VICTORIA

Auditor General

Victoria

Access to specialist medical outpatient care

Ordered to be printed

VICTORIAN GOVERNMENT
PRINTER
June 2006

PP No. 200, Session 2003-06.

ISBN 1 921060 22 0

AUDITOR GENERAL
VICTORIA

The Hon. Monica Gould MP
President
Legislative Council
Parliament House
Melbourne

The Hon. Judy Maddigan MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance audit report on *Access to specialist medical outpatient care*.

Yours faithfully

JW CAMERON
Auditor-General

1 June 2006

Foreword

Public hospital-based outpatient clinics are a core part of the acute health system. Along with emergency departments, they act as a major pathway for people to access inpatient care, including elective surgery. Outpatient clinics also perform an important preventative role through the early diagnosis and management of medical conditions, which may reduce the demand for inpatient services.

The audit points to a need for the Department of Human Services to improve its strategic planning activities for outpatient services, given its fundamental and growing importance in the healthcare chain.

Hospitals have developed several strategies to improve access and responsiveness. Often, this has involved entering into private arrangements to increase available outpatient services. Such arrangements must be managed with care so as not to create risks to the state/Commonwealth funding agreement.

During the conduct of this audit, the department commenced work on an outpatient improvement program. While it is too early to know what impact this will have, it is a positive step towards creating a more effective outpatient service delivery pathway.

We hope that this report will make a useful and lasting contribution to the consideration of this important aspect of healthcare in our community.

JW CAMERON
Auditor-General

1 June 2006

Contents

1. Executive summary

1.1 Specialist medical outpatient services

Hospitals provide outpatient services to non-admitted patients for services that include specialist medical assessment and treatment, consultations before and after admission to hospital, managing chronic conditions and diagnostic tests.

Outpatient clinics provide important support and services to both hospital-based inpatients and to community-based, non-admitted patients. Outpatient clinics are an entry point to inpatient care and provide ongoing care to patients after discharge from inpatient care. Outpatient clinics also provide essential specialist diagnosis and treatment to support community-based care.

Timely access to outpatient services is important for patient wellbeing and has the potential to affect patient outcomes and demand on other areas of the health system. Promptly diagnosing and treating medical conditions may prevent unnecessary inpatient admissions, reducing demand on health services and associated health care costs.

There are both state and Commonwealth funding streams for specialist outpatient care. The Commonwealth funds Victoria, under the Australian Health Care Agreement (AHCA), to provide a range of specialist medical outpatient clinics free of charge to public patients. The Department of Human Services (DHS) distributes these funds to health services under the Victorian Ambulatory Classification System (VACS) or through a non-admitted grant. The Commonwealth also funds specialist medical care where specialists provide care in a private capacity through the Medicare Benefits Schedule (MBS) system. Generally, these private MBS-billed services are not within the scope of this audit.

However, there are many MBS-billed clinics located within public hospital outpatient departments. Where health services provided resources to MBS-billed clinics located within hospital outpatient departments, we examined whether the management arrangements provided appropriate safeguards against financial and legal risks.

1.2 Is central planning and management of outpatient services effective?

DHS determines funding and target activity levels for outpatient clinics each year as part of the process of setting system-wide health funding priorities.

Over the period 2000-01 to 2005-06, outpatient funding for the major health services has increased by 42 per cent. Activity targets have also increased over this period, although not at the same rate (15 per cent).

Generally, health services have delivered greater than target levels of activity. Between 2000-01 and 2004-05, VACS-funded health services reported 327 000 patient encounters in addition to their agreed targets. DHS only funds health services for the agreed level of activity, and health services must absorb the costs of any unfunded activity.

While DHS has paid significant attention in recent years to developing a comprehensive health planning framework, current statewide planning for outpatient services is significantly weaker than other elements of the framework.

The *Metropolitan Health Strategy* is one of the key strategic service planning documents for health services. While this strategy considers inpatient and emergency department services in detail (including access, usage and demand), it does not contain any analysis of demand, patient demographics or presentation patterns for outpatient services.

In 2006, DHS released its *Care in your community* framework. As ambulatory services, outpatient services fall within this framework. The framework document considers outpatient services, although not in detail.

DHS currently collects limited information to inform outpatient planning. It collects activity data (the number of people accessing these services) for VACS-funded patient encounters and non-admitted grant-funded occasions of service. It has also developed a Schedule of Clinics, which details the outpatient services Victoria's health services provide. However, it contains only VACS-funded outpatient clinics. Outpatient clinics funded through the non-admitted grant and MBS-billed clinics located in health services are not included.

This is the extent of data collection by DHS relating to outpatient services. DHS does not collect any performance data. The rudimentary nature of current data collection means that DHS is not able to adequately inform planning, know whether it is meeting its policy objectives or assess how well health services are performing.

Considerable work needs to be done to obtain better information on service needs, demand and use for outpatient services. DHS has recently commenced work in a number of areas. The *Care in your community* framework identifies several key actions in relation to outpatient services, including the review and improvement of outpatient services. In addition, DHS has recently commenced several targeted initiatives to examine outpatient services and provide leadership for health service improvement in this area. These include a Patient Flow Collaborative and an Outpatient Improvement Program.

It is too early to tell how effective these initiatives will be in improving statewide planning for outpatient services.

Recommendations

1. **DHS should develop a targeted access plan for outpatient services.**
2. **DHS should collect better information, including:**
   - **service profiles, with information on the number and type of non-admitted grant and MBS clinics added to the Schedule of Clinics**
   - **outpatient activity, with information on non-admitted grant and MBS clinic activity, that is consistent with VACS reporting**
   - **the number of patients receiving inpatient care following assessment or treatment at an outpatient clinic, and the type of inpatient care received**
   - **demographic data on outpatient services users**
   - **outpatient demand forecasting.**
3. **DHS should develop a range of benchmarks to measure service delivery performance in outpatient services, including measures of access and timeliness.**
4. **DHS' planned review of VACS should ensure that:**
   - **the funding model provides adequate incentive and flexibility for health services to consider emerging models of care**
   - **the activity target setting process takes into account the number of people waiting for outpatient care and the length of time they have waited.**

RESPONSE provided by Chief Executive Officer, Bendigo Health Care Group

Recommendation 1

Agree.

Recommendation 2

Agree.

Recommendation 3

Agree.

Recommendation 4

Agree.

RESPONSE provided by Secretary, Department of Human Services

In general, with some exceptions as provided below, the report presents a fair picture of the difficulties and complexities of operating outpatient services, involving more than 2 million medical, allied health and ancillary public occasions of service in Victorian hospitals annually, covering a range of acute and chronic conditions, that may or may not be associated with a hospital admission.

The move to shorter lengths of stay in hospitals, more same-day surgery, the shortage of specialist services in some areas and the establishment of demand management programs, especially for elective surgery, has led to increased interest in new models of ambulatory care and better management of outpatient services. The performance audit is timely in that it coincides with several recent initiatives of DHS that focus on outpatient services, and these have been identified in the audit report.

A key strength of the Victorian model of human services delivery is that the government sets the broad policy parameters and individual agencies are responsible for managing within the resources provided to deliver services that meet the needs of their local population. In health, this means an emphasis on local clinical and financial decision-making that promotes service planning and service delivery designed to meet the needs of particular groups. Accountability is provided through the Health Services Act 1988. The Act establishes the statutory framework for the governance of public hospitals (including public health services). Boards of health services are appointed by the Governor in Council and are charged with the responsibility for independently overseeing the performance of the hospital. In the case of public health services, the Act also sets out a comprehensive list of the functions of the board and CEO.

RESPONSE provided by Secretary, Department of Human Services - continued

The Act balances the need to allow boards sufficient discretion to perform their role, with the need to ensure adequate accountability to parliament and government, and contains a variety of tools to achieve this. While welcoming advice provided by the Auditor-General on fine-tuning policy settings, the department is of the view that some of the recommendations envisage prescriptive centralised management of health services that would be cumbersome, inflexible and would not allow the exercise of clinical judgement, innovation and localised expertise in the delivery of health services.

Information on waiting times for outpatient appointments have been published in the report at Appendix C that could be misleading, due to the potential lack of data comparability.

Recommendation 1

Agree.

The development of a targeted access plan, along the lines of the Statewide Elective Surgery Program and the Statewide Emergency Access Program previously developed by DHS will be considered as part of the Outpatient Services Review.

The current contacts in DHS for VACS development and service improvement (changes to clinics and funding arrangements etc.) are posted on the Department's website www.health.vic.gov.au/vacs. This information will be reviewed to ensure comprehensive coverage and clarity.

With regard to Figure 3C, the Statewide Planning Framework for ear, nose and throat services has now developed recommendations related to consistent guidelines and practices for accessing public ear, nose and throat outpatient services so that access is equitable, appropriate and based on clinical need. These can be viewed at www.health.vic.gov.au/ent/index.htm.

RESPONSE provided by Secretary, Department of Human Services - continued

Recommendation 2

Partially agree.

DHS has been collecting information on attendances by detailed clinical category from a greater number of health services from July 2005, in compliance with National Minimum Data Set (NMDS) requirements for outpatients. This increased the number of hospitals reporting outpatient attendances consistent with VACS clinical categories from 19 to 29 health service campuses across Victoria. Also in cooperation with the Commonwealth Government, DHS is progressing towards unit-record level data collection of public outpatient services for 95 Victorian health services and public hospitals, for progressive implementation from July 2008.

As the clinic schedules currently collected by DHS inform funding distribution for public clinics at VACS-funded health services, the services concerned have an incentive to ensure accuracy. DHS is not convinced of the cost-effectiveness of increasing the reporting burden on hospitals to collect information that will not be required for funding purposes. However, development of a targeted access plan could include the development of key performance measures for which there will be data requirements, and development of a strategic policy framework; both of which will involve obtaining an overview of privately-funded hospital outpatient services, most likely through surveys.

The development of unit-record level data containing patient identifiers will enable overview of service provision between inpatient and outpatient care. This will also enable the collection of relevant demographic data on outpatient services users, facilitated by the progressive introduction of HealthSMART into both VACS and non-VACS-funded health services.

DHS has undertaken limited outpatient demand forecasting utilising existing VACS data. The introduction of unit-record level data, and periodic surveys of both public and private (MBS-funded) outpatient services will enable more cohesive and comprehensive forecasting for planning purposes. The forecast of outpatient demand data also needs to take into account changing inpatient demand, as this is one key driver (but not the only driver) of outpatient demand.

RESPONSE provided by Secretary, Department of Human Services - continued

Recommendation 3

Partially agree.

Consideration of benchmarks and performance indicators will be possible when unit-record level data are available and will be investigated as part of the Outpatient Services Review. However, DHS considers that a performance indicator targeting access based on need for care will not be introduced easily, given the difficulty of achieving standard definitions for urgency of care.

Recommendation 4

Partially agree.

Part one of recommendation 4 is a key action of "Care in your community: a planning framework for integrated ambulatory health care", DHS' overarching planning framework for ambulatory care, and will be taken up by DHS' Outpatient Services Review to commence in 2006.

The VACS target setting process currently includes review of hospital-provided information on demand for services. Implementation of unit record data collection will inform part of the target setting process by providing standardised data on the number of patients waiting for appointments and information on time waited. However, negotiation of targets involves coming to an understanding of what constitutes appropriate increased demand and what kind of demand needs to be managed by health services. There are many other factors involved in setting targets for individual health services, including community health availability, private specialists' availability and whether the health service has undertaken any relevant service reviews.

RESPONSE provided by Chief Executive Officer, Eastern Health

Recommendation 1

Agree.

Recommendation 2

Agree.

Only non-admitted grant-funded clinics should be added to the Schedule of Clinics.

Only outpatient activity for non-admitted grant clinics should be collected in addition to the VACS activity.

RESPONSE provided by Chief Executive Officer, Eastern Health - continued

Recommendation 3

Agree.

Recommendation 4

Agree.

RESPONSE provided by Chief Executive Officer, St Vincent's Health

We fully support the proposed review of outpatients' services by DHS and look forward to participating in the patient flow collaborative and outpatient improvement program. St Vincent's Health is committed to continuing the reforms it commenced in 2004 and 2005.

1.3 Is health service planning and management of outpatient services effective?

Health services undertake a range of planning activities, although the extent of planning varied across those that we audited. All 4 health services performed strategic planning in line with the DHS guidance. However, only some health services formally planned for outpatient services operationally.

Health services undertook basic forecasting, using their inpatient data to estimate growth in outpatient demand.

Health services may decide to open new outpatient clinics to better meet demand for services or to complement inpatient services. Opening new clinics can create additional costs for the health service, through staff wages and also through downstream impacts on other hospital services. Health services varied in their approach to assessing the costs associated with new clinics.

The dual funding streams for outpatient clinics (state-funded VACS or MBS-billed clinics by agreement with specialists) create both flexibility and complexity for health services in making decisions about service delivery. Arrangements with specialists to provide MBS-billed clinics can allow health services to facilitate specialist service provision even when VACS funds are not available.

However, the decision to provide clinics under VACS or through arrangements for MBS-billed clinics can impact on health service financial performance. Most health services charged MBS-billed clinics fees, although for those that did, the revenue was not always sufficient to cover the cost of the resources (such as physical space, staff, administration costs and consumables).

While we accept that at times a decision may be made to provide services at a deficit, this needs to be an informed business decision.

Arrangements for MBS-billed clinics also bring legal complexities, which if not fully understood and managed appropriately can place the health service and the state at risk of non-compliance with the Australian Health Care Agreement or the *Health Insurance Act 1973*.

If health services make arrangements to use MBS-billed clinics, they need to ensure that there is clear legal separation between state-funded health service operations and MBS-billed clinics, and that there are effective processes in place to ensure that patient election procedures are followed.

In the 4 health services we audited, we found that arrangements for MBS-clinics were not comprehensively documented, and in some health services MBS-billed clinics were operating without agreements at all. Patient election procedures were also often weak.

While DHS has previously issued advice to health services on this area, the development of revised guidance, including model agreements, should be a priority.

Recommendations

5. **DHS should work closely with hospitals to ensure that:**
   - **hospitals are aware of, and comply with, the AHCA and Health Insurance Act requirements as they relate to outpatient services**
   - **hospitals have appropriate documentation of private practice and licence agreements for outpatient services**
   - **hospitals have appropriate documentation relating to outpatient election processes.**
6. **DHS should issue guidance to health services on fees for MBS-billed clinics, with consideration for appropriate costs.**

RESPONSE provided by Chief Executive Officer, Bendigo Health Care Group

Recommendation 5

Agree.

Recommendation 6

Agree.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 5

Agree.

DHS considers that the issue identified in this audit of inadequate documentation regarding private practice agreements and patient election processes in the health services that were audited is a matter of serious concern.

DHS acknowledges that inadequate documentation gives rise to potential risks for health services and for the state, and will continue to work closely with health services to:

- *ensure that they are aware of the requirements of the Australian Health Care Agreement and the Health Insurance Act 1973 as they relate to outpatient services, noting that DHS has previously advised health services of their Australian Health Care Agreement obligations through hospital circulars 33/2003 of 11 December 2003 and 34/2004 of 24 November 2004*
- *ensure that all health services have appropriate documentation in place regarding private practice arrangements and, where appropriate, patient election processes relevant to outpatient services.*

Recommendation 6

Partially agree.

Arrangements are between individual health services and private practitioners and these vary across health services, and it is not practicable to provide a template for fees and cost recovery. DHS will work closely with hospitals to ensure that they have written agreements in place with private practitioners relating to the use of hospital facilities and services.

RESPONSE provided by Chief Executive Officer, St Vincent's Health

The lack of comprehensive documentation in regard to the "MBS clinics" does not necessarily imply that health services are not appropriately managing risks of potential non-compliance with the ACHA or the Health Insurance Act.

St Vincent's Health is committed to improving its documentation and is progressing the implementation of its comprehensive private practice agreements (as endorsed by DHS) and policy processes in keeping with its legal obligations.

RESPONSE provided by Chief Executive Officer, Eastern Health

At the outset, Eastern Health believes that the report is generally fair and balanced with respect to its discussion and recommendations regarding:

- *data collection*
- *planning*
- *funding mechanisms.*

Eastern Health agrees with all but 2 of the recommendations.

However, Eastern Health does not agree that the report's analysis and recommendations regarding the attendance of patients at private practitioners located on public hospital premises are fair, balanced or accurate.

Moreover, the recommendations on this issue contain an inherent contradiction. On one hand, the report recommends more control and management of "MBS-billed clinics" and on the other, it recommends more separation of public hospitals and private clinics. The 2 recommendations are contradictory.

This contradiction stems, in our view, from a presumption that there is a difference between the patients attending private practitioners located in rooms at public hospitals and the patients attending private practitioners located in premises outside public hospitals.

This misunderstanding is best demonstrated in Figure 2C. This Figure suggests that there are 4 types of patients of which 3 receive "free" services. However, in fact, there are only 2 kinds of patients: public VACS/non-admitted grant patients who receive "free" services"; and patients attending a private practitioner whose treatment is paid for, or reimbursed to the patient, by Medicare. The latter is not "free" wherever it is located.

RESPONSE provided by Chief Executive Officer, Eastern Health - continued

The Australian Health Care Agreement itself states that a patient receiving services from a medical specialist exercising a right of private practice or having a contract with a public hospital is not a patient of a public hospital.

A medical practitioner may bill a patient direct or "bulk bill" Medicare. This arrangement does not make the service "free" and neither does it make the attending patients "public".

A public hospital service, by comparison, is "free" because there is no specific charge for it and the patient is not required to pay either the public hospital or the medical practitioner.

Second, the report argues that election processes which apply to admitted inpatients under the agreement also apply to private outpatients.

However, the agreement itself does not refer to an election process for anyone other than admitted inpatients. As noted above, the agreement states that a patient receiving services from a private practitioner exercising a right of private practice or having a contract with a public hospital is not a patient of that public hospital.

As a result, the report's suggestion that there is a risk of a perception that public hospitals with private clinics without election processes or private practice agreements do not fully comply with the Australian Healthcare agreement or the Health Insurance Act 1973 is, in our view, unwarranted.

Recommendation 5

Partially agree.

Disagree that an election process is required.

Recommendation 6

Disagree.

There is no need for DHS to issue guidelines, as these arrangements do not relate to public patients.

Further comment by the Auditor-General

I disagree that there is an inherent contradiction in recommendations 4 and 5. The report does not recommend there be more "control and management". It notes, based on legal advice from the Victorian Government Solicitor's Office, what actions a health service should take to ensure there is adequate separation of private clinics that are commonly located in outpatient departments. What the report does recommend is that health services have the appropriate documentation to clearly demonstrate that these private clinics, because of their location in outpatient departments, are not services provided by, or on behalf of, the health service.

Figure 2C reflects the observations and findings made by my staff. While some private practitioners lease "rooms" within the hospital and are therefore quite distinct from the services the hospital provides, in many instances private clinics were located within the outpatient department. To the patient attending at the outpatient clinic, there is no discernable difference between the public and private clinics. This is what Figure 2C demonstrates.

The statement within the Australian Health Care Agreement, that a patient receiving services from a medical specialist , exercising a right of private practice or having a contract with a public hospital, is not a patient of a public hospital, is included as a note to the definition of "private patient". We sought advice from the Victorian Government Solicitor's Office on this definition note. The advice stated that for a patient not to be a patient of a public hospital in these circumstances, the patient must elect to be treated as a private patient.

Clause 41(b) of the Australian Health Care Agreement is very similar to the private patient definition note. It states:

"An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

(b) the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient".

Two elements must therefore be satisfied before the patient is not a patient of the hospital:

- *the named specialist must be exercising a right of private practice. In the majority of cases, private clinics were run by doctors contracted to the health service. This relationship was neither employment or governed by a visiting medical officer agreement.*
- *The patient must choose to be treated as a private patient. This is what the advice from the Victorian Government Solicitor's Office stated. To choose is undoubtedly the same as electing.*

Further comment by the Auditor-General - continued

While the Australian Health Care Agreement does not describe an election process (and neither do I recommend an election process), the agreement does state the need for election.

1.4 Are health services managing outpatient appointments effectively?

There is currently little publicly available data that measures access to outpatient services, and no common methodology for measuring the time that patients wait for appointments. We surveyed major health services to establish how long patients wait for a first appointment for 6 high-volume outpatient specialties.

Across all surveyed hospitals, the median time to first appointment for patients classified as "urgent" was between 5-9 days across the 6 specialties. Times ranged from zero to 41 days for urgent appointments.

The median time to first appointment for patients classified as "semi-urgent" was between 14 and 34 days across the 6 specialties. Times ranged from zero to 182 days.

The median time to first appointment for patients classified as "non-urgent" (or "routine") was between 15 and 165 days across the 6 specialties. Times ranged from zero to 912 days.

While health services advise that they can generally facilitate appointments for the most urgent patients reasonably quickly (usually by overbooking), patients classified as "non-urgent" may have significant waits for an appointment.

The possible length of wait means that it is crucial that general practitioners and health service staff have a shared understanding of ratings of urgency. Effective prioritisation of patients needs to ensure that patients are seen according to their clinical urgency, and not simply in the order they were referred.

While some health services had developed internal prioritisation guidelines to assist staff undertaking this process, each of the 4 health services prioritised patients differently. The inconsistent approach creates the potential for patients with the same condition to wait different times for their first appointment.

The information technology systems in place to manage bookings of patients waiting for outpatient appointments limit the capacity of health services to track referrals, prepare reports or do any analysis of bookings. Some electronic booking systems do not have the capacity to manage long waits, and secondary waiting lists need to be created. DHS plans to address many of the IT issues with the implementation of Health*SMART*.

However effective the technology for managing outpatient waiting lists becomes, problems will remain in ensuring the accuracy of lists if current practices for managing outpatient waiting lists in health services do not improve.

Outpatient waiting lists are currently not always accurate. Patients who have been on the lists for a long time may no longer need their appointment, either because their medical condition has changed or because they have been treated elsewhere. Auditing waiting lists can identify patients who no longer need their appointment, potentially reducing the number of patients who "fail-to-attend" and freeing-up appointments for other patients.

Only limited (often targeted) auditing of outpatient waiting lists occurred at each of the 4 health services we visited, with many not regarding the benefits of freeing-up appointments and reducing "fail-to-attends" as a worthwhile investment. Auditing waiting lists can be an intensive exercise, and with limited resources, health services often have to give priority to other aspects of outpatient service delivery.

Recommendations

7. **DHS should develop guidelines for referral policies and procedures.**
8. **To aid in clinical assessment, DHS should develop recommended clinical prioritisation protocols and clinical categories of urgency, with recommended performance standards for each category.**
9. **DHS should take action to develop and report measures of access (waiting times) for outpatient services.**
10. **All health services should progress to electronic booking systems.**

RESPONSE provided by Chief Executive Officer, Bendigo Health Care Group

Recommendation 7

Agree.

Recommendation 8

Agree.

Recommendation 9

Agree.

Recommendation 10

Agree.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 7

Agree.

