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SOLVING THE SURGICAL WAITING LIST PROBLEM? NEW ZEALAND'S 'BOOKING SYSTEM'

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SUMMARY

This article discusses the development and implementation of New Zealand's booking system for publicly funded non-urgent surgical and medical procedures. The 'booking system' emerged out of New Zealand's core services debate and the government's desire to remove waiting lists. It was targeted for implementation by mid-1998. However, the booking system remains in an unsatisfactory state and a variety of problems have plagued its introduction. These include a lack of national consistency in the priority access criteria, failure to pilot the system and a shortfall in the levels of funding available to treat the numbers of patients whose priority criteria 'scores' deem them clinically eligible for surgery. The article discusses endeavours to address these problems. In conclusion, based on the New Zealand experience, the article provides lessons for policy-makers interested in introducing surgical booking systems. Copyright © 2000 John Wiley & Sons, Ltd.

KEY WORDS: prioritization; waiting lists; booking system; New Zealand; health policy

INTRODUCTION

Waiting lists for non-urgent surgical and medical procedures are commonplace in countries that maintain publicly funded health services. The reasons why waiting lists exist are unclear, although various explanations have been forwarded by those who have studied them (e.g. Frankel and West, 1993). It has been suggested, for instance, that waiting lists exist simply because demand outweighs the capacity to deliver, or because service providers are inefficient. It has also been questioned whether waiting lists are a positive or negative aspect of health care delivery, from the perspective of both those responsible for service delivery and those awaiting care (e.g. Globerman, 1991; Goddard and Tavakoli, 1998; Naylor and Slaughter, 1994; Pope, 1991). Contributing to the waiting list phenomenon have been contemporary trends affecting health care such as ageing populations, increasing availability of new and expensive technologies and treatments and, in keeping with this, a generally increasing propensity of citizens to demand more care. Perhaps the one clear aspect

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of waiting lists is that people frequently languish for a very long time while awaiting treatment, and there is often little by way of explicit ranking of those waiting in terms of their need for treatment or monitoring of their conditions while they wait.

In New Zealand, an endeavour has been made to replace waiting lists with a new system in which patients are first 'scored' and prioritized in keeping with their clinical and social need for treatment and then, if deemed eligible, 'booked' for surgery. The new system, formally introduced on 1 July 1998, emerged out of the reforms to New Zealand's publicly funded health sector of the early-1990s. It promised to reshape radically both the clinical decision-making process and the way in which patients obtain access to health services. Much work has been undertaken in developing the new 'booking system', but substantial problems have emerged through the process of implementation which could prove to be as 'counterproductive' as the former waiting list system if not rectified.

This article discusses the development and implementation of New Zealand's 'booking system', and is derived from various available documents and the initial findings of a current research project in which the authors are involved. First, the article outlines the origins of the booking system and the concurrent development of priority access criteria. Next, it details the process of implementing the new system through the clinical groups within public hospitals. Third, various methodological and practical problems which have emerged through the development and implementation of the new system, or remain as 'hangovers' from the waiting list era, are discussed. Fourth, the article outlines efforts to remedy the problems. Drawing upon the New Zealand experience, the conclusion offers recommendations for policy-makers considering the adoption of a booking system for the prioritization of patients.

NEW ZEALAND'S HEALTH REFORMS AND THE CORE SERVICES DEBATE

The New Zealand health sector has been the subject of one of the most extensive reshaping exercises of any developed country in contemporary times, of which a great deal has been written elsewhere (e.g. Ashton, 1991, 1999; Salmond *et al*., 1994). In brief, in 1991, a series of structural reforms were unveiled with an overriding objective to create a market-oriented and highly competitive health system (Upton, 1991). Implemented in mid-1993, the reforms included a split between the purchase and provision of health services, functions previously performed by a number of regionally based partially elected health boards. Four new Regional Health Authorities (RHAs) were formed to purchase a range of publicly funded health services from available providers which had been funded previously from a variety of sources. The goal for the RHAs was to obtain, within a fixed budget, the best services for the best price and, in turn, to enhance the efficiencies of service providers. On the provision side, public hospitals were grouped into 23 Crown Health Enterprises (CHEs), with a prime objective of winning service contracts from the RHAs and profiting from the exercise through efficiency gains and market capitalization. CHEs were expected to compete with each other, and with other private or non-profit providers, for the public health dollar.

