									
Days waited at 50th percentile	26	28	22	31	30	36	n.p.	23	27
Days waited at 90th percentile	168	187	134	242	157	292	n.p.	149	175

n.p. not published.

.. not applicable.

Proportion waiting more than 12 months

Table 3.2 shows the proportion of patients admitted from waiting lists who waited more than 12 months, by the specialty of the surgeon who was to perform the surgery and by State and Territory.

Orthopaedic surgery and ear, nose and throat surgery and were the specialties with the highest proportion of patients who waited more than a year to be admitted (6.6% and 7.0% respectively). Cardio-thoracic surgery had the lowest proportion of patients who waited more than a year (0.1%), followed by gynaecological surgery (0.9%) and neurosurgery (1.0%).

There was marked variation among the States and Territories in the proportion of patients who waited more than a year to be admitted for some surgical specialties. For example, 1.6% of patients admitted for orthopaedic surgery waited more than a year in the Northern Territory compared with 18.1% of patients in Western Australia. For ophthalmology, 1.8% of patients waited more than a year to be admitted in the Northern Territory compared with 17.6% of patients in Tasmania.

Table 3.2: Proportion of patients admitted from waiting lists who waited more than 12 months, by specialty of surgeon and State and Territory, 1999-00

Surgical specialty	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Cardio-thoracic	0.0	0.1	0.2	0.1	0.3	0.2	n.p.	..	0.1
Ear, nose & throat surgery	6.8	7.0	7.1	9.4	4.5	10.0	n.p.	7.1	7.0
General surgery	1.0	3.0	1.9	3.0	1.0	7.1	n.p.	1.5	1.8
Gynaecology	0.6	1.8	1.0	0.3	0.1	0.9	n.p.	0.2	0.9
Neurosurgery	0.2	2.8	0.8	1.1	0.1	1.6	n.p.	..	1.0
Ophthalmology	6.1	1.9	9.6	6.3	2.8	17.6	n.p.	1.8	5.4
Orthopaedic surgery	5.4	7.4	4.0	18.1	5.0	13.6	n.p.	1.6	6.6
Plastic surgery	0.7	3.6	2.9	6.1	1.9	3.1	n.p.	3.1	2.9
Urology	1.1	2.2	1.4	1.3	2.1	9.7	n.p.	0.0	1.8
Vascular surgery	1.6	3.1	2.5	5.1	0.4	4.8	n.p.	..	2.4
Other	0.0	0.2	0.6	5.6	0.0	0.5	n.p.	0.5	0.9
Total	2.4	3.6	3.0	5.7	2.2	6.6	n.p.	1.6	3.1

n.p. not published.

.. not applicable.

Admissions from waiting lists

Table 3.3 presents State and Territory information on the total number of patients admitted for elective surgery from waiting lists in 1999-00. Nationally, admissions from waiting lists were highest for general surgery (145,309) and lowest for neurosurgery (8,139). Admissions from waiting lists were highest for general surgery for all jurisdictions except the Northern Territory, where the highest number of admissions was for gynaecological surgery. Neurosurgery had the lowest number of admissions for all States and Territories where it is undertaken.

Table 3.3: Admissions from waiting lists, by specialty of surgeon and State and Territory, 1999-00

Surgical specialty	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Cardio-thoracic	4,727	3,544	4,055	1,058	683	486	n.p.	0	14,553
Ear, nose & throat surgery	16,807	12,346	8,831	4,512	3,379	974	n.p.	547	47,396
General surgery	62,170	26,791	33,112	9,986	8,054	3,408	n.p.	1,788	145,309
Gynaecology	37,333	15,762	17,075	6,770	4,135	2,749	n.p.	1,946	85,770
Neurosurgery	3,197	1,976	1,500	665	677	124	n.p.	0	8,139
Ophthalmology	17,647	13,180	7,820	4,973	2,920	437	n.p.	514	47,491
Orthopaedic surgery	26,642	16,446	19,621	5,874	4,825	1,700	n.p.	615	75,723
Plastic surgery	7,372	8,970	7,635	3,421	2,902	1,315	n.p.	97	31,712
Urology	17,317	11,085	8,479	4,784	3,915	1,809	n.p.	76	47,465
Vascular surgery	4,599	2,731	2,566	961	1,110	188	n.p.	0	12,155
Other	4,470	3,485	2,024	1,524	83	408	n.p.	203	12,197
Total	202,281	116,316	112,718	44,528	32,683	13,598	n.p.	5,786	527,910

n.p. not published.

4 Indicator procedure

In this chapter data are reported for patients who were admitted from waiting lists for elective surgery by indicator procedure and by State and Territory.

Distribution of days waited

Table 4.1 shows State and Territory data on the distribution of days waited by patients admitted from waiting lists, by indicator procedure. Nationally, the indicator procedure with the lowest median waiting time was coronary artery bypass graft (15 days) and the indicator procedure with the highest median waiting time was total knee replacement (112 days).

For cystoscopy, median waiting times did not vary greatly among the States and Territories, ranging from 21 days in Western Australia to 38 days in South Australia. There was however, marked variation among the States and Territories in the median waiting time for septoplasty, from 44 days in Western Australia to 97 days in New South Wales and 451 days in Tasmania.

The length of time by which 90% of patients had been admitted also varied by indicator procedure, from 88 days for coronary artery bypass graft to 575 days for septoplasty.

Table 4.1: Days waited by patients admitted from waiting lists, by indicator procedure and State and Territory, percentiles, 1999–00

Indicator procedure	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Cataract extraction									
Days waited at 50th percentile	90	63	38	106	41	142	n.p.	85	73
Days waited at 90th percentile	347	175	429	290	255	531	n.p.	224	316
Cholecystectomy									
Days waited at 50th percentile	42	42	39	39	41	84	n.p.	61	42
Days waited at 90th percentile	213	186	160	183	134	399	n.p.	233	195
Coronary artery bypass graft									
Days waited at 50th percentile	14	12	19	17	7	42	n.p.	..	15
Days waited at 90th percentile	87	66	109	44	91	139	n.p.	..	88
Cystoscopy									
Days waited at 50th percentile	25	24	28	21	38	32	n.p.	35	26
Days waited at 90th percentile	103	132	142	119	186	228	n.p.	130	125
Haemorrhoidectomy									
Days waited at 50th percentile	34	53	42	41	60	64	n.p.	93	41
Days waited at 90th percentile	162	299	257	256	173	602	n.p.	371	223
Hysterectomy									
Days waited at 50th percentile	38	41	35	30	40	42	n.p.	53	37
Days waited at 90th percentile	151	200	99	89	127	137	n.p.	166	140

(continued)

Table 4.1 (continued): Days waited by patients admitted from waiting lists, by indicator procedure and State and Territory, percentiles, 1999–00

Indicator procedure	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Inguinal herniorrhaphy									
Days waited at 50th percentile	36	40	35	38	41	83	n.p.	57	37
Days waited at 90th percentile	185	232	167	165	126	393	n.p.	209	190
Myringoplasty									
Days waited at 50th percentile	93	60	95	144	61	219	n.p.	251	92
Days waited at 90th percentile	389	432	688	531	316	819	n.p.	528	475
Myringotomy									
Days waited at 50th percentile	31	29	43	42	30	34	n.p.	15	33
Days waited at 90th percentile	192	95	175	196	84	73	n.p.	62	144
Prostatectomy									
Days waited at 50th percentile	27	30	23	18	27	42	n.p.	43	26
Days waited at 90th percentile	115	175	153	70	153	59	n.p.	260	133
Septoplasty									
Days waited at 50th percentile	97	116	70	44	90	451	n.p.	117	94
Days waited at 90th percentile	398	593	787	847	393	1627	n.p.	604	575
Tonsillectomy									
Days waited at 50th percentile	94	47	50	77	47	210	n.p.	49	64
Days waited at 90th percentile	379	310	301	295	347	491	n.p.	309	349
Total hip replacement									
Days waited at 50th percentile	83	98	55	162	86	209	n.p.	76	88
Days waited at 90th percentile	364	301	237	476	308	449	n.p.	240	345
Total knee replacement									
Days waited at 50th percentile	115	124	69	226	102	261	n.p.	196	112
Days waited at 90th percentile	432	403	334	595	331	580	n.p.	328	424
Varicose veins stripping & ligation									
Days waited at 50th percentile	59	134	57	58	87	349	n.p.	132	69
Days waited at 90th percentile	292	644	533	396	311	977	n.p.	458	410
Not applicable									
Days waited at 50th percentile	20	23	19	25	25	31	n.p.	17	21
Days waited at 90th percentile	123	169	104	218	128	262	n.p.	125	138
Total									
Days waited at 50th percentile	26	28	22	31	30	36	n.p.	23	27
Days waited at 90th percentile	168	187	134	242	157	292	n.p.	149	175

n.p. not published.

