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Committee for Health, Social Services and Public Safety

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Review of Waiting Times: Mr Pedro Gomes, Ministry of Health, Portugal

9 April 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Mr Pedro Gomes Ministry of Health, Portugal

The Chairperson: We have Mr Pedro Gomes with us. Good afternoon, you are very welcome. You are the national coordinator of the central unit of the integrated management system of the waiting list for surgery for the Portuguese Government. The procedure is for you to give a 10-minute presentation, and then we will open things up for questions and answers.

Mr Pedro Gomes (Ministry of Health, Portugal): I must read because my English is not fluent enough for me to improvise, so excuse me. Thank you for the invitation. I hope to transmit what we are doing in Portugal regarding access to surgery.

Portugal is a country in southern Europe with 10 million people and a GDP per capita of €15,000. Regarding health resources, we have 417 doctors and 622 nurses per 100,000 inhabitants. We have 235 hospital beds per 100,000 habitants in 109 hospitals and 1,400 primary care units. The national health service performs 3,800 consultations, 88 hospital admissions and 50 surgeries per 100,000 inhabitants per year. The total state expenditure on health, as a percentage of GDP, is 6·3. The infant mortality rate is 3·4 per 1,000 live births, and life expectancy is 80 years.

Since 1998, successive Governments have tried to find solutions to the problem of access to surgical services, experiencing various measures, yet have failed to reverse the problem. The problem of access, which manifested itself particularly through excessive delay for surgery, found its roots in a culture of poorly oriented services for patients. Professionals worked in a rigid organisational architecture to ensure survival of the institution in the logic of preserving corporate interests and pursuing concepts that did not encourage conduct that intended efficiency.

Other problems include equitable access, demographic change, technological change and a culture in a society where people become more demanding and aware of their rights, reinforcing the need for

intervention. We also recognised the absence of updated and credible information that supported decision-making for all stakeholders.

The waiting list for surgery integrated management system (SIGIC) was created in 2004 by the Minister of Health to fight against waiting lists for surgery. By then, the median waiting time was nearly nine months for more than 200,000 patients. Now, the waiting time is three months for 1,500 patients. SIGIC is coordinated nationally by a central unit and is supported by five regional units and by hospital units based in public and private care providers. The activity of surgical services is not limited to performing surgical procedures; it involves every phase of screening, investigating procedures, analysis, and complementary medical treatments, pre and post surgery. The activity of this service cannot be evaluated without taking into account that they are integrated in the network of care that includes primary care, hospital and community care.

As of 2013, SIGIC represented more than 500,000 surgeries, five million appointments and a business volume of €1·5 billion. SIGIC has a matrix management approach that integrates needs expressed by patients, pathology and the various elements of the varied change in surgical services. SIGIC observes the distribution of demands, process compliance and the public disclosure of results and promotes competition and negotiation, and improves efficiency and effectiveness of the entire system so that it is contributing to its sustainability.

The SIGIC business model is sustained by an information model named SIGLIC, which is a financial funding model, a correlating model and a business process model to manage the waiting list for surgery. SIGIC's main goal is to focus the services provided by hospitals to meet patients' needs by reducing the waiting time for surgery, guarantee equity in access to surgical treatments, promote efficiency and effectiveness in health services, ensure quality and transparency in management and information and to ensure the responsibility of players involved in the process. An additional goal is to guarantee that the system is sustainable according to the budget constraints that Portugal faces nowadays.

The patient waiting time for treatment cannot be measured by taking into account only the waiting time between inscription and surgery. Monitoring access is done in order to know the partial waiting times in all processes, which starts with the detection of health problems and finishes with the treatment provided, with measurement of the gain in health for the patient. The next step for SIGIC will be measuring the referral to treatment times.

SIGLIC addresses, in an innovative way, the information for clinical governance, focusing on the core business of health. The approach to a disease or a set of diseases is made with the establishment of a care plan that projects the necessary events to treat a patient. The events occur, as many as are needed, to complete the diagnosis and treatment of the patients. Those sets of events are aggregated in one tri-periodic episode.

SIGLIC has warnings for players involving the management of financial penalties. SIGIC stakeholders can access information through reports from SIGLIC according to their profile access. Access restrictions are applied to those profiles. All hospitals have to transfer normalised data automatically every day to a central data centre. Data is analysed, qualified and reported back to hospitals. Indicators are regularly produced and used to form management decisions. SIGLIC collects data to provide information for the Government to plan, regulate and make the best decisions in political and economic terms.