Integral to the new system was an attempt to define the 'core services' to be provided to solve the problem of escalating demand for an ever-increasing range of health services and, ultimately, to cap the health budget. In the government's own words, core services were to be those '... to which we believe everyone should have access, on affordable terms and without unreasonable waiting time' (Upton, 1991: 75). The government itself was not prepared to determine the 'core', and chose instead to establish a committee, with a very broad-ranging brief, to facilitate public discussion on its behalf and, from this, to produce advice on what services ought to be publicly funded. The government suggested that the core might be either a definition of *people* eligible for treatment from the public health service, or a defined *list* of publicly funded services which would be universally available (Upton, 1991). Following its own studies into health services rationing (Bridgeport Group, 1992; Campbell *et al*., 1993), the Core Services Committee recognized that achieving either of the government's ideals would be a contentious and interminable task. It came to the conclusion that a more practicable way forward would be to work on the development of criteria for the prioritization of patients, and guidelines for efficient and effective clinical practice (Core Services Committee, 1992; Cumming, 1997).

THE CORE SERVICE COMMITTEE AND WAITING LISTS

The Core Services Committee (CSC) commissioned a number of reports including 1993 study of waiting lists (Fraser *et al*., 1993), which noted that waiting lists in New Zealand had always existed and had effectively doubled in length in the two decades prior to 1992. This was despite the fact that there had been a substantial increase in surgical throughput over the same period.[†] The report emphasized that waiting lists failed to provide a measure for a hospital's throughput, and failed to give an indication to patients of how long they could expect to wait for treatment. Furthermore, the criteria for entry to public waiting lists lacked both standardization (individual clinicians made decisions based on their professional judgement), and a singular point of entry (specialists from both the public and private sectors could place patients onto public hospital waiting lists).

The waiting list report contained two key recommendations. First, that waiting lists be abolished and replaced by a system in which the patient would be booked for operation at the time of specialist assessment. Second, that criteria based on both the patient's *need for treatment* and their *ability to benefit* be developed so that eligibility for treatment could be determined in accordance with predetermined standards. It was suggested that such a system would provide transparency and consistency to decisions relating to treatment, provide certainty to patients and make clear the level of actual need for non-urgent surgery. In terms of the further development and implementation of the booking system, the report recommended that:

[†]In 1973, 33 000 people were awaiting surgery on public hospital waiting lists; by 1992, the number of people on waiting lists had grown to 64 000 Fraser *et al*., 1993: 10). In 1995, the waiting list contained 85 574 patients, equating to 24 per 1000 of total population (Ministry of Health, 1997).

- specialists should lead the way in forging a consensus around priority criteria, and commit to make the booking system work;
- CHEs should provide appropriate infrastructure to facilitate the operation of a booking system and its adoption by specialists;
- the four RHAs should encourage providers to adopt booking systems as soon as possible, and monitor the movements of patients once booked for surgery;
- Royal Colleges of specialists should work to facilitate the participation of their members in the development of priority criteria, and encourage members to support the booking system;
- the CSC should work to facilitate and monitor progress on the above mentioned points.

The report was skeptical about the prospects for the booking system if not carefully implemented and fully supported by the various stakeholders. In particular, it noted that any scoring system for according priority of access to treatment could be open to abuse by clinicians and patients in pursuit of higher priority. It also cautioned that inadequate resources could undermine the system, especially if providers were unable to honour the 'booked' appointments for surgery. Finally, the report recommended that priority criteria and booking systems be developed on a *national* basis, with the input of all relevant parties, although it was also noted that *regional* initiatives could be cultivated on a 'pilot' basis.

DEVELOPING PRIORITY CRITERIA

The recommendations of the waiting list report received the endorsement of both the CSC and the government, opening the way for the development of priority criteria. In March 1994, a partnership between the purchasing RHAs and the CSC was formed to facilitate work on five priority criteria projects – cataract surgery, coronary bypass surgery and angioplasty, hip and knee joint replacements, prostate surgery and hysterectomy (Core Services Committee, 1994). For each of the projects, various stakeholders (specialists, general practitioners and hospital managers) were solicited for information on existing referral and decision-making processes, and how these might be made more fair. In tandem, a review of literature in the field was conducted and preliminary recommendations forged on which an advisory group of specialists was asked to comment. Recommendations were then circulated to all registered specialists for comments, and further revisions followed (Hadorn and Holmes, 1997a).