. . not applicable.

Proportion waiting more than 12 months

State and Territory information on the proportion of patients who waited more than 12 months to be admitted from waiting lists for elective surgery is shown by indicator procedure in Table 4.2. The indicator procedure with the highest proportion of patients waiting more than a year was septoplasty (19.7%), followed by myringoplasty (14.9%). The

lowest proportion of patients waiting more than a year were waiting for a coronary artery bypass graft (0.1%).

The proportion of patients admitted from waiting lists who waited more than a year varied among the States and Territories. For example, 2.4% of patients waited more than a year for admission for cataract extraction in Victoria, compared with 33.9% in Tasmania. For total hip replacement, the proportion ranged from 5.7% in Victoria to 18.8% in Western Australia.

Table 4.2: Proportion of patients admitted from waiting lists who waited more than 12 months, by indicator procedure and State and Territory, 1999-00

Indicator procedure	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Cataract extraction	8.3	2.4	14.2	5.0	3.1	33.9	n.p.	1.5	7.0
Cholecystectomy	2.3	2.0	2.1	5.2	0.6	11.4	n.p.	1.6	2.5
Coronary artery bypass graft	0.0	0.1	0.3	0.0	0.3	0.0	n.p.	..	0.1
Cystoscopy	1.0	1.4	1.1	2.2	3.1	5.4	n.p.	1.0	1.4
Haemorrhoidectomy	2.0	6.9	7.5	7.6	0.5	13.5	n.p.	10.5	4.4
Hysterectomy	1.4	1.9	0.8	0.4	0.1	0.9	n.p.	2.6	1.2
Inguinal herniorrhaphy	1.6	5.0	3.0	2.8	0.0	10.3	n.p.	3.6	2.8
Myringoplasty	12.8	11.8	18.2	17.9	7.8	27.3	n.p.	31.7	14.9
Myringotomy	1.8	0.4	2.9	1.2	0.5	0.0	n.p.	0.0	1.4
Prostatectomy	1.1	2.7	3.7	1.3	5.0	0.0	n.p.	5.9	2.2
Septoplasty	13.7	23.5	24.5	21.1	10.9	61.0	n.p.	25.0	19.7
Tonsillectomy	11.6	7.7	6.8	6.3	8.1	20.0	n.p.	6.0	8.9
Total hip replacement	9.9	5.7	5.8	18.8	8.3	16.1	n.p.	7.1	8.9
Total knee replacement	15.9	12.4	8.1	29.2	8.8	26.3	n.p.	4.3	14.3
Varicose veins stripping & ligation	5.8	25.6	14.9	12.1	7.6	47.9	n.p.	13.3	12.3
Not applicable	1.2	3.1	2.1	5.4	1.5	5.5	n.p.	0.9	2.3
Total	2.4	3.6	3.0	5.7	2.2	6.6	n.p.	1.6	3.1

n.p. not published.

.. not applicable.

Admissions from waiting lists

Table 4.3 provides information on the number of patients admitted from waiting lists for elective surgery in 1999-00, by indicator procedure and State and Territory. Overall, 29.9% of patients admitted for elective surgery were waiting for one of the indicator procedures. There was some variation among the States and Territories: Victoria and Western Australia had the highest proportion of admissions for the indicator procedures (32.1%) and the Northern Territory had the lowest proportion (20.0%).

Cataract extraction was the highest volume indicator procedure for all jurisdictions except Queensland and Tasmania, where cystoscopy was the highest. Myringoplasty was the lowest volume indicator procedure for all States and Territories except Tasmania and the Northern Territory, where prostatectomy and total hip replacement were the lowest respectively. Coronary artery bypass grafts are not done in the Northern Territory.

Table 4.3: Admissions from waiting lists, by indicator procedure and State and Territory 1999–00

Indicator procedure	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Cataract extraction	12,631	8,264	4,372	3,352	1,816	183	n.p.	327	30,945
Cholecystectomy	6,969	3,179	3,641	1,027	852	421	n.p.	125	16,214
Coronary artery bypass graft	2,058	1,623	1,621	270	325	349	n.p.	0	6,246
Cystoscopy	10,838	6,150	4,983	2,176	1,621	665	n.p.	193	26,626
Haemorrhoidectomy	1,583	493	583	291	207	37	n.p.	19	3,213
Hysterectomy	5,687	2,141	2,581	1,277	697	449	n.p.	39	12,871
Inguinal herniorrhaphy	5,881	2,747	3,028	984	789	301	n.p.	138	13,868
Myringoplasty	375	373	303	246	103	22	n.p.	41	1,463
Myringotomy	798	2,864	2,116	986	183	127	n.p.	58	7,132
Prostatectomy	2,441	1,244	723	390	343	18	n.p.	17	5,176
Septoplasty	1,302	1,360	486	674	248	41	n.p.	16	4,127
Tonsillectomy	4,884	3,381	2,800	1,230	802	55	n.p.	117	13,269
Total hip replacement	2,033	1,469	874	448	554	155	n.p.	14	5,547
Total knee replacement	2,689	1,191	1,180	486	614	137	n.p.	23	6,320
Varicose veins stripping & ligation	2,122	805	1,003	453	436	71	n.p.	30	4,920
Not applicable	139,990	79,032	82,424	30,238	23,093	10,567	n.p.	4,629	369,973
% indicator procedures	30.8	32.1	26.9	32.1	29.3	22.3	n.p.	20.0	29.9
Total	202,281	116,316	112,718	44,528	32,683	13,598	n.p.	5,786	527,910

n.p. not published.

Appendix 1 New South Wales

The information presented in this section relates to the management of elective surgery. It is intended to provide contextual material for the data presented in the report, as well as to provide information for appropriate interpretation of the comparative data presented in the front part of the report and in the State and Territory specific appendixes, where included. New South Wales did not agree to their clinical urgency category data being included in this report.

New South Wales has a decentralised system for the management of elective surgery. Individual hospitals administer their own waiting lists, and Area Health Services, which are responsible for the management of public hospitals in New South Wales, are becoming increasingly involved in the management of elective surgery in order to maximise efficiency in the use of resources within the Area Health Service.

New South Wales Health negotiates performance agreements with each Area Health Service on an annual basis. These agreements include required levels of performance for the management of elective surgery. Ongoing liaison between the New South Wales Health Department, the Area Health Services and the hospitals is undertaken to allow for appropriate forward planning to improve access to elective surgery.

Timely access to hospital services on the basis of clinical need and waiting time is given ongoing high priority at the hospital, Area Health Service and State level. Clinical urgency categorisation is undertaken by the patient's specialist, in consideration of the relative urgency of each patient's condition.

Appendix 2 Victoria

The information presented in this section relates to the management of elective surgery. It is intended to provide contextual material for the data presented in the report, as well as to provide information for appropriate interpretation of the comparative data presented in the front part of the report and in the State and Territory specific appendixes, where included. Victoria did not agree to their clinical urgency category data being included in this report.

Victoria has a decentralised system for managing elective surgery. Waiting lists are managed by Health Services, which involves management across several campuses, where a health service covers more than one hospital.

The Victorian Quality Framework includes incentives for timely treatment of clinical urgency category 1 patients and for minimising the proportion of overdue clinical urgency category 2 patients.

Clinical urgency categories used are intended to be consistent with the agreed national standard published in the *National Health Data Dictionary* (NHDC 1999).

In 2000–01, the national method for counting time spent in urgency categories was adopted. Previously, only the time spent in the most recent clinical urgency category was reported.

Appendix 3 Queensland

The information presented in this section relates to the management of elective surgery. It is intended to provide contextual material for the data presented in the report, as well as to provide information for appropriate interpretation of the comparative data presented in the front part of the report and in the State and Territory specific appendixes, where included.

Elective surgery in Queensland is managed through an established waiting list program. This program is managed both centrally, by the Surgical Access Team within Queensland Health and operationally by elective surgery coordinators and liaison officers at the 33 public hospitals which undertake the majority of elective surgery in Queensland. In addition, statewide guidelines have been developed by Queensland Health for the management of elective surgery waiting lists.

The waiting list program provides incentive funding to hospitals that can undertake additional elective surgery above agreed baseline activity targets. Approximately \$70 million dedicated funding was allocated in 1999-00 for this purpose.

Clinical urgency categories used are intended to be consistent with the agreed national standard published in the *National Health Data Dictionary* (NHDC 1999). The guidelines for the management of waiting lists, developed by Queensland Health, provides definitions and instructions regarding the allocation of clinical urgency categories.

Queensland overview

This section reports Queensland data on the proportion of patients who were admitted for elective surgery after having waited on a waiting list for an extended period, by hospital peer group and clinical urgency category (Table A3.1).