Since the beginning of the programme, we have observed a positive evolution in all indicators. The number of episodes in waiting lists has diminished regardless of the increase in admissions. At the same time, production has increased due to a new possibility for medical teams to operate on patients after work at a price per patient. The overall result is the dramatic fall in waiting times by 59%. The referral of patients to the private sector plays a little role — 5% to 7% — but is nevertheless important. Access to surgery, measured by the number of inscriptions per year, has successfully improved. Last year, we saw an increase of 42% over numbers from 2006 and an increase of 3% compared to the year before. The extent of the inscriptions list for surgery on 31 December 2013 shows a decrease of 20% compared to 2006. However, there is an increase of 5% compared to 2012.

The reduction in the waiting times is notable. That decreased 59% over 2006 and 6·7% compared with 2012. Nowadays, the average waiting time is 2·8 months. Surgical activity maintains a sustained growth of 57% since 2006. Between 2012 and 2013, that growth was 1·8%, which we consider satisfactory given the current crisis and given the 8% reduction in the budget for surgery. The percentage of patients who exceeded the maximum guaranteed responses, which has improved

greatly since 2006 through a reduction of 7%, still has a high value at 12%. Nevertheless, it has decreased by 15% compared to 2012.

Why does SIGIC work? It works because it established penalties for non-compliance with the guaranteed maximum response time. That reduces waiting times, and allowing doctors in public hospitals to do additional surgery promotes productivity. The analysis of express demand allows possible optimisations in reallocating resources. Through the analysis of supply for each provider, it is possible to increase productivity. The monitoring of compliance can correct errors. The collection of standardised data that allows us to compare providers and benchmark them increases efficiency. Identification of who is responsible for each event and the management of information in documents allows accountability. All stakeholders, physicians, patients and managers share the same information and so control each other. Patient transfers are automatic when the risk exists of exceeding the maximum waiting times guaranteed for surgery. In this case, the original public hospital pays the bill. The regular publication of the time results promotes accountability and allows all stakeholders to control the process. Publication of rates of productivity and non-conformity promotes quality and efficiency.

The Chairperson: Thank you very much for your detailed presentation. I think that you said there were penalties for non-compliance.

Mr Gomes: Yes.

The Chairperson: Can you explain what those are?

Mr Gomes: When it comes to the hospitals, we have a set of rules. Those rules are about complying with the maximum time for surgery, but there are also rules according to equity: if you pass one patient in front of another, that is a non-conformity. If you do not keep your registers well, that is a non-conformity. All of that has a penalty that is contractually established with the hospitals. So, the hospital will have less money if there are lots of non-conformities and penalties.

The Chairperson: Some of the information that we are gathering has been around the whole patient journey. You said that we need to look at the period from when a person is referred for treatment right through their entire journey. Is that your —

Mr Gomes: No. We have two different systems, and we are trying to integrate them. That is the future. Now, we are monitoring the time between inscription in the list, which is a central, national list, and treatment. We have another programme that monitors the period between referral and the first consultation, and we have a gap between the first consultation and the inscription in the list. That gap is not monitored. We have established that that gap can be from five days in urgent cases to one month in non-urgent cases, but it is not monitored. What we are trying to do is to monitor the three time periods: between referral and first consultation at the hospital; between first consultation at the hospital and inscription in the list; and the last one is between inscription and treatment.

The Chairperson: So, is it better to look at the entire patient journey when trying to deal with waiting times?

Mr Gomes: From the point of view of the patient, it would be better, without a doubt, because what matters to the patient is that he has a problem and the time begins to count when the problem surges. If possible, the ideal is to measure the time between going to the general practitioner and then from the general practitioner to the hospital and so on until the problem is solved. However, you have to see whether you have the means to address the problems that are disclosed through that. You can see that you would have to make more investment in the system to cover the whole process. That is why we are delaying the viewing of the process as a whole for a little bit, because if you have dark points, the system will adapt and will monitor the times at the darkest points.

The Chairperson: I noted as well that you talked about political will in relation to this. Is that a big factor in trying to tackle waiting times? What was your experience in Portugal? What was the biggest driver for trying to tackle issues around waiting times?

Mr Gomes: In Portugal, we have a problem and a blessing in that our constitution says that every person is entitled to every kind of treatment that will make them well, so it is difficult for the Government to establish a line to draw under what you should provide to people or what you cannot

provide. Prices are going up, and technology in medicine gets more sophisticated all the time, so the reality is that we cannot afford to pay for everything. However, we also cannot establish that line. That is the trade-off that would be necessary to solve politically. SIGIC is now doing the process more efficiently, so we can achieve more surgery. We had a productivity gap. We can make public hospitals more productive if we establish the right incentives.