Through the first two of the projects (cataract and bypass surgery) there was a relatively high level of agreement over the medical factors that ought to be incorporated in the priority criteria, largely because these factors were supported by findings from international studies. In the other three projects, however, a consensus emerged that inclusion of only medical factors provided a very narrow set of priority criteria, and that social factors also ought to be accounted for in the prioritizing process. Determining social factors was considered by respondents to be a highly subjective process and, therefore, best left for the community itself to work through.

Accordingly, in mid-1994, the CSC established a public consultation project, arranging public forums in which randomly selected participants were presented with the medical priority criteria, then asked whether social factors should be incorporated and, if so, which ones. These meetings elicited an extended list of such factors including age, family and general health status, ability to work and current work status, time on a waiting list, limitations on activities, and so forth. As with the CSC's earlier opinion-gathering exercises (Bridgeport Group, 1992), a strongly expressed viewpoint was that if government funding for health was adequate, then 'rationing' by prioritization would be unnecessary (Core Services Committee, 1994: 40).

By 1996, significant progress in developing priority criteria had been made in all five projects, and work was under way in developing criteria for other procedures (Core Services Committee, 1996). However, the foundations for some problems which would later plague the functioning of the booking system were being laid. First, and in keeping with the preference for competitive arrangements promulgated under the 1993 health reforms, the criteria were not being developed on a national basis, as recommended in the waiting list report, but locally between individual hospitals and the RHAs. To further compound this situation, to finance the move to the booking system the four purchasing RHAs were negotiating separate individualized contracts with each of their constituent CHEs. Second, it was becoming clear that the levels of funding available were not sufficient to treat all patients whose scores deemed them clinically eligible for surgery. There was a gap between the level of operations purchased (the financial threshold), and the cut-off levels preferred by clinicians (the clinical threshold). Third, only limited attention was given to piloting the new processes, meaning that by the time the booking system was implemented in full, both the priority criteria and the systems for booking patients remained in an underdeveloped and largely untested state.

Given the relative 'success' with developing priority criteria, but not with testing or implementing it, the government declared its wish that all hospitals have booking systems in place by mid-1998 (Shipley, 1996). Recognizing that the numbers of people on waiting lists for surgery was likely to thwart this goal, in May 1996, a funding injection of NZ$130 million (an addition of around 3.5% to the health budget) dedicated to clearing waiting list 'backlogs' was announced. As a incentive to hospitals to hasten the process of implementation, these funds (known as the Waiting Times Fund) were only accessible when it could be demonstrated that priority assessment criteria had been developed for use, along with a system to book patients. The Waiting Times Fund money was to be used to reassess (using the priority criteria) and treat those deemed eligible from the old pre-May 1996 waiting lists, while money from ongoing contracts was meant for the assessment and treatment of new patients presenting to hospitals. It was envisaged that eventually all those waiting for surgery would be reassessed and either treated or turned away because they were ineligible for treatment, and that waiting lists for non-urgent procedures would no longer exist (Ministry of Health, 1996). The Waiting Times Fund money stimulated hospitals into action and, by the end of 1996, most of the 23 CHEs had received funds for a range of priority criteria and assessment systems, although many were still not at the stage of 'booking' people for surgery.

In December 1996, a restructuring of the 1993 health reforms was announced by a newly formed Coalition Government. The key changes have been detailed elsewhere (e.g. Hornblow, 1997; Martin, 1997). Of relevance to this discussion, the four RHAs were amalgamated into one central purchasing agent, renamed the Health Funding Authority (HFA),[‡] and it was pledged that guaranteed waiting times of no more than 6 months for various surgical procedures would be introduced. This was to be supported by a NZ$50 million addition to the existing Waiting Times Fund (Coalition Agreement, 1996), a sum subsequently increased to $84 million per year for a period of 3 years. In line with the government's promises, the HFA made the replacement of waiting lists with the booking system a priority. Thus, in its funding agreements it stipulated that all public hospitals were to adopt the new system for the assessment of all patients of non-urgent services by 1 July 1998. To assist hospitals in meeting this goal the HFA formed a group of staff (the National Waiting Times Project Group) to work with hospitals to resolve some of the difficulties encountered in introducing the booking system.