DHS has developed a standard GP referral form that meets international standards and has been taken up by some GPs and health services. The methodology used in the Patient Flow Collaborative allows individual sites to identify the problems or blockages that are specific to their health service. The Patient Flow Collaborative - Outpatients will utilise this methodology so that health services can design solutions that fit with their circumstances.

Further, data definitions developed in the outpatient NMDS process will provide national guidelines for processing referrals to assist with achieving national data consistency.

Recommendation 8

Partially agree.

Clinical prioritisation protocols will be considered as part of the Patient Flow Collaborative - Outpatients.

RESPONSE provided by Secretary, Department of Human Services – continued

Recommendation 8 - continued

Clinical categories of urgency are appropriate for managing emergency demand, where the majority of clinical categories of urgency are based on the length of time that can elapse without treatment before a patient's condition becomes life threatening or deteriorates significantly, and for managing access to elective surgery once a patient has been assessed by a specialist.

However, the development of clinical categories of urgency for outpatient appointments involves more subjective criteria, which are more difficult to codify and monitor. DHS is aware that categorisation of urgency guidelines have been developed in the United Kingdom and New Zealand as aids to assessment, rather than replacement for individual clinical judgement. These are not internationally recognised standards but may be useful tools for guiding individual clinical decisions. DHS will continue to monitor and evaluate these developments, but until international standards are available, it would be more appropriate to continue to enable individual clinicians to make clinical decisions at the local level about urgency and treatment time in the context of their assessment of the individual patient.

Recommendation 9

Agree.

DHS is examining the capability of current hospital systems to collect unit-record level data, including waiting times. Data definitions that have been agreed nationally are essential to the uniform treatment and classification of the waiting period. The current Australian Health Care Agreement between the Commonwealth and Victoria requires both parties to work together to develop performance indicators, including waiting times, for access to services for admitted and non-admitted patient services.

Recommendation 10

Agree.

DHS' HealthSMART strategy is making a significant investment in upgrading hospital IT infrastructure and, progressively from 2008, will provide additional capacity for bookings to be performed electronically and for standardised referral forms to be lodged electronically.

RESPONSE provided by Chief Executive Officer, Eastern Health

Recommendation 7

Agree.

Recommendation 8

Agree.

Recommendation 9

Agree.

Recommendation 10

Agree.

RESPONSE provided by Chief Executive Officer, Northern Health

Recommendation 10

Agree.

RESPONSE provided by Chief Executive Officer, St Vincent's Health

It is our view that the data collection tool utilised by the Victorian Auditor-General's Office does not adequately reflect the activities of outpatient services. The exclusion of over-bookings from the data misrepresents how "urgent" and "semi-urgent" patients are managed and does not reflect the length of time in which "urgent" and "semi-urgent" patients are seen (from the date of referral). While St Vincent's has taken considerable steps to reduce over-bookings, due to 3 weeks of low activity during the Christmas period, demand was underestimated and over-bookings had to be made.

1.5 Are health services optimising the productive use of outpatient resources?

If demand for outpatient services is greater than available capacity, then patients will have to wait to see a specialist. However, lack of capacity is not the only factor that can cause waiting times to grow. Even if *average* capacity matches *average* demand, a mismatch between daily demand and daily capacity can cause queues. Understanding variations in demand and capacity and better matching them can lead to shorter waiting times for patients and more efficient use of resources.

All 4 health services we audited used clinic schedules to manage capacity. Clinic schedules were generally set by the specialist in charge of the clinic with limited input from health service management to monitor patient throughput, fairness in specialist workload or the match of capacity to demand.

All health services used overbooking of "full" outpatient clinics to see patients at short notice. While this action provided increased flexibility, it can also lead to greater waiting times for those attending the clinic or a clinic running over time as the specialist has to see more patients.

Some health services also reserved spaces for urgent patients, reducing the need to overbook clinics. This system was most effective, however, if the reserved spots were allocated to other patients if not filled before the clinic. At the 2 health services that reserved appointments, practices varied.

Many booked patients at outpatient clinics “fail-to-attend” their appointments, with rates of non-attendance at some clinics ranging from 5 per cent to 30 per cent of booked patients. Patients waiting for a first appointment are more likely not to attend than review patients.

Non-attendance can mean underutilised capacity and health services commonly compensated for anticipated non-attendance by over-booking clinics. However, the administrative costs (such as the cost of retrieving medical records) for each patient that “fails-to-attend” can be significant, and these costs are not recoverable.

All health services had strategies to manage “fail-to-attend” patients, although the extent of these strategies varied. However, strategies were developed without formally investigating the reasons for non-attendance and none had formally assessed the effectiveness of the strategies they had put in place.

Health service cancellation of outpatient clinics is a common occurrence and is most often caused by specialist unavailability. While unplanned absences are often unavoidable, planned absences at short notice are problematic. All health services had polices requiring specific periods of notice for planned leave. However, compliance with these policies by many specialists was poor, and not enforced by hospital management.

At all the health services we audited, access to diagnostic services was timely. However, for most health services, strategies to ensure that patients had undergone their diagnostic tests before their appointment were limited and inconsistent. This can often mean that the patient needs to be re-appointed purely because full information was not available at the time of the appointment.

Ensuring that the medical record is complete, contains the relevant test results and is available at the time of the appointment is also essential to preventing unnecessary re-appointment. Most health services reported that medical record transfer and preparation was not as good as it could be. Medical records were often transferred to the outpatient department on the day the clinic ran, providing inadequate time for clinical staff to review the files.

With high demand for outpatient appointments and specialists' time, it is essential that patients are only brought back for review of their medical condition if it is clinically necessary. In a number of specialties we examined, up to 80 per cent of patients seen in outpatient clinics were there for review visits.

While the decision to discharge a patient at the end of their outpatient treatment is ultimately one for the specialist, little work had occurred at most of the health services in reviewing rates of discharge and re-appointment and developing guidance on discharge. The approach to discharge from outpatient clinics was generally less active than it typically is in inpatient wards.

Most health services were conscious of the issues identified above, but reported that they were too busy to formally review or evaluate outpatient clinic practices. Practice change tended to be incremental and ad-hoc and depending upon the nature of the change, was reliant on specialist support.

One health service we examined had received funding to systematically review and improve clinic practices. The health service reported that having the assistance and capacity to address outpatient clinic practices as a project had been a key success factor in implementing improvement.

Recommendations

11. **Health services should review their clinic schedules to ensure they:**
    - **reflect specialist attendance time at clinics**
    - **address variation in new and review patient quotas for specialists working in the same specialty**
    - **factor in teaching time**
    - **optimise the sequence of new and review patients.**

12. **Health services and DHS should review "fail-to-attend" patients, including:**
    - **investigating the reasons why patients "fail-to-attend"**
    - **performing a cost analysis of "fail-to-attend" patients**
    - **developing strategies to reduce the rate of "fail-to-attend" patients**
    - **collecting and monitoring "fail-to-attend" data.**
13. **To improve the operations of outpatient clinics, health services should:**
    - **ensure effective discharge strategies are in place in outpatient clinics, and monitor discharge rates**
    - **implement strategies to ensure regular review of outpatient clinic practices**
    - **take steps to ensure that all necessary tests are completed before the patient attends for their appointment**
    - **put systems in place to ensure that medical records are available at the time of the clinic and that all relevant documentation is included**
    - **develop internal guidelines to better manage clinic overbookings.**

RESPONSE provided by Chief Executive Officer, Bendigo Health Care Group

Recommendation 11

Agree.

Recommendation 12

Agree.

Recommendation 13

Agree.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 12

Partially agree.

Rather than manage the issue of "fails-to-attend" centrally, DHS considers it more appropriate and cost-effective for individual hospitals to develop and monitor strategies to reduce "fails-to-attend", tailored to their individual circumstances. DHS is prepared to consider providing guidance to health services on auditing waiting lists.

RESPONSE provided by Chief Executive Officer, Eastern Health

Recommendation 11

Agree.

Recommendation 12

Agree.

Investigating the reasons why patients "fail-to-attend" is very labour intensive and not covered in the VACS model.

Specific enhancement funding is required to develop strategies to reduce the rate of patients "failing-to-attend", given the legacy of IT systems in place.

Recommendation 13

Agree.

There is a need to bolster GP liaison to ensure that all necessary tests are completed before the patient attends for an appointment.

RESPONSE provided by Chief Executive Officer, Northern Health

Recommendation 11

Agree.

Recommendation 12

Agree.

Recommendation 13

Agree.

RESPONSE provided by Chief Executive Officer, St Vincent's Health

Improving access for surgical outpatients cannot be achieved until the surgical waiting list key performance indicators are reviewed. Recommendation 11, referring to the optimisation of "new" and "review" patients, is unrealistic in relation to key performance indicators which require hospitals to meet total waiting list targets. An increase in new outpatients causes an increase in referrals to the elective surgery waiting list (due to the high proportion of new patients requiring surgical intervention), which reduces the ability to meet waiting list targets.

St Vincent's would welcome the opportunity to increase the number of new patients seen within our surgical clinics, however, this would require increased WIES to fund the resulting increase in surgical activity as well as revised key performance indicators which measure the flow of patients through the health service.

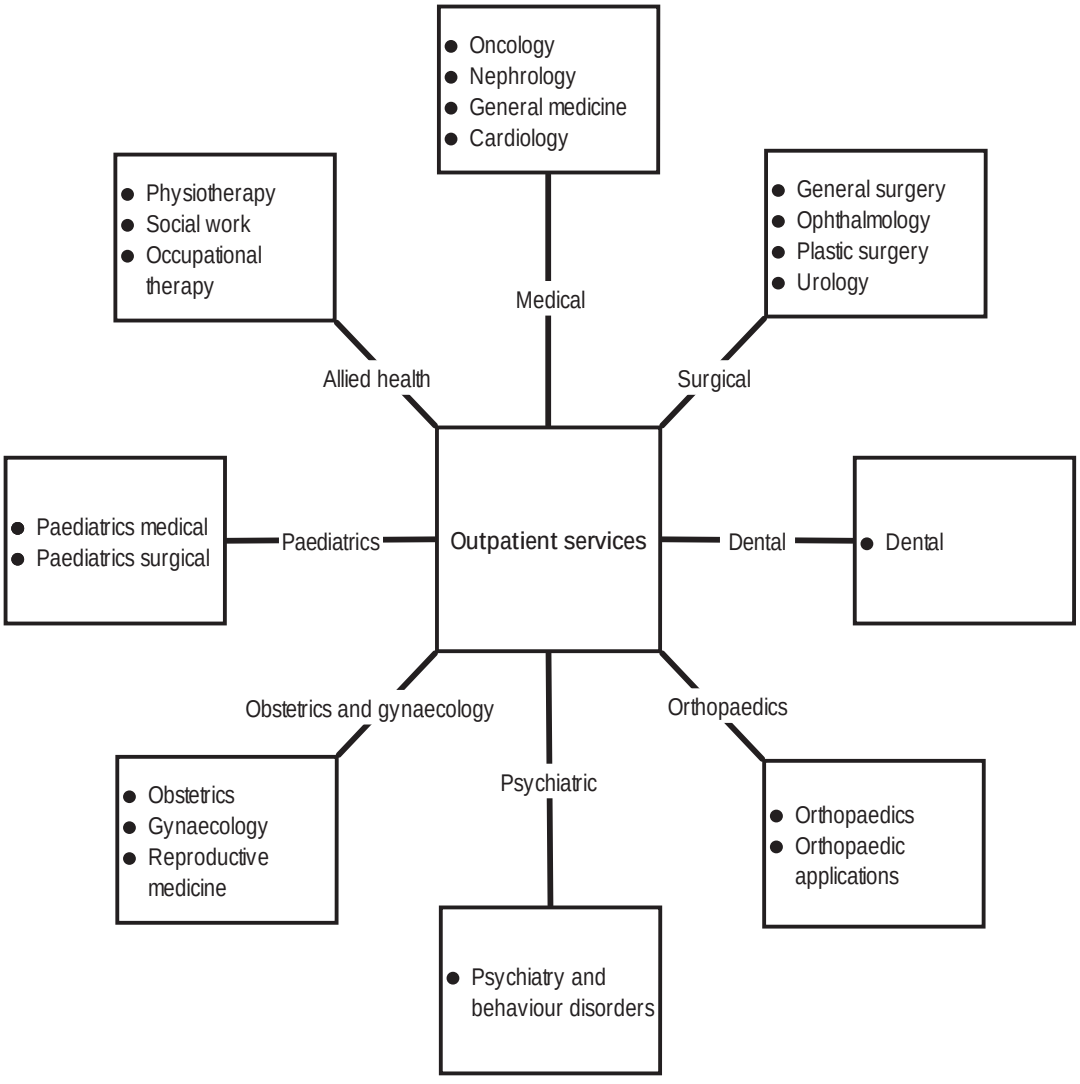
2. About specialist medical outpatient services

2.1 What are outpatient services?

Hospital outpatient services are provided to non-admitted patients and cover a range of services, including specialist medical care, allied health and diagnostic services.

Figure 2A illustrates the major outpatient services provided in Victorian hospitals.

FIGURE 2A: MAJOR VICTORIAN OUTPATIENT SERVICES

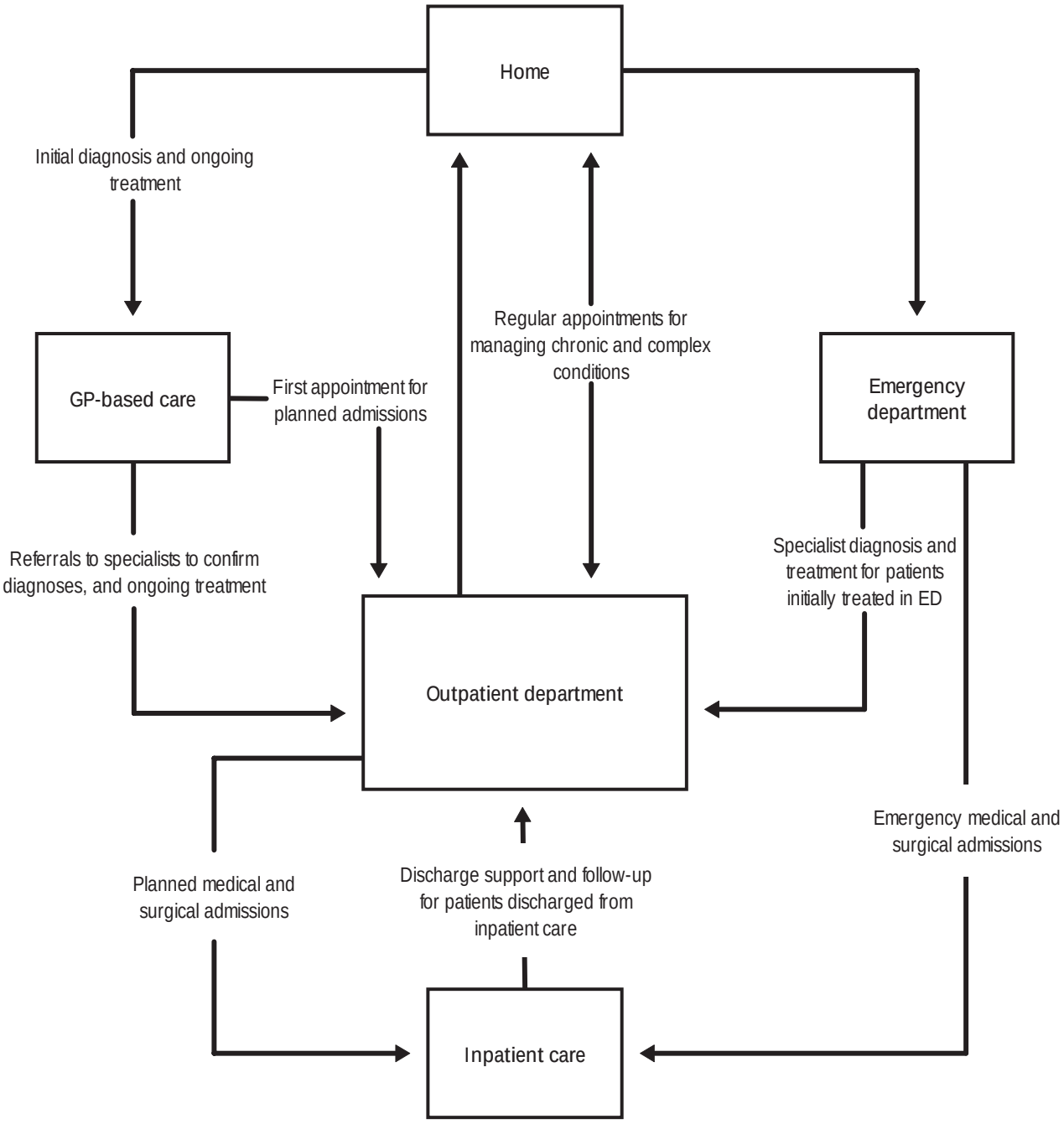


Source: Victorian Auditor-General's Office, from information supplied by DHS.

Outpatient services are one of the most common ways that patients come into contact with the health system. They are a source of free specialist medical treatment, provision of specialist assessment, consultations before admission to hospital, specialist management of chronic conditions, diagnostic tests, and care following discharge from hospital.

Figure 2B illustrates some of the ways that outpatient clinics interact with other parts the health system. Outpatient clinics are on a number of important "pathways" for patient care, and are a key link between community-based health care and hospital inpatient care. They are also an important location for teaching medical students, residents and registrars.

FIGURE 2B: PATHWAYS TO CARE



Source: Victorian Auditor-General's Office.

The vast majority of patients who access outpatient services are seeking review of their medical condition. Approximately 20 per cent[1] of patients accessing outpatient services are new patients, attending for an initial assessment. It is not correct to assume that specialists will add all patients attending an outpatient department to the elective surgery waiting list or admit them as a medical inpatient. The decision to do this is a clinical one, and the rates at which specialists may add patients to elective surgery waiting lists vary for each specialty.

Delays in accessing outpatient care have the potential to affect patient outcomes and demand on other areas of the hospital, especially if the patient's condition deteriorates before they have their outpatient appointment. Promptly diagnosing and treating medical conditions may prevent unnecessary inpatient admissions, reducing demand on health services generally and reducing associated health care costs.

2.2 How do Victoria and the Commonwealth share responsibility for the provision of specialist medical care?

The Victorian and Commonwealth governments share responsibility for funding specialist medical services. Under the Australian Health Care Agreement[2] (AHCA), the Commonwealth funds Victoria to provide a range of public hospital-based services, including specialist medical outpatient services.

As a condition of funding, the Commonwealth requires Victoria to provide these services free of charge to public patients. Victoria must also maintain the range of services that were provided in 1998, although there is no requirement to increase the range of services.

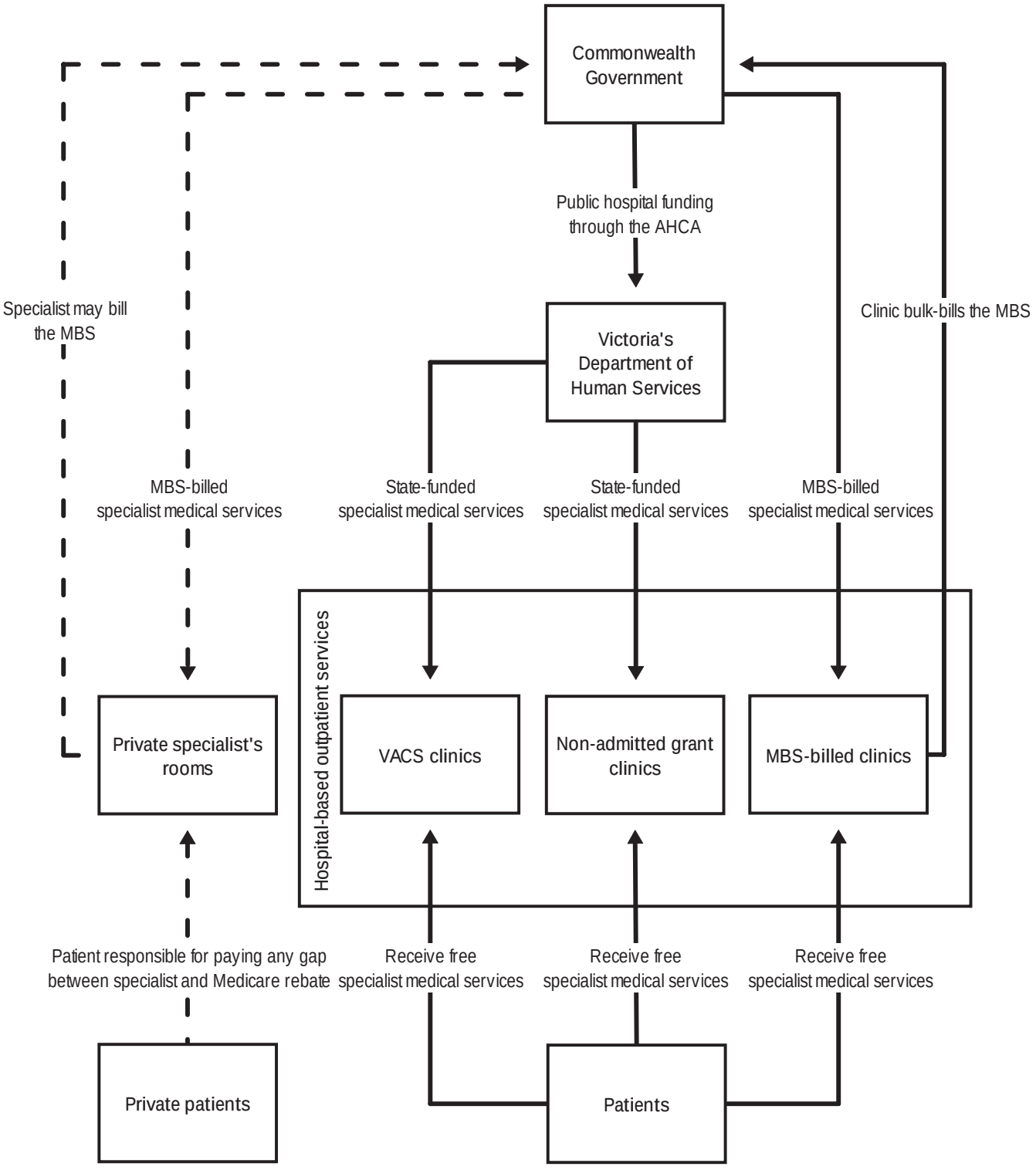
Separately, the Commonwealth "funds" specialists working in a private capacity, through Medicare Benefits Schedule (MBS) rebates. In some instances, this funding extends to specialists located in public hospitals in a private capacity[3] . These specialists use bulk-billing arrangements to provide services to patients. The funding model for specialist medical services is demonstrated in Figure 2C.

[1] Victorian Auditor-General's Office survey of outpatient services 2005.

[2] The Commonwealth provides these grants to Victoria under the Australian Health Care Agreement 2003-08 (known as the Medicare Agreement).