The Chairperson: Finally, from me, one of the pieces of information that we found is that sometimes investment or money can be injected into part of the issue, but it does not address the overall issue. Sometimes, it can actually almost support bad practice.

Mr Gomes: Yes, I understand the question. In Portugal, we pay for medical acts. So, if a hospital does more medical acts, even if they are not needed, it will get paid more. That is why we are trying to change that to another form of funding that sees the whole tri-periodic episode. For example, when you have to replace a hip, you get a certain amount for the consultation, examination etc. That stops the increase in multiple appointments that are eventually not needed but are added to increase the budget. If we can, at the same time, put different systems, public and private, in competition with each other, we expect that we can maintain costs at the lowest price. The problem with that is that, at the same time that you measure access and production, you should also measure quality and health results, because you can have degrees of quality. We have seen that in several aspects — minor points, but it happens.

The Chairperson: Finally, definitely, have you seen better health outcomes as a result of tackling waiting times?

Mr Gomes: We had a big problem with access in Portugal. We have had a huge increase in access. Nowadays, people can go to the hospital. In the past, we had waiting lists of two or three years. Overall, that has reduced dramatically. Nowadays, most people have treatment within three months. However, in the worst cases, you see six or eight months. One thing that we have also — and we are not quite well, but we are much better — is a difference throughout the country. In the north, we have much better access than in the south. We are trying to make the different parts of the country more homogenous and alike.

The Chairperson: Is there evidence that that is improving health outcomes for the population?

Mr Gomes: General health outcomes have not decreased. We do not have precise measures of health outcomes. We have the gross health outcome measures, such as net mortality, life expectancy and so on. With these programmes, we need to have a programme for each kind of pathology, because we must know what is better with regard to plastic surgery, orthopaedics and so on, which do not have a great impact on survival. We have to make several studies. We need programmes for each of those pathologies. It is not case-sensitive enough to see the big picture. With the big picture, we are a little better than in the past but a little worse over the past year, not in surgery but in other areas on account of the crisis and with less access to others. That is also a problem. You must address health as a whole because, if you focus on only surgery, in other areas such as diabetes, you can have a big fall.

Last year, we were slightly worse but, generally, had better results in surgery. It is not specific for surgery and each pathology. That is something we have yet to do.

Mr Wells: What I find so extraordinary about what you are saying is that we see Portugal as undergoing an incredibly difficult economic time since 2008. Were you able to continue the progress through this economic downturn and a cut in the health budget?

Mr Gomes: Yes. I am also amazed with that. The public health service has a big role in health assistance in Portugal. Eighty per cent of all health assistance is public. The restrictions in budgets for hospitals are essentially in the salaries for doctors, nurses and so on. They are not responding yet. I do not know what will happen in the future, but they are staying there and not leaving, yet they are earning much less than three or four years ago. You can have a medical career doctor or consultant in a hospital earning 40% less than two or three years ago.

We have strong measures in public expenditure. Our taxes are much higher and salaries have decreased. We have the possibility of extra-time work. That used to be well paid but not now. All in all, we are working the same amount but earning much less.

Mr Wells: Did I pick you up right that you said that only 1,500 patients are waiting more than three months? Is that right?

Mr Gomes: It is important to understand that we have two possible ways to measure waiting times. We measure the time for the patients who are not yet operated on or treated and who are still on the list. We have 150,000 people on that list.

Mr Wells: Right, 150,000. But everyone else —

Mr Gomes: The median waiting time for those people is three months. The most recent figure is 2·8 months.

Mr Wells: Does that mean that every other patient has to wait less than three months?

Mr Gomes: No.

Mr Wells: It is the average.

Mr Gomes: That is the median. If you see the curve of the time taken to operate on people, you will see that most people are treated within one and a half to two months. You then have a queue in that line, and lots of people wait for six, nine or 10 months. Certain specialties have major difficulties in overcoming those waiting times. So, the median is three months; the average is three months.

Mr Wells: You managed to bring overall waiting times down by 59%.

Mr Gomes: Yes, because the median was eight months. In the past, the average was eight months.

Mr Wells: I was very interested in your idea that a patient could refer themselves to a private hospital, get the work done, and then the Portuguese health service would pay.