Table A3.1: Waiting times statistics for patients admitted from waiting lists, by hospital peer group and clinical urgency category, Queensland, 1999–00

Peer group	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
Principal referral & women's & children's hospitals				
% extended wait	5.1	8.4	12.4	8.5
% in each category	27.7	48.5	23.8	100.0
Total admissions	23,670	41,507	20,403	85,580
Large hospitals				
% extended wait	4.1	9.0	10.7	8.4
% in each category	22.9	47.2	29.9	100.0
Total admissions	4,005	8,253	5,216	17,474
Medium hospitals				
% extended wait	4.4	4.3	5.9	5.0
% in each category	19.8	38.1	42.1	100.0
Total admissions	1,822	3,504	3,875	9,201
Total^(a)				
% extended wait	5.0	8.2	11.1	8.1
% in each category	26.2	47.3	26.5	100.0
Total admissions	29,521	53,341	29,856	112,718

(a) Includes data for hospitals not included in the specified hospital peer groups.

Overall, 8.1 % of patients were admitted from waiting lists with extended waits, 5.0% in clinical urgency category 1, 8.2% in clinical urgency category 2 and 11.1% in clinical urgency category 3. The highest proportion of patients admitted from waiting lists was in clinical urgency category 2 (47.3%), followed by 26.5% in category 3 and 26.2% in category 1.

For clinical urgency category 1, the highest proportion of patients admitted with extended waits was from hospitals in the 'Principal referral and women's and children's hospitals' peer group and the lowest proportion was in the 'Large hospitals' peer group.

Specialty of surgeon—Queensland

Table A3.2 shows the proportion of patients who were admitted from waiting lists with extended waits, by the specialty of the surgeon who was to perform the elective surgery and by clinical urgency category. Overall, ear, nose and throat surgery accounted for the largest proportion of patients admitted with extended waits (14.9%), followed by ophthalmology (11.8%). The surgical specialty with the lowest proportion of patients admitted with extended waits (disregarding 'other' surgery) was gynaecology (4.7%).

The surgical specialty with the lowest proportion of patients admitted from waiting lists with extended waits in clinical urgency category 1 was orthopaedic surgery (2.4%) and the surgical specialty with the highest proportion was vascular surgery (10.4%).

Table A3.2: Proportion of patients admitted from waiting lists with extended waits, by specialty of surgeon and clinical urgency, Queensland, 1999–00

Surgical specialty	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cardio-thoracic	4.3	15.4	2.8	9.2
Ear, nose & throat surgery	5.1	15.6	19.8	14.9
General surgery	4.0	7.5	6.7	6.3
Gynaecology	6.3	4.2	4.1	4.7
Neurosurgery	3.9	8.2	5.4	6.0
Ophthalmology	5.3	3.6	22.7	11.8
Orthopaedic surgery	2.4	10.3	14.8	9.9
Plastic surgery	4.7	7.8	14.3	8.3
Urology	8.6	9.7	5.0	8.1
Vascular surgery	10.4	7.9	19.4	10.4
Other	3.4	4.7	1.7	3.2
Total	5.0	8.2	11.1	8.1

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by surgical specialty in Table A3.3. For cardio-thoracic surgery, the highest proportion of patients admitted from waiting lists were in clinical urgency category 1 (48.7%) and the lowest proportion were in clinical urgency category 3 (6.1%). For orthopaedic surgery the highest proportion of patients were in clinical urgency category 2 (54.5%).

Cardio-thoracic surgery and neurosurgery were the surgical specialties with the highest proportion of patients admitted from waiting lists in the most urgent clinical urgency category (category 1, 48.7% and 43.1% respectively).

Indicator procedure—Queensland

Table A3.4 shows the proportion of patients admitted from waiting lists with extended waits by indicator procedure and clinical urgency category. Overall, myringoplasty accounted for the largest proportion of patients admitted with extended waits (28.7%). The smallest proportion of patients admitted with extended waits was 5.7% for hysterectomy.

In clinical urgency category 1, the indicator procedure with the lowest proportion of patients admitted with extended waits was haemorrhoidectomy (3.0%). The indicator procedure with the highest proportion of patients admitted with extended waits in clinical urgency category 1 was myringoplasty (27.3%).

Table A3.3: Proportion of patients admitted from waiting lists, by clinical urgency and specialty of surgeon, Queensland, 1999–00

Surgical specialty	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cardio-thoracic	48.7	45.3	6.1	100.0
Ear, nose & throat surgery	20.9	44.5	34.5	100.0
General surgery	29.3	43.0	27.7	100.0
Gynaecology	25.3	51.1	23.6	100.0
Neurosurgery	43.1	45.8	11.1	100.0
Ophthalmology	10.9	47.0	42.1	100.0
Orthopaedic surgery	19.3	54.5	26.2	100.0
Plastic surgery	26.0	54.5	19.5	100.0
Urology	33.4	40.8	25.8	100.0
Vascular surgery	39.9	47.6	12.4	100.0
Other	26.4	36.0	37.6	100.0
Total	26.2	47.3	26.5	100.0

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by indicator procedure in Table A3.5. Coronary artery bypass graft was the indicator procedure with the highest proportion of patients admitted from waiting lists who were in clinical urgency category 1 (44.1%). The indicator procedure with the lowest proportion of admitted patients in clinical urgency category 1 was septoplasty (2.3%).

Table A3.4: Proportion of patients admitted from waiting lists with extended waits, by indicator procedure and clinical urgency, Queensland, 1999–00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	8.4	4.0	27.8	16.3
Cholecystectomy	5.7	12.1	8.4	10.2
Coronary artery bypass graft	5.6	20.6	9.1	13.6
Cystoscopy	7.4	10.6	3.4	7.5
Haemorrhoidectomy	3.0	9.9	21.6	13.2
Hysterectomy	13.1	4.9	2.8	5.7
Inguinal herniorrhaphy	3.9	8.9	8.5	8.1
Myringoplasty	27.3	20.7	36.2	28.7
Myringotomy	5.1	21.2	5.8	12.3
Prostatectomy	9.6	16.6	21.6	14.7
Septoplasty	0.0	6.7	42.6	26.1
Tonsillectomy	6.1	17.5	13.4	15.0
Total hip replacement	14.7	24.8	22.5	23.5
Total knee replacement	7.0	28.2	25.3	26.5
Varicose veins stripping & ligation	2.9	6.6	26.6	17.6
Not applicable	4.6	6.6	8.8	6.5
Total	5.0	8.2	11.1	8.1

Table A3.5: Proportion of patients admitted from waiting lists, by clinical urgency and indicator procedure, Queensland, 1999-00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	4.4	44.7	50.9	100.0
Cholecystectomy	15.8	59.5	24.7	100.0
Coronary artery bypass graft	44.1	52.5	3.4	100.0
Cystoscopy	28.4	41.0	30.6	100.0
Haemorrhoidectomy	11.5	53.5	35.0	100.0
Hysterectomy	16.6	55.9	27.4	100.0
Inguinal herniorrhaphy	12.8	52.9	34.2	100.0
Myringoplasty	3.6	46.2	50.2	100.0
Myringotomy	9.4	42.6	48.1	100.0
Prostatectomy	39.0	45.0	16.0	100.0
Septoplasty	2.3	43.2	54.5	100.0
Tonsillectomy	4.7	46.5	48.8	100.0
Total hip replacement	7.8	68.3	23.9	100.0
Total knee replacement	3.6	66.5	29.8	100.0
Varicose veins stripping & ligation	3.4	40.7	55.9	100.0
Not applicable	30.3	46.5	23.3	100.0
Total	26.2	47.3	26.5	100.0

Appendix 4 Western Australia

The information presented in this section relates to the management of elective surgery. It is intended to provide contextual material for the data presented in the report, as well as to provide information for appropriate interpretation of the comparative data presented in the front part of the report and in the State and Territory specific appendixes, where included.

Western Australia has a centralised waiting list management system. The National Health Data Dictionary (NHDC, 1999) definition for clinical urgency category is used in this system to assist in treating patients according to their clinical need and within the prescribed time.

Incentives are provided to hospitals to treat patients in clinical urgency category 1 on time. That is, if 90% of clinical urgency category 1 patients are treated on time, then funding assistance is provided for patients in categories 2 and 3.

There have been no changes since the 1999–00 waiting times collection that may affect data in the future.

Western Australia overview

This section reports Western Australian data on the proportion of patients who were admitted for elective surgery after having waited on a waiting list for an extended period, by hospital peer group and clinical urgency category (Table A4.1).