[3] The arrangements supporting this are complex, and are described in detail in Part 4 of this report.

FIGURE 2C: COMMONWEALTH AND STATE FUNDING RESPONSIBILITIES FOR SPECIALIST MEDICAL SERVICES



Source: Victorian Auditor-General's Office.

There is an important distinction to make in relation to the MBS specialist services. In some health services, medical specialists may lease space to run private specialist services within the hospital premises. These services are usually physically separate from the health service's outpatient department. They use no other hospital resources (such as staff and administration) and conduct their business at "arm's length" from the health service.

Specialists providing services to private patients in their rooms (either leased within hospital grounds or outside the hospital) bill the MBS for the services they provide. These services have been illustrated on the left side of Figure 2C. They are not the subject of this audit of hospital outpatient services.

When we discuss the MBS clinics in this report, we are referring to those clinics that are commonly located within the hospital's outpatient department, and for which the health service typically provides booking services, administrative and nursing staff.

We cannot audit the practices of private specialists in MBS-billed clinics, as they do not fall within the scope of our audit mandate under the *Audit Act 1994*. Therefore, we did not examine processes and practices occurring within MBS clinics. However, we examined the management processes that health services have in place to support these clinics. In keeping with this, where we have made recommendations to health services, we have confined the scope of the recommendations to state-funded outpatient clinics. However, many recommendations provide examples of good practice that others should consider.

2.2.1 MBS-billed specialist medical services

To the patient, in most cases there is no apparent difference between state-funded and MBS-billed specialist medical services because of their co-location within the outpatient department. However, these arrangements have implications for the provision of funds by Victoria and the Commonwealth, as well as understanding the data included in this report.

MBS-billed outpatient clinics operate under numerous models, with variations both within and across health services. Generally, the MBS-billed outpatient clinics in Victorian health services may have the following arrangements in place:

- The health service may enter into a contractual arrangement with the specialist (usually a visiting medical officer) to provide outpatient services in a private capacity. In some instances, the health service may enter an arrangement with a full-time employed specialist who utilises their right of private practice.

- Referrals are generally made to an outpatient clinic rather than to a particular specialist without taking into account whether it is a Victorian Ambulatory Classification System (VACS) funded clinic or an MBS clinic. As both clinic types usually operate out of the same space (the outpatient department) there is no apparent difference in the type of clinic from the patient's perspective.
- Where a patient is referred to an MBS clinic, the health service asks them for their Medicare card[4]. The specialist, using their Medicare provider number, then bulk-bills the consultation fee (and ancillary services such as radiology and pathology) to the MBS.
- In some cases, the health service acts as an agent for the specialist by collecting and distributing to the specialist the collected consultation fees.
- The health service usually charges the specialist a fee, either in the form of a percentage of each Medicare charge, or through a set licence fee. This fee is intended to cover the cost of providing the specialist with physical space, power, phone, nursing support, administration and consumables.
- The private specialists may not maintain their own medical histories, instead using the health service's patient histories. These histories are stored at, and maintained by, the health service.
- Health services may collect performance and activity data for the private clinics (where they are able) in the same way they do for VACS clinics and combine them for an overall picture of their outpatient department activity. This information is only used within health services, and not submitted to any external agencies.

2.3 How many people use specialist medical outpatient services?

Currently, more people in Victoria receive care in an outpatient setting than in an inpatient setting, and this is likely to continue growing as improved medical technology reduces inpatient lengths of stay and as outpatient care substitutes for inpatient care.

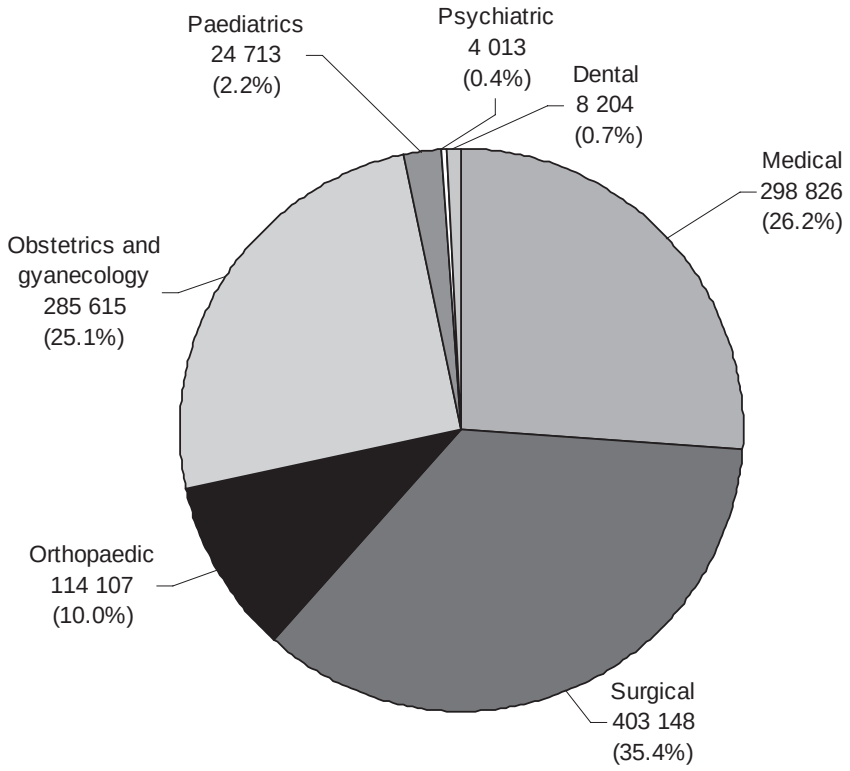
[4] Patients attending a VACS clinic must also provide their Medicare card to prove their eligibility to receive free services as a public patient.

In 2004-05, Victoria provided funding for approximately 1.2 million outpatient encounters[5] for specialist medical care in VACS outpatient clinics. This figure excludes allied health, dental and patients who see a psychiatrist funded by mental health services.

The Department of Human Services (DHS) has identified[6] that users of outpatient services at public hospitals are generally those with chronic illness, from older age groups and those from a lower socio-economic background.

Figure 2D illustrates the patient volumes for the main VACS specialties.

FIGURE 2D: VOLUME OF VICTORIAN AMBULATORY CLASSIFICATION SYSTEM (VACS) ENCOUNTERS BY SPECIALTY, 2004-05



Source: Victorian Auditor-General's Office, from data supplied by DHS.

Figure 2D only includes VACS-funded attendances. It does not include patients seen under non-admitted grant arrangements, mainly at small suburban and rural and regional hospitals. DHS funded approximately 115 000 attendances at an outpatient department in 2004-05 under this grant. However, the way hospitals report the data means it cannot be disaggregated into these categories.

---

[5] DHS defines an encounter as "the clinic visit, plus all ancillary services (pathology, radiology and pharmacy) provided within 30 days either side of the clinic visit".

[6] Department of Human Services 1997, *Non-admitted patient services: a literature review and analysis.*

Figure 2D also excludes patients who attended a specialist located at a public hospital outpatient department, where that consultation was billed by the clinic to the MBS. The number of patients attending outpatient departments under this arrangement cannot be established, as DHS does not collect this information, and the Health Insurance Commission information aggregates all MBS-funded visits to specialists, whether they are located in a public health service or in private rooms.

2.4 How much does Victoria spend on specialist medical outpatient services?

DHS funds health services to provide outpatient services through 2 funding systems: VACS and the non-admitted grant[7].

These are described in detail in Part 3 of this report, but briefly:

- 17 of the 20[8] public health services in Victoria receive their outpatient funding through the activity-based VACS system. In 2005-06, these health services will receive $319 million for outpatient services.
- Smaller suburban hospitals, rural hospitals and 2 of the regional public health services are funded through a non-admitted grant, which covers a broad range of services to non-admitted patients, including allied health and specialist medical care in outpatients. In 2005-06, these hospitals and health services will share $66 million.

In Part 3 of this report we discuss funding policy and trends in detail.

2.5 About this audit

The audit objective was to examine whether Victoria's major public health services are providing accessible, responsive and efficient specialist medical care in an outpatient setting.

[7] Health services receive 2 types of non-admitted grant: one for emergency, that generally funds emergency departments and another that funds other non-admitted services. When we talk about the non-admitted grant in this report, we are referring to the latter.

[8] There are 20 public health services in Victoria, including Dental Health Services Victoria. DHS funds dental health services differently from the other public health services, and is not included in this audit.

We conducted detailed fieldwork in 4 health services to examine how well they met the audit objective. We also conducted a survey of all public health services to obtain indicative information on outpatient waiting times. This means that some analysis refers to all health services, while other analysis refers to the 4 health services we examined in detail. This is indicated throughout the report.

The audit was performed in accordance with the Australian auditing standards applicable to performance audits and, accordingly, included such tests and procedures considered necessary.

We provide further details about our audit methodology, including the cost of the audit, in Appendix A.

3. Is central planning and management of outpatient services effective?

3.1 Introduction

To ensure that outpatient services keep pace with demand and changing models of care, a managed approach to the delivery of these services is essential.

As the Department of Human Services (DHS) has a role in funding specialist medical outpatient services, it was our expectation that it would be involved in identifying priorities, targeting funding across the health services, coordinating activity and making decisions to address specific problems.

In assessing whether DHS managed central planning and coordination of outpatient services effectively, we examined whether:

- the funding and target setting process was responsive to service needs
- statewide planning for outpatient service delivery was effective
- sound data was available for planning and performance monitoring.

3.2 Is funding and target setting responsive to service needs?

As a purchaser of health care, DHS needs to balance demand for services with a finite pool of health funding. It also needs to ensure that funding is distributed equitably, taking into account needs and priorities across the whole health system.

3.2.1 The Department of Human Services' funding systems for outpatient services

Victorian Ambulatory Classification System

DHS primarily purchases outpatient services through the Victorian Ambulatory Classification System (VACS), which accounts for 84 per cent of Victoria's outpatient funding. DHS implemented VACS in 1997 to overcome perceived funding inequities with the previous block-grant model.

VACS payments have both fixed and variable components, with the variable component based on the number of patient encounters[1] and the complexity of each type of encounter. The total funding a health service receives depends on the level and complexity of their activity, taking into account the funding cost weight attached to each of the 35 specialties within VACS.

Depending on the cost weight, each encounter attracts a percentage of a base payment, which in 2005-06 was $146. For example, in 2005-06, general medicine encounters attract a weight of 1.355. Given the $146 base payment, health services would receive a payment of approximately $198 for each patient attending a general medicine clinic. This process creates a weighted encounter.

DHS adjust the value of the base payment each year through indexation and an assessment of any price increases. Over the period 2000-01 to 2005-06, the base payment paid for VACS activity to health services has increased from $114 for each encounter in 2000-01 to $146 per encounter in 2005-06.

DHS determines annual outpatient cost weights through cost studies based on data health services submit voluntarily[2]. There has been significant variation in the number of health services submitting the data each year. Between 1999-2000 and 2001-02, an average of 12 (out of 19) health services have submitted outpatient costing data. In 2002-03, 9 health services submitted costing data, while in 2003-04, this number increased to 16.

DHS does not consider the number of health services providing outpatient cost data as relevant for setting cost weights, provided there is a sufficient sample of health services. DHS advised that it considers the current range of health services submitted data (between 9 and 16) to be a sufficient sample.

DHS has acknowledged that if a health service that does not submit the cost data is a major provider in a particular clinical area, its non-submission may disadvantage it insofar as the clinical category weights will not reflect its cost structure.

---

[1] DHS defines an encounter as "the clinic visit, plus all ancillary services (pathology, radiology and pharmacy) provided within 30 days either side of the clinic visit".

[2] While DHS requires inpatient cost data each year, outpatient cost data is a by-product of this exercise, and DHS encourage rather than require health services to supply outpatient costing information.

While DHS considers VACS to be an improvement on the previous funding model, through the *Care in your community* framework[3] it has also identified several limitations impacting on how health services deliver outpatient services. These limitations include a lack of flexibility and incentives for health services to implement alternate approaches to service delivery. For example, a number of health services are starting to consider using multi-disciplinary[4] clinics in certain specialties. However, the cost weight is based on average practice across hospitals and the health service would need to absorb any additional cost as the VACS encounter price does not reflect this model of care.

DHS has recently conducted an audit of VACS data, and now plans a review of the funding model to ensure that it reflects current and future needs.

Non-admitted grant

In 2 health services (LaTrobe Hospital and Goulburn Valley Health) and a number of smaller hospitals, DHS funds outpatient services through a non-admitted grant.

The non-admitted grant is not solely for outpatient services, but rather a broad range of non-admitted services. The health services have discretion as to how much of this funding they allocate to outpatient services, and which outpatient services they allocate it to.

The non-admitted grant is paid as a block-grant, and has none of the variable elements present under VACS. DHS determine the level of funding to allocate based on historical funding, with annual adjustments in line with the consumer price index (CPI). Funding outpatient services in this way is similar to the way that DHS funded large health services before the introduction of VACS, and does not consider movements in demand or activity for outpatient services.

In 2004, DHS reviewed the non-admitted funding grant for rural health services and found that while these hospitals used the funding flexibly to meet community needs, the purpose of the grant lacked clarity and was not linked to performance goals or monitoring[5].

---

[3] Department of Human Services Victoria 2006, *Care in your community*.

[4] Where the patient appointment involves a number of different treating parties – for example, a medical practitioner, allied health practitioner and/or specialist nurse practitioner.

[5] Department of Human Services 2004, *Group C Hospitals Non-admitted Patient Grant Review.*

3.2.2 Setting activity targets

Health services and DHS negotiate VACS activity targets annually, as part of overall funding negotiations. Activity targets determine the level of funding each health service will receive, and identify how many patients the health service will see in that year. These negotiations take into account statewide service priorities (for example, elective surgery priority areas) and individual health service needs.

Because many patients follow a "pathway" of care where outpatient clinics provide pre-admission and post-discharge care, the decision on how much VACS funding to allocate is linked to the agreed level of activity in other areas (such as inpatient services).

The absence of any robust data means that DHS decisions on how much VACS funding to allocate does not take into account the number of patients waiting for outpatient appointments, or the length of time those patients have been waiting unless the health service specifically raises it as a concern. Therefore, DHS cannot be sure that activity targets accurately reflect the level of demand for outpatient services. As we discuss in section 3.4.1 of this report, there are no agreed measures of access to outpatient services.

When DHS and health services agree on the total VACS activity target and DHS has approved the specialty to run as a VACS clinic, health services decide which specialties to allocate the funding to. An exception to this was in 2005-06 when DHS allocated additional units of VACS specifically for increasing throughput in priority areas for elective surgery.

DHS do not set activity targets for the non-admitted grant, with health services deciding activity levels for the outpatient services they provide.

3.2.3 Growth in funding and service delivery targets

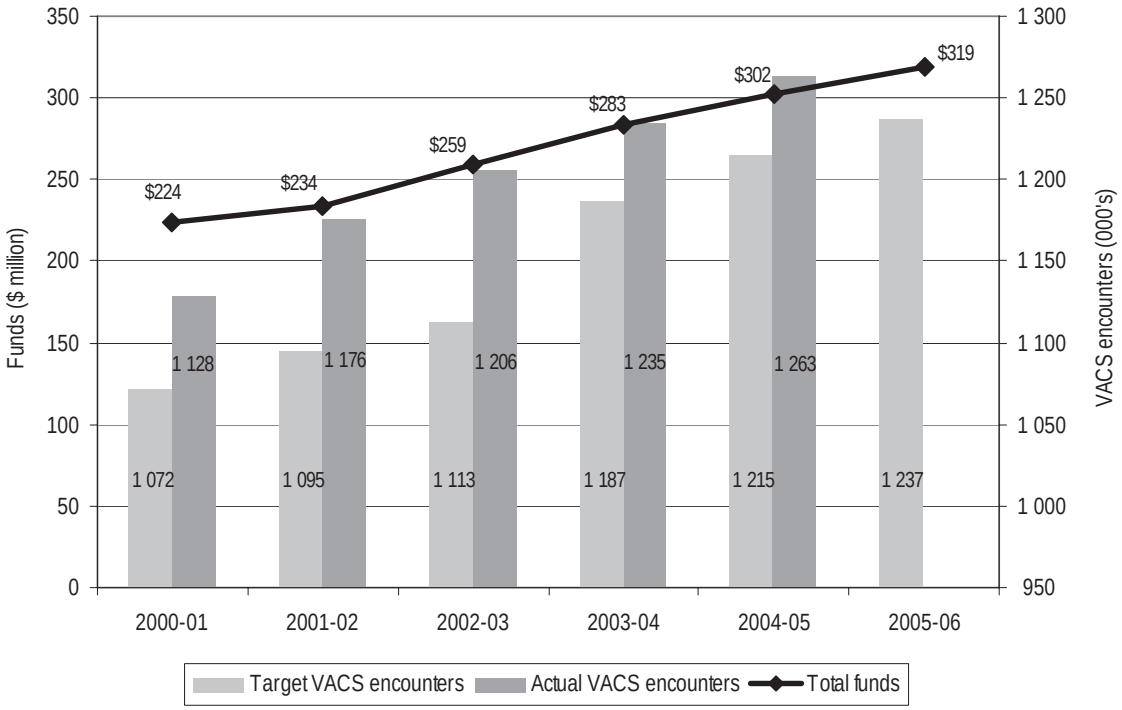
Over the period 2000-01 to 2005-06, VACS funding, service delivery targets and actual service delivery have all increased steadily.

Figure 3A shows that:

- total funding provided for VACS outpatient clinics has increased by 42 per cent over this 5-year period (an average of 8.4 per cent)
- as funding has increased, service delivery targets (the number of weighted encounters health services have agreed to provide) have also increased, but not at the same rate. Targets have increased by 15 per cent over the period (3 per cent a year)

- actual activity has increased in each year, with a 12 per cent increase over the 5-year period[6] (3 per cent a year). In each year, actual activity has exceeded the service delivery target.

FIGURE 3A: GROWTH IN VACS FUNDING AND SERVICE DELIVERY



Source: Victorian Auditor-General's Office, from data supplied by DHS.

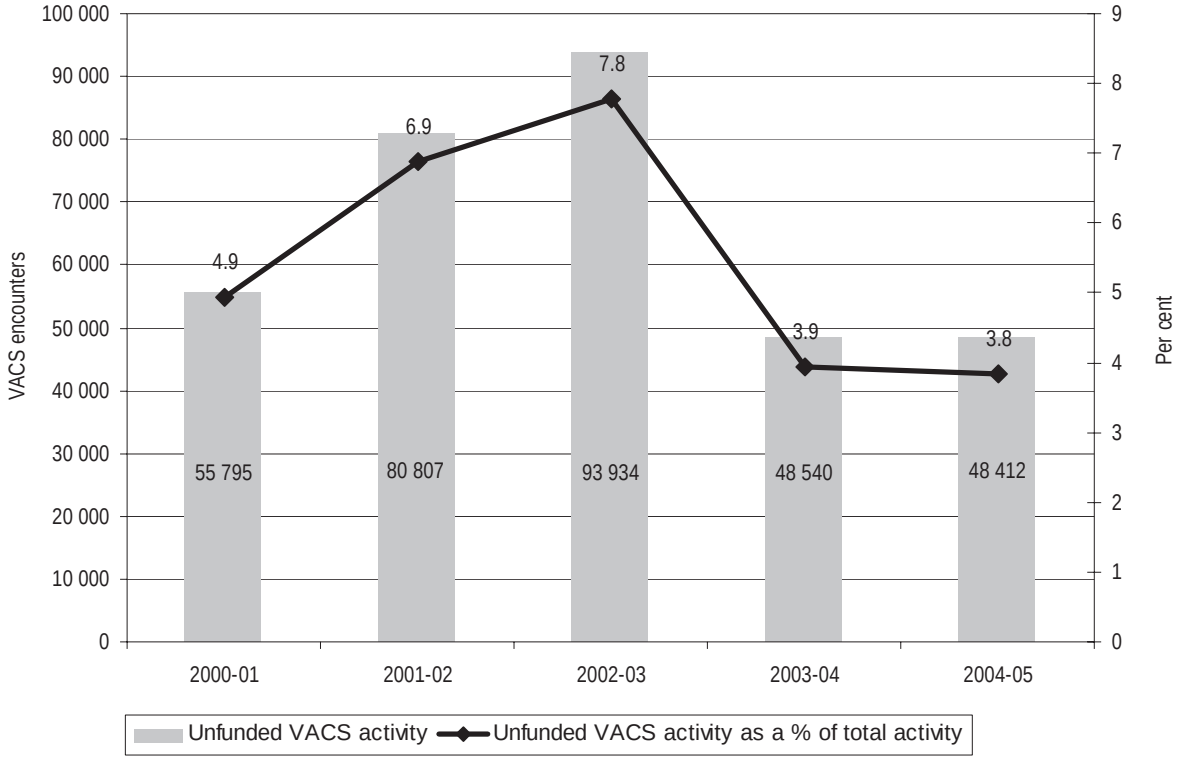
DHS does not fund activity above the target, and the amount of unfunded activity over the target must be absorbed by the health service.

Figure 3B shows:

- unfunded activity grew significantly before the 2003-04 activity target adjustment
- unfunded activity as a percentage of total activity has decreased from a peak of 7.8 per cent in 2002-03 to 3.8 per cent in 2004-05.

[6] 2005-06 performance data was not available at the time of reporting.

FIGURE 3B: UNFUNDED VACS ACTIVITY



Note: In 2000-01 and 2001-02, one health service misreported its VACS encounters, with the effect that for these 2 years, the level of unfunded activity may be higher than it actually was.

Source: Victorian Auditor-General's Office, from data supplied by DHS.

In 2003-04, in recognition that the difference between actual and target activity was widening and to "recognise the additional demand associated with overall patient growth"[7], DHS provided an adjustment to activity targets. For most of the VACS-funded health services, DHS increased its activity targets for 2003-04 to match the previous calendar year's actual activity. Some health services also received additional VACS targets to meet future growth.

Non-admitted grant funding has also increased in the same period, increasing from $53.2 million in 2000-01 to $65.6 million in 2005-06 (23 per cent).

3.2.4 Conclusion – funding and target setting

While outpatient funding has increased over the past 5 years, and at a greater rate than increases in VACS activity targets, it is unclear whether funding has increased at an appropriate rate, as it is not based on robust clinical costing data.

[7] Department of Human Services *Policy and Funding Guidelines 2003-04.*

DHS has identified limitations with the VACS funding model, and is taking action to review it.

The process through which DHS allocates funding and agrees with health services on activity levels in outpatient clinics takes into account inpatient activity and statewide priorities. However, the central target setting process does not consider the number of patients waiting or the length of time they have waited.

