



Access to specialist medical outpatient care

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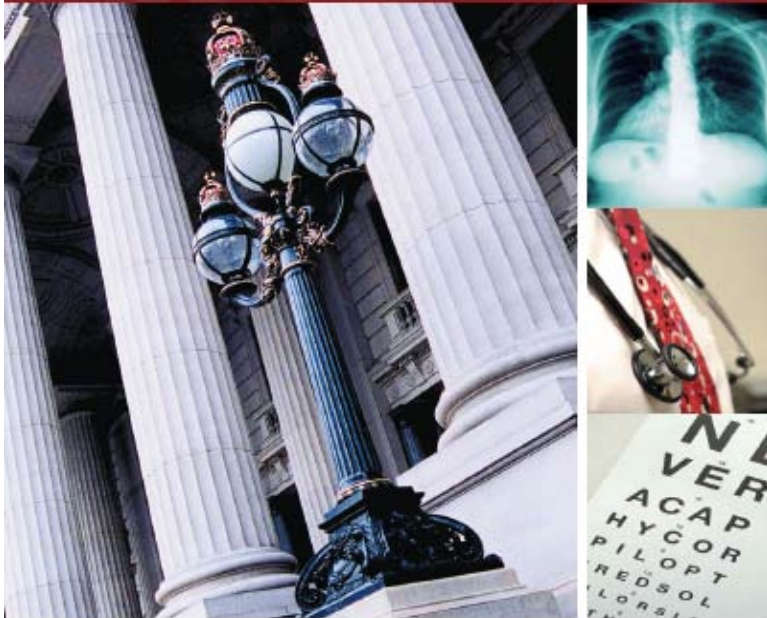
Outpatient Audit June 2006



Auditor-General's Report Access to specialist medical outpatient care

2006:2

June 2006




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Auditor-General's Report

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Access to specialist medical outpatient care

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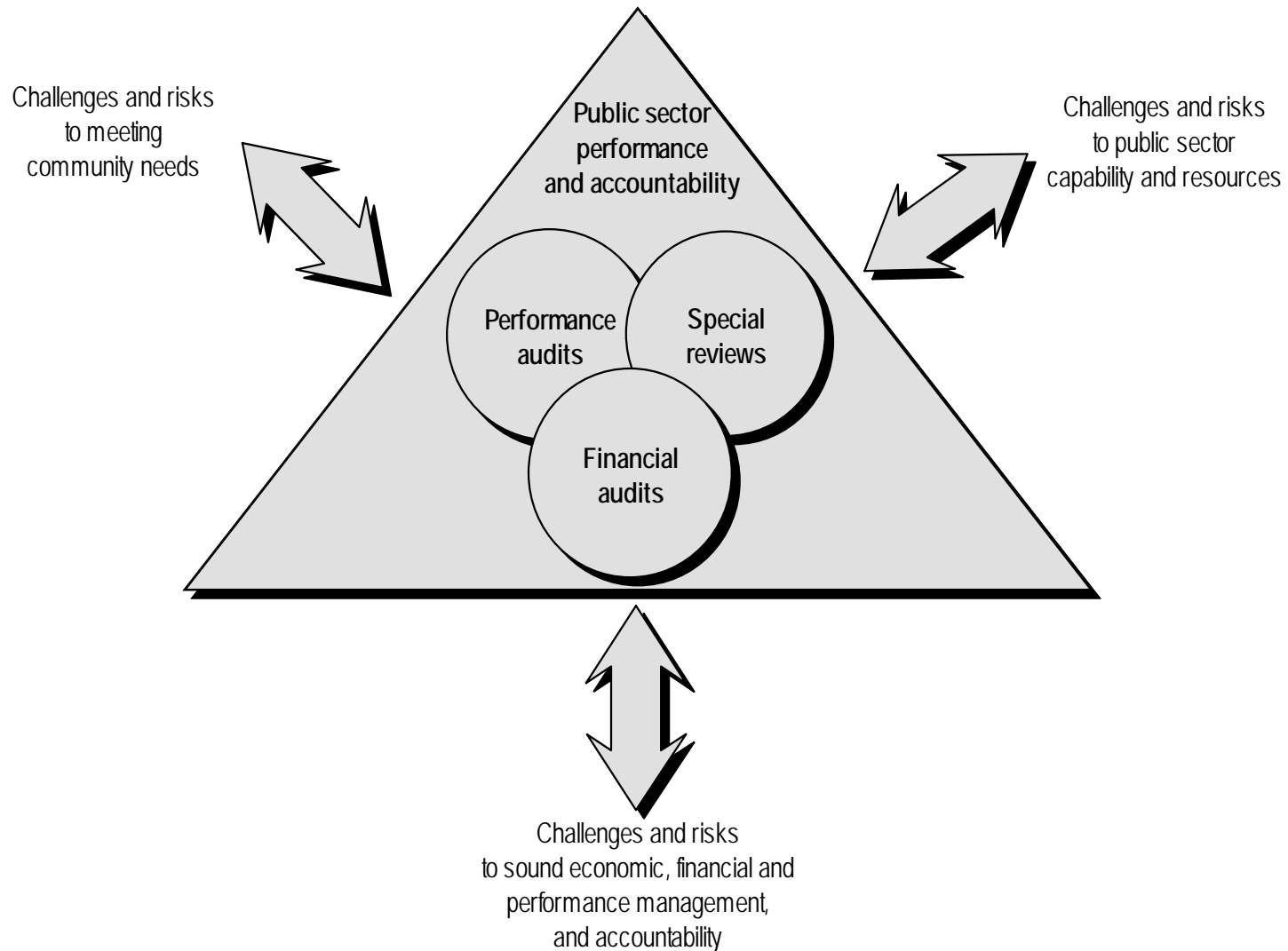