Table A4.1: Waiting times statistics for patients admitted from waiting lists, by hospital peer group and clinical urgency category, Western Australia, 1999–00

Peer group	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
Principal referral & women's & children's hospitals				
% extended wait	14.0	26.9	16.4	18.0
% in each category	33.7	23.6	42.8	100.0
Total admissions	8,773	6,133	11,136	26,042
Large hospitals				
% extended wait	..	..	..	..
% in each category	..	..	..	..
Total admissions	..	..	..	..
Medium hospitals				
% extended wait	19.3	22.7	3.7	10.6
% in each category	15.6	23.3	61.1	100.0
Total admissions	2,886	4,309	11,291	18,486
Total^(a)				
% extended wait	15.3	25.2	10.0	14.9
% in each category	26.2	23.5	50.4	100.0
Total admissions	11,659	10,442	22,427	44,528

(a) Includes data for hospitals not included in the specified hospital peer groups.

.. not applicable.

Overall, 14.9 % of patients were admitted from waiting lists with extended waits, 15.3% in clinical urgency category 1, 25.2% in category 2, and 10.0% in category 3. The highest proportion of patients admitted from waiting lists was in clinical urgency category 3 (50.4%), followed by 26.2% in category 1 and 23.5% in category 2.

For clinical urgency category 1, the highest proportion of patients admitted with extended waits was from hospitals in the 'Medium hospitals' peer group. Elective surgery waiting times data were not reported for hospitals in the 'Large hospitals' peer group.

Specialty of surgeon—Western Australia

Table A4.2 shows the proportion of patients who were admitted from waiting lists with extended waits, by the specialty of the surgeon who was to perform the elective surgery and by clinical urgency category. Overall, orthopaedic surgery accounted for the largest proportion of patients admitted with extended waits (30.0%), followed by plastic surgery

(25.2%). The surgical specialty with the lowest proportion of patients admitted with extended waits was urology (5.9%).

The surgical specialties with the lowest proportions of patients admitted from waiting lists with extended waits in clinical urgency category 1 (disregarding 'other' surgery) were urology and vascular surgery (11.2% and 11.4% respectively) and the surgical specialty with the highest proportion was orthopaedic surgery (23.1%).

Table A4.2: Proportion of patients admitted from waiting lists with extended waits, by specialty of surgeon and clinical urgency, Western Australia, 1999–00

Surgical specialty	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cardio-thoracic	12.4	13.6	7.7	12.6
Ear, nose & throat surgery	16.7	26.0	13.9	17.2
General surgery	13.1	24.5	5.9	13.1
Gynaecology	18.0	7.7	0.3	6.1
Neurosurgery	12.6	32.5	4.9	18.6
Ophthalmology	21.6	26.6	8.2	14.0
Orthopaedic surgery	23.1	48.1	26.0	30.0
Plastic surgery	17.4	39.5	17.4	25.2
Urology	11.2	4.0	2.8	5.9
Vascular surgery	11.4	39.2	9.3	15.7
Other	10.5	15.5	7.5	8.9
Total	15.3	25.2	10.0	14.9

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by surgical specialty in Table A4.3. Most patients admitted from waiting lists for orthopaedic surgery were in clinical urgency category 3 (62.3%), followed by 20.5% in category 2 and 17.2% in category 1.

Cardio-thoracic surgery and neurosurgery were the surgical specialties with the highest proportions of patients admitted from waiting lists in the most urgent clinical urgency category (category 1, 78.6% and 52.5% respectively).

Indicator procedure—Western Australia

Table A4.4 shows the proportion of patients admitted from waiting lists with extended waits, by indicator procedure and clinical urgency category. Overall, total hip replacement accounted for the largest proportion of patients admitted with extended waits (43.8%). The smallest proportion of patients admitted with extended waits was 6.1% for cystoscopy.

In clinical urgency category 1, the indicator procedure with the lowest proportion of patients admitted with extended waits was cystoscopy (12.4%). The indicator procedure with the highest proportion of patients admitted with an extended wait in clinical urgency category 1 was total knee replacement (74.2%).

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by indicator procedure in Table A4.5. Coronary artery bypass graft was the

indicator procedure with the highest proportion of patients admitted from waiting lists who were in clinical urgency category 1 (85.9%). The indicator procedures with the lowest proportion of admitted patients in clinical urgency category 1 were tonsillectomy and septoplasty (4.2% and 4.3% respectively).

Table A4.3: Proportion of patients admitted from waiting lists, by clinical urgency and specialty of surgeon, Western Australia, 1999–00

Surgical specialty	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cardio-thoracic	78.6	20.1	1.2	100.0
Ear, nose & throat surgery	11.3	24.5	64.2	100.0
General surgery	31.5	26.5	42.0	100.0
Gynaecology	23.8	22.0	54.2	100.0
Neurosurgery	52.5	35.2	12.3	100.0
Ophthalmology	13.5	21.7	64.9	100.0
Orthopaedic surgery	17.2	20.5	62.3	100.0
Plastic surgery	35.3	35.5	29.2	100.0
Urology	34.8	19.5	45.7	100.0
Vascular surgery	37.5	18.8	43.7	100.0
Other	19.3	9.7	71.0	100.0
Total	26.2	23.5	50.4	100.0

Table A4.4: Proportion of patients admitted from waiting lists with extended waits, by indicator procedure and clinical urgency, Western Australia, 1999–00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	38.9	31.4	5.2	12.8
Cholecystectomy	29.3	27.3	9.2	20.3
Coronary artery bypass graft	19.4	5.7	n.p.	17.4
Cystoscopy	12.4	5.0	3.8	6.1
Haemorrhoidectomy	19.6	29.9	11.9	17.9
Hysterectomy	30.3	9.3	0.5	6.6
Inguinal herniorrhaphy	24.7	30.5	5.0	16.7
Myringoplasty	23.1	35.7	24.5	27.6
Myringotomy	31.8	27.0	2.0	12.1
Prostatectomy	14.5	7.3	3.7	9.5
Septoplasty	20.7	35.1	25.4	26.6
Tonsillectomy	30.8	28.3	8.3	14.1
Total hip replacement	69.2	57.5	30.4	43.8
Total knee replacement	74.2	47.3	35.6	40.3
Varicose veins stripping & ligation	50.0	43.3	12.3	18.8
Not applicable	13.2	24.7	10.8	14.8
Total	15.3	25.2	10.0	14.9

n.p. not published because denominator less than 10.

Table A4.5: Proportion of patients admitted from waiting lists, by clinical urgency and indicator procedure, Western Australia, 1999–00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	6.4	20.7	72.8	100.0
Cholecystectomy	20.0	38.9	41.2	100.0
Coronary artery bypass graft	85.9	13.0	1.1	100.0
Cystoscopy	23.7	18.6	57.7	100.0
Haemorrhoidectomy	15.8	26.5	57.7	100.0
Hysterectomy	13.9	21.9	64.1	100.0
Inguinal herniorrhaphy	17.3	32.3	50.4	100.0
Myringoplasty	5.3	28.5	66.3	100.0
Myringotomy	8.6	30.0	61.4	100.0
Prostatectomy	44.1	27.9	27.9	100.0
Septoplasty	4.3	14.4	81.3	100.0
Tonsillectomy	4.2	24.4	71.4	100.0
Total hip replacement	11.6	32.6	55.8	100.0
Total knee replacement	6.4	19.1	74.5	100.0
Varicose veins stripping & ligation	6.2	13.2	80.6	100.0
Not applicable	31.9	23.4	44.8	100.0
Total	26.2	23.5	50.4	100.0

Appendix 5 South Australia

The information presented in this section relates to the management of elective surgery. It is intended to provide contextual material for the data presented in the report, as well as to provide information for appropriate interpretation of the comparative data presented in the front part of the report and in the State and Territory specific appendixes, where included.

South Australia has a decentralised system for the management of elective surgery waiting lists, with the eight major public hospitals managing their own lists. Seven of these hospitals are part of the Department's booking list information system. These 'Booking List' hospitals are Women's and Children's Hospital, Flinders Medical Centre, Lyell McEwin Health Service, Modbury Hospital, Repatriation General Hospital, Royal Adelaide Hospital and The Queen Elizabeth Hospital.

The Department of Human Services (DHS) receives elective surgery data from the Booking List hospitals on a monthly basis, and monitors elective surgery performance indicators and undertakes investigations where problems are identified. Hospitals are required to manage their elective surgery in accordance with the DHS *Policy for the Management of Elective Surgical Admissions in Metropolitan Public Hospitals* and report data in accordance with *Booking List Information System Guidelines*.

Additional funding was allocated for additional elective surgery activity in 1994-95 to 1997-98, then in 2000-01 and 2001-02. Additional funding in 2001-02 is targeted at patients waiting longer than 12 months for hip and knee surgery, paediatric ear, nose and throat surgery and the reduction of overdue urgent and semi-urgent patients.

It is intended that clinicians determine a patient's urgency classification based on the agreed national standard published in the *National Health Data Dictionary* (NHDC 1999). Specific guidelines for clinical urgency categorisation of patients are not used.

There have been no changes since the 1999-00 waiting times collection that may affect data in the future. The collection of gynaecology elective surgery data at Women's and Children's Hospital commenced in October 1999.