3.3 Is statewide planning for outpatient service delivery effective?

DHS is responsible for ensuring that Victorians have timely and appropriate access to health services. In carrying out this role, it has a multi-faceted approach to planning:

- Strategic service planning considers the future level, mix and distribution of services, funding policy and infrastructure.
- Clinical specialty planning coordinates clinical specialties both in a geographic sense, and across acute and sub-acute parts of the health system. DHS prepares these plans in complex clinical areas such as cancer care, stroke care and ophthalmology.
- Targeted plans and programs address key action areas where DHS believes statewide leadership and intervention will be beneficial, such as access to emergency services and access to elective surgery.

This approach to planning addresses the complexity of the health system, looking at services in terms of regional access, delivery channels, clinical specialties and patient pathways.

In keeping with this approach, when we assessed central planning for outpatient services, we considered the way that the broader planning frameworks integrate outpatient services and provided health services and DHS staff with clear guidance.

3.3.1 Strategic service planning

DHS has 2 major strategic service plans that are relevant to specialist medical outpatient services: the Metropolitan Health Strategy and the Ambulatory Care Framework.

Metropolitan Health Strategy

DHS produced the Metropolitan Health Strategy in 2003 as the key planning and policy document for the provision of health care services across metropolitan Melbourne for the next 5 to 10 years. The strategy includes extensive data analysis on a number of key areas of the health system, including:

- service demand, including use of inpatient services, waiting times for community health centres, dental health services, growth in emergency department presentations and mental health presentations
- analysis on usage patterns in inpatient care
- forecasts of future demand in emergency departments
- analysis of general practitioner (GP) numbers per population by region.

However, the strategy includes no analysis of demand, patient demographics or presentation patterns for outpatient services. As we discuss in section 3.4 of this report, the current information DHS has on these areas for outpatients is limited.

Ambulatory Care Framework

As part of the Metropolitan Health Strategy, DHS has undertaken extensive work developing an ambulatory care framework. Outpatient services fall under this framework.

The Ambulatory Care Framework, entitled *Care in your community: A planning framework for integrated health care* identifies issues relating to the nature of outpatient funding, models of care, access, the lack of consistent and useful data and work force issues. It also identifies key actions to address some of these issues. These include:

- reviewing outpatient funding arrangements in 2006, with a focus on developing a model that encourages best practice and transparency in delivery of outpatient services
- improving the systemic functioning of outpatient departments
- partnering with health services to develop consistent statewide approaches to business practice change, with a focus on the effective integration with other parts of the health care system.

3.3.2 Specialty planning

The Programs Branch of DHS is responsible for developing statewide planning frameworks for clinical specialties. The Metropolitan Health Strategy identifies the need for specialty planning frameworks to:

- guide the redistribution of hospital capacity

- review service systems to facilitate the most appropriate application and provision of specialty services[8].

The frameworks consider the range of services needed, and focus on how health services will deliver these from an inpatient, outpatient and emergency access perspective. The framework identifies several priority areas for specialty planning, and Figure 3C summarises these, as well as their focus on outpatient services.

FIGURE 3C: OUTPATIENT PLANNING BY SPECIALTY AND PRIORITY AREA

Specialty/priority area	Focus on outpatient services
Statewide planning framework for ophthalmology services.	Developed recommendations related to consistent guidelines and practices for accessing public ophthalmology outpatient services so that access is equitable, appropriate and based on clinical need.
Statewide planning framework for ear, nose and throat services.	Draft discussion paper. Information on how this framework will focus on outpatient services was unavailable at the time of preparing this report.
Stroke care strategy for Victoria.	Draft discussion paper. Information on how this framework will focus on outpatient services was unavailable at the time of preparing this report.
Victorian maintenance renal dialysis program.	Discusses outpatient services in the context of the type of service delivery models, and indirect reference to outpatient services through a discussion of staffing needs.
Victoria cancer services framework.	Indirect reference to outpatient services through discussion of the cancer services framework principles. The cancer services framework has also mapped the outpatient services operated by health services for future statewide initiatives and planning.
Statewide maternity services.	Discusses different models of maternity care (which is mostly outpatient-based) involving primary care, hospital specialists and midwives.

Source: Victorian Auditor-General's Office.

3.3.3 Targeted access planning and programs

In addition to strategic service planning and specialty planning, DHS also implements targeted improvement planning and programs for key areas of the health system.

The Statewide Emergency Access Program and the Statewide Elective Surgery Program undertake extensive planning that encompasses targeted interventions, ensures consistent approaches to the provision of care and also measures the extent to which health services are meeting policy objectives.

[8] Department of Human Services 2003, *Metropolitan Health Strategy*.

These programs measure and monitor the effectiveness of emergency departments and elective surgery access. They also provide leadership for health services in addressing issues. To date, there is no comparable program for outpatient services, even though outpatient services are an important pathway into and out of inpatient care.

Outpatient services program responsibility

There is no specific area in DHS with program responsibility for outpatient services. We identified 8 program areas within DHS that have a role in overseeing the planning, funding and delivery of DHS-funded outpatient services. Staff in outpatient management roles in audited hospitals mentioned that they have difficulty knowing who to contact or where to go for advice.

3.3.4 Planned initiatives in outpatient services

DHS has advised that during 2006 a number of initiatives have commenced, or will commence, to examine outpatient services and provide leadership for health service improvement in this area.

Patient Flow Collaborative

Collaborative projects are a method of enabling rapid change, encouraging health services to work together, and building change management capacity in the health sector. In previous years, the first phase of the Patient Flow Collaborative focused on various areas of the health system. The Patient Flow Collaborative II in 2006 will focus on outpatient services and build on the first Patient Flow Collaborative project, including improved executive engagement and data collection.

Specific actions planned for the collaborative include:

- integrating current work in the community sector to ensure that referrals to outpatient services contain all relevant information, allowing specialists to assess patients in one visit without the need for further tests
- supporting the policy directions described in *Care in your community: a planning framework for integrated ambulatory health care* to encourage adoption of innovative service models
- examining the business operations of outpatient services to improve efficiency, patient satisfaction and resource utilisation.

Outpatient Improvement Program

DHS has commenced a review of outpatient services and has employed a senior project officer to lead the review. DHS advise that it will engage health services and other key stakeholders throughout the process. While DHS is currently scoping the review, it envisages the program could cover:

- The development of an overarching policy and strategic purchasing framework for outpatient services, which may include an analysis of the levels and types of outpatient services that are most effectively provided in a hospital setting. The policy and purchasing framework may also consider which services could be more appropriately provided in a community setting (rather than in an outpatient setting), as well as those services Victoria should fund and administer and those more appropriately funded and administered by the Commonwealth.
- The development of a more refined funding tool for outpatient services, establishing closer links between funding and the cost of providing outpatient services.
- The development of new models of care for outpatient services.
- A focus on service improvement/service redesigns within outpatient settings. This could include, for example, best practice regarding appointment scheduling and referral, and providing increased information to patients about outpatient departments.

The outcomes of the outpatient collaborative will inform the outpatient improvement program.

3.3.5 Conclusion - statewide planning for outpatients

DHS has paid significant attention in recent years to developing a comprehensive health planning framework. However, current statewide planning for outpatient services is significantly weaker than other elements of the framework. There has been little analysis of demand, usage patterns or projection of future needs.

Outpatient services have also received less attention in DHS' service improvement initiatives to date. Work has commenced in 2006 to address this. As much of this work is at the early planning stages, it is too soon to assess whether it will be sufficient.

3.4 Is sound data available for planning and performance monitoring?

The use of data in the planning process is essential if planning is to be effective. Knowing the trends and patterns in the use of health care, and being able to forecast future demand for specific areas of health care enables planners to effectively focus funding and resources.

3.4.1 DHS data collection

Service delivery information

The main dataset DHS uses for outpatient services is the Agency Information Management System (AIMS). Current data relating to outpatient services that DHS collect is summarised below:

- ***Service profile*** - DHS currently require all VACS-funded health services to provide a list of the VACS clinics they operate. DHS collates these lists and includes them in a schedule of clinics, which provides DHS with a current profile of clinics. This information only relates to VACS services, as DHS does not have information on clinics provided under the non-admitted grant or Medicare Benefit Schedule (MBS) clinics.

As we have discussed, DHS-funded outpatient activity represents only part of the outpatient activity occurring in Victorian hospitals. Most hospitals also have MBS clinics, and for some health services we visited, 50-60 per cent of their actual specialist medical outpatient activity occurs in these clinics. DHS has previously required information on MBS clinics, but does not collect this any more.

- ***Activity data*** – VACS-funded health services submit a monthly return to DHS detailing the number of encounters for the 35 weighted specialties[9]. Health services funded through the non-admitted grant[10] submit a monthly return detailing occasions of service for 4 main specialty categories (obstetrics and gynaecology, paediatrics, medical, and surgical).

DHS collects and analyses only limited information relating to the outpatient services it funds in Victorian Hospitals. There is less information on services funded through the non-admitted grant than those funded through the VACS system.

[9] Health services must also provide this information for the 12 unweighted specialties. These specialties are not within the scope of this audit.

[10] Suburban hospitals, rural hospitals and 2 regional public health services.

Forecasting demand

DHS does not forecast future demand for outpatient services. DHS attempted to forecast demand for outpatient services in 2002, however, due to concerns about the quality and accuracy of the data used, does not use the forecasts in any outpatient planning.

Even though DHS, through the development of the *Care in your community* framework, has undertaken much work into considering how and where it will provide outpatient services in the future, this has not been informed by comprehensive data. The absence of comprehensive data has been identified in this planning framework as an issue impacting on DHS' ability to make changes to outpatient services.

Measuring performance

DHS does not measure the performance of outpatient services, as it does for elective and emergency. It has no access indicators, and the only measure of timeliness for non-admitted patient services relates to sub-acute services[11], and not the acute hospital-based outpatient services.

Timeliness of access to outpatient services

As we identified in Part 2 of this report, timeliness of access to outpatient services is critical to patient care. Even though various government policies[12] identify the need for timely health services, DHS does not collect this type of information for outpatient services.

During this audit, we conducted a case study analysis of the time to the next available appointment in 6 key medical outpatient specialties. This study, which is reported in detail in Appendix C of this report, showed the following trends:

- While all health services were able to provide appointments for the most urgent patients, there was significant variation in the time frame for the next appointment.
- For non-urgent patients in some specialties, the time span until the next available appointment could be long - up to 2 years in some specialties.
- Data gathered shows some "hot spots"- particular clinical specialties that had access problems.

More detail of our analysis is in Part 5 of this report.

---

[11] Sub-acute ambulatory care service clients contacted within 3 days of referral.

[12] *Growing Victoria Together*, DHS' *Departmental Plan* and the Victorian government budget papers.

National development in outpatient data systems

The weakness of Victoria's data on outpatient activity is common to many Australian states. In recognition of this, the current Australian Health Care Agreement commits the state and territory health departments to working with the Commonwealth to develop a national minimum dataset for non-admitted patients.

While DHS is currently collecting aggregate information at the clinical category level for outpatient services, patient level data (including waiting times) is not expected until 2008 with the introduction the next Australian Health Care Agreement. DHS is currently conducting a study to determine the ability of all Victorian hospitals to comply and what, if any, investment DHS may have to make to ensure compliance.

3.4.2 Conclusion - data

Sound data is not available that establishes either the level of activity, likely demand for outpatient services or how well health services are performing. The current data DHS collects is at best rudimentary, and is not able to adequately inform planning or inform DHS whether it is meeting its policy objectives.

3.5 Overall conclusion

Central planning for, and management of, outpatient service delivery is weak and needs improvement.

DHS has increased the funding for outpatient services, and the unit price paid to health services for activity each year for the last 6 years. Service delivery in outpatient clinics has increased each year and generally exceeded targets set.

However, it is unclear if this increased service delivery is keeping pace with demand, and making a difference in the health system. This is because central planning has not given detailed consideration to the role and objectives for outpatient services, there is weak service and access information, and there is no performance monitoring.

Addressing the planning gaps around outpatient services will be challenging, particularly given that there are shared state and Commonwealth funding responsibilities, and DHS-funded service in this area is only part of the picture.

However outpatient services have a crucial role as a pathway to inpatient care, in providing preventative care and in providing alternatives to inpatient admission. This means they are integral to the systems approach that Victoria is taking to address the needs of the health system.

DHS has recognised this importance and commenced work to improve central planning and management. The planning and program management that DHS have previously undertaken to address elective and emergency access may provide a model for the future.

Recommendations

1. **DHS should develop a targeted access plan for outpatient services.**
2. **DHS should collect better information, including:**
   - **service profiles, with information on the number and type of non-admitted grant and MBS clinics added to the Schedule of Clinics**
   - **outpatient activity, with information on non-admitted grant and MBS clinic activity, that is consistent with VACS reporting**
   - **the number of patients receiving inpatient care following assessment or treatment at an outpatient clinic, and the type of inpatient care received**
   - **demographic data on outpatient services users**
   - **outpatient demand forecasting.**
3. **DHS should develop a range of benchmarks to measure service delivery performance in outpatient services, including measures of access and timeliness.**
4. **DHS' planned review of VACS should ensure that:**
   - **the funding model provides adequate incentive and flexibility for health services to consider emerging models of care**
   - **the activity target setting process takes into account the number of people waiting for outpatient care and the length of time they have waited.**

RESPONSE provided by Chief Executive Officer, Bendigo Health Care Group

Recommendation 1

Agree.

Recommendation 2

Agree.

Recommendation 3

Agree.

Recommendation 4

Agree.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 1

Agree.

The development of a targeted access plan, along the lines of the Statewide Elective Surgery Program and the Statewide Emergency Access Program previously developed by DHS will be considered as part of the Outpatient Services Review.

The current contacts in DHS for VACS development and service improvement (changes to clinics and funding arrangements etc.) are posted on the Department's website www.health.vic.gov.au/vacs. This information will be reviewed to ensure comprehensive coverage and clarity.

With regard to Figure 3C, the Statewide Planning Framework for ear, nose and throat services has now developed recommendations related to consistent guidelines and practices for accessing public ear, nose and throat outpatient services so that access is equitable, appropriate and based on clinical need. These can be viewed at www.health.vic.gov.au/ent/index.htm

RESPONSE provided by Secretary, Department of Human Services - continued

Recommendation 2

Partially agree.

DHS has been collecting information on attendances by detailed clinical category from a greater number of health services from July 2005, in compliance with National Minimum Data Set (NMDS) requirements for outpatients. This increased the number of hospitals reporting outpatient attendances consistent with VACS clinical categories from 19 to 29 health service campuses across Victoria. Also in cooperation with the Commonwealth Government, DHS is progressing towards unit-record level data collection of public outpatient services for 95 Victorian health services and public hospitals, for progressive implementation from July 2008.

As the clinic schedules currently collected by DHS inform funding distribution for public clinics at VACS-funded health services, the services concerned have an incentive to ensure accuracy. DHS is not convinced of the cost-effectiveness of increasing the reporting burden on hospitals to collect information that will not be required for funding purposes. However, development of a targeted access plan could include the development of key performance measures for which there will be data requirements, and development of a strategic policy framework; both of which will involve obtaining an overview of privately-funded hospital outpatient services, most likely through surveys.

The development of unit-record level data containing patient identifiers will enable overview of service provision between inpatient and outpatient care. This will also enable the collection of relevant demographic data on outpatient services users, facilitated by the progressive introduction of HealthSMART into both VACS and non-VACS-funded health services.

DHS has undertaken limited outpatient demand forecasting utilising existing VACS data. The introduction of unit-record level data, and periodic surveys of both public and private (MBS-funded) outpatient services will enable more cohesive and comprehensive forecasting for planning purposes. The forecast of outpatient demand data also needs to take into account changing inpatient demand, as this is one key driver (but not the only driver) of outpatient demand.

RESPONSE provided by Secretary, Department of Human Services - continued

Recommendation 3

Partially agree.

Consideration of benchmarks and performance indicators will be possible when unit-record level data are available and will be investigated as part of the Outpatient Services Review. However, DHS considers that a performance indicator targeting access based on need for care will not be introduced easily, given the difficulty of achieving standard definitions for urgency of care.

Recommendation 4

Partially agree.

Part one of recommendation 4 is a key action of "Care in your community: a planning framework for integrated ambulatory health care", DHS' overarching planning framework for ambulatory care, and will be taken up by DHS' Outpatient Services Review to commence in 2006.

The VACS target setting process currently includes review of hospital provided information on demand for services. Implementation of unit record data collection will inform part of the target setting process by providing standardised data on the number of patients waiting for appointments and information on time waited. However, negotiation of targets involves coming to an understanding of what constitutes appropriate increased demand and what kind of demand needs to be managed by health services. There are many other factors involved in setting targets for individual health services, including community health availability, private specialists' availability and whether the health service has undertaken any relevant service reviews.

RESPONSE provided by Chief Executive Officer, Eastern Health

Recommendation 1

Agree.

Recommendation 2

Agree.

Only non-admitted grant-funded clinics should be added to the Schedule of Clinics.

Only outpatient activity for non-admitted grant clinics should be collected in addition to the VACS activity.

RESPONSE provided by Chief Executive Officer, Eastern Health - continued

Recommendation 3

Agree.

Recommendation 4

Agree.

RESPONSE provided by Chief Executive Officer, St Vincent's Health

We fully support the proposed review of outpatients' services by DHS and look forward to participating in the patient flow collaborative and outpatient improvement program. St Vincent's Health is committed to continuing the reforms it commenced in 2004 and 2005.

4. Is health service planning and management of outpatient services effective?

4.1 Introduction

Public health services, as a major provider of specialist medical outpatient services in Victoria, need to plan to ensure that they are able to meet the current and future needs of the community.

As we have previously discussed, Victoria's public health services provide (or facilitate the provision of) outpatient services to public patients under a number of different arrangements:

- clinics directly funded by the state government under the Victorian Ambulatory Classification System (VACS) or the non-admitted grant scheme
- Medicare Benefits Schedule (MBS) clinics that specialists provide under private practice arrangements or licence agreements with a health service. The specialists charge consultations to the MBS and pay the health service a fee to cover the provision of resources such as booking systems, administrative staff and consumables. The health service may calculate this fee as a flat rate, or as a percentage of each consultation charged to the MBS.

In this audit, we examined the management processes that health services have in place for VACS, MBS and non-admitted grant clinics.

In assessing how effectively health services planned and managed their outpatient service delivery, we considered whether:

- health service planning for outpatient service delivery was effective
- health services facilitated MBS-billed clinics effectively to ensure that they complied with Commonwealth obligations.

4.2 Is health service planning for outpatient service delivery effective?

4.2.1 Strategic planning

DHS requires all health services to perform strategic planning to address key statewide health policies. There are, however, different requirements depending on the geographic location of each health service.

Figure 4A highlights the policy directions for health services in the metropolitan and regional areas.

FIGURE 4A: STRATEGIC PLAN POLICY REQUIREMENTS

Metropolitan health services	Rural and regional health services
Ambulatory care policy directions	Cancer services
Mental health	Palliative care
Cancer services	Rehabilitation
Maternity	Ophthalmology
Older persons	Ear, nose and throat
Paediatrics	Dementia
Hospital demand management strategy	

Source: Victorian Auditor-General's Office.

At the 4 health services we visited, all planned strategically with their strategic plans broadly considering the policy requirements outlined in DHS advice. Information relating to ambulatory care considered the health service's clinical services, as well as identifying capital requirements for outpatient services.

Other planning

Health services varied in how they planned for outpatient services operationally. While 2 health services did not plan for the operation of outpatient clinics, St Vincent's Health and Northern Health used a variety of planning strategies:

- St Vincent's Health had developed strategic business models and improvement plans for each clinic speciality, as well as an outpatient quality plan. It also conducted patient and staff surveys to gain feedback on outpatient services.
- Northern Health used business plans at the health service, hospital and outpatient department level to plan for the operation of outpatient clinics.

4.2.2 Planning data and performance monitoring

Health services having access to sound data on access, use and demand is essential if they are to plan effectively.

Forecasting demand

Health services we visited acknowledged that they had considerable difficulty in forecasting outpatient demand in the absence of any DHS data. Without DHS forecasting data, most health services did not formally forecast demand, while some health services were able to establish a basic indicator of outpatient demand by examining growth in inpatient services.

Measuring performance

All the health services we visited had some performance measures for outpatient services. However, the extent of measures varied considerably depending on the capability of the health service's information systems:

- ***Bendigo Health*** collected patient "fail-to-attend" data, the number of patients attending and the number of referrals and provided this to the performance reporting unit as well as medical and surgical executive staff for review.
- ***Eastern Health*** collected a range of data, although it varied across the different campuses. At Box Hill Hospital, the data collected and analysed included total activity, "fail-to-attend" and clinic cancellation rates. At Maroondah Hospital, the data included activity, waiting times and clinic cancellations.
- ***Northern Health*** collected a large amount of patient access data to assist with planning and improving service delivery. The data included the number of referrals, patients booked for an appointment and patients attending, "fail-to-attend" rates, cancellation and discharge rates.
- ***St Vincent's Health*** also collected a large amount of patient access data. Data collected included the number of referrals, patients booked for an appointment and patients attending, "fail-to-attend" discharge rates clinic visit duration and uptake to waiting list from surgical clinics.

4.2.3 Allocating VACS activity targets

As we discussed in Part 3 of this report, each year DHS and the health service negotiate the level of funding and activity for VACS clinics, as part of overall funding negotiations. While the 2 parties negotiate the overall activity and funding, the allocation of funding to specialties is up the health service.

Getting health service VACS targets right is important for 2 reasons:

- Activity in outpatient clinics is linked to activity in other areas of the health service. For example, if the health service wants to increase elective surgery throughput, it needs to have sufficient VACS funding to cover the activity needed pre-admission and post-discharge.
- VACS is capped, and DHS funds health services only for the agreed level of activity target. If this is below the level of demand for outpatient services, health services may have to absorb the cost of the additional activity, or limit access to these services. If health services deliver less than their target, DHS may require them to repay any unspent funds.