Mr Gomes: They do not refer themselves. The central office automatically emits a voucher when the patient achieves 75% of the maximum time guaranteed. In Portugal, we have four categories of maximum time guaranteed. For normal situations, priority is nine months. When the time comes to six months and 22 days, a voucher is automatically emitted. The voucher covers all private hospitals that perform the type of surgery that the person needs. Each person can choose to stay in his hospital or to go to one of the private hospitals and have surgery performed.

Mr Wells: And the state will pay for that, automatically.

Mr Gomes: Yes.

Mr Wells: How do you keep within your budget, because, presumably, at six months and 22 days, most people will say that they will go to the private hospital?

Mr Gomes: Most people do not achieve six months. The average is three months, so most people do not have the option to have the voucher. The problem is to do with how the queue forms. When you measure times, how do you get the higher time or the lower time? It has lots to do with how people are managed in the list time. If you have a regular, normal curve and everyone is treating everybody in more or less the same time, you should not have any person with vouchers, because no one will achieve the six months to have the voucher. The problem is that some specialities in some hospitals have longer queues. Those queues and those persons will achieve six months, 10 months. At six months, they receive the voucher. One thing that we have in mind when contracting with privates, as far as the budget is concerned, is that the private is contracted for less than the money expended in public health. So, if the person goes to a private hospital, it will cost the government less.

Mr Wells: That is fascinating, but I do not think that many private clinics here would agree to charge less than what the state pays for the operation; they just would not take on the work. So, you must have a good relationship with the private sector.

Mr Gomes: We have a problem with productivity in the public sector. The private sector is able to do things more productively. If you have a hospital that is set up to treat very complicated situations at

the same time that it is going to treat simple situations that are the most frequent, you have an investment that is not going to rise. You have all kinds of people working there, but they are not needed for most of the things that are being done there. We are not yet able to achieve the maximisation of productivity in public hospitals. Private hospitals can be much more productive than public hospitals. They can achieve 20% lower costs than the public hospital. Public costs are also incremented with some contaminations, because, even if we have a separate social department that is not in healthcare, the social department cannot give responses at the time. The public hospitals will then have patients that cannot go anywhere else.

Mr Wells: We have had evidence from Scotland, which has a central monitoring system where all the waiting lists are fed through to one desk. You have a similar system in Portugal.

Mr Gomes: Yes.

Mr Wells: Is it you who sees all the statistics?

Mr Gomes: Yes.

Mr Wells: So, you are able to identify hospitals that are performing poorly and those that are performing well. In the Portuguese system, is there an ability to move patients to hospitals that have capacity? You have 109 hospitals, I think. Do you, as a central control, move patients around?

Mr Gomes: You cannot move patients without their agreement; you must ask them whether they want to move. That is the first problem. The second problem is that it is worse to move patients from one hospital to the other, if the other has more capacity to respond in real time, because you will move the problem from one place to another. We are trying to do that; we are trying to incentivise; and we are trying to make organisational policies in public hospitals in the sense that they will want to get more patients. However, we cannot give incentives to the professionals at this time because, now that we are in crisis, the incentives have been cut off. It is forbidden to give incentives above salary, so it is not easy, at this time, to incentivise other hospitals, even if they are performing better, to receive patients from another place.

So, there are two things. First, you must get the consent of the patient to move them to another list or to another hospital, because the patient has already spoken with the doctor and has agreed with that particular doctor what kind of surgery they will have and what the consequences of that surgery may be and so on, and we do not think that it is ethical to just take that patient and put them in another place. It can be done, but only if he consents. We can say that if he goes there, he will be treated in less time, but mobility is also a problem. Many patients will not want to pay the extra that comes with mobility issues. If you take the patient from one place to another that is far from the original hospital, that would be a problem for moving.

Mr Beggs: Thank you for your presentation. I was interested in your emphasis that placing a penalty has forced hospitals to improve their productivity. How do you pitch the penalty at the right level to the right organisation? The set-up of each may limit their ability to respond. If you pitch it too high, you will just completely undermine the service, and they will not be able to reply to it. How do you pitch the level of the penalty, and how do you know whether there is capacity in a hospital to improve?

Mr Gomes: We have benchmarking on productivity, so we know which hospital and which sector in a hospital is performing badly in comparison with the other ones. That is one point. As to how we apply the penalties, so far it has been just at a financial level for the hospital as a whole. That is not very effective because it is difficult to close a hospital. So, even if that hospital does not perform well enough financially, it will be sustained by the Government. It will be paid off. In contracting with the top managers now, the contract includes penalties, and you can eventually not continue as a top manager if you fail to meet the targets. We are now doing that. It is very recent and was put in place just last year and this year. This year, we are also introducing restraints to additional practice. Additional practice for doctors is seen as an incentive. It is not really an incentive because we are paying them for doing things, but they are seen as incentives. We are now trying to limit access to that practice if they do not achieve the minimal productive standards that we publish. So, you can earn the rest of the money for the rest of the production if you achieve the minimal standards that are published. The minimal standards are based on the top 25 for productivity in all countries. So, it is a big step to achieve that kind of additional payment.