South Australia overview

This section reports South Australian data on the proportion of patients who were admitted for elective surgery after having waited on a waiting list for an extended period, by hospital peer group and clinical urgency category (Table A5.1).

Table A5.1: Waiting times statistics for patients admitted from waiting lists, by hospital peer group and clinical urgency category, South Australia, 1999–00

Peer group	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
Principal referral & women's & children's hospitals				
% extended wait	12.4	14.3	3.7	7.4
% in each category	26.1	14.1	59.9	100.0
Total admissions	5,942	3,210	13,654	22,806
Large hospitals				
% extended wait	13.9	9.3	3.5	7.0
% in each category	20.1	25.6	54.3	100.0
Total admissions	1,983	2,529	5,365	9,877
Medium hospitals				
% extended wait	..	..	..	..
% in each category	..	..	..	..
Total admissions	..	..	..	..
Total^(a)				
% extended wait	12.7	12.1	3.6	7.3
% in each category	24.2	17.6	58.2	100.0
Total admissions	7,925	5,739	19,019	32,683

(a) Includes data for hospitals not included in the specified hospital peer groups.

.. not applicable.

Overall, 7.3% of patients were admitted from waiting lists with extended waits, 12.7% in clinical urgency category 1, 12.1% in category 2 and 3.6% in category 3. The highest proportion of patients admitted from waiting lists was in clinical urgency category 3 (58.2%) followed by 24.2% in category 1 and 17.6% in category 2.

For clinical urgency category 1 the highest proportion of patients admitted with extended waits was from hospitals in the 'Large hospitals' peer group. Elective surgery waiting times data were not reported for hospitals in the 'Medium hospitals' peer group.

Specialty of surgeon—South Australia

Table A5.2 shows the proportion of patients who were admitted from waiting lists with extended waits, by the specialty of the surgeon who was to perform the elective surgery and by clinical urgency category. Overall, urology accounted for the largest proportion of patients admitted with extended waits (11.5%), followed by orthopaedic surgery (9.9%). The

surgical specialty with the lowest proportion of patients admitted with extended waits was vascular surgery (2.3%).

The surgical specialties with the lowest proportions of patients admitted from waiting lists with extended waits in clinical urgency category 1 (disregarding 'other' surgery) were cardio-thoracic surgery and vascular surgery (2.5% and 3.3% respectively) and the surgical specialty with the highest proportion was urology (21.3%).

Table A5.2: Proportion of patients admitted from waiting lists with extended waits, by specialty of surgeon and indicator procedure, South Australia, 1999-00

	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
Surgical specialty	(per cent)			
Cardio-thoracic	2.5	34.8	0.4	5.9
Ear, nose & throat surgery	12.7	21.3	6.1	8.8
General surgery	9.7	8.4	1.8	5.1
Gynaecology	14.9	14.3	0.2	6.8
Neurosurgery	9.8	7.4	0.5	6.5
Ophthalmology	8.5	6.8	3.4	4.2
Orthopaedic surgery	17.2	20.1	6.8	9.9
Plastic surgery	12.9	14.4	3.5	8.4
Urology	21.3	9.7	4.9	11.5
Vascular surgery	3.3	2.0	1.0	2.3
Other	0.0	0.0	0.0	0.0
Total	12.7	12.1	3.6	7.3

Table A5.3: Proportion of patients admitted from waiting lists, by clinical urgency and specialty of surgeon, South Australia, 1999-00

	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
Surgical specialty	(per cent)			
Cardio-thoracic	46.1	13.0	40.8	100.0
Ear, nose & throat surgery	15.6	10.8	73.6	100.0
General surgery	23.8	22.2	54.0	100.0
Gynaecology	29.3	16.2	54.5	100.0
Neurosurgery	51.1	18.0	30.9	100.0
Ophthalmology	8.5	10.1	81.4	100.0
Orthopaedic surgery	15.0	11.6	73.4	100.0
Plastic surgery	26.8	22.3	50.9	100.0
Urology	32.7	26.7	40.6	100.0
Vascular surgery	49.5	13.8	36.8	100.0
Other	36.1	10.8	53.0	100.0
Total	24.2	17.6	58.2	100.0

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by surgical specialty in Table A5.3. Most patients admitted from waiting lists for orthopaedic surgery were in clinical urgency category 3 (73.4%). For cardio-thoracic surgery, most patients were in clinical urgency category 1 (46.1%).

Neurosurgery and vascular surgery were the surgical specialties with the highest proportions of patients admitted from waiting lists in the most urgent clinical urgency category (category 1, 51.1% and 49.5% respectively).

Indicator procedure—South Australia

Table A5.4 shows the proportion of patients admitted from waiting lists with extended waits, by indicator procedure and clinical urgency category. Overall, prostatectomy accounted for the largest proportion of patients admitted with extended waits (17.5%). The smallest proportion of patients admitted with extended waits was 3.3% for myringotomy.

In clinical urgency category 1, the indicator procedure with the lowest proportion of patients admitted with extended waits was coronary artery bypass graft (2.7%). The indicator procedure with the highest proportion of patients admitted with extended waits in clinical urgency category 1 was septoplasty (70.6%).

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by indicator procedure in Table A5.5. Prostatectomy was the indicator procedure with the highest proportion of patients admitted from waiting lists who were in clinical urgency category 1 (41.4%). The indicator procedures with the lowest proportions of admitted patients in clinical urgency category 1 were cataract extraction and tonsillectomy cataract extraction (2.8% and 3.0% respectively).

Table A5.4: Proportion of patients admitted from waiting lists with extended waits, by indicator procedure and clinical urgency, South Australia, 1999–00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	20.0	11.0	3.5	4.6
Cholecystectomy	21.7	11.4	1.4	9.0
Coronary artery bypass graft	2.7	38.5	0.6	7.4
Cystoscopy	28.4	13.3	6.7	15.2
Haemorrhoidectomy	17.6	13.5	0.7	4.3
Hysterectomy	16.3	24.7	0.3	9.8
Inguinal herniorrhaphy	12.5	11.1	0.0	4.4
Myringoplasty	n.p.	0.0	8.4	8.7
Myringotomy	11.8	15.0	0.7	3.3
Prostatectomy	23.9	13.2	12.8	17.5
Septoplasty	70.6	31.3	12.1	17.3
Tonsillectomy	20.8	23.8	9.3	11.1
Total hip replacement	52.4	37.9	10.3	16.8
Total knee replacement	60.6	37.3	10.2	15.5
Varicose veins stripping & ligation	27.3	10.3	8.8	9.9
Not applicable	10.3	10.1	2.6	6.1
Total	12.7	12.1	3.6	7.3

n.p. not published because denominator less than 10.

Table A5.5: Proportion of patients admitted from waiting lists, by clinical urgency and indicator procedure, South Australia, 1999-00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	2.8	8.5	88.7	100.0
Cholecystectomy	19.5	37.2	43.3	100.0
Coronary artery bypass graft	34.5	16.0	49.5	100.0
Cystoscopy	31.3	25.4	43.3	100.0
Haemorrhoidectomy	8.2	17.9	73.9	100.0
Hysterectomy	23.0	23.8	53.2	100.0
Inguinal herniorrhaphy	10.1	28.5	61.3	100.0
Myringoplasty	3.9	3.9	92.2	100.0
Myringotomy	9.3	10.9	79.8	100.0
Prostatectomy	41.4	19.8	38.8	100.0
Septoplasty	6.9	6.5	86.7	100.0
Tonsillectomy	3.0	10.0	87.0	100.0
Total hip replacement	7.6	11.9	80.5	100.0
Total knee replacement	5.4	9.6	85.0	100.0
Varicose veins stripping & ligation	5.0	8.9	86.0	100.0
Not applicable	28.3	17.4	54.3	100.0
Total	24.2	17.6	58.2	100.0

Appendix 6 Tasmania

Elective surgery services are provided from four hospitals (three public hospitals and one private hospital under contract) in Tasmania. In addition, there are some procedures (i.e. cataract surgery) where public hospitals contract with private hospitals to provide this care. Data for the private hospital are not provided to the National Elective Surgery Waiting Times collection.

The Elective Surgery Management Information System (ESMIS) is used in the public hospitals to provide information for managers and clinicians on trends in waiting times and related aspects of elective surgery activity. ESMIS enables information on waiting times for elective surgery, additions and removals from the elective surgery list and postponements and cancellations to be reported at a variety of levels (from statewide to procedure or clinician).

In February 2000 the Hospitals and Ambulance Service published a policy and guidelines for the management of elective surgery in Tasmanian public hospitals. Initiatives being implemented from the policy include

- ensuring that people requesting non-essential surgery (i.e. not clinically required) are not placed on elective surgery lists.
- improved processes for clerical and clinical review of patients.
- provision of information to patients of expected waiting time for elective surgery.
- regular provision of information to general practitioners of waiting times for elective surgery.