THE BOOKING SYSTEM IN ACTION

By 1 July 1998, however, New Zealand was far from introducing a nationally consistent booking system. A report from the National Waiting Times Project Group indicated that there were 'significant differences regionally and even between hospitals both in approach and implementation' (Health Funding Authority, 1998). Such was the degree of variation throughout New Zealand that no single prioritizing tool was shared by all 23 hospitals for any one treatment, while the protracted contracting process meant that many financial thresholds for access to treatment had not been agreed to between the CHEs and the HFA. Despite the injection of Waiting Times Fund money, waiting list 'backlogs' had not disappeared. Moreover, certainty for patients had not greatly improved as the majority of hospitals were not giving patients a date for surgery within 10 days of their assessment; they were either giving patients an indication of when they may expect surgery, or were failing to inform them of whether or not they would receive surgery.

There are three main problem areas which help to explain New Zealand's failure to introduce a nationally consistent and satisfactory booking system. The first lies with the development and use of the clinical priority assessment criteria (CPAC), the second is in the practical ramifications of the booking system, and the third concerns the funding of public health services in New Zealand.

The tools for prioritization

Specialists cooperated with the development of the priority criteria because they wished for greater consistency of access and for the development of 'objective

[‡] In mid-1998, the 23 CHEs were renamed Hospital and Health Services (HHSs). To avoid confusion, the CHE acronym is used in the remainder of this article.

measures of symptoms and functional status' that could present the level of 'unmet need' in the community (Hadorn and Holmes, 1997b: 135). However, they were divided in their involvement and they experienced difficulty in arriving at a point of consensus over the components and weighting of the various categories contained within the priority criteria (Halliwell, 1998). This lack of agreement, combined with the competitive nature of New Zealand's health system and the accompanying reluctance of the four RHAs and hospitals within the four regions to communicate freely with each other, resulted in the development of different priority criteria in use for the same procedure throughout the country.

As yet it is unknown which of the varying criteria designs are best for prioritizing access to a specified treatment. A study of people assessed for cholecystectomy investigated the relationships between three different priority criteria which had been developed by (1) the funding authority, (2) the Core Services Committee clinicians working party, and (3) a linear analogue scale measuring clinical judgment of urgency of treatment. Little agreement was found between the three types of criteria with differences as great as 30 (out of 100 possible) points for any one patient measured with all three criteria. Consequently, the authors of the study questioned whether the newer 'objective' methods for determining priority are any advance on clinical judgement and called for tools to be developed 'on the basis of evidence that incorporates quality of life data and with the full collaboration of clinicians, epidemiologists and the general public' (Dennett and Parry, 1998).

To date, there has been little evidence for the test–retest or inter-rater reliability of the priority criteria, although this is an aspect of the new system which experience suggests has proven to be problematic (cf. Malpass, 1998). For example, one study found that only 3 out of 39 patients assessed for cataract surgery received the same score on the cataract priority criteria when scored by two different examiners, while the scores for individual patients varied between examiners by as much as 27 points (Halliwell, 1998). Where access to surgery hinges on one point such variations may be to the detriment of those patients denied treatment.

The practicalities of the booking system

In February 1996, HealthCare Otago, the CHE which serves the Otago region, became the first to introduce a booking system for a major speciality when its eye department introduced a booking system for access to cataract surgery. This system has been promoted as a example, to other CHEs in New Zealand and to the international community, of one which is robust and well developed (HealthCare Otago, 1996). However, our research has revealed that the practical operation of this 'exemplar' booking system has not been straight forward. Since February 1996, the eye department has variously been unable to book patients within the stipulated time frame of 6 months, unable to indicate when, or even if, people can expect to receive cataract surgery, and some patients who have received 'booked' dates for surgery have subsequently had surgery postponed more than once. These problems appear to have arisen as a consequence of the contracting process and uncertainty over where the financial thresholds should rest from one year to the next. While financial thresholds are theoretically 'sustainable', that is, able to be calculated according to

the level of funding, previous levels of provision and cost weights of services provided, and the anticipated acute workload, in practice the thresholds appear to move quite dramatically. In the HealthCare Otago eye department the thresholds for access commenced in 1996 at a priority criteria score of 38 points (when the clinical threshold was placed at 27 points), subsequently dropped to 27 points, then later increased to 30 points. In November 1998, the threshold was increased once more to 38 points. From a clinical perspective, people scoring 30 points or more are unlikely to be able to drive and cannot read with ease (HealthCare Otago, 1996). HealthCare Otago has not been alone with the problem of fluctuating financial access thresholds, and reports suggest that shifting priority criteria thresholds and difficulties in establishing a nationally consistent system have complicated the process of booking people for treatment (Health Funding Authority, 1998).