Mr Beggs: Do you have a uniform health accounting system to attribute costs? Depending where overheads are parked, that can have a major bearing.

Mr Gomes: Yes. All episodes are coded by ICD-9. Now with no country having ICD-9, we are migrating to ICD-10. All episodes are coded.

Mr Beggs: What percentage increase in productivity have you achieved through those pressures on the hospitals and the public service?

Mr Gomes: We achieved nearly 50% of the productivity of the hospital. That is not in accordance with the expenditure. That account is not yet made. The expenditure has also risen but the price per unit is falling, and we estimate that it is over 20% less than three or four years ago, based on measuring productivity on an expenditure and income basis.

Mr Beggs: I have a final question. You mentioned earlier that screening and various tests are all part of an integrated service. I am picking up that, with our service, depending on where it is parked, it can be a blockage. Who decides when the test occurs? Is it the GP, or do you have to see the consultant before you get that added delay to an operation or a process?

Mr Gomes: In theory, to go to a consultant, you must go to the GP first. In Portugal, we are still trying to change what happens in practice. Until now, just 30% of people who go to the first consultation with a consultant come from a public GP. The other ones are patients who go to the hospital and are cross-referred from other consultants and other hospitals. So, we are trying to improve, including through having a financial incentive for referrals that come from a GP. However, it is not forbidden to have a patient consultation if that patient did not come from a GP.

Mr Beggs: To what extent can GPs request appropriate tests, as opposed to consultants, so that there is not a bottleneck at consultant level?

Mr Gomes: That is also quite different around the country. When the funding for examinations was not provided to GPs, they could ask for whatever, because it would not affect their budget. Now, we have two kinds of system for GPs. We are changing, but that change is slow. We have 30% in the new form, which permits that GPs have incentives to their practice in functions to do with the quality of services and attendance numbers etc, but examinations are also included in that funding. Those GPs do not want to ask for very many examinations, and they refer earlier to the consultant in the hospital. If the examination is asked for by the consultant, it is the hospital that pays, not the funding for the GP. We have a mixed situation now.

Mr McKinney: I want to ask about the IT system, which is clearly key to the whole project. How difficult or easy was it to commission and implement that system?

Mr Gomes: We had a good start because 80% of the hospitals had the same information system. So, we could change one system and it would change 80% of the whole system. That system was a public government one. We asked the other hospitals to alter their systems to match the central one, so it was not very difficult. Now, we have experienced serious problems in matching different systems when trying to match the private care system with the hospital system. That has been a problem, but the first one was not.

If you have a strong determination and say, "Things must go there, and requests for functions are those", and you tell people that, if they do not comply with those requests in three months, you will not process them, things will change quickly enough.

Mr McKinney: Was there a big cost implication with the IT system?

Mr Gomes: We have an estimation for all the modifications and implementation of the IT system of €1·5 million a year for five years.

Mr McKinney: So, it is not an extraordinary cost.

Mr Gomes: That is to connect all hospitals and to have a central system to analyse data and make reports and all that.

Mr McKinney: Just to be clear then: the system has to be available in common to all hospitals.

Mr Gomes: Yes.

Mr McKinney: And all hospitals must have an electronic record of the patient.

Mr Gomes: Not a complete electronic record, but the consultations must be electronic. Medical text does not comply.

Mr McKinney: It is not necessary. It is simply a record of —

Mr Gomes: The system has two ways of working. One way is to interact with local systems, and data passes from the local system to the central system. Hospitals that do not have a local system that is good enough, with all that is required to connect, can connect directly to the central system and put their information in there. That is what is happening in most private hospitals that have less quantity and do not want to acquire another system. They use the central system as their own electronic process management system.

The Chairperson: OK. Thank you for that information and for taking the time to come here. This is something that the Committee takes very seriously, and your evidence today will feed into that. It is important in respect of the central unit, and we have heard that before, as some members have pointed out. Thank you for your information. We will reflect on it, and it will form part of our recommendations. Thank you very much. Safe journey home.

Mr Gomes: Thank you.