- Why we did the audit
- How we did the audit
- What we found
- What we recommended
- What next?

Public sector strategic influences



Audit coverage



Auditing in the Public Interest



- Potential social, environmental and financial risks to the community
- High public interest and/or materiality of public resources
- Potential for improved resource/financial management
- Potential for enhanced accountability

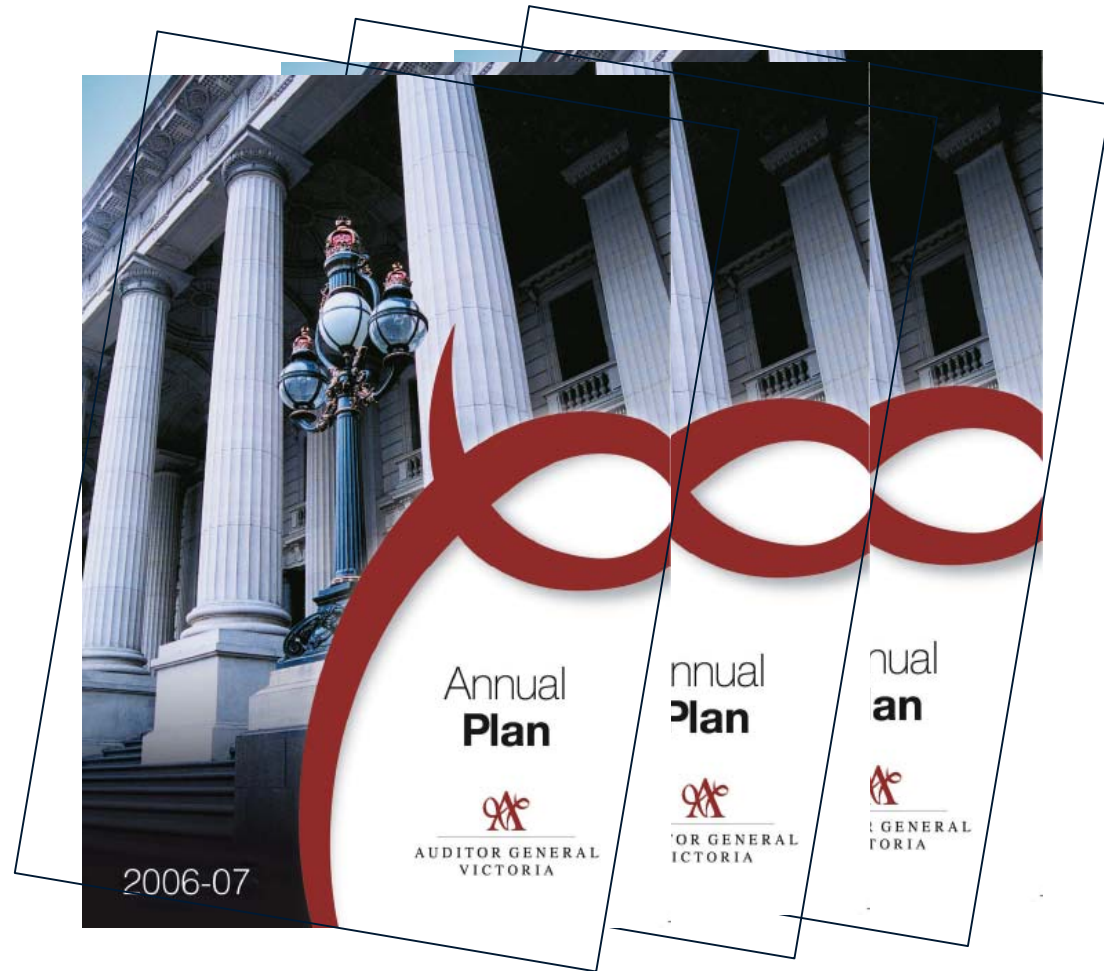
Immediacy is a key determinant when prioritising projects.