The booking system, and associated priority criteria, has been praised for being explicit, yet many patients presenting for assessment are unaware of the different components of the priority criteria, and in some cases are unaware that they are being 'scored' by the staff assessing them. Moreover, people who fail to meet the financial threshold, and their general practitioners, are not informed which components of the priority criteria have prevented them from acquiring enough points to be eligible for surgery (Derrett *et al*., 2000). In addition to the uncertainty surrounding the administration of the priority criteria, the concern raised in the original waiting list report (Fraser *et al*., 1993) that staff performing the assessments may deliberately inflate priority scores, or that patients may exaggerate their symptoms to achieve a higher 'score' seems to have been borne out. For instance, a surgeon at a large metropolitan hospital in the capital city (Wellington) stated that he would inflate the scores of his patients to ensure that they receive surgery, even where this would mean that people with greater need who had consulted with surgeons scoring 'accurately' could be denied treatment (*Otago Daily Times*, 7 September 1998). Similarly, anecdotal evidence suggests that the booking of patients has been influenced by patients placing pressure on those managing the system. Such problems were certainly in existence with the former waiting list system, in which specialists were able to move people up the list and patients could queue jump by complaining loudly (Hadorn and Holmes, 1997b). There is little evidence to date which demonstrates that the booking system will lessen the opportunities for the minority of specialists, managers or patients who may seek to circumvent it.

There has been a lack of research into the outcome of patients who meet the financial threshold and go on to receive surgery. Of even greater concern is the lack of consideration of the outcomes and experiences of those people who fail to meet the threshold, particularly for the group that fall in the gap between the clinical and financial thresholds. We know that there are quality of life deficits associated with being on lengthy waiting lists (Derrett *et al*., 1999), but we do not known that these problems are improved by the booking system. There is a real risk that those who meet the clinical but not the financial threshold will become a large invisible group within New Zealand society. Despite their numerical imprecision, waiting lists at least enabled New Zealanders to comprehend the magnitude of the problem and to campaign for improvements to the levels of the health services provided. In many cases, patients with insufficient 'points' to meet the financial threshold have been

advised to return to their general practitioners (GPs), who in New Zealand are private providers, to explore the possibilities for alternative treatment. Many GPs have explored all possible avenues for the management of their patients in the community prior to referring them for specialist hospital-based assessment. Thus, the practice of referring patients back to their GP is placing both doctors and patients in an impossible position. In many cases the only option for patients will be to pay for surgery privately, which is beyond the financial means of a substantial number of New Zealanders. Such 'cost shifting' from hospitals to individuals may mean the priority criteria and the booking system is helping to create a health system where access to services for many is determined in accordance with ability to pay, rather than the need and ability to benefit from treatment.

Funding, contracting and the implications of 'rationing'

It has been reported that the response from doctors to the prospect of the booking system had 'been largely one of relief that thousands of patients on waiting lists will now be provided with surgery' (Hadorn and Holmes, 1997a). To be fair, many of these doctors had been hopeful that surgery and treatments would be purchased by the funding authorities to a credible clinical threshold, not a fluctuating financial threshold. Moreover, many doctors were skeptical from the outset as to the potential of the booking system to make real changes in terms of patient access to services (Dennett and Parry, 1998).

Unfortunately, the concerns of some specialists involved in developing the priority criteria that 'the government or the regional health authorities would use the criteria to specify arbitrary numerical cut-off points below which surgery would not be funded' (Hadorn and Holmes, 1997b) in times of scarce health resources would seem to have been realised. In an isolated but illustrative case, a 42-year-old farmer in the then Minister of Health's own electorate (Southland) died while languishing in the gap between the clinical and financial thresholds for cardiac surgery. In the aftermath of this event, it emerged that the population in the southern region of New Zealand were waiting twice as long for surgery as those in the northern regions (*Otago Daily Times*, 7 April 1998). Despite the obvious regional differences between the clinical and financial thresholds, additional resources have failed to reduce this gap. This is partly because the base contract levels of surgery purchased actually declined following the 1993 health reforms, and have only recently returned to 1993 levels.