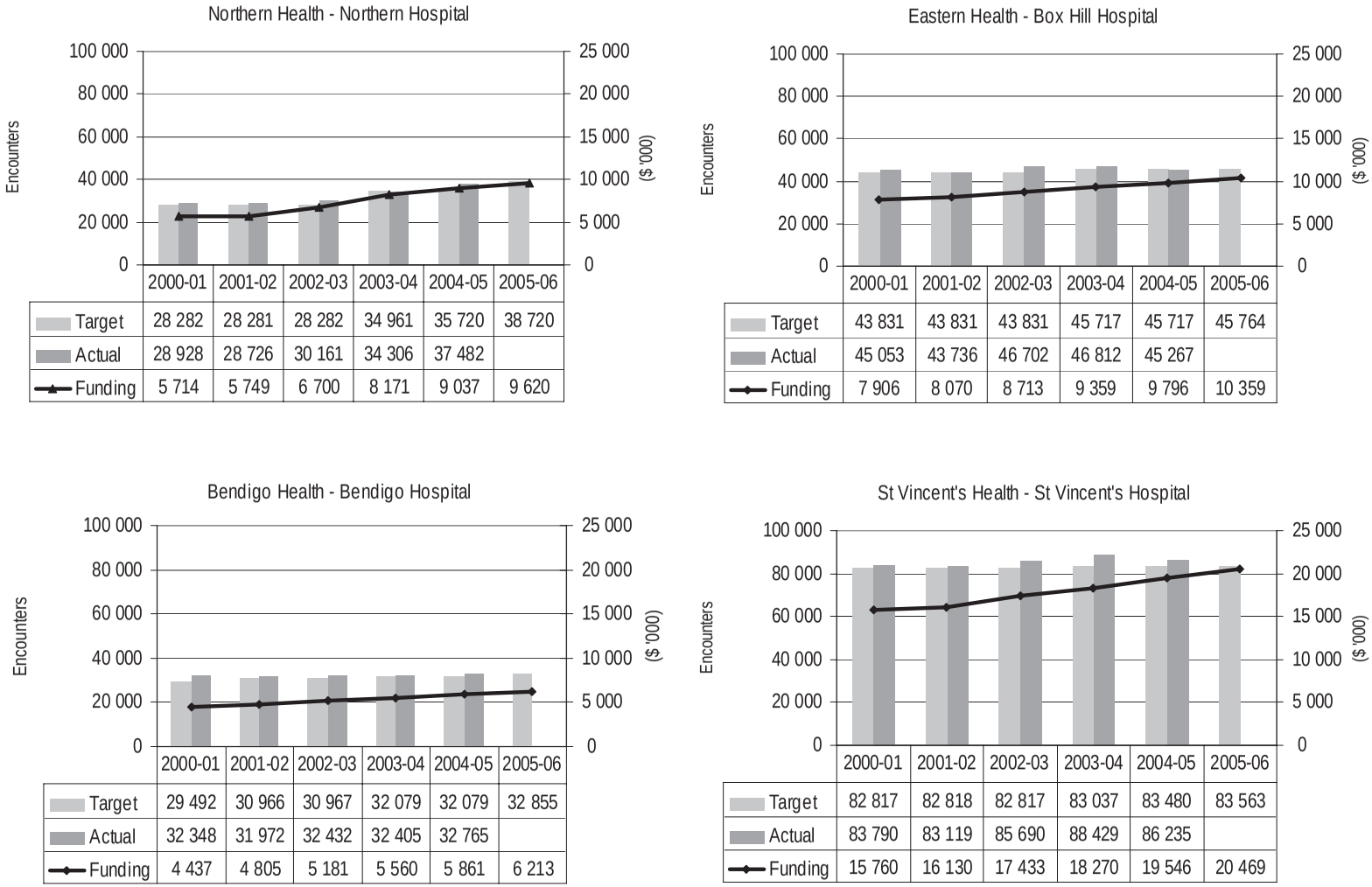
The health services we audited varied in their approach to managing the activity negotiation process and how they allocated their activity targets across the specialities.

When deciding how to allocate VACS funding across the specialties, all health services used the previous year's activity as a guide, although some health services also considered inpatient activity, as well as "fail-to-attend" rates, clinic cancellation rates and clinic over-booking rates.

The difference between activity targets and actual activity for the 4 health services we visited are highlighted in Figure 4B on the next page, which shows the following:

- All the health services regularly exceeded their VACS activity targets.
- ***Northern Health*** exceeded its targets in 4 of the past 5 years, while its VACS funding (excluding allied health) increased by 68 per cent over the period.
- ***Bendigo Health*** exceeded its targets in each of the past 5 years, while its VACS funding (excluding allied health) increased by 40 per cent over the period.
- ***Eastern Health*** (Box Hill Hospital) exceeded its targets in 3 of the past 5 years, while its VACS funding (excluding allied health) increased by 31 per cent over the period.
- ***St Vincent's Health*** exceeded its targets in each of the past 5 years, while its VACS funding (excluding allied health) increased by 30 per cent over the period.

FIGURE 4B: VACS ACTIVITY TARGETS COMPARED WITH ACTUAL ACTIVITY



Note: Actual activity for 2005-06 was not available at the time of reporting.

Source: Victorian Auditor-General's Office, from data supplied by DHS and DHS policy and funding guidelines.

Where health services had activity in addition to their agreed targets and were unable to fund it under their VACS funding, health services had to absorb the cost. All health services managed excess demand by limiting access to outpatient services to ensure that they did not exceed their funded activity by excessive amounts. When demand exceeds access, then outpatient waiting lists are created.

Staff at some health services mentioned that they were reluctant to increase activity and VACS targets in some specialties as there was a financial disincentive to do so. They believed that additional outpatient activity in surgical specialties without a commensurate increase in inpatient activity could create pressure on their elective surgery waiting lists, which would put at risk their elective surgery bonus funding if the health service did not meet specified targets.

4.2.4 Planning for new outpatient clinics

Opening new clinics or varying existing clinics can create additional costs for health services, through salaries and impacts on other hospital services. All health services we visited considered changes to outpatient services (such as introducing a new clinic or changing the level of service) in relation to inpatient services provided. Where the health service identified a need for a new speciality or had expanded its inpatient or emergency services, it considered what outpatient services were needed to provide for the successful operation of the specialty.

New clinics were proposed by clinical areas, by health service management or by DHS in response to identified needs. Health service approaches to reviewing these proposals for their operational, funding source and financial impacts varied:

- ***Northern Health*** used a business case model, looking at impacts on operations, costs and current resources. It considered the direct costs of running the clinic, indirect costs such as support staff and the "downstream" implications (such as impact on allied health, diagnostic services and inpatients). Financial viability was an important consideration, but Northern Health noted that there may be situations where a clinic that was not financially viable would go ahead for clinical reasons.
- ***Eastern Health*** used 2, less detailed pro-formas for analysing new clinic proposals. It considered funding sources and service need (waiting time and other demands). It did not analyse downstream and cross-service impacts in detail.

- ***St Vincent's Health*** had not opened a new VACS clinic recently, but advised that if the circumstance arose it would follow a business case approach. In deciding whether to operate a new clinic as either VACS or MBS, the health service advised that it would take into consideration the differences between the management requirements of the 2 models, and the value of funding. In the case of a highly specialised but low resource use clinic, it would use the MBS, as the management overheads on such clinics were generally lower and it would be easier to manage administratively. However, for any clinic with a high resource requirement it would try and obtain approval from DHS and allocate VACS funding.
- ***Bendigo Health*** used a business case model that considered costs (premises, staff and equipment) and revenue. There was no apparent consideration of the downstream implications of the new service.

4.2.5 Understanding costs and revenue

Differences in the funding structure of VACS and the MBS system mean that the decision to run or facilitate outpatient specialist clinics under one system or the other can have different impacts on health service viability.

Each health service we examined took a different approach to assessing the costs for service provision. We conducted an assessment of costs and revenue of service provision using the same costing methodology for each health service. We looked at the full and marginal[1] cost of providing and facilitating VACS and MBS clinics[2], and the revenue earned through these clinics.

The analysis indicated that:

- most health services were operating both their VACS and MBS outpatient clinics at a deficit (at both marginal and full cost)
- one health service was generating a surplus with its VACS-funded clinics, however it ran its MBS clinics at a loss
- no health service recovered the full cost of providing MBS clinics, and only 2 health services recovered the marginal costs of these clinics. In every other case, the revenues received from facility fees for MBS clinics were inadequate to cover the costs.

[1] "Full cost" includes both the direct cost of conducting the activity and a cost component for health service overheads such as infrastructure and management. "Marginal cost" is the direct cost of conducting the activity and does not include overhead costs which would not disappear if the activity ceased.

[2] Our analysis excluded revenues from other sources, such as Pharmaceuticals Benefits Scheme (PBS) revenues. Where revenues were excluded, related costs were also excluded.

VACS funding levels are determined through an annual review of health service data. However, health services have more flexibility in setting the level of revenue they receive for MBS clinics, as this is generally negotiated between the health service and the clinician. Across the 4 health services, we found significant variation in how they set the fees to recover the costs of facilitating MBS clinics.

Bendigo Health

Bendigo Health had arrangements for 3 clinics where local specialists utilised space at the hospital for some sessions, but managed their own bookings, billing and medical records. Cost recovery arrangements for these 3 clinics varied:

- One was charged a private clinic fee of $55 per patient (with plans to revise this to $85 per patient).
- One was charged a percentage of the consultation fee billed against the MBS.
- A third MBS clinic operated without an agreement or a fee. The health service advised that it had not pursued this because of the risk of losing the doctor's services.

Bendigo Health also had an MBS clinic which was staffed by a full-time employee. The cost recovery structure for this clinic was based on a 100 per cent donation model, where all revenue earned by specialists under the MBS was returned to the health service.

There has been no analysis to ensure that the fees meet the direct costs of providing the resources, although the health service has undertaken to conduct a review of the fees currently charged.

Eastern Health

Eastern Health charges fees for all its MBS clinics (at both the Box Hill and Maroondah Hospitals), however, the fees varied across the campuses.

Box Hill Hospital introduced new fees for all its MBS clinics in 2005. The current arrangement is $75 for a session with less than 15 patients and $95 for a session with more than 15 patients. Additional fees are then charged depending on what additional resources (such as nursing and consumables) they use.

Box Hill Hospital based its fee structure on the fees charged in 2001, which was the last time they were reviewed.

Maroondah Hospital fees ranged between $30 and $200 per clinic session. Like Box Hill Hospital, the fees were based on historical calculations, and the hospital has not recently reviewed the fees to ensure that they meet the direct costs of providing the resources.

Northern Health

Northern Health has 3 models in use for MBS clinics:

- A full-time employee arrangement, where 100 per cent of the revenue for MBS-billed consultations is donated to Northern Health.
- A visiting medical officer (VMO) arrangement where up to 55 per cent (depending on the level of support provided by the hospital) of the MBS rebate is recovered from the doctor.
- A flat fee arrangement where non-employee doctors are charged $100 (excluding GST) per session.

The health service is, however, implementing new business case templates (for new specialist clinic proposals) in an attempt to manage the costs of these services. Each proposal is now assessed for its cost-effectiveness, with cash inflows and outflows estimated over a 3-year period to establish the net cash flows.

St Vincent's Health

St Vincent's Health has recently implemented new charges for all of its MBS-billed clinics. Previously, clinics had different fees, with either $30 or $65 charged depending on individually negotiated arrangements. All MBS clinics are now charged $65 per clinic session.

This fee is intended to cover the costs of providing the following resources: utilities, simple medical and surgical supplies, furniture, reception staff, medical records, computers and maintenance and lodgment of Medicare claims. St Vincent's Health told us that this fee also includes a buffer in the event that revenue from the private clinics is put at risk through, for example, a clinic closure.

During our visit to St Vincent's Health, we were concerned to discover that due to an apparent oversight in the billing processes for the MBS clinics, the health service had not collected fees for the use of resources in 2003-04 and 2004-05. Recovery of the outstanding amounts has been progressive during 2005-06, and an automatic billing system has now been implemented. St Vincent's Health advised us that the outstanding amount (as of March 2006) was $22 000, down from approximately $100 000 at the time of our visit in November 2005.

4.2.6 Conclusion - planning

Health services undertake some rudimentary strategic planning for outpatient services, but the lack of robust data hampers this.

Health services varied in their ability to prepare internal performance data. The limited range of data at some health services affects their ability to effectively plan, particularly at the operational level. Not surprisingly, the 2 health services with the greatest range of internal performance measures also have the most developed operational planning.

Many health services are incurring a deficit on both VACS and MBS-billed clinics. VACS clinics can incur a deficit when actual activity exceeds funded activity, or when a health services cost structure differs from the average as used in developing the funding formula.

While health services have little flexibility in determining the funding they receive under VACS, they have more flexibility to determine the revenue they receive for MBS clinics, and the ability to fund service delivery through arrangements under the MBS gives health services potential flexibility to expand service delivery beyond the level DHS funds. However, health services need to carefully consider the financial impacts of these arrangements. Currently, arrangements for identifying and recovering the costs of MBS clinics are ad hoc and inconsistent.

While we accept that there will be times when a health service will make a decision to run outpatient clinics at a loss in order to provide a clinically important service, or in order to retain the services of a specialist, this needs to be an informed decision.

4.3 Do health services facilitate MBS-billed clinics effectively to ensure that they comply with Commonwealth obligations?

All Victorian health services are obliged to adhere to the requirements outlined in both the Health Insurance Act and the Australian Health Care Agreement (AHCA).

The Health Insurance Act governs the payment of Medicare benefits, while the AHCA governs the terms on which the Commonwealth Government funds state governments for the delivery of public hospital services.

A failure to comply with the obligations contained in both the Act and AHCA potentially places both health services and the State of Victoria at risk of financial penalty.

4.3.1 Health Insurance Act

The Health Insurance Act is legislation enacted by the Commonwealth Government to manage the payment of Medicare benefits. This legislation is important for health services that facilitate MBS-billed outpatient clinics by providing specialists with resources to work privately. Usually, these resources include space within the hospital, and may sometimes include administrative support, staff and consumables.

If health services do not adequately separate these outpatient services from the publicly-funded outpatient services, they run the risk of not complying with the Act and of being subject to financial penalty.

4.3.2 Health service requirements under the Health Insurance Act

In assessing whether health services effectively facilitated MBS clinics to ensure compliance with the Health Insurance Act, we sought advice from the Victorian Government Solicitor's Office (VGSO) on the key elements that health services needed to abide by.

The VGSO's advice identified several key actions a health service should take to ensure that the MBS-billed clinics complied with the Act and to show that the arrangements were genuinely separate from the health service. These actions included:

- Demonstrating a separation of the MBS-billed clinics from the health service. This may be done through the use of private practice agreements, especially where the specialist was either a full-time employee or a VMO. A licence agreement would also demonstrate a separation from the health service where the specialist was neither an employee nor VMO.
- Locating MBS-billed clinics away from the outpatient department would help to demonstrate a genuinely separate arrangement, although this is not essential provided there is proper documentation to establish an appropriate separation.
- MBS-billed clinics should use separate patient medical files, unless proper procedures are followed. These procedures include informed patient consent to the private specialist accessing the patient file and the health service maintaining and updating the files (where legally necessary).

4.3.3 Complying with the Health Insurance Act

At the 4 health services we visited, the number of MBS outpatient clinics varied significantly, ranging from 9 per cent of all outpatient clinics to 69 per cent.

Private practice and licence agreements

All 4 health services facilitated MBS-billed clinics. These clinics were run by either full-time employees or VMOs exercising a right of private practice (a situation that would normally require a private practice agreement) or through non-employee specialists (a situation that would normally require a licence agreement).

Of the 4 health services, only one could demonstrate that it had implemented private practice agreements, and this was only for some of the MBS-billed clinics. This health service plans to continue implementing these agreements. One other health service planned to implement private practice agreements throughout 2006 after becoming aware that the previous agreements had expired and had not been renewed.

Only one health service could demonstrate that it had formalised licence agreements with the private specialists, but only for a minority of its clinics.

Location of MBS-billed outpatient clinics

Three of the health services we audited had their MBS-billed outpatient clinics co-located with the publicly-funded clinics in the outpatient department. One health service located its facilitated MBS-billed clinics in a separate part of the building, with clear signage indicating that they were private clinics.

Unless there is proper documentation to establish an appropriate separation, co-location increases the risk that these clinics could be construed as being provided by, or on behalf of, the health service.

Separate medical records

Only one health service could demonstrate that its MBS-billed clinics used patient files that were not stored and maintained by the health service. For the remaining health services, the private specialists used the health service's patient files, and none could demonstrate that they had processes to ensure that the patient provided them with informed consent to access the file.

We are not suggesting that any of the health services we audited have not complied with the Health Insurance Act. Our focus was whether the health services are adequately managing the risks of possible non-compliance.

4.3.4 Purpose and obligations in the Australian Health Care Agreement

The AHCA is an agreement between the Commonwealth of Australia and the State of Victoria that details the responsibilities of both parties in providing public hospital services, and the principles that Victoria should follow when delivering public hospital services. Broadly, Victoria must ensure that:

- public health services give patients the *choice* to receive, free of charge as public patients, access to health and emergency services
- patients access these services based on clinical need and within a clinically appropriate period
- patients have equitable access to these services, regardless of where they live.

A core feature of the AHCA is that it prohibits health services from raising a charge against the MBS for hospital services they provide to public patients.

As non-compliance with the AHCA can jeopardise Victoria's funding under the agreement, DHS has provided advice[3] to all Victorian health services in 2003 and 2004 emphasising the importance of compliance.

The advice identifies the need for health services to meet the compliance requirements of the AHCA, requires health services to familiarise themselves and understand all the sections of the AHCA and also requires health services to consult with DHS before taking any action that might not comply with the AHCA.

We also sought advice from the VGSO to assess whether health services complied with the AHCA in relation to MBS-billed clinics. Central to this advice was that:

- patients referred for outpatient services at a health service should be given the opportunity to elect to be treated as either a public or private patient
- the information provided must be sufficient for them to fully understand that the specialist may provide the service on a private basis
- the information should consider that some patients may have difficulty in understanding the distinction.

---

[3] Department of Human, Services *Hospital Circular* 33/2003 and 34/2004.

This election requirement applies even if the patient does not incur any out of pocket expenses and the full cost is bulk-billed.

4.3.5 Compliance with election procedures

The AHCA states that where a doctor refers a patient to a named specialist working in a private capacity within the hospital, they are not a patient of the hospital. However, our legal advice indicates that to ensure the patient does not become a patient of the hospital they need to elect to receive treatment as a private patient.

At the 4 health services we visited, we did not see any evidence that patient election occurred when they attended at the outpatient department. However, as we cannot examine the activities of GPs (because they do not come within the scope of our audit mandate) we cannot be certain that election does not occur at this point.

In the event that a patient attends a clinic that bills the consultation to the MBS, but they do not elect to become a private patient, then this situation creates several significant risks for the health services and Victoria.

A detailed analysis of the AHCA obligations as they relate to MBS-billed clinics in health services, DHS interpretation of these obligations, and the risks of non-compliance is located in Appendix B of this report. Briefly, some of the risks of non-compliance include:

- patients attending private clinics not electing to be treated as a private patient remain a public patient
- outpatient services provided to public patients (including the consultation and ancillary services) are charged against the MBS
- outpatient review appointments provided to patients who were public inpatients are charged against the MBS.

4.3.6 Conclusion - supervising MBS clinics

The arrangements health services make with specialists to provide MBS-billed clinics on health service premises need to be robust to prevent any risk that these services do not comply with the Health Insurance Act or the AHCA.

In the health services we examined, documentation of arrangements with specialists, either through private practice agreements or licence agreements was patchy. Some health services had documented agreements for some but not all of their clinics, some had allowed agreements to expire, and some did not have agreements.

The lack of documented agreements means that these arrangements lack clarity. The formal separation of the "private" practice in MBS-billed clinics from the state-funded operations of the health service is not evident.

Having documented licence agreements or private practice agreements would put beyond challenge the separation of these clinics from the health service. All health services have since commenced work to address this issue.

Health services also need to ensure that MBS-billed clinics operating on health service premises have clearer patient election processes. Many health services assumed that election occurred at the time the GP referred the patient. However, we could not be confident, based on the evidence presented to us and the procedures in place, that this was the case.

4.4 Overall conclusion

Health services planning and management of outpatient services is not as effective as it could be. In particular, the supervision of service delivery arrangements through MBS clinics is poor.

All health services we audited planned their outpatient services to some extent, although much of this planning occurs without the use of robust data to inform decisions and direction. As we have discussed in Part 3 of this report, better data is needed to improve planning for outpatient services at both state and health service level.

All health services we examined have made arrangements with specialists to provide MBS-billed outpatient clinics. This offers flexibility and can increase service delivery, but increases the complexity of the management task for health services. The full financial and legal implications of these arrangements need to be considered and managed more effectively.

The arrangements required to ensure compliance with Commonwealth requirements for MBS-billed clinics in health services are complex, and in many cases we were not confident that health services had the necessary documentation and procedures in place to manage the risks of possible non-compliance.

While DHS has previously issued guidance in these areas, the development of revised guidance, including model agreements, should be a priority.

Recommendations

5. **DHS should work closely with hospitals to ensure that:**
   - **hospitals are aware of, and comply with, the AHCA and Health Insurance Act requirements as they relate to outpatient services.**
   - **hospitals have appropriate documentation of private practice and licence agreements for outpatient services.**
   - **hospitals have appropriate documentation relating to outpatient election processes.**
6. **DHS should issue guidance to health services on fees for MBS clinics, with consideration for appropriate costs.**

RESPONSE provided by Chief Executive Officer, Bendigo Health Care Group

Recommendation 5

Agree.

Recommendation 6

Agree.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 5

Agree.

DHS considers that the issue identified in this audit of inadequate documentation regarding private practice agreements and patient election processes in the health services that were audited is a matter of serious concern.

DHS acknowledges that inadequate documentation gives rise to potential risks for health services and for the state, and will continue to work closely with health services to:

- *ensure that they are aware of the requirements of the Australian Health Care Agreement and the Health Insurance Act 1973 as they relate to outpatient services, noting that DHS has previously advised health services of their Australian Health Care Agreement obligations through hospital circulars 33/2003 of 11 December 2003 and 34/2004 of 24 November 2004*

RESPONSE provided by Secretary, Department of Human Services - continued

Recommendation 5 - continued

- *ensure that all health services have appropriate documentation in place regarding private practice arrangements and, where appropriate, patient election processes relevant to outpatient services.*

Recommendation 6

Partially agree.

Arrangements are between individual health services and private practitioners and these vary across health services, and it is not practicable to provide a template for fees and cost recovery. DHS will work closely with hospitals to ensure that they have written agreements in place with private practitioners relating to the use of hospital facilities and services.

RESPONSE provided by Chief Executive Officer, St Vincent's Health

The lack of comprehensive documentation in regard to the "MBS clinics" does not necessarily imply that health services are not appropriately managing risks of potential non-compliance with the ACHA or the Health Insurance Act.

St Vincent's Health is committed to improving its documentation and is progressing the implementation of its comprehensive private practice agreements (as endorsed by DHS) and policy processes in keeping with its legal obligations.

RESPONSE provided by Chief Executive Officer, Eastern Health

At the outset, Eastern Health believes that the report is generally fair and balanced with respect to its discussion and recommendations regarding:

- *data collection*
- *planning*
- *funding mechanisms.*

Eastern Health agrees with all but 2 of the recommendations.

However, Eastern Health does not agree that the report's analysis and recommendations regarding the attendance of patients at private practitioners located on public hospital premises are fair, balanced or accurate.

RESPONSE provided by Chief Executive Officer, Eastern Health - continued

Moreover, the recommendations on this issue contain an inherent contradiction. On one hand, the report recommends more control and management of "MBS-billed clinics" and on the other, it recommends more separation of public hospitals and private clinics. The 2 recommendations are contradictory.

This contradiction stems, in our view, from a presumption that there is a difference between the patients attending private practitioners located in rooms at public hospitals and the patients attending private practitioners located in premises outside public hospitals.