Evaluating services where there are challenges and risks to meeting community needs / managing demand

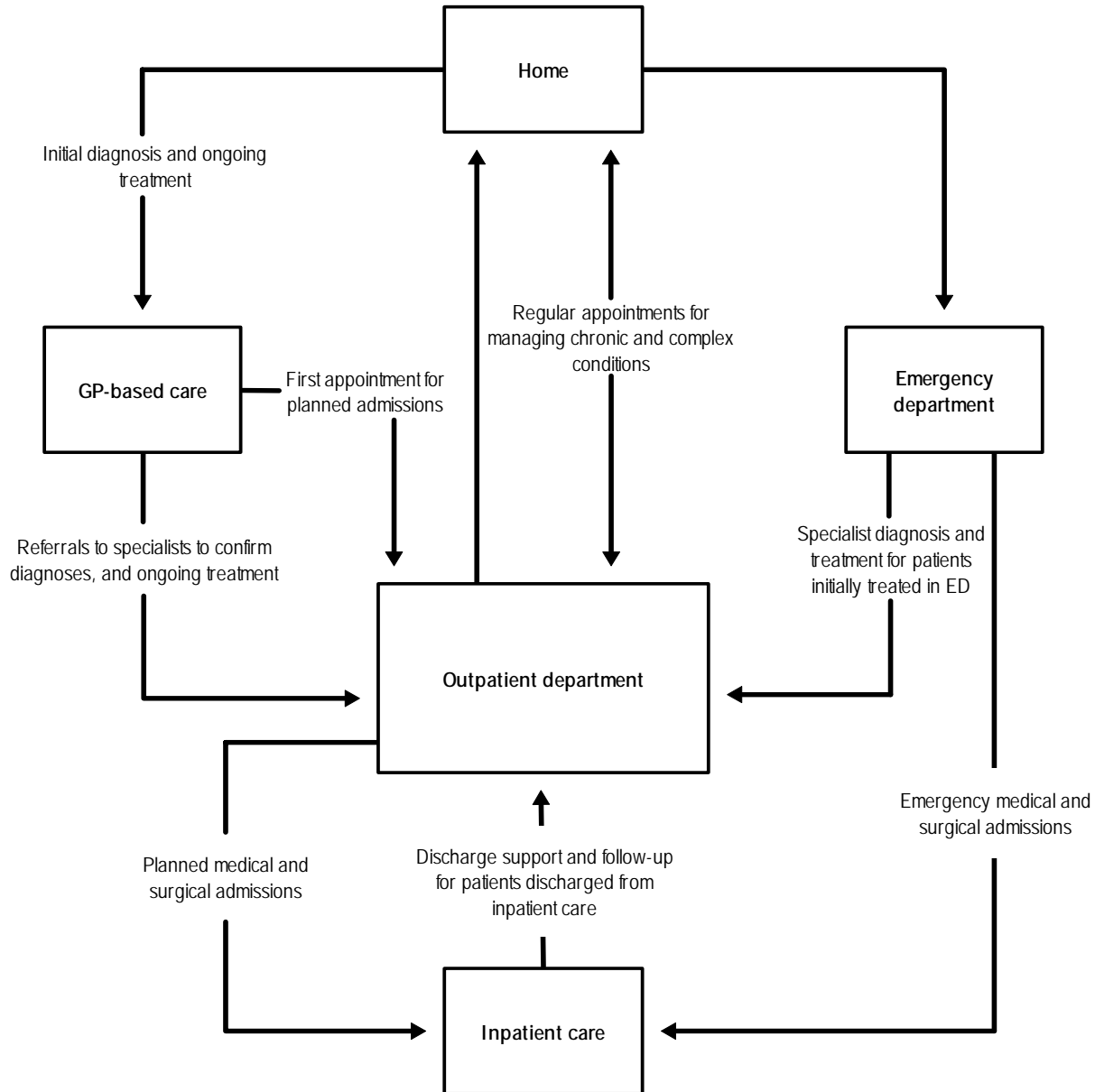
- Managing medical equipment (March 2003)
- Managing emergency demand (May 2004)
- Managing patient safety (March 2005)
- Access to specialist medical outpatient care (June 2006)
- Access to public hospitals - In-patient flow and bed management (Planned 2006-07)