In addition to the problems associated with inadequate resourcing of non-urgent surgery are the varied and complex contracting processes introduced in 1993 with the split between purchase and provision of services. Because the 1993 health reforms required the 23 CHEs to act in a competitive and business-like manner, a range of contracting styles developed (Howden-Chapman and Ashton, 1994). Thus, some hospitals had contracts with the HFA specifying a total amount of elective surgery to be provided, while others had contracts where the amount of elective surgery provided was determined by the unpredictable volumes of acture surgery, as all surgery (acute and elective) came from the one budget. In the latter type of contract, managers were required to set the financial thresholds for surgery at a higher level than they thought was necessary to allow for any unanticipated increases in acute

levels. Once funding levels had been agreed to between the HFA and the hospitals, discretionary changes could not be made even where there were groups of people in genuine need of surgery. As a case in point, a doctor caring for a young child denied access to grommet surgery commented that, 'the points system, which was necessary because funds were constrained, had stringent criteria and did not leave room for compassion' (*Otago Daily Times*, 15 October 1998).

The system whereby funding contracts are negotiated annually, with occasional interim funding injections, is problematic for New Zealand hospitals. It has been difficult for them to recruit additional staff to meet short-term increases in purchased levels of surgery. If the contracting system had a longer-term focus, and hospitals could offer staff contracts for 3 years, instead of 6 months or 1 year, then opportunities to perform additional procedures would be enhanced. Because of the year to year, *ad hoc* approach to funding many hospitals have been unable to supply contracted levels of surgery, contributing to the number of people waiting for non-urgent procedures. Finally, and further eroding the establishment of workable booking systems, it has emerged that, because of restricted funding levels, hospitals have engaged in the practice of 'volume shifting', in which booking system funding allocations were transferred to other underfunded areas such as acute surgery and accident and emergency services. This has occurred as the HFA has been unable to adequately monitor or enforce its multiple funding contracts with hospitals (Ministry of Health, 1999).

ADDRESSING THE PROBLEMS: THE NATIONAL WAITING TIMES PROJECT GROUP

In mid-1998, the HFA formed a National Waiting Times Project Group (NWTP) dedicated to resolving the numerous problems that have arisen with the introduction of the booking system. As a first step, and to the displeasure of the government (see Ministry of Health, 1998: 19-21), the NWTP shifted the deadline for full implementation of the booking system to July 2000. Moreover, they retreated from the original policy of referring all patients who did not meet the financial threshold back to their GPs, recommending, instead, that hospitals place patients who met the clinical threshold but failed to meet the financial threshold on what was known as the 'residual waiting list' (RWL). People in this 'residual' group were informed that they did not have enough points for surgery, given the funding levels, but that they would be reconsidered for surgery should this situation change within the next 12 months. This meant that the only people who became completely invisible were those failing to meet the clinical threshold, a situation that also existed under the former waiting list system. While certainty was not offered to those on the RWL, and many were likely to seek alternative treatment, they remained on the hospital records.

The NWTP also worked with teams of health professionals to develop acceptable national criteria to be used in all public hospitals throughout New Zealand. This allowed for regional comparisons to be made and theoretically for the levels of service provided to be similar between regions, and sought to bring the booking system into line with the original objectives of being fair and consistent. Yet while

it seems an agreeable prospect that New Zealanders will require the same priority assessment score using the same criteria for access to treatment within similar time frames irrespective of where they live in New Zealand, national consistency carries the risk of reducing effective services. Hospitals providing more treatment than the national average may be forced to provide less treatment. This could have consequences, not only for the people requiring treatment, but for the overall configuration of hospital services. Unless funding is improved to a credible level there could be further contraction in the scope of New Zealand's public health system.

The NWTP held regular meetings with hospital managers and clinicians to look at problems as they arose, and to suggest possible ways of addressing these. It established phone lines with pre-recorded messages to inform the public about the new booking system, and funded small research projects investigating various aspects of the system. Despite these positive steps, the NWTP faced an uphill battle. The numbers of patients prioritized and booked with certainty was limited, and the numbers of new referrals continued to grow. At the time of writing, the number of new patient referrals for first specialist assessment was around 121 000, of whom 41 000 had been waiting to see a specialist for longer than 6 months (Health Funding Authority, 2000). To compound matters, many of those previously prioritized and not given certainty were being re-referred by their GPs for reassessment.