There are mechanisms in place to ensure that management of elective surgery is integrated across all hospitals. An Elective Surgery Steering Committee meets regularly to consider strategic approaches to ensure quality services that meet the expectations of patients, managers and clinicians. A Statewide Surgical Service Committee has an ongoing role to advise on the planning and co-ordination of services. The Committee is presently reviewing all areas of surgical services and this includes waiting times for elective surgery.

Finally ESMIS reporting is undertaken at a statewide level to provide information on relevant performance measures across all sites. A quarterly bulletin is provided to the Division's executive committee on trends in key performance indicators.

The Policy and Guidelines for the Management of Admission for Elective Surgery include definitions of clinical urgency that are consistent with the National definitions and business rules to assist clinicians in assigning a clinical urgency category to patients.

As ESMIS commenced from 1 July 1999 Tasmania was able to provide unit record data for the 1999-00 waiting times collection. To date there have been no changes since that will affect data for the future years.

Tasmania overview

This section reports Tasmanian data on the proportion of patients who were admitted for elective surgery after having waited on a waiting list for an extended period, by hospital peer group and clinical urgency category (Table A6.1).

Table A6.1: Waiting times statistics for patients admitted from waiting lists, by hospital peer group and clinical urgency category, Tasmania, 1999-00

Peer group	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
Principal referral & women's & children's hospitals				
% extended wait	24.9	44.3	18.8	30.5
% in each category	43.4	35.5	21.1	100.0
Total admissions	4,732	3,869	2,295	10,896
Large hospitals				
% extended wait	n.p.	n.p.	n.p.	n.p.
% in each category	46.6	25.6	27.8	100.0
Total admissions	1,260	691	751	2,702
Medium hospitals				
% extended wait	..	..	..	..
% in each category	..	..	..	..
Total admissions	..	..	..	..
Total^(a)				
% extended wait	25.2	42.7	21.1	30.1
% in each category	44.1	33.5	22.4	100.0
Total admissions	5,992	4,560	3,046	13,598

(a) Includes data for hospitals not included in the specified hospital peer groups.

.. not applicable.

n.p. not published because there was only one hospital in the peer group.

Overall, 30.1% of patients were admitted from waiting lists with extended waits, 25.2% in clinical urgency category 1, 42.7% in category 2, and 21.1% in category 3. The highest proportion of patients admitted from waiting lists was in clinical urgency category 1 (44.1%) followed by 33.5% in category 2 and 21.1% in category 3.

Specialty of surgeon—Tasmania

Table A6.2 shows the proportion of patients who were admitted from waiting lists with extended waits, by the specialty of the surgeon who was to perform the elective surgery and by clinical urgency category. Overall, orthopaedic surgery accounted for the largest proportion of patients admitted with extended waits (52.0%), followed by cardio-thoracic surgery (45.9%). The surgical specialty with the lowest proportion of patients admitted with extended waits (disregarding 'other' surgery) was gynaecological surgery (15.1%).

The surgical specialties with the lowest proportions of patients admitted from waiting lists with extended waits in clinical urgency category 1 (disregarding 'other' surgery) were vascular surgery and gynaecological surgery (14.9% and 16.6% respectively) and the surgical specialty with the highest proportion was cardio-thoracic surgery (47.1%).

Table A6.2: Proportion of patients admitted from waiting lists with extended waits, by specialty of surgeon and clinical urgency, Tasmania, 1999–00

Surgical specialty	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cardio-thoracic	47.1	33.3	n.p.	45.9
Ear, nose & throat surgery	23.5	35.1	25.0	28.0
General surgery	21.9	47.5	24.5	31.0
Gynaecology	16.6	18.4	3.8	15.1
Neurosurgery	26.3	50.0	50.0	35.5
Ophthalmology	24.2	48.0	27.3	31.6
Orthopaedic surgery	23.4	76.1	30.6	52.0
Plastic surgery	29.0	38.2	9.4	29.4
Urology	32.7	30.8	36.7	33.1
Vascular surgery	14.9	53.8	36.4	30.9
Other	14.2	13.3	0.4	4.9
Total	25.2	42.7	21.1	30.1

n.p. not published because denominator less than 10.

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by surgical specialty in Table A6.3. Most patients admitted from waiting lists for ophthalmology were in clinical urgency category 3 (62.9%). For orthopaedic surgery most patients were in clinical urgency category 2 (51.2%).

Cardio-thoracic surgery and neurosurgery were the surgical specialties with the highest proportions of patients admitted from waiting lists in the most urgent clinical urgency category (category 1, 91.8% and 61.3% respectively).

Indicator procedure—Tasmania

Table A6.4 shows the proportion of patients admitted from waiting lists with extended waits by indicator procedure and clinical urgency category. Overall, total knee replacement accounted for the largest proportion of patients admitted with extended waits (78.1%). The smallest proportion of patients admitted with extended waits was 9.4% for myringotomy.

In clinical urgency category 1, the indicator procedures with the lowest proportion of patients admitted with extended waits were myringotomy and haemorrhoidectomy (26.9% and 27.3%, respectively). The indicator procedure with the highest proportion of patients admitted with extended waits in clinical urgency category 1 was prostatectomy (78.6%).

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by indicator procedure in Table A6.5. Coronary artery bypass graft was the indicator procedure with the highest proportion of patients admitted from waiting lists who

were in clinical urgency category 1 (91.7%). The indicator procedure with the lowest proportions of patients admitted from waiting lists who were in clinical urgency category 1 was varicose veins stripping and ligation (1.4%).

Table A6.3: Proportion of patients admitted from waiting lists, by clinical urgency and specialty of surgeon, Tasmania, 1999–00

Surgical specialty	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cardio-thoracic	91.8	8.0	0.2	100.0
Ear, nose & throat surgery	32.3	34.8	32.9	100.0
General surgery	46.1	33.2	20.7	100.0
Gynaecology	44.9	37.8	17.3	100.0
Neurosurgery	61.3	37.1	1.6	100.0
Ophthalmology	14.2	22.9	62.9	100.0
Orthopaedic surgery	26.9	51.2	21.9	100.0
Plastic surgery	54.8	32.2	13.0	100.0
Urology	49.2	27.1	23.7	100.0
Vascular surgery	53.7	34.6	11.7	100.0
Other	29.4	3.7	66.9	100.0
Total	44.1	33.5	22.4	100.0

Table A6.4: Proportion of patients admitted from waiting lists with extended waits, by indicator procedure and clinical urgency, Tasmania, 1999–00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	52.6	62.7	62.9	61.7
Cholecystectomy	48.5	64.5	25.0	50.8
Coronary artery bypass graft	56.3	32.1	0.0	54.2
Cystoscopy	31.6	31.1	18.2	29.2
Haemorrhoidectomy	27.3	61.5	38.5	43.2
Hysterectomy	28.2	16.5	2.9	16.3
Inguinal herniorrhaphy	28.2	53.1	24.1	39.2
Myringoplasty	n.p.	75.0	35.3	45.5
Myringotomy	26.9	5.2	n.p.	9.4
Prostatectomy	78.6	n.p.	..	61.1
Septoplasty	n.p.	50.0	74.2	70.7
Tonsillectomy	n.p.	76.9	26.3	43.6
Total hip replacement	43.8	83.0	48.3	68.4
Total knee replacement	37.5	90.7	74.1	78.1
Varicose veins stripping & ligation	n.p.	63.3	80.0	71.8
Not applicable	21.4	41.6	17.2	26.8
Total	25.2	42.7	21.1	30.1

.. not applicable.

n.p. not published because denominator less than 10.

Table A6.5: Proportion of patients admitted from waiting lists, by clinical urgency and indicator procedure, Tasmania, 1999-00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	10.4	36.6	53.0	100.0
Cholecystectomy	31.4	46.8	21.9	100.0
Coronary artery bypass graft	91.7	8.0	0.3	100.0
Cystoscopy	45.3	38.2	16.5	100.0
Haemorrhoidectomy	29.7	35.1	35.1	100.0
Hysterectomy	24.5	52.8	22.7	100.0
Inguinal herniorrhaphy	23.6	48.8	27.6	100.0
Myringoplasty	4.5	18.2	77.3	100.0
Myringotomy	20.5	75.6	3.9	100.0
Prostatectomy	77.8	22.2	0.0	100.0
Septoplasty	4.9	19.5	75.6	100.0
Tonsillectomy	7.3	23.6	69.1	100.0
Total hip replacement	20.6	60.6	18.7	100.0
Total knee replacement	17.5	62.8	19.7	100.0
Varicose veins stripping & ligation	1.4	42.3	56.3	100.0
Not applicable	46.6	31.1	22.3	100.0
Total	44.1	33.5	22.4	100.0

Appendix 7 Australian Capital Territory

The information presented in this section relates to the management of elective surgery. It is intended to provide contextual material for the data presented in the report, as well as to provide information for appropriate interpretation of the comparative data presented in the front part of the report and in the State and Territory specific appendixes, where included. Waiting times for elective surgery data have not been reported for the Australian Capital Territory because data were not available for one of the two public acute hospitals.