Annual Plan 2006-07





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- One of the most common patient contacts with the public health system
- Over 2 million medical, allied health and ancillary occasions of service annually
- Source of free specialist medical treatment before and after inpatient care
- Outpatient services are a major health care pathway

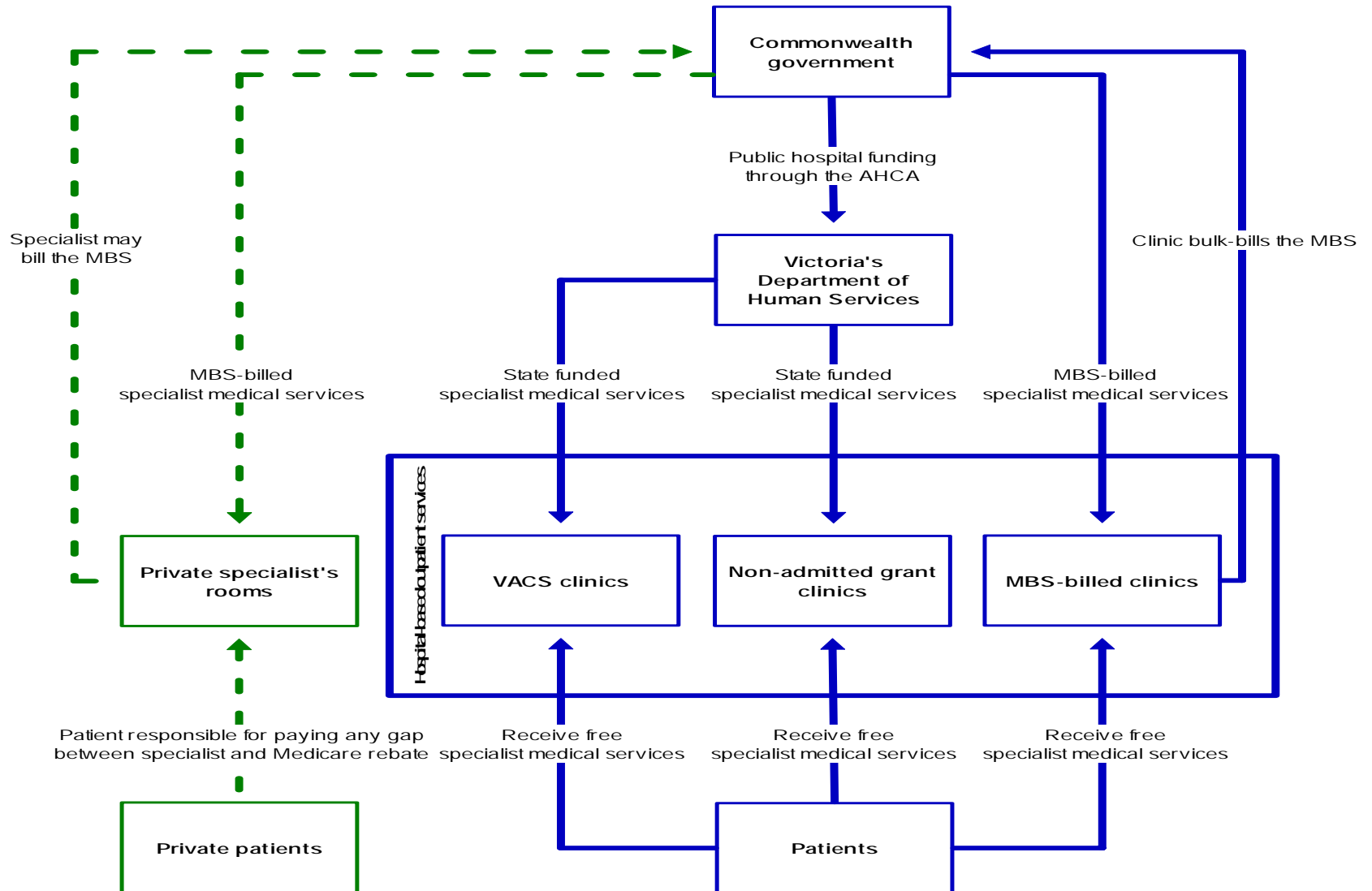


- Is central planning and management of outpatient services effective?
- Is health service planning and management of outpatient services effective?
- Are health services managing outpatient appointments effectively