This misunderstanding is best demonstrated in Figure 2C. This Figure suggests that there are 4 types of patients of which 3 receive "free" services. However, in fact, there are only 2 kinds of patients: public VACS/non-admitted grant patients who receive "free" services"; and patients attending a private practitioner whose treatment is paid for, or reimbursed to the patient, by Medicare. The latter is not "free" wherever it is located.

The Australian Health Care Agreement itself states that a patient receiving services from a medical specialist exercising a right of private practice or having a contract with a public hospital is not a patient of a public hospital.

A medical practitioner may bill a patient direct or "bulk bill" Medicare. This arrangement does not make the service "free" and neither does it make the attending patients "public".

A public hospital service, by comparison, is "free" because there is no specific charge for it and the patient is not required to pay either the public hospital or the medical practitioner.

Second, the report argues that election processes which apply to admitted inpatients under the agreement also apply to private outpatients.

However, the agreement itself does not refer to an election process for anyone other than admitted inpatients. As noted above, the agreement states that a patient receiving services from a private practitioner exercising a right of private practice or having a contract with a public hospital is not a patient of that public hospital.

As a result, the report's suggestion that there is a risk of a perception that public hospitals with private clinics without election processes or private practice agreements do not fully comply with the Australian Healthcare agreement or the Health Insurance Act 1973 is, in our view, unwarranted.

RESPONSE provided by Chief Executive Officer, Eastern Health - continued

Recommendation 5

Agree.

Disagree that an election process is required.

Recommendation 6

Disagree.

There is no need for DHS to issue guidelines, as these arrangements do not relate to public patients.

Further comment by the Auditor-General

I disagree that there is an inherent contradiction in recommendations 4 and 5. The report does not recommend there be more "control and management". It notes, based on legal advice from the Victorian Government Solicitor's Office, what actions a health service should take to ensure there is adequate separation of private clinics that are commonly located in outpatient departments. What the report does recommend is that health services have the appropriate documentation to clearly demonstrate that these private clinics, because of their location in outpatient departments, are not services provided by, or on behalf of, the health service.

Figure 2C reflects the observations and findings made by my staff. While some private practitioners lease "rooms" within the hospital and are therefore quite distinct from the services the hospital provides, in many instances private clinics were located within the outpatient department. To the patient attending at the outpatient clinic, there is no discernable difference between the public and private clinics. This is what Figure 2C demonstrates.

The statement within the Australian Health Care Agreement, that a patient receiving services from a medical specialist , exercising a right of private practice or having a contract with a public hospital, is not a patient of a public hospital, is included as a note to the definition of "private patient". We sought advice from the Victorian Government Solicitor's Office on this definition note. The advice stated that for a patient not to be a patient of a public hospital in these circumstances, the patient must elect to be treated as a private patient.

Further comment by the Auditor-General - continued

Clause 41(b) of the Australian Health Care Agreement is very similar to the private patient definition note. It states:

"An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

(b) the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient".

Two elements must therefore be satisfied before the patient is not a patient of the hospital:

- *the named specialist must be exercising a right of private practice. In the majority of cases, private clinics were run by doctors contracted to the health service. This relationship was neither employment or governed by a visiting medical officer agreement.*
- *The patient must choose to be treated as a private patient. This is what the advice from the Victorian Government Solicitor's Office stated. To choose is undoubtedly the same as electing.*

While the Australian Health Care Agreement does not describe an election process (and neither do I recommend an election process), the agreement does state the need for election.

5. Are health services managing outpatient appointments effectively?

5.1 Introduction

With increasing demand for outpatient services, health services face the challenge of optimising the use of available resources. Knowing how to manage patient flows, as well as fluctuations in demand and capacity, is the first step in meeting this challenge. Patient referrals, clinical prioritisation and booking practices are tools that health services use to manage patient flows and influence how soon the specialist will see the patient in an outpatient clinic.

In assessing whether health services managed outpatient appointments effectively, we examined:

- the availability of appointments for new patients in 6 key medical specialties at Victoria's health services
- whether referrals to outpatient clinics were managed effectively
- whether outpatient booking systems were effective.

5.2 How long until the next appointment?

As we have discussed, there is limited collection or reporting of data on access to outpatient services in health services. However, as indicated in Appendix C of this report, there are operational reasons why it can be difficult for health services to predict waiting times with precision. Therefore, the following data should be interpreted carefully.

As part of our audit, we gathered data on waiting times for first appointments for 6 specialties from Victorian hospital outpatient clinic booking systems.

The data relates to both publicly-funded outpatient clinics and Medicare Benefits Schedule (MBS) clinics, where outpatient department staff are responsible for booking these appointments.

Because this data provides the context for understanding why effective prioritisation of patients and timely processing of bookings is important, we include it here. Detailed hospital level performance data is provided in Appendix C of this report.

Detail on our methodology is provided in Appendix A of this report.

5.2.1 Next available appointment by urgency

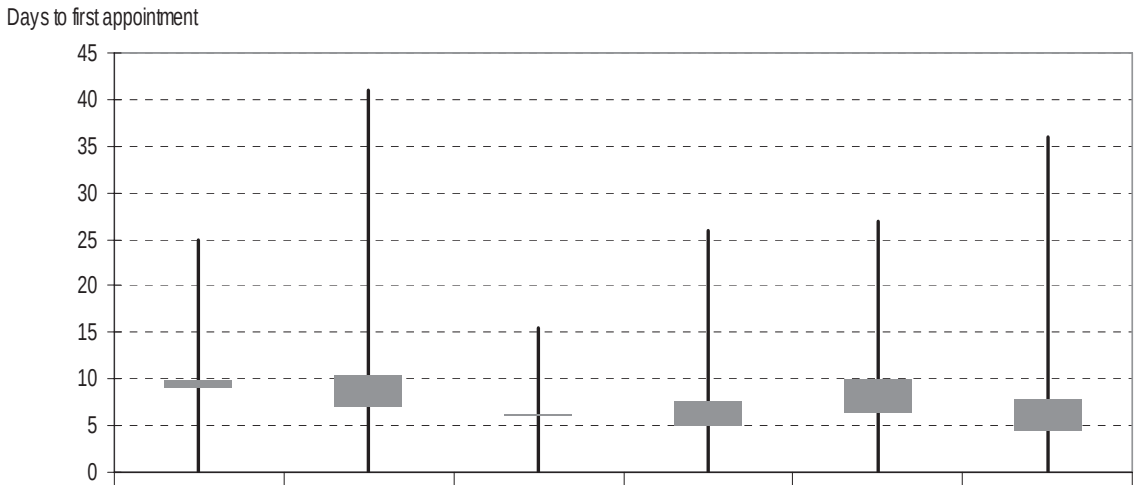
Access for "urgent" referrals

We asked health services to tell us how long it would be until the next available appointment for patients who were assessed as "urgent". The information was validated as part of the audit.

Figure 5A shows that across the 6 specialties, at the time of our survey, there was a median time of around 5-9 days to the next available appointment for a patient assessed as "urgent". However, the range of times until the next available appointment was wide (from zero to 41 days).

All health services reported that overbooking[1] clinics or rescheduling non-urgent or review patients facilitated access to appointments. As we discuss in Part 6 of this report, this practice brings additional complexity to patient scheduling.

FIGURE 5A: INDICATIVE TIMES FOR NEXT AVAILABLE FIRST APPOINTMENT FOR NEW PATIENTS WHO ARE ASSESSED AS "URGENT"



	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

Note: The upper tail extreme represents the maximum reported time, and the lower tail extreme represents the minimum reported time. The upper edge of the box represents the mean, and the lower edge of the box represents the median.

Source: Victorian Auditor-General's Office.

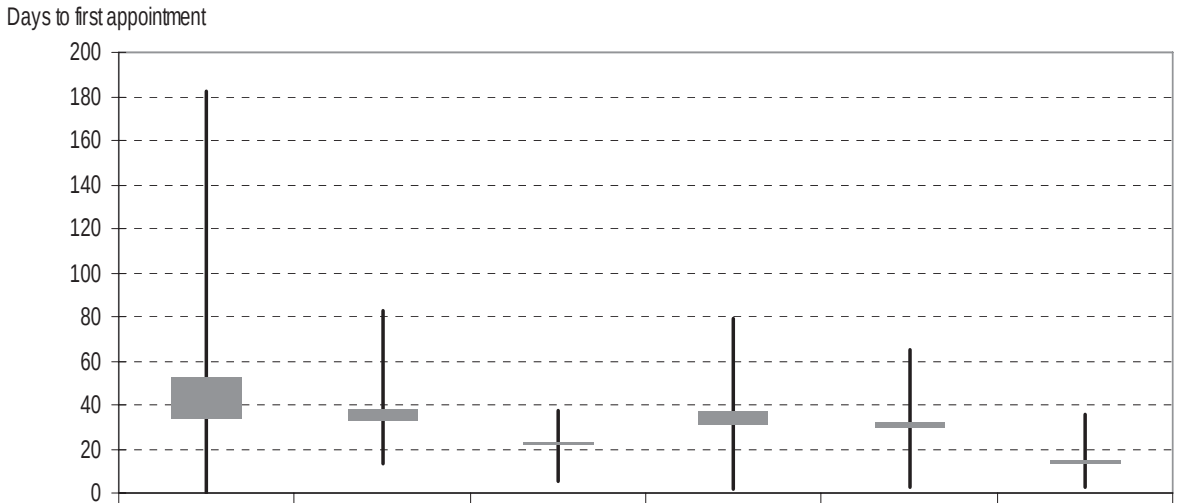
[1] This report discusses overbooking in Part 6.

Access for "semi-urgent" referrals

We also asked health services to tell us when the next available appointment would be for patients who were assessed as being "semi-urgent". Not all hospitals used this category for all specialties.

Figure 5B shows that for semi-urgent appointments, the median time to next appointment ranged from 14 days for oncology appointments, up to 34 days for ear, nose and throat. However, the range of times until the next available (non-urgent) appointment was wide (from zero days up to 182 days).

FIGURE 5B: INDICATIVE TIMES FOR NEXT AVAILABLE FIRST APPOINTMENT FOR NEW PATIENTS WHO ARE ASSESSED AS "SEMI-URGENT"



	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

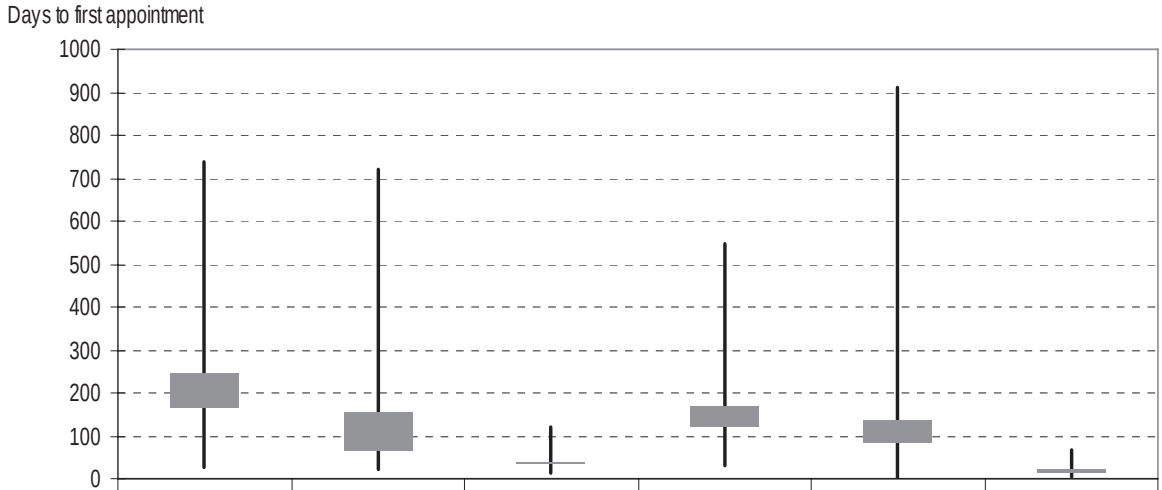
Note: The upper tail extreme represents the maximum reported time, and the lower tail extreme represents the minimum reported time. The upper edge of the box represents the mean, and the lower edge of the box represents the median.

Source: Victorian Auditor-General's Office.

Access for "non-urgent" referrals

Figure 5C shows that the largest range of times, and the longest median times to an appointment are for new patients assessed as "non-urgent". Orthopaedics, urology and ophthalmology show the widest range of times, with periods in excess of 700 days to the next available appointment in some specialties at some hospitals.

FIGURE 5C: INDICATIVE TIMES FOR NEXT AVAILABLE FIRST APPOINTMENT FOR NEW PATIENTS WHO ARE ASSESSED AS "NON-URGENT"



	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

Note: The upper tail extreme represents the maximum reported time, and the lower tail extreme represents the minimum reported time. The upper edge of the box represents the mean, and the lower edge of the box represents the median.

Source: Victorian Auditor-General's Office.

Some health services advised us that when there were long waits until the next available appointment, they implemented strategies to assist the patient to manage their condition in the interim. For example, some hospitals with long waits until the next available orthopaedic appointment referred patients for physiotherapy.

Such long periods until the next available appointment create problems for health services in managing bookings. As we discuss in section 5.4.1, some electronic booking systems cannot manage dates so far into the future and health services frequently need to create secondary waiting lists to manage these referrals.

5.2.2 Conclusion - next available appointment

While this data needs to be read cautiously, it suggests that there can be significant waits for appointments at outpatient clinics in some specialties. In the interim, these patients must be managed by their general practitioner (GP). There is potential that the medical condition of non-urgent patients may deteriorate, requiring a more urgent appointment.

The impact of these waits depends on other strategies to manage them, including whether health services triage referrals appropriately and inform GPs of the waits.

5.3 Do health services manage referrals effectively?

Patients can only access specialist medical outpatient services with a referral. Typically, this will be from the patient's GP. But referrals to outpatient clinics also come from elsewhere within the health service, including referrals from inpatient wards for follow-up treatment and review for patients discharged from the emergency department. Before a health service can allocate an outpatient appointment to a patient, it needs to process the referral and confirm the patient's urgency.

5.3.1 Referral policies and procedures

Clear outpatient referral policies and procedures can enhance the efficiency and effectiveness of the referral process. They do this by informing administrative staff of the processes they should follow when managing referrals, and give guidance to referring specialists on the information the health service requires.

At the health services we visited, the use of outpatient referral policies and procedures varied. Bendigo Health and the Angliss Hospital (within Eastern Health) did not have a documented policy or procedure to inform staff and referrers of the requirements. The remaining health services and hospitals had developed protocols to help administrative staff to manage referrals. Generally, the protocols detailed the processes staff should follow after they had received a referral, and in some instances what to do if the referral was incomplete or illegible.

With the exception of one hospital, this information was designed for administrative staff, and not referrers.

Referral documentation

To ensure that referrers provided health services with the necessary information and that consistent referral processes occurred within their outpatient department, most health services had developed standardised local referral forms. Only the Angliss Hospital at Eastern Health had not developed a standardised referral form. There was considerable variation in the content of these forms across all the health services. This variation is demonstrated in Figure 5D.

FIGURE 5D: CONTENTS OF REFERRAL FORMS - AUDITED HEALTH SERVICES

	Bendigo Health	Northern Health	Eastern health		St Vincent's Health
			Box Hill	Maroondah	
Referring doctor name, details	✓	✓	✓	✓	✓
Referring doctor provider number	✗	✓	✓	✓	✓
Patient name, DOB, contact details	✓	✓	✓	✓	✓
Patient Medicare number	✗	✓	✓	✓	✓
Interpreter required	✗	✓	✓	✓	✓
Veterans Affairs/TAC/WorkCover	✗	✓	✗	✗	✗
Clinic type	✗	✓	✗	✗	✓
Previous patient	✗	✓	✗	✗	✓
Urgency of appointment	✗	✓	✓	✓	✓
Preferred campus	n.a	✓	✓	✓	n.a
Presenting problem and current medication (reason for referral)	✓	✓	✓	✓	✓
Past medical history/diagnoses	✓	✗	✓	✓	✓
Attachment of investigative material (if new appointment)	✓	✓	✓	✓	✓

Note: The Angliss Hospital is not included as it did not have a standard referral form.

Note: "n.a" refers to "not applicable".

Source: Victorian Auditor-General's Office.

This variation is at odds with the way health services manage referrals for other areas within the hospital, such as elective surgery. To ensure consistency of referrals for elective surgery, the Department of Human Services (DHS) has recently required that health services providing elective surgery develop minimum referral requirements in line with their referral policy. This approach would assist outpatient departments.

Processing referrals

All health services managed referrals to outpatient clinics centrally. Generally, clerical staff processed referrals within 24-48 hours of receipt. "Processing" included:

- checking the legibility of the referral
- date stamping the referral and ensuring all investigations accompanying the referral were attached
- verifying the patient's details and updating the patient management system
- assigning a temporary UR[2] number or noting on the referral that the patient was new to the hospital.

Where the referral was unreadable or incomplete, staff either contacted the GP by telephone to verify referral content, or faxed a hospital referral form to the GP, with a request to resubmit the referral.

Central processing of referrals ensured consistency and also helped to minimise the risk of lost referrals by limiting their movement. However, the majority of health services did not track referrals after they had received them (such as which specialist was reviewing the referral or when it was forwarded for review). This increased the risk of loss and also of delays in making patient appointments.

Once clerical staff had processed the referrals, they were filed in the outpatient department (by clinic) in readiness for the patient's appointment.

Working with GPs

All health services audited told us that the quality of GP referrals they received varied considerably and that this was an ongoing problem for them. Issues related mostly to the legibility and completeness of referral forms or referral letters.

Many health services were working with GP liaison officers and the GP divisions to improve the quality of referrals. This work has led to the development of a standardised local referral form (discussed earlier).

Both St Vincent's Health and Northern Health had provided their local GPs with information packs to improve the quality of referrals.

Providing GPs with information on waiting times can help them to plan how they will manage their patient while they wait for their appointment. This is especially important if the wait is long.

---

[2] UR stands for unit record, with health services creating a new UR for each new patient.

Of the hospitals we audited, only Box Hill Hospital (Eastern Health) provided local GPs with information on waiting times for new non-urgent outpatient appointments. The health service compiled this information manually and posted it on the internet every 3 months for GPs to access. The health service has not yet evaluated the effectiveness and usefulness of the service, but plans to do so in 2006.

St Vincent's Health was working on a webpage for GPs, which would include outpatient access data, and planned the launch for May 2006.

5.3.2 Prioritising outpatient referrals

Before a health service makes an outpatient appointment for a referred new patient[3], it makes an assessment on how urgently the patient needs to see a specialist.

While the referring doctor makes an assessment of urgency on the referral, the health service will consider the comparative urgency of all patients referred. By prioritising patients, the hospital ensures that specialists see patients according to their clinical urgency and not simply in the order that they were referred.

All health services we examined used a 2-step prioritisation approach. At 3 of the health services, clinical staff (nursing and medical) reviewed referrals and allocated an urgency category to them. This decision was made first by nursing staff and then reviewed by medical staff. At the remaining health service, clerical staff made the first assessment of clinical urgency, which was then reviewed by medical staff.

To assist staff with consistent prioritisation, some health services had developed prioritisation guidelines. These provided information including the medical conditions applicable to each urgency category and the expected time to appointment for specific conditions. Where guidance was not available, decisions on urgency were made based on the skills and knowledge of individual clinical staff.

Across the health services audited:

- ***St Vincent's Health*** had developed prioritisation guidelines for each clinic. These guidelines included a target time to see patients assessed in each category: "urgent" - 1 week, "semi-urgent" - 2-4 weeks and "non-urgent" within 8 weeks. St Vincent's guidelines included a list of typical conditions that might be assigned to each category.

[3] Some patients are referred from within the hospital, including those completing an episode of inpatient care. Generally, these patients are not prioritised as they need to see a specialist at a pre-determined time.

- ***Bendigo Health*** used a standard 3-category prioritisation rating for all clinics. These categories were aligned to the categories used for the elective surgery waiting list – "urgent" to be seen within 30 days; "semi-urgent" to be seen in 90 days, "non urgent" to be seen at the next available appointment.
- ***Eastern Health's*** Box Hill Hospital had developed prioritisation guidelines for the majority of its clinics, with some specifying which clinical conditions applied to each category, and expected time to appointment for different conditions. Completed clinic profiles were available to GPs through the internet.
- ***Northern Health*** had prioritisation guidelines for some clinics, but at many, patient priority was determined on a case-by-case basis by consultants at each clinic.

All health services audited had some clinics where nurses, rather than consultants, assessed the urgency of referrals. Not all of these clinics had developed protocols on the appropriate times to treatment for typical conditions.

5.3.3 Conclusion - managing referrals

Health services generally managed outpatient referrals well, with timely processing and prioritisation. However, the lack of documented processes at some health services means that their systems and processes risk failing in the absence of knowledgeable staff. It also means they are likely to continue to have problems with the quality and comprehensiveness of GP referrals.

5.4 Are booking systems effective?

Around 80 per cent of patients in outpatient clinics are review patients, including patients who have completed an episode of inpatient care and require review at a specified time, and patients who require ongoing specialist management for complex conditions.

When they are managing bookings, health services have to balance the needs of these review patients and the needs of new patients who have not yet had their first appointment.

5.4.1 Electronic booking systems

Most referrals were booked and managed through a central, electronic booking system. As shown in Figure 5E, the systems used varied across health services.

FIGURE 5E: OUTPATIENT ELECTRONIC BOOKING SYSTEMS

Hospital	Central outpatient booking system used
Bendigo Health	Homer
Eastern Health	Homer
Northern Health	Hospro
St Vincent's Health	IBA – Unicare (PAS)

Source: Victorian Auditor-General's Office.

At 3 of the 4 health services, the outpatient booking system was an integral part of the wider health service patient management systems. At St Vincent's Health, while the outpatient booking management system was separate, it was linked to the inpatient management system. At the same hospital, the Oncology Unit had a long established information system used to record patient treatment, GP and specialist information, as well as patient appointments and details. Specialists who required access from satellite oncology clinics were able to access the oncology system through the internet.

At the time of our audit, Eastern Health's Angliss Hospital had a manual booking system in place and used an appointment book to record all appointments. The hospital had no backup system in place to ensure that any loss of booking information would not jeopardise patient access. Eastern Health advise that it has since commenced implementation of an electronic booking system at the Angliss Hospital.

All health services reported significant functional constraints in their current electronic system, limiting referral tracking, reporting and analysis of bookings.

The time to the next available appointment for new patients was so long for some high-demand clinics that electronic booking systems were unable to manage these bookings. To work around this, outpatient departments created secondary waiting lists. As appointments became available, patients were transferred manually from this secondary list and allocated an appointment. Some health services acknowledged that procedures for managing this transfer were inefficient and patients were often not taken off the waiting list once booked, leading to inaccuracies in outpatient waiting lists.

The limitations of current electronic outpatient booking systems are well known to DHS and hospitals. DHS has planned improvements for inclusion in Health*SMART*, a $323 million program to implement the Victorian Whole-of Health Information and Communication Technology (ICT) Strategy. The Patient and Client Management System will include improved functionality for management of outpatient services.

5.4.2 Auditing outpatient waiting lists

Nearly all outpatient clinics have waiting lists[4] of new patients who are waiting to attend clinics. If these lists are accurate, they can tell health services what the level of demand for outpatient services is. If health services know whether the list is growing or reducing, they can get a sense of whether their service delivery is keeping pace with demand.

However, outpatient waiting lists are not always accurate because:

- if the time to the next appointment is very long, some patients may be booked for an appointment at more than one hospital in the hope of getting an appointment sooner
- while patients wait for their appointment, their circumstances may change (for example, their condition may deteriorate and require emergency care, or their condition may improve). As a result, they may no longer need their appointment.

If health services audit their outpatient waiting lists, they can identify patients who no longer need their appointments. This can reduce the incidence of patients who "fail-to-attend" (FTA), and free-up appointment slots for other patients.

At all the health services we visited, auditing of outpatient waiting lists occurred, but was either limited to targeted auditing of long-wait specialties or was a one-off exercise. Where health services did undertake an audit, the rudimentary nature of the audit tools meant the effectiveness of the exercise was limited. They did not regard the benefits of freeing-up appointments and reducing FTA patients as a worthwhile investment.

Auditing waiting lists was an intensive exercise. Health services had limited resources, with priority often given to other aspects of outpatient services.

None of the 4 health services had formalised processes for managing waiting lists.

5.4.3 Conclusion - booking systems

Health services are operating with electronic booking systems that cannot cope with the length of some waiting times. DHS is to address this. While all the health services we visited saw little benefit in regularly reviewing appointments to ensure that patients were more likely to attend (due to the resource requirements), limited or one-off audits will do little to improve inefficiencies that inaccurate outpatient waiting lists cause.

---

[4] The outpatient waiting list should not be confused with the elective surgery waiting list, which refers to patients who are waiting for a planned admission to hospital and surgery.

5.5 Overall conclusion

Health services generally manage outpatient referrals and bookings well, although inconsistent and undocumented processes, as well as outdated technology, hamper their effectiveness.

DHS has developed guidelines on referral processes for elective surgery. DHS could use these guidelines as a basis to develop consistent referral processes within outpatient departments.

DHS has also developed guidelines on ratings of urgency for patients waiting for elective surgery and emergency department care. However, there is no standard in health services for either the categories of urgency or how quickly a patient should have their appointment in outpatient clinics. This creates the risk that, in situations of high demand, the availability of resources rather than clinical necessity, determines service timeliness.

The different patient management/outpatient booking systems that health services use limit their ability to implement consistent processes across the health sector. For some health services, limitations in booking some non-urgent patients can lead to operational inefficiencies. DHS is planning to address these issues through Health*SMART* initiatives.

All health services maintain outpatient appointment waiting lists. These lists are likely to contain patients who no longer need their appointment. Health services have an ad hoc and limited approach to auditing these lists, and this means that many new patients cannot access earlier appointments. The lack of regular auditing is also likely to lead to a continuation of unnecessary FTA patients.

Across health services, there is strong demand for appointments to access specialist medical services. While the time from referral to appointment for urgent patients is relatively quick, for non-urgent patients in some specialties the waiting time can be substantial.

The patient's medical condition may deteriorate during long waiting times for outpatient clinic appointments, placing pressure on other parts of the health system, such as emergency departments.

Some health services provide GPs with accessible information on how long referred patients must wait until the next available appointment – others do not. Better information may help GPs manage their patients who are waiting for their specialist appointment.

Recommendations

7. **DHS should develop guidelines for referral policies and procedures.**
8. **To aid clinical assessment, DHS should develop recommended clinical prioritisation protocols and clinical categories of urgency, with recommended performance standards for each category.**
9. **DHS should take action to develop and report measures of access (waiting times) for outpatient services.**
10. **All health services should progress to electronic booking systems.**

RESPONSE provided by Chief Executive Officer, Bendigo Health Care Group

Recommendation 7

Agree.

Recommendation 8

Agree.

Recommendation 9

Agree.

Recommendation 10

Agree.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 7

Agree.

DHS has developed a standard GP referral form that meets international standards and has been taken up by some GPs and health services. The methodology used in the Patient Flow Collaborative allows individual sites to identify the problems or blockages that are specific to their health service. The Patient Flow Collaborative - Outpatients will utilise this methodology so that health services can design solutions that fit with their circumstances.

RESPONSE provided by Secretary, Department of Human Services - continued

Recommendation 7 - continued

Further, data definitions developed in the outpatient NMDS process will provide national guidelines for processing referrals to assist with achieving national data consistency.

Recommendation 8

Partially agree.

Clinical prioritisation protocols will be considered as part of the Patient Flow Collaborative - Outpatients.

Clinical categories of urgency are appropriate for managing emergency demand, where the majority of clinical categories of urgency are based on the length of time that can elapse without treatment before a patient's condition becomes life threatening or deteriorates significantly, and for managing access to elective surgery once a patient has been assessed by a specialist. However, the development of clinical categories of urgency for outpatient appointments involves more subjective criteria, which are more difficult to codify and monitor. DHS is aware that categorisation of urgency guidelines have been developed in the United Kingdom and New Zealand as aids to assessment, rather than replacement for individual clinical judgement. These are not internationally recognised standards but may be useful tools for guiding individual clinical decisions. DHS will continue to monitor and evaluate these developments, but until international standards are available, it would be more appropriate to continue to enable individual clinicians to make clinical decisions at the local level about urgency and treatment time in the context of their assessment of the individual patient.

Recommendation 9

Agree.

DHS is examining the capability of current hospital systems to collect unit-record level data, including waiting times. Data definitions that have been agreed nationally are essential to the uniform treatment and classification of the waiting period. The current Australian Health Care Agreement between the Commonwealth and Victoria requires both parties to work together to develop performance indicators, including waiting times, for access to services for admitted and non-admitted patient services.

RESPONSE provided by Secretary, Department of Human Services - continued

Recommendation 10

Agree.

DHS' HealthSMART strategy is making a significant investment in upgrading hospital IT infrastructure and, progressively from 2008, will provide additional capacity for bookings to be performed electronically and for standardised referral forms to be lodged electronically.

RESPONSE provided by Chief Executive Officer, Eastern Health

Recommendation 7

Agree.

Recommendation 8

Agree.

Recommendation 9

Agree.

Recommendation 10

Agree.

RESPONSE provided by Chief Executive Officer, Northern Health

Recommendation 10

Agree.

RESPONSE provided by Chief Executive Officer, St Vincent's Health

It is our view that the data collection tool utilised by the Victorian Auditor-General's Office does not adequately reflect the activities of outpatient services. The exclusion of over-bookings from the data misrepresents how "urgent" and "semi-urgent" patients are managed and does not reflect the length of time in which "urgent" and "semi-urgent" patients are seen (from the date of referral). While St Vincent's has taken considerable steps to reduce over-bookings, due to 3 weeks of low activity during the Christmas period, demand was underestimated and over-bookings had to be made.

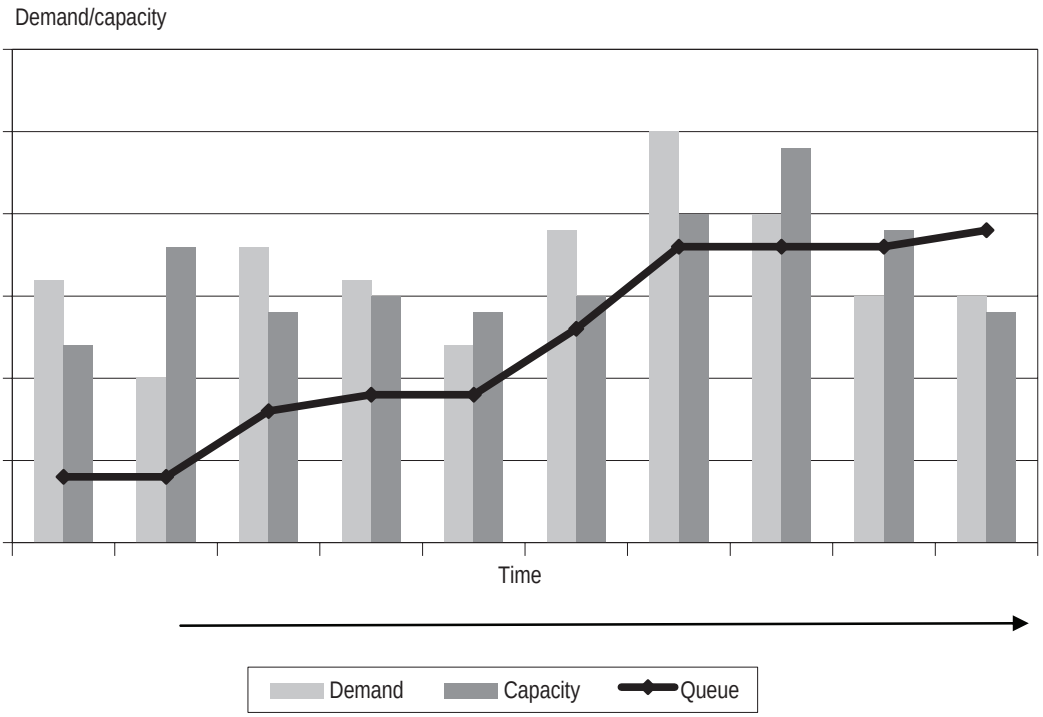
6. Are health services optimising the productive use of outpatient resources?

6.1 Introduction

If demand for outpatient services is greater than available capacity, then patients will have to wait to see a specialist. However, lack of capacity is not the only factor that can cause waiting times to grow. Even if *average* capacity matches *average* demand, a mismatch between daily demand and daily capacity can cause queues.

This happens because when demand exceeds capacity, appointments are postponed and those patients increase the queue. This excess demand is carried forward. However, when capacity is underutilised because it exceeds demand (for example, when booked patients "fail-to-attend"), this saving cannot be carried forward. This relationship is illustrated in Figure 6A.

FIGURE 6A: RELATIONSHIP BETWEEN DEMAND, CAPACITY AND GROWTH IN QUEUE



Note: Figure 6A intentionally contains no data, and is illustrative only.

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.

Figure 6A shows how a queue or waiting list can steadily increase even though average demand matches average capacity, because of mismatches in daily demand and capacity.

Understanding variations in demand and capacity and better matching them can lead to shorter waiting times for patients and more efficient use of resources.

Outpatient department and clinic practices can affect the health service's ability to maximise its available capacity. Practices include how health services schedule their clinics and also how they manage waiting patients.

In assessing whether health services optimised the productive use of outpatient resources, we examined whether:

- health services managed clinic schedules and capacity effectively, minimising disruptions to scheduling
- clinics made best use of available resources.

6.2 Do health services manage clinic schedules and capacity effectively?

Clinic schedules (also known as templates) enable health services to plan how many patients they can see within capacity constraints. The information they contain includes:

- when the clinic will run (weekly/fortnightly)
- how many hours it will run
- how many patients the clinic can see within this time
- how many patients will be new and how many will be review
- the order in which the specialist will see the patients
- allocated time for specialists to review patient histories.

For most health services, the specialist in charge of the clinic sets the duration of the clinic and the number of new and review patients they would see.

This process involves limited input from health service management to monitor patient throughput, fairness in specialist workload across specialities or optimal use of outpatient capacity. We found significant variation in the number of patients seen for the same specialty, within and across most health services.

All health services we visited had reviewed their clinic schedules to try to optimise clinic capacity, although the extent of these reviews varied. Three health services had undertaken only limited reviews, even though they had concerns about the ability of their clinic schedules to:

- accurately reflect attendance time at clinics by some specialists
- ensure that specialist resources are adequate for each clinic, by aligning resource allocation for theatre, inpatient and outpatient services
- factor in teaching time
- address variation in new and review patient quotas for specialists working in the same specialty
- optimise the sequence of new and review patients
- ensure that the appointment duration for a new or review patient is appropriate.

Only St Vincent's Health had reviewed its clinic schedules to address many of the listed issues, and also to standardise the number and type of patients on each of their clinic schedules.

6.2.1 Appointment booking practices

Booking practices can have a direct influence on the capacity and efficiency of an outpatient clinic. If health services use a flexible approach (for example, overbooking), they can increase the capacity of the clinic to see more patients, including urgent patients and patients requiring review at a specified time. However, this approach can also lead to greater in-clinic waiting times for patients.

Health services can also manage variation in clinic capacity by setting aside appointments for specific patient types. Urgent patients are more likely than other patients to create variation in clinic capacity due to the unpredictable nature of their demand. Reserving appointments in clinic schedules for anticipated urgent patients can reduce the need for overbooking. However, this approach can also lead to situations where clinic capacity is not utilised if the patient does not attend.

Overbooking fully booked clinics was common practice for health services we audited, with many considering this practice a necessity to cope with demand. While overbooking was common practice, most health services had limited guidelines to define the circumstances when overbookings could be made, and the extent of allowable overbooking. This meant that when overbooking was necessary, it often involved time consuming negotiations with individual specialists, who generally approved overbooking requests.

St Vincent's Health and Bendigo Health had set up clinic templates with appointment times reserved for urgent patients. For St Vincent's Health, if reserved appointments for urgent patients had not been allocated 1-2 weeks before the clinic, then they were allocated to a review patient. This meant that the needs of urgent patients were met, while minimising instances of underutilised capacity.

In the other health services, outpatient department staff placed urgent patients into a "full" clinic, creating an overbooking.

6.2.2 "Fail-to-attend" patients

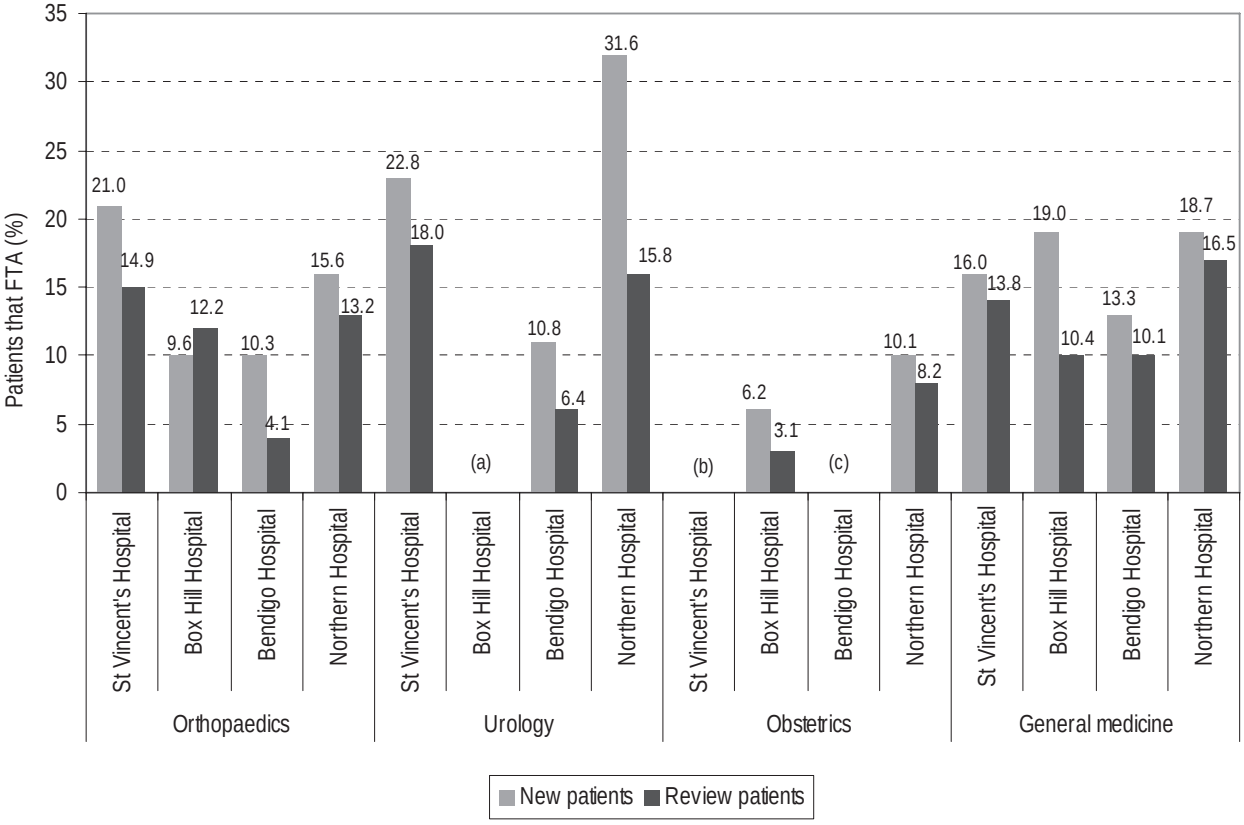
Patients "fail-to-attend" (FTA) outpatient clinic appointments for a variety of reasons, including improvements in their condition, accessing health care through other means (such as the emergency department) or forgetting the appointment. For health services, a high FTA rate complicates appointment scheduling and can mean that they have underutilised capacity.

Health services can also incur significant administrative costs as a result of patients not attending. One metropolitan health service (not included in this audit) estimated that each FTA patient costs the health service approximately $130[1]. This hidden cost of FTA patients includes staff time spent retrieving and preparing patient histories, clerical and administrative costs such as rebooking and re-issue of appointment letters.

The rate of patients "failing-to-attend" across all health services is not monitored statewide in Victoria. At the health services we visited, the failure of patients to attend their appointment without prior notification is a widespread problem. As an example, Figure 6B shows data from 4 specialties at the health services audited.

[1] Western Health 2005, *Outpatients Redevelopment Project – Final Report*.

FIGURE 6B: SELECTED ANNUAL FAIL TO ATTEND RATES, 2004-05



(a) and (c) These clinics were unable to disaggregate their data into new and review patients.
(b) St Vincent's Hospital does not run obstetric clinics and, therefore, does not have data.
Note: St Vincent's Health measures FTA rates as a percentage of patients who attend the clinic. This increases the FTA rate compared to hospitals that measure FTA rates as a percentage of all bookings.
Source: Victorian Auditor-General's Office.

The FTA rate in 4 specialties in the hospitals examined ranged from around 4 per cent for patients attending orthopaedic clinics in Bendigo Health to a maximum of 31 per cent of new patients for urology in Northern Health.

While new patients are the smallest proportion of all patients seen in an outpatient department (approximately 20 per cent in the specialties we examined), they are more likely than review patients to FTA their appointment.

A DHS report has identified research showing a link between patients "failing-to-attend" their appointment and the length of time they have waited for that appointment. The longer they wait, the greater the chance of "failing-to-attend"[2].

[2] Department of Human Services 1997, *Non-Admitted Patient Services: A Literature Review and Analysis.*

Reducing the rate of "fail-to-attend" patients

With the exception of Bendigo Health, all audited health services monitored their FTA rates, with the data showing significant variation across specialties. However, health services had implemented only ad hoc strategies to address the issue.

The main strategy that health services used to address the possible underutilisation of clinic capacity was to overbook clinics by an amount equivalent to the expected FTA rate for that clinic. If more patients attended than expected, then greater in-clinic waiting times could be expected.

Other strategies implemented (to varying degrees) across the health services to reduce the rate of FTA patients included:

- an automated reminder letter for all new patient appointments
- individual outpatient clinics making reminder calls to patients. Health services considered this strategy time consuming and of limited use due to difficulties in contacting patients, even though it might be cheaper than a patient "failing-to-attend" for their appointment
- investigating and trialling SMS messaging to remind patients of appointments
- notifying the patient's GP if they "fail-to-attend" their appointment.

Figure 6C highlights the range of strategies the health services we audited use.

FIGURE 6C: STRATEGIES TO MANAGE AND REDUCE THE NUMBER OF "FAIL-TO-ATTEND" PATIENTS

	Bendigo Health	Eastern Health			Northern Health	St Vincent's Health
		Box Hill Hospital	Maroondah Hospital	Angliss Hospital		
FTA policy	×	✓	×	×	✓	✓
FTA process	✓	~	✓	✓	✓	✓
Reminder calls	×	~	×	×	~	~
Reminder letter	×	✓	×	×	^	×
GP notification	✓	✓	×	~	^	✓
SMS messaging	×	×	×	×	×	×

Note: The ~ symbol indicates the strategy is used in some clinics.

The ^ symbol indicates the strategy was planned for implementation in December 2005.

Source: Victorian Auditor-General's Office.

Health services had developed these strategies without formally investigating the reasons why their patients FTA. None of the audited health services had specifically evaluated the effectiveness of their strategies, or the costs associated with patients that FTA.

Most health services had established (but generally undocumented) processes for managing individual patients that FTA. Individual specialists generally determined how they would manage the follow-up of particular FTA patients. Information on previous attendance and clinical need was taken into account before a decision was made on whether to make another appointment or remove the patient from the outpatient waiting list.

Only one health service had a clearly defined and documented process with specific instructions for each specialty. The other health services had either draft processes or none at all.

6.2.3 Clinic cancellations and managing staff absence

Cancellations

As health services often book outpatient clinic appointments 2-3 months in advance, clinic cancellations, even with a number of weeks notice, can cause major scheduling difficulties. Clerical and nursing staff face the challenge of fitting patients into already full clinics with the flow-on effect of increasing the waiting time for patients to their appointment.

Rescheduling patients because of clinic cancellations was time consuming and a burden for clerical and nursing staff and inconvenient for patients. This was exacerbated when specialists provided outpatient departments with inadequate notice to cancel clinics. Short notice (less than 1-2 weeks) cancellation severely reduced the opportunity for hospital staff to notify patients, resulting in some patients arriving at the hospital and being turned away.

Even though clinic cancellations were common practice, few of the health services we audited had policies or protocols governing clinic cancellation or had reviewed the reasons for cancellations.

This meant that efforts to address the causes of cancellation were limited, and where cancellations occurred, the lack of guidance meant that health services risked applying inconsistent practices both within and across health services.

Managing staff absence

The most common cause of clinic cancellation was that the specialist was unavailable. When specialists are unavailable and their workload cannot be picked up by other specialists, the health service often has no alternative other than to cancel the clinic and reschedule the patients.

As most specialists working in outpatient clinics have a role in inpatient care and elsewhere in the health service, there were times when unplanned absences were unavoidable. Where specialists were absent at short notice, health services cancelled clinics and rescheduled patients. Occasionally, the workload of the absent specialist was shared among other specialists where clinics were run by more than one specialist, removing the need to cancel clinics.

Health services had more control over how they managed planned absences for leave. All health services had staff leave policies, which generally required staff to provide the health service with a number of weeks notice of their planned leave. While this did not eliminate the need for clinic cancellations (especially where the absence was unplanned), adequate notification gave the health service greater control and flexibility over the rescheduling process. However, across the 4 health services audited, compliance with these policies was poor and not enforced by hospital management.