New Zealand's recent general election resulted in a change of government and plans are in place to change the structure of the public health sector once again. The HFA is to be abolished and many of its functions absorbed by the Ministry of Health. The focus of the health sector has continued to move towards collaboration, and public elections for health boards are to be held in 2001. While the current Labour-led government has stated its ongoing commitment to the development of the booking system, the precise outcomes of these health sector changes and the consequences for the booking system are as yet unclear.

The NWTP has been renamed the Elective Services group. It continues to monitor the implementation of the booking system and to develop, together with health professionals, new approaches for prioritization of patients. Interestingly, some of the new priority criteria are giving clinical judgement a much stronger emphasis than in previous criteria. However, national consistency in terms of the priority criteria used within the booking system remains a distant goal. The RWL is targeted to be removed by the end of June 2000. Prioritized patients are either to be: (1) given a booked date for treatment; (2) given certainty that they will receive treatment within 6 months of their assessment; (3) placed on an active care and review list (if they are just below the financial access threshold, have to meet some other requirement such as stopping smoking, or require ongoing specialist review); (4) planned or staged for treatment (such as for paediatric cardiac surgery); or (5) discharged back to the care of their GP or simply discharged entirely (people with low priority who will not be treated given current funding levels, no longer require surgery, have relocated or died) (Health Funding Authority, 2000).

These revised categories for the booking system will increase the certainty provided to patients assessed for treatment. Uncertainty for people on the RWL has been a problem with the booking system to date. Some people incorrectly believed

they would receive surgery within a year of placement on the former RWL, whereas very few of them actually received surgery and the majority were merely discharged (Derrett *et al*., 2000). Yet the revised categories do not address the ongoing problem of invisibility for the patients who fail to meet the financial threshold, despite meeting the clinical threshold. Booking systems need to ensure that people are quickly reassessed should GPs recommend this, that GPs are informed that quick reassessment is to be encouraged where patients' conditions deteriorate, and that GPs and patients are given more information about the priority score itself. The revised booking system categories no longer discuss clinical thresholds or the gap that exists between clinical thresholds and financial thresholds. Care must be taken to ensure that this change in terminology does not result in even less consideration of the group who miss out because of the need to prioritize and ration services in a climate of insufficient resources.

CONCLUSION

This article has outlined the development and implementation of New Zealand's booking system for access to non-urgent surgical procedures. The booking system emerged as an alternative to the waiting list with the promise of providing certainty to patients in need of an awaiting treatment, and with creating a transparent, consistent and equitable process of allocating health care resources. It needs to be recognized that the replacement of waiting lists with booking systems has been a substantial undertaking, involving the establishment of new processes for patient assessment and the purchase and provision of services across a larger number of hospitals. This stated, it is asserted that the transition from one system to another in New Zealand has been less than satisfactory. This has, in turn, been detrimental to the performance to date of the booking system, and it is likely to be some time before the system is functioning smoothly.

There has been much international interest in New Zealand's booking system (e.g. Dixon and New, 1997; Edwards, 1999; Ham, 1997; Smith, 1997). Given this, it is essential that the lessons of New Zealand's convoluted transition are heeded if transparency, consistency and equity are the aims of any country looking to introduce a similar system of priority criteria and booking for treatment.

Based upon the New Zealand experience, there are three key factors for which policy-makers need to account. First, it is imperative that priority criteria and access thresholds are developed in a manner in which there is national consistency, so that patients of the same health system can be assured of the same access to treatment, regardless of which public hospital they are referred to. This, of course, presupposes that the resources are available to ensure that the access thresholds are funded to a credible and clinically acceptable level. Second, it needs to be made clear what the intention of any booking system is: to make practicable the setting of financial thresholds, or to add transparency and rationality to the process of patient assessment? Policy-makers need to consider very carefully the financial implications of transparency and points scoring if they wish to avoid the prospect of developing either a 'residual waiting list' or of rendering invisible the people not meeting

financial thresholds. Finally, it would appear from the New Zealand experience that rigorous piloting of priority criteria and systems for booking people is fundamental. As discussed in this article, only limited piloting of the booking system or the criteria was ever conducted; the government simply decided that national introduction on a predetermined date was the way forward. Many of the problems which have beleaguered New Zealand's booking system since its introduction in 1998 could have been averted if the multiple facets of the system had been explored in controlled experimental settings. Short of these lessons, as New Zealand's current experience demonstrates, the performance of booking systems and waiting lists is likely to be comparable.

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