- Are health services optimising the productive use of outpatient resources?

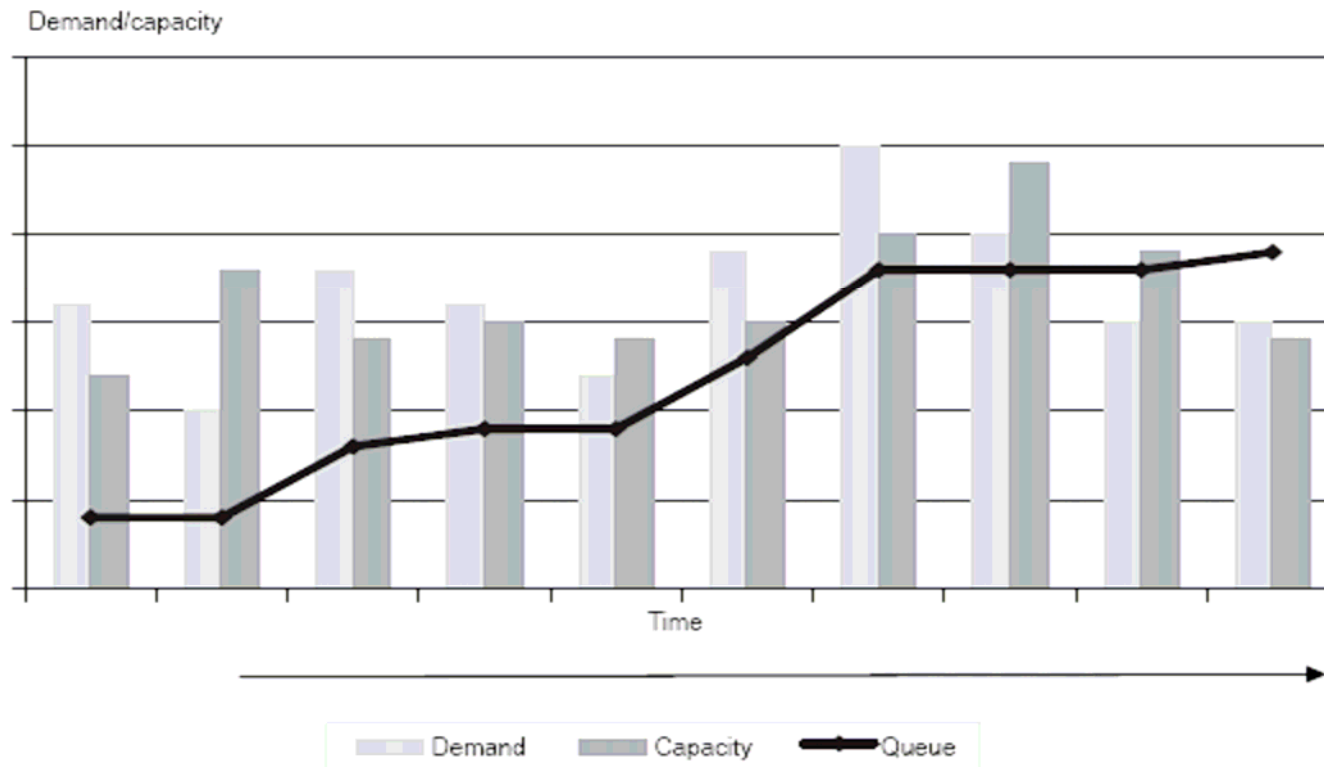


- Detailed fieldwork in 4 health services
 - Bendigo, Eastern, Northern, St. Vincent's
- Fieldwork in DHS
 - Planning for outpatient services
- Survey of 25 hospitals on waiting times
 - DHS classified A and B hospitals

Accessing specialists



Demand, capacity and growth in queue



Source: Adapted from Silvester, Lendon and Bevan, "Reducing waiting times in the NHS: is lack of capacity the problem", *Clinician Management* 12:3, 2004, Radcliffe Publishing.