6.2.4 Conclusion - managing schedules and capacity

All the clinics at the outpatient departments we audited used clinic schedules to manage capacity. However, this was often determined by the clinician, with limited oversight and review. Variation in the schedules meant that there was a risk that performance could become inefficient and add to delays in patients accessing specialist medical services.

Outpatient clinics currently work around patients who FTA, rather than trying to address the causes. All health services experienced similar disruptions to their outpatient clinics, however, attempts to understand and address the causes of disruption require improvement.

6.3 Do clinics make best use of available resources?

As we have previously discussed, around 80 per cent of patients attending specialist medical outpatient clinics are there for review appointments. In many cases this is clinically necessary. However, review appointments can also occur because a specialist did not have all the information they needed to properly investigate, diagnose and treat the patient.

By making sure that the right resources and information are in place at the right time, health services can reduce the incidence of unnecessary re-appointment.

6.3.1 Access to diagnostic tests and medical records

Diagnostic tests

Common diagnostic tests include blood tests, ultrasound and x-rays. Timely provision of results prior to an outpatient appointment ensures that the specialist is able to maximise the effective use of the appointment.

At all the health services we audited, specialists and support staff told us that access to diagnostic services was generally timely. However, for most of the health services, strategies to ensure that patients had undergone their diagnostic tests before their appointment, or that health services coordinated tests to coincide with the appointment, were limited and inconsistent. This has the potential to restrict the specialist's ability to fully investigate the patient's condition, make a comprehensive diagnosis and develop a treatment plan at the time of the appointment. This often resulted in the patient requiring a further appointment.

Some electronic booking systems have the capacity to note bookings of diagnostic tests prior to specialist clinic appointment. The consistency with which this facility was used varied, due to lack of documented and clearly defined clinic protocols and responsibilities for booking diagnostic tests.

Medical records

A specialist needs a patient's medical record during the consultation to ensure that they consider all the available information related to the patient's condition. Ensuring that the medical record is complete, contains the relevant test results and is available at the time of the appointment is essential.

Generally, storage in outpatient departments was not adequately secure to enable staff to retrieve medical records well in advance of a patient's appointment. Medical records were transferred from Health Information Services (HIS) to outpatient clinics on the day of the clinic. This meant that there was often inadequate time for clinical staff to review patient files prior to the appointment and ensure that all clinical documentation and test results were available.

Typically, outpatient departments provided HIS with a list of medical records required at least 2 days before each clinic. Prior to transfer, HIS clerks check patient files to ensure that all outstanding patient documentation was filed.

Most health services reported that medical record transfer and preparation was not as reliable as it could be. Where medical records did not reach the outpatient department, or were incomplete, clinic clerical staff had to source missing medical records on the day of the clinic.

In an effort to improve accountability for the consistency and completeness of documentation before transferring medical records, one hospital rostered clerical staff in HIS the day before the outpatient clinic and then in the outpatient clinic on the following day.

6.3.2 Discharging patients

With high demand for outpatient appointments and specialist's time, it is essential that patients are only brought back for review if it is clinically necessary. Outpatient clinics need to discharge[3] patients that other service providers, such as general practitioners (GPs), can manage as soon as clinically appropriate. Many patients are not discharged when they could be, and while they remain in the system unnecessarily, they utilise appointments they may not need.

The decision on when to discharge patients will always be one for the specialist. However, hospitals can implement strategies to reduce the incidence of patients requiring unnecessary additional appointments. This includes monitoring discharge rates, developing clear statements of criteria for discharge, and making it easy for specialists to prepare discharge documentation.

[3] While patient discharge is normally associated with inpatient services, health services also refer to patient discharge from an outpatient clinic. The point at which an outpatient clinic discharges a patient is when that patient no longer needs to receive specialist medical treatment and/or needs no further review.

We found the approach to discharge from outpatient services was generally less active in outpatient clinics than it typically is in inpatient wards. In the 4 health services that we audited:

- only one monitored discharge rates across all specialties
- there was little action to standardise discharge letters, and it could take up to 6 weeks for patient discharge information to reach GPs.

Only St Vincent's Health had a documented outpatient discharge policy that identified the criteria against which a patient would be deemed ready for discharge. At the same hospital, one specialty had recently implemented a desktop discharge check list for specialists and commenced a shared care model of outpatient management between some specialists and GPs.

6.3.3 Reviewing and evaluating clinic practices

Most health services reported that they were too busy to formally review or evaluate outpatient clinic practices. For the most part, they addressed practices as gaps or problems arose, rather than through a system-wide review of outpatient practices. Practice change tended to be incremental and ad hoc and depending upon the nature of the change, was reliant on specialist support.

St Vincent's Health had received seed funding to conduct a comprehensive review (the Better Clinics project) and commenced implementation of its recommendations. This initiative is described in Figure 6D.

FIGURE 6D: ST VINCENT'S HEALTH: BETTER CLINICS – IMPROVING THE PATIENT JOURNEY

The Better Clinics project was funded through a Clinical Innovation Funding (CliF) grant linked to the 2004-05 Patient Flow Collaborative funding rounds.

St Vincent's Health received approximately $140 000 in project funding for the project entitled "Better Clinics – Improving the patient journey".

St Vincent's Hospital undertook an organisational redesign of its outpatient clinics to:

- improve the effectiveness and efficiency of the service offered to patients
- improve the referral process for general practitioners (GPs) and other referring agencies
- enhance the roles of medical, nursing and clerical staff working within the clinics.

The Better Clinics project was designed as a high involvement project, led and facilitated by a steering committee, design team, drivers group and other committees to "drive" the change. External consultants provided the project methodology and facilitated the deliberations of the design team.

Review and analysis of clinic processes and practices was conducted through interviews with key stakeholders (patients, referring GPs, medical and clinic staff), open forums and a SWOT analysis.

Themes and areas of improvement emerged and were consolidated in the project recommendations. The resulting internal processes were developed to manage clinics and improve overall efficiency through a variety of ways including:

- development of standard paper and electronic referral templates
- involvement of lead nurses in the prioritisation of new patient referrals
- increased utilisation of the Patient Management System to manage clinic capacity, overbooking and urgent referrals
- management of doctor availability
- development of standard "fail-to-attend" protocols
- identifying information required for performance monitoring and how to get it
- involvement of key stakeholders including IT, pathology, radiology, allied health and GP liaison.

Staff engagement was a critical component of the implementation process, which was achieved and strengthened through the establishment and promotion of medical leadership and collaboration between nurses, clerks and medical staff. Key appointments were made, including a Head of Clinic, nursing and clerical team leaders, supported by a clinics business manager with oversight of all clinics. Strategies for developing staff skills and capabilities through training, team and relationship building and collaboration were implemented to support system changes.

Each clinic established a business model identifying its strategic profile, functional management plan and systems to evaluate clinic performance. Specifically, these included:

- clinic aims
- long term vision
- conditions treated (and not treated)
- patient volume and mix
- appointment duration
- time for teaching
- doctor availability (leave planning)
- referral guidelines
- protocols for the prioritisation of referrals
- patient management protocols
- overbooking policy
- management of patients who 'fail-to-attend'
- discharge planning
- GP correspondence protocol
- specific clinic management protocols
- clinic meetings.

Clinics are issued with a monthly report focusing on attendance and referral activity and ancillary services to enable them to monitor performance, identify problem areas and adjust systems accordingly.

The next steps will address development of performance targets, improve resource utilisation, implement further shared care service models, development of clinic specific discharge criteria and promotion of a recently developed GP website.

All health services indicated their desire to participate in collaborative forums to increase their ability to influence change and to learn from other health organisations. Three of the 4 health services had recently been invited to participate in the Expert Working Group for the DHS Patient Collaborative Outpatient Improvement Program.

6.3.4 Conclusion - making best use of available resources

Outpatient clinics generally have satisfactory access to diagnostic tests. However, difficulties in ensuring the availability of results and medical records, combined with a limited focus on improving discharge strategies and reviewing clinic practices means that outpatient clinics may not be making the best use of their available resources.

6.4 Overall conclusion

Managing existing capacity to meet and match demand requires that health services optimise the productive use of their resources. Not all health services are doing this.

Not all clinic schedules fully address factors affecting clinic capacity. This can lead to inefficient operations and cause added delays for patients needing to access specialist medical services.

While all health services used flexible booking practices, if clinics do not manage these practices well there is the potential for operational inefficiencies, greater in-clinic patient waits and underutilised capacity.

Patients who FTA their appointment are a significant issue for all health services. Little work has been done to understand the causes and reduce the rates of patients not attending their appointment. Overbooking to compensate for expected non-attendances does little to address the reasons why patients do not attend their appointment, and can lead to greater in-clinic waits if fewer patients FTA than the health service anticipated. Health services we audited should give greater weight to the costs associated with this patient group, and their impact on clinic and administrative efficiencies.

Clinic cancellations were a regular part of the operation of outpatient clinics. The many operational demands on outpatient specialists mean that this is likely to be the case in the future. However, clear guidance within health services on when and how they should reschedule appointments, and better adherence by staff to leave policies would help to reduce the impact of cancellations on patients and administrative staff.

The availability of diagnostic tests and medical records can also affect outpatient clinic efficiency. While access to diagnostic testing was good, strategies to ensure relevant tests were completed and results were available before the patient's appointment were limited. If results are unavailable at the time of the appointment, it is likely the health service will have to make a new appointment, increasing delays for the patient and adding to administrative burdens.

The majority of health services we audited did not have documented discharge strategies. The lack of guidance may contribute to delayed discharge of some patients if there is uncertainty about when, and under what conditions, a specialist should discharge a patient.

Recommendations

11. **Health services should review their clinic schedules to ensure they:**
    - **reflect specialist attendance time at clinics**
    - **address variation in new and review patient quotas for specialists working in the same specialty**
    - **factor in teaching time**
    - **optimise the sequence of new and review patients.**
12. **Health services and DHS should review FTA patients, including:**
    - **investigating the reasons why patients FTA**
    - **performing a cost analysis of FTA patients**
    - **developing strategies to reduce the rate of FTA patients**
    - **collecting and monitoring FTA data.**
13. **To improve the operations of outpatient clinics, health services should:**
    - **ensure effective discharge strategies are in place in outpatient clinics, and monitor discharge rates**
    - **implement strategies to ensure regular review of outpatient clinic practices**
    - **take steps to ensure that all necessary tests are completed before the patient attends for their appointment**
    - **put systems in place to ensure that medical records are available at the time of the clinic and that all relevant documentation is included**
    - **develop internal guidelines to better manage clinic overbookings.**

RESPONSE provided by Chief Executive Officer, Bendigo Health Care Group

Recommendation 11

Agree.

Recommendation 12

Agree.

Recommendation 13

Agree.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 12

Partially agree.

Rather than manage the issue of "fails-to-attend" centrally, DHS considers it more appropriate and cost-effective for individual hospitals to develop and monitor strategies to reduce "fails-to-attend", tailored to their individual circumstances. DHS is prepared to consider providing guidance to health services on auditing waiting lists.

RESPONSE provided by Chief Executive Officer, Eastern Health

Recommendation 11

Agree.

Recommendation 12

Agree.

Investigating the reasons why patients "fail-to-attend" is very labour intensive and not covered in the VACS model.

Specific enhancement funding is required to develop strategies to reduce the rate of patients "failing-to-attend", given the legacy of IT systems in place.

Recommendation 13

Agree.

There is a need to bolster GP liaison to ensure that all necessary tests are completed before the patients attends for an appointment.

RESPONSE provided by Chief Executive Officer, Northern Health

Recommendation 11

Agree.

Recommendation 12

Agree.

Recommendation 13

Agree.

RESPONSE provided by Chief Executive Officer, St Vincent's Health

Improving access for surgical outpatients cannot be achieved until the surgical waiting list key performance indicators are reviewed. Recommendation 11, referring to the optimisation of "new" and "review" patients, is unrealistic in relation to key performance indicators which require hospitals to meet total waiting list targets. An increase in new outpatients causes an increase in referrals to the elective surgery waiting list (due to the high proportion of new patients requiring surgical intervention), which reduces the ability to meet waiting list targets.

St Vincent's would welcome the opportunity to increase the number of new patients seen within our surgical clinics, however, this would require increased WIES to fund the resulting increase in surgical activity as well as revised key performance indicators which measure the flow of patients through the health service.

Appendix A. About the audit

Audit objectives and scope

This audit assessed whether Victoria's major public health services are providing accessible, responsive and efficient specialist medical care in an outpatient setting, and specifically whether:

- central planning and management of outpatient services was effective
- health service planning and management of outpatient services was effective
- health services managed outpatient appointments effectively
- health services optimised the productive use of outpatient resources.

Audit approach

We conducted fieldwork in 4 health services (3 metropolitan health services and one large regional health service) to gather information relating to the audit objectives. We also conducted limited fieldwork in 19 public health services to gather key access data for the high-volume outpatient clinics.

Major metropolitan and regional health services were the focus of the audit, as they are the setting for the majority of specialist medical outpatient activity.

The audit also examined service planning in the Department of Human Services (DHS) for the provision of outpatient services.

The audit was performed in accordance with the Australian auditing standards applicable to performance audits and, accordingly, included such tests and procedures considered necessary.

Survey method

We surveyed metropolitan and regional health services on the date of the next available appointment for new "urgent", "semi-urgent" and "non-urgent" referrals for 6 medical specialties. We limited the survey to those hospitals that DHS classifies as A and B[1]. Where a health service had a number of hospital campuses, we asked them to respond for each A and B hospital campus providing outpatient services.

[1] A definition is contained in the glossary under 'National peer-group'.

The survey consisted of 12 questions that were applied to 6 outpatient specialties (orthopaedics; urology; general medicine; ear, nose and throat; ophthalmology; and oncology).

We tested a pilot survey on the 4 health services that we examined in detail. Most hospitals provided clarification or qualifications with their survey response. Where relevant, these are included as interpretive notes with the data. Where a response was unclear or incomplete, we contacted the respondent listed on the survey response for more information. We also visited a sample (18) of the hospitals to confirm the validity of the responses.

After we collated the survey results, we provided health service CEOs with data on their hospital's reported level of performance, the median response of surveyed hospitals and the range of responses. We asked them to confirm the data, and offered the chance repeat the snapshot if they felt that particular aspects had changed since the original survey.

We sent surveys to health services on 15 December 2005 and asked that they return them 13 January 2006. This coincides with the period that specialists and nursing staff traditionally take leave and clinics either slow down or close.

To ensure that waiting times were not artificially increased because of the timing of the survey, we asked if the specialty would be closed during the holiday period and, if so, for how long. This period was subtracted off the difference between the reporting date and the appointment date.

Why we chose this method

Our method was based on the "third next available appointment" approach, which Canada[2], the United Kingdom and the United States use widely to measure access to primary care and specialist care.

In this approach, appointment clerks report on the date of the "third next available appointment" for new patients. The "third next" appointment is generally selected rather than the "next" appointment, because the hospital can usually accommodate one or 2 urgent bookings as an overbooking, or through casual vacancies caused by cancellations.

We did not use the terminology "third next available appointment" as we wanted to keep our survey clear and simple for the staff completing it. Instead, we asked hospitals to report when the next available appointment was, without including overbookings.

---

[2] Fraser Institute 2005, *Waiting your turn: hospital waiting lists in Canada* 15th Edition.

Acknowledgment

Specialist assistance and advice to the audit team was provided by:

- Professor Judith Dwyer, Director, Health Service Management Development Unit, Flinders University
- Dr Cam Bennett, Chair of the Division of Medicine at Royal Brisbane Hospital and Senior Lecturer in Medicine at the University of Queensland
- Dr Cathy Balding, independent consultant with specialist knowledge in the hospital and DHS environments.

The Victorian Government Solicitor's Office also provided legal advice to the audit team.

We appreciate the support and assistance of management and staff at the agencies and departments listed below.

Public sector organisations participating in the audit

Audited agencies

Bendigo Health
Eastern Health
Northern Health
St Vincent's Health
Department of Human Services

Surveyed agencies

Austin Health (Austin Hospital)
Ballarat Health (Ballarat Hospital)
Barwon Health (Geelong Hospital)
Bayside Health (Alfred Hospital)
Bendigo Health (Bendigo Hospital)
Eastern Health (Box Hill Hospital and Maroondah Hospital)
Goulburn Valley Health (Shepparton Hospital)
Latrobe Regional Hospital
Melbourne Health (Royal Melbourne Hospital)
Mercy Health[3] (Mercy Women's Hospital and Mercy Werribee Hospital)

[3] Mercy Health is not a defined public health service under the *Health Services Act 1988*.

Northern Health (Northern Hospital)
Peninsula Health (Frankston Hospital)
Peter MacCallum Cancer Centre
Southern Health (Monash Medical Centre, Dandenong and Casey Hospitals)
St Vincent's Health[4] (St Vincent's Hospital)
The Royal Children's Hospital
The Royal Victorian Eye and Ear Hospital
The Royal Women's Hospital
Western Health (Western Hospital and Sunshine Hospital)

Organisations consulted

Victorian Healthcare Association
Health Services Commissioner
Health Issues Centre
General Practice Divisions (Victoria)
Royal Australasian College of Physicians
Council of the Ageing
Faculty of Health Sciences, La Trobe University

Cost of the audit

The cost of this audit was $510 000. This cost includes staff time, overheads, expert advice and printing.

[4] St Vincent's Health is not a defined public health service under the *Health Services Act 1988*.

Appendix B. Risks of non-compliance with the Australian Health Care Agreement

FIGURE B1: KEY OBLIGATIONS OF THE AUSTRALIAN HEALTH CARE AGREEMENT – RISKS OF NON-COMPLIANCE

AHCA clause	DHS advice in hospital circulars	Risks for hospitals of non-compliance with AHCA
6 Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals.	No advice.	When health services arbitrarily direct a patient to a private specialist, they are not giving that patient the choice to receive health services free of charge, as public patients. Where a valid election does not occur, the status of the patient defaults to public.
7 In applying the principles at clause 6, the Commonwealth and Victoria agree that: (b)[1] All public hospital services available to private patients should be accessible on a public patient basis, where there is a demonstrated clinical need.	Commonwealth Government officials have verbally advised that the intention is to ensure that public patients can access the same services as private patients in public hospitals. This applies to both admitted and non-admitted services and refers to clinical services. Hence, public hospitals are not allowed to only offer certain clinical services to private patients.	If the only specialist clinic the health service operates is a private clinic and patients are either turned away until they have a valid Medicare card, or are required to pay an up-front fee, this puts that health service at risk of breaching clause 7 by not providing the service to the patient in a public capacity.
41 An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless: (a) There is a third party arrangement with the hospital or Victoria to pay for such services, or (b) The patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.	Outside of (third party arrangements), patients presenting at public hospital outpatient departments must be treated free of charge. The term "free of charge" in clause 41 and throughout the agreement means that public hospitals cannot charge the patient directly, nor can they bill against the MBS irrespective of whether there is no cost to the patient.	As most of the private clinics operated by the health services we visited had their private clinics located in the outpatient department, there is an expectation that the patient will be treated as a public patient. The exception offered by clause 41 is where the patient is referred to a named specialist and chooses to be treated as a private patient. Irrespective of whether patients are actually referred to a named specialist, given the absence of patient election at outpatient departments in the 4 health services we visited, there is a risk health services and specialists are inappropriately billing consultations to the MBS for services provided to public patients, and therefore breaching clause 41.

[1] Clause 7(a) and 7(c) have been omitted because they were not directly relevant.

FIGURE B1: KEY OBLIGATIONS OF THE AUSTRALIAN HEALTH CARE AGREEMENT – RISKS OF NON-COMPLIANCE - continued

AHCA clause		DHS advice in hospital circulars	Risks for hospitals of non-compliance with AHCA
42	Where a patient chooses to be treated as a public patient, services that are a component of the episode of care (such as pathology and diagnostic imaging) will be regarded as part of the patient episode of care and will be provided free of charge as public hospital services.	Commonwealth Government officials have advised that clause 42 is intended to apply to non-admitted services, although this is not stated in the agreement. The intention of clause 42 is to prohibit the raising of any charges to the patient, or billing against the MBS for associated services such as pathology and radiology.	Patients failing to elect to be treated as private patients default to a public patient status. If patients attending a private clinic have not elected to be private patients, then any of the ancillary services the specialist bills to the MBS as part of the consultation (such as pathology and radiology) are at risk of breaching clause 42, as the cost of these services should be met by the health service.
43	Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms.	The intention behind this clause is that pre-admission and post-discharge care should be provided free of charge with no billing against the MBS for patients who have elected to be public patients.	Many of the private clinics we identified on our visits see both new and review patients. If the patient was an admitted public patient but was reviewed by a specialist in a private clinic following discharge from the hospital, then raising a charge against the MBS for this type of consultation is likely to breach clause 43, as the costs should be met by the health service.
44	Victoria acknowledges that in considering compliance with the principles in clause 6, the Commonwealth will take account of the following: (a) Services provided to public patients which generate charges against the Commonwealth MBS are in breach of this agreement.	Clause 44 largely restates principles that are implicit in other section of the agreement relating to the prohibition on billing against the MBS for services provided to public patients, and the broad principle that patients must retain the right to access public hospital services as public patients.	Where the patient has not elected to be a private patient and their consultation is billed against the MBS, then specialists and health services are likely to breach this broad clause of the AHCA.

Source: Victorian Auditor-General's Office.

Appendix C. Outpatient survey data

Gathering the data

We asked outpatient departments to advise us, *on the day they completed the survey*, when the next appointment for a new patient referred to see a specialist would be available. Because outpatient clinics generally prioritise new patients based on advice from the referring general practitioner (GP) about patient urgency, we asked them to tell us, for each speciality, when the next appointment would be for patients who were assessed as "urgent", "semi-urgent" or "non-urgent".

We asked this question for 6 of the highest demand medical specialties: general medicine; orthopaedics; urology; ear nose and throat; ophthalmology; and oncology.

A list of the hospitals we surveyed is contained in Appendix A of this report.

Understanding the data

Gathering information on how many people are waiting for an appointment and estimating how long they will wait to see a specialist is complex and imprecise. In Part 5 of this report, we outline some of the operational reasons why it can be difficult for health services to predict waiting times with precision. Some of the factors that the reader should take into account when interpreting the data in this appendix are outlined below:

- ***Consistency of responses across hospitals may vary.*** As this is the first time a survey of this nature has been conducted, the comparability of data associated with new patients should be qualified for potential interpretational differences. While we endeavoured to clarify differences, care should be taken in comparing hospital performance because of varying practices across hospitals.
- ***Projected times are based on performance at the time of the survey.*** If a hospital changes the number of clinics they run, or the number of new patients they see in each clinic, then the projected waiting time will change. If the outpatient clinic sees more patients, then the waiting time may reduce; if they see less, then it may increase.

- ***The information reported only relates to* new *patients.*** The information in the charts is about patients who have been referred to an outpatient clinic to see a medical specialist, but have not yet had their first appointment. Many patients in outpatient clinics are there for a review or follow-up visit. Health services schedule these review and follow-up patients for an appointment at the clinically appropriate time, and are not included