The Australian Capital Territory introduced a new strategy for managing elective surgery in September 2001. Waiting lists are now managed centrally by the Elective Surgery Access Team within the Department of Health and Community Care. An Elective Surgery Coordinator responsible to the Elective Surgery Project Coordinator within the department has been appointed to each of the two hospitals to manage waiting lists.

The Elective Surgery Coordinators are implementing a telephone information service at the hospitals that will provide consumers and general practitioners with access to current waiting list information. An information brochure has also been developed which will advertise the telephone number of the information service, and this brochure will be available at doctors' rooms, pharmacies, health centres and hospitals.

During 2000-01 incentive payments were offered each month for having no patients in clinical urgency category 1 (the most urgent category) with long waits. This has been continued for 2001-02. This scheme has had a marked effect on the number of patient waiting longer than desirable, with six months in a row showing no clinical urgency category 1 patients with long waits.

Additional funding targeting the surgical specialties with the highest numbers of patients with long waits: orthopaedic surgery, general surgery and plastic surgery, was allocated in 2000-01 and 2001-02, and since September 2001 there has been an increased emphasis on improving the accuracy of the waiting times for elective surgery data collection.

Appendix 8 Northern Territory

The information presented in this section relates to the management of elective surgery. It is intended to provide contextual material for the data presented in the report, as well as to provide information for appropriate interpretation of the comparative data presented in the front part of the report and in the State and Territory specific appendixes, where included.

The Northern Territory has a decentralised system for the management of elective surgery, with all five hospitals responsible for managing their own waiting lists. Surgeons, surgical registrars, theatre scheduling officers and elective theatre waitlist support officers all have key roles in managing hospital's waiting lists for elective surgery.

Recently, a project has been established to improve the quality of data for waiting times for elective surgery. This has involved clinical review and administrative audits of the data. Regular administrative audits are aimed at ensuring the waiting list data accurately reflects the number of patients assessed as waiting for elective surgery.

Regular clinical reviews of patients waiting for elective surgery are undertaken by the specialist consultant, registrar, resident medical officer and by review of the medical record to ensure that waiting lists accurately reflect the clinical urgency of patients on waiting lists.

Guidelines for clinical urgency categorisation are included in the document *Waiting Lists for Elective Surgery in Northern Territory Hospitals Policy and Procedures*. It is intended that urgency categorisation be based on the agreed national standard published in the *National Health Data Dictionary* (NHDC 1999).

Northern Territory overview

This section reports Northern Territory data on the proportion of patients who were admitted for elective surgery after having waited on a waiting list for an extended period, by hospital peer group and clinical urgency category (Table A8.1).

Table A8.1: Waiting times statistics for patients admitted from waiting lists, by hospital peer group and clinical urgency category, Northern Territory, 1999–00

Peer group	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
Principal referral & women's & children's hospitals				
% extended wait	n.p.	n.p.	n.p.	n.p.
% in each category	40.9	33.7	25.3	100.0
Total admissions	1,527	1,259	945	3,731
Large hospitals				
% extended wait	n.p.	n.p.	n.p.	n.p.
% in each category	2.7	38.9	58.4	100.0
Total admissions	38	548	823	1,409
Medium hospitals				
% extended wait	..	..	..	..
% in each category	..	..	..	..
Total admissions	..	..	..	..
Total^(a)				
% extended wait	11.6	16.4	4.2	10.6
% in each category	29.1	35.1	35.8	100.0
Total admissions	1,683	2,029	2,074	5,786

(a) Includes data for hospitals not included in the specified hospital peer groups.

.. not applicable

n.p. not published because there was only one hospital in the peer group.

Overall, 10.6% of patients were admitted from waiting lists with extended waits, 11.6% in clinical urgency category 1, 16.4% in clinical urgency category 2 and 4.2% in clinical urgency category 3. The highest proportion of patients admitted from waiting lists was in clinical urgency category 3 (35.8%) followed by 35.1% in category 2 and 29.1% in category 1.

Specialty of surgeon—Northern Territory

Table A8.2 shows the proportion of patients who were admitted from waiting lists with extended waits, by the specialty of the surgeon who was to perform the elective surgery and by clinical urgency category. Overall, orthopaedic surgery accounted for the largest proportion of patients admitted with extended waits (21.5%), followed by general surgery (15.2%). The surgical specialty with the lowest proportion of patients admitted with extended waits (disregarding 'other' surgery) was gynaecological surgery (3.5%).

The surgical specialty with the lowest proportion of patients admitted from waiting lists with extended waits in clinical urgency category 1 was gynaecological surgery (3.3%), and the surgical specialty with the highest proportion was ophthalmology (47.8%).

Table A8.2: Proportion of patients admitted from waiting lists with extended waits, by specialty of surgeon and clinical urgency, Northern Territory, 1999–00

Surgical specialty	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cardio-thoracic	..	..	..	..
Ear, nose & throat surgery	12.6	14.0	14.8	14.1
General surgery	19.5	20.6	4.3	15.2
Gynaecology	3.3	5.1	0.8	3.5
Neurosurgery	..	..	..	..
Ophthalmology	47.8	27.3	2.2	8.9
Orthopaedic surgery	28.0	36.1	3.2	21.5
Plastic surgery	8.6	18.5	25.0	13.4
Urology	n.p.	0.0	0.0	0.0
Vascular surgery	..	..	..	..
Other	8.7	8.3	0.0	2.5
Total	11.6	16.4	4.2	10.6

.. not applicable.

n.p. not published because denominator less than 10.

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by surgical specialty in Table A8.3. Most patients admitted from waiting lists for orthopaedic surgery were in clinical urgency category 2 (43.3%). For ophthalmology, most patients were in clinical urgency category 3 (80.4%).

Plastic surgery and gynaecological surgery were the surgical specialties with the highest proportions of patients admitted from waiting lists in the most urgent clinical urgency category (category 1, 59.8% and 43.4% respectively).

Indicator procedure—Northern Territory

Table A8.4 shows the proportion of patients admitted from waiting lists with extended waits by indicator procedure and clinical urgency category. Overall, total knee replacement accounted for the largest proportion of patients admitted with extended waits (47.8%). The smallest proportion of patients admitted with extended waits was 3.4% for myringotomy.

In clinical urgency category 1, the indicator procedure with the lowest proportion of patients admitted with extended waits was inguinal herniorrhaphy (8.3%). The indicator procedure with the highest proportion of patients admitted with an extended wait in clinical urgency category 1 was cataract extraction (45.8%).

The proportion of patients admitted from waiting lists in each clinical urgency category is presented by indicator procedure in Table A8.5. Myringotomy was the indicator procedure with the highest proportion of patients admitted from waiting lists who were in clinical

urgency category 1 (31.0%). The indicator procedure with the lowest proportion of admitted patients in clinical urgency category 1 was cataract extraction (7.3%).

Table A8.3: Proportion of patients admitted from waiting lists, by clinical urgency and specialty of surgeon, Northern Territory, 1999–00

Surgical specialty	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cardio-thoracic	..	..	..	..
Ear, nose & throat surgery	23.2	30.0	46.8	100.0
General surgery	27.0	41.8	31.3	100.0
Gynaecology	43.4	37.0	19.6	100.0
Neurosurgery	..	..	..	..
Ophthalmology	8.9	10.7	80.4	100.0
Orthopaedic surgery	16.3	43.3	40.5	100.0
Plastic surgery	59.8	27.8	12.4	100.0
Urology	2.6	18.4	78.9	100.0
Vascular surgery	..	..	..	..
Other	11.3	17.7	70.9	100.0
Total	29.1	35.1	35.8	100.0

.. not applicable.

Table A8.4: Proportion of patients admitted from waiting lists with extended waits, by indicator procedure and clinical urgency, Northern Territory, 1999–00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	45.8	28.6	1.9	8.0
Cholecystectomy	42.9	35.2	7.7	31.2
Coronary artery bypass graft	..	..	..	..
Cystoscopy	23.2	26.7	1.3	15.5
Haemorrhoidectomy	..	50.0	n.p.	36.8
Hysterectomy	n.p.	n.p.	4.5	7.7
Inguinal herniorrhaphy	8.3	28.8	10.9	21.0
Myringoplasty	..	n.p.	34.3	34.1
Myringotomy	0.0	5.6	0.0	3.4
Prostatectomy	n.p.	n.p.	0.0	35.3
Septoplasty	..	..	25.0	25.0
Tonsillectomy	27.3	13.2	10.3	12.8
Total hip replacement	n.p.	n.p.	0.0	28.6
Total knee replacement	..	62.5	n.p.	47.8
Varicose veins stripping & ligation	..	n.p.	19.0	23.3
Not applicable	..	..	..	..
Not reported	9.9	13.7	2.8	9.0
Total	11.6	16.4	4.2	10.6

.. not applicable.

n.p. not published because denominator less than 10.

Table A8.5: Proportion of patients admitted from waiting lists, by clinical urgency and indicator procedure, Northern Territory, 1999–00

Indicator procedure	Clinical urgency			All patients
	Category 1	Category 2	Category 3	
	(per cent)			
Cataract extraction	7.3	10.7	82.0	100.0
Cholecystectomy	22.4	56.8	20.8	100.0
Coronary artery bypass graft	..	..	..	..
Cystoscopy	29.0	31.1	39.9	100.0
Haemorrhoidectomy	0.0	52.6	47.4	100.0
Hysterectomy	20.5	23.1	56.4	100.0
Inguinal herniorrhaphy	8.7	58.0	33.3	100.0
Myringoplasty	0.0	14.6	85.4	100.0
Myringotomy	31.0	62.1	6.9	100.0
Prostatectomy	29.4	52.9	17.6	100.0
Septoplasty	0.0	0.0	100.0	100.0
Tonsillectomy	9.4	32.5	58.1	100.0
Total hip replacement	14.3	50.0	35.7	100.0
Total knee replacement	0.0	69.6	30.4	100.0
Varicose veins stripping & ligation	0.0	30.0	70.0	100.0
Not applicable	..	..	..	..
Not reported	32.8	35.5	31.7	100.0
Total	29.1	35.1	35.8	100.0

.. not applicable.

Appendix 9 Hospital peer groups

When making comparisons, it is useful if the units being compared have been grouped into categories so that variation in the variable of interest is explained by the attributes defining the group (Hindle 1999). Hospital peer groups have been developed by the Institute for cost per casemix-adjusted separation analysis (as reported in *Australian Hospital Statistics*), designed to explain variability in the average cost per casemix-adjusted separation and to group hospitals into broadly similar groups in terms of their volume of admitted patient activity and geographical location. Details of the derivation of these peer groups are contained in Appendix 11 of *Australian Hospital Statistics 1998–99* (AIHW 2000a).

This hospital peer group classification has been adapted for use in this report. The grouping is undertaken using the same logic, that is, based mainly on the admitted patient activity and the Rural, Remote, Metropolitan Area (RRMA) classification of the hospital's geographical location. However, some establishments that form part of a network for the purposes of cost per casemix-adjusted separation analysis report to the National Elective Surgery Waiting Times Data Collection individually. Therefore, the peer group classification used here classifies hospitals that individually report waiting times data, rather than the networks. In addition, only the top level in the peer group hierarchy has been used.

Table A9.1 summarises the hospital peer group classification used for this report. The peer groups have been allocated names that are broadly descriptive of the types of hospitals included in each category.

A full list of hospitals included in each group (and those included in the National Elective Surgery Waiting Times Data Collection) is available with this report on the Institute's web site (www.aihw.gov.au).

Table A9.1: Hospital peer group classification used for this report

Peer group	Includes
Principal referral and women's and children's hospitals	Metropolitan hospitals with >20,000 acute casemix-adjusted separations a year and rural hospitals with >16,000 acute casemix-adjusted separations a year. Specialised acute women's and children's hospitals with >10,000 acute casemix-adjusted separations a year.
Large hospitals	Metropolitan acute hospitals treating more than 10,000 acute casemix-adjusted separations a year. Rural acute hospitals treating >8,000 acute casemix-adjusted separations a year and remote hospitals with >5,000 casemix-weighted separations a year.
Medium hospitals	Medium acute hospitals, treating between 5,000 and 10,000 acute casemix-adjusted separations a year. Medium acute hospitals, treating between 2,000 and 5,000 acute casemix-adjusted separations per annum, plus acute hospitals treating <2,000 casemix-adjusted separations a year but with >2,000 separations a year.
Other hospitals ^(a)	Small rural acute hospitals (mainly small country town hospitals) acute hospitals treating <2,000 separations a year, and with less than 40% non-acute and outlier patient days of total patient days. Small non-acute hospitals treating <2,000 separations a year and with more than 40% non-acute and outlier patient days of total patient days. (Community non-acute). Small remote hospitals (<5,000 acute casemix-weighted separations a year but not 'multi-purpose services' and not 'community non-acute'). Most have <2,000 separations a year. Sub- and non-acute hospitals – a majority of patient days are generally accounted for by rehabilitative and palliative care, maintenance and non-acute patients Other non-acute (e.g. geriatric treatment centres combining rehabilitation and palliative care with a few acute patients). Prison medical services, special circumstance hospitals, metropolitan hospitals with <2,000 acute casemix-adjusted separations a year, hospitals with <200 separations a year, etc. Psychiatric hospitals.

(a) Waiting times for hospitals included in this group are included in the total in Table 2.1.

Glossary

For further information on the terms used in this report, refer to the *National Health Data Dictionary Version 8.0* (NHDC 1999).

Clinical urgency category: a clinical assessment of the urgency with which a patient requires elective hospital care. The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the clinical urgency categories, regardless of how long it is estimated they will need to wait for surgery. The categories used in this report are defined as follows:

- clinical urgency category 1 – admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency;
- clinical urgency category 2 – admission within 90 days desirable for a condition causing some pain, dysfunction or disability but that is not likely to deteriorate quickly or become an emergency;
- clinical urgency category 3 – admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

No time limit is placed on the clinical urgency category 3 patients in this classification.

Elective care: care that, in the opinion of the treating clinician, is necessary and for which admission can be delayed for at least 24 hours.

Elective surgery: elective care in which the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians and some procedures for which the associated waiting time is strongly influenced by factors other than the supply of services. The procedures that are excluded are:

- organ or tissue transplant procedures;
- procedures associated with obstetrics (for example, elective caesarean section, cervical suture);
- cosmetic surgery (defined as the relevant procedures that do not attract a Medicare rebate);
- biopsy of kidney (needle only);
- biopsy of lung (needle only);
- bronchoscopy (including fibre-optic bronchoscopy);
- colonoscopy;
- dental procedures;
- endoscopic retrograde cholangio-pancreatography;
- endoscopy of biliary tract, oesophagus, small intestine or stomach;
- endovascular interventional procedures;
- gastroscopy;
- miscellaneous cardiac procedures;
- oesophagoscopy;

- panendoscopy (except when involving the bladder);
- proctosigmoidoscopy
- sigmoidoscopy.

Extended wait: when a patient waits longer for admission than is desirable (see 'Clinical urgency category'). Clinical urgency category 1 patients with extended waits are those patients who have waited for more than 30 days for admission. Clinical urgency category 2 patients have extended waits if they have waited more than 90 days. Clinical urgency category 3 patients with extended waits are those patients who have waited for more than 12 months.

Overdue patient: a patient whose wait has exceeded the time that has been determined as clinically desirable in relation to the clinical urgency category to which they have been assigned. Overdue patients are clinical urgency category 1 patients who have waited for more than 30 days and clinical urgency category 2 patients who have waited for more than 90 days.

Ready for care patients: patients who are prepared to be admitted to hospital (or to begin the process leading directly to being admitted to hospital). Patients who are not ready for care are those not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital.

Removal: a patient may be removed from a waiting list for a number of reasons. These are classified as:

- admission as an elective patient for awaited procedure at this hospital
- admission as an emergency patient for awaited procedure at this hospital
- could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)
- treated elsewhere for awaited, declining the surgery or the surgery not being required, death or being unable to be contacted.

Surgical procedure: a procedure used to define surgical Australian Refined Diagnosis Related Groups version 4.1 (DHAC 1998), excluding procedures as detailed in 'Elective surgery' above. This definition of surgical procedure is used for the purpose of estimating coverage in this report.

Throughput data: data that relate to a specified period including the numbers of patients added to waiting lists, admitted from waiting lists and removed from waiting lists for reasons other than admission, and the lengths of time waited.

Waiting list: a register that contains essential details about patients who have been assessed as needing elective hospital care. Elective surgery waiting lists are registers of patients who have been assessed as needing elective surgery in a hospital. A waiting list therefore includes patients who have been allocated an admission date (and may be referred to as 'booked' patients) as well as those who have not been allocated an admission date.

Waiting time: the length of time spent on the waiting list, between the date of listing and the date of admission or other removal from the waiting list, or the census date. Days spent as 'not ready for care' are excluded. In the situation in which a patient's clinical urgency

category changes during their wait, there is variation among the States and Territories in the way in which the waiting time is calculated.

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