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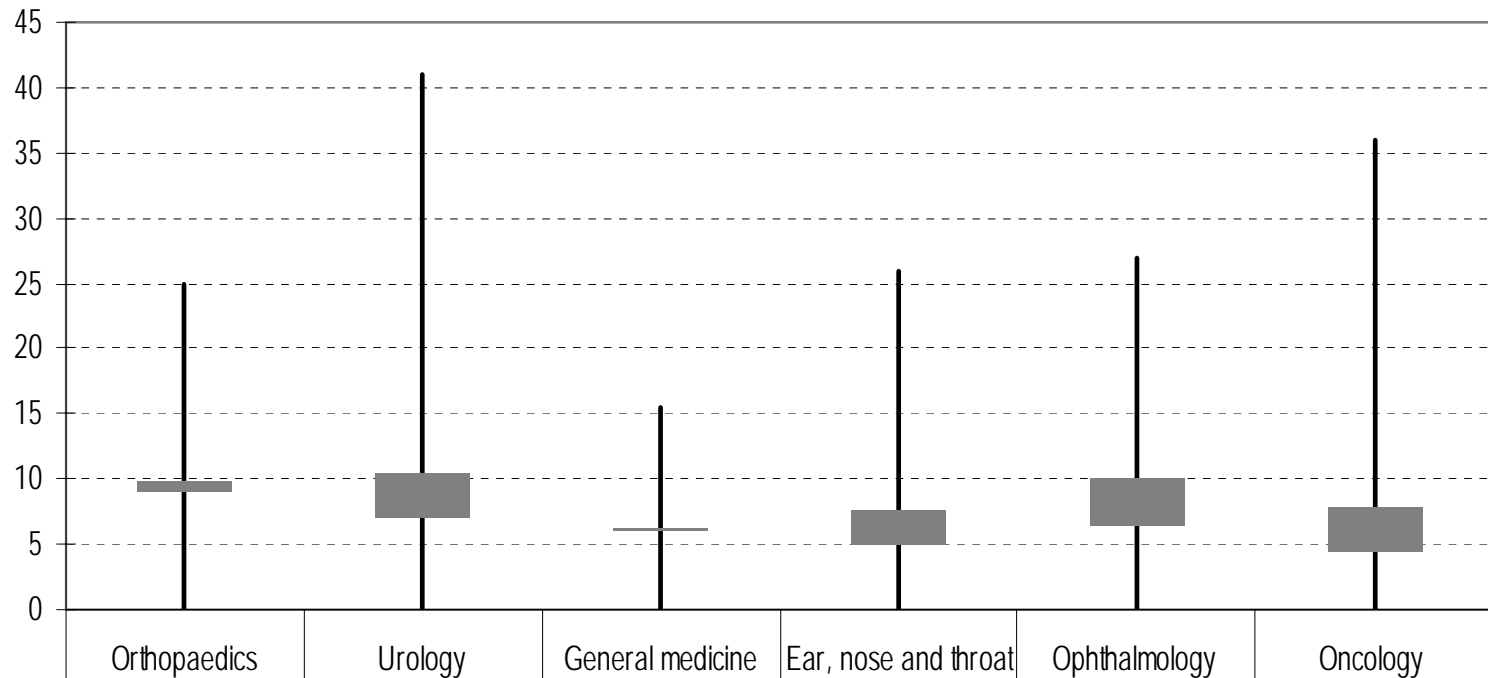
- Asked for waiting times for NEW appointments

- Information sought for 6 high volume specialties
 - Orthopaedics
 - Urology
 - General Medicine
 - Ear, Nose and Throat
 - Ophthalmology
 - Oncology

Indicative waiting times for new appointments – “Urgent”



Days to first appointment

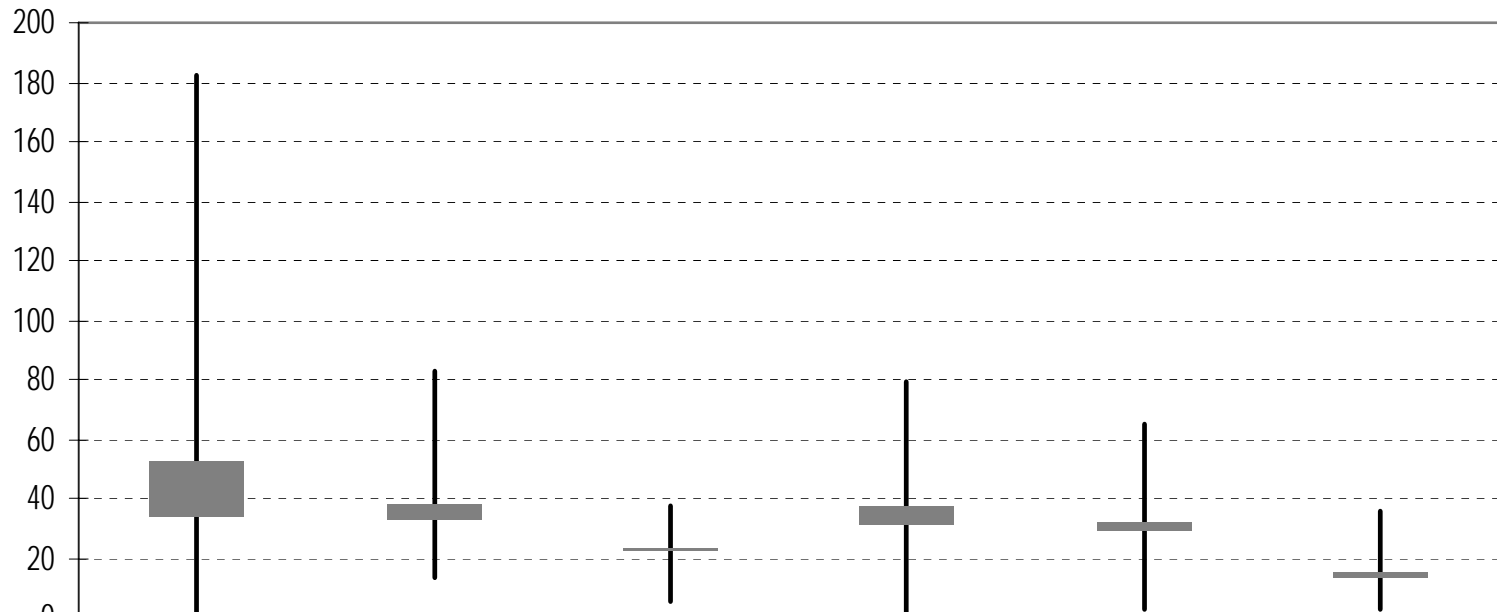


	Orthopaedics	Urology	General medicine	Ear, nose and throat	Ophthalmology	Oncology
Median	9	7	6	5	7	5
Maximum	25	41	16	26	27	36
Minimum	0	0	0	0	0	0
Average	10	11	6	8	10	8

Indicative waiting times for new appointments – “Semi-Urgent”



Days to first appointment

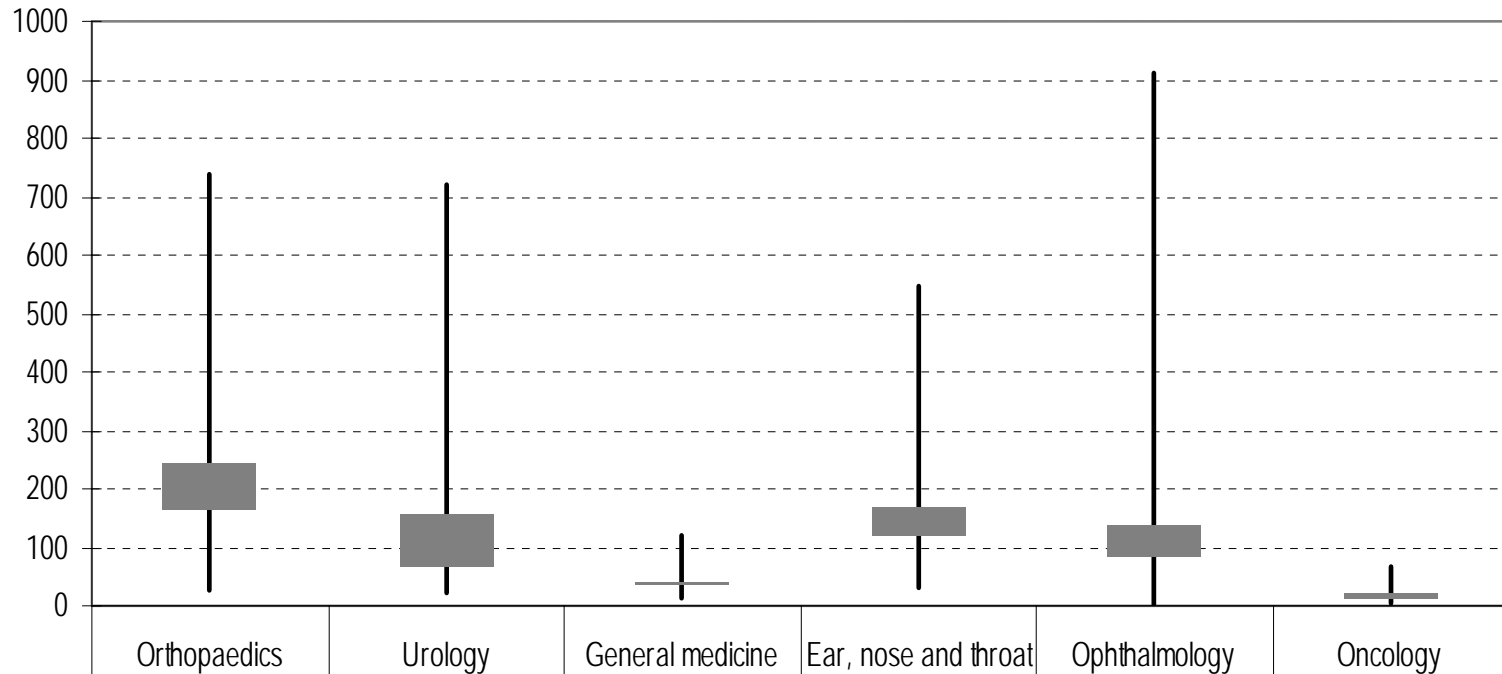


	Orthopaedics	Urology	General medicine	Ear, nose and throat	Ophthalmology	Oncology
Median	34	33	23	32	30	14
Maximum	182	83	37	80	65	36
Minimum	0	13	5	2	3	3
Average	52	38	23	37	32	15

Indicative waiting times for new appointments – “Non-Urgent”



Days to first appointment



	Orthopaedics	Urology	General medicine	Ear, nose and throat	Ophthalmology	Oncology
Median	165	68	35	121	83	15
Maximum	737	721	120	546	912	68
Minimum	28	22	12	30	0	5
Average	246	155	42	171	140	21



- Long waits for non-urgent appointments
- No consistent prioritisation categories across hospitals
- Electronic appointment booking systems limited by functional constraints



➤ Clinic schedules

- Limited review to ensure productive clinics

➤ Fail-to-attend patients

- Impact on clinic efficiency and health service costs
- Insufficient strategies to reduce incidence

➤ Clinic cancellations

- Common occurrence, impacting on patients

➤ Access to diagnostic services

- Access is good but preparing for tests not so good

➤ High number of review appointments (up to 80%)



➤ Complex task

- Poor support data for planning
- Includes both MBS and state funded clinics

➤ Most health services facilitate MBS-billed clinics to provide additional services

- Financial risks to the State if not documented and managed appropriately

➤ Risks to inpatient bonus funding by improving outpatient access

- Pressure on surgical waiting lists



- No specific planning by DHS for outpatients
- Increased outpatient funding and activity targets
 - Generally to support inpatient funding increases, not based on clear picture of service need
 - Funding model does not support new models of care
- DHS collects insufficient data
 - No performance measures
 - No demand forecasting
 - Can DHS say whether it is meeting its policy objectives?



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Recommendations



- Clear, shared guidelines on referral and clinical prioritisation, measure and report on access to appointments, all health services to progress to electronic booking services
- Review of clinic schedules, better understanding and management of fail-to-attends, work on discharge strategies
- Improved documentation of MBS clinics, better guidance on setting fees and cost recovery for MBS clinics
- Targeted access planning, improve data collection, review funding model to include more flexibility



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Auditing in the public interest

www.audit.vic.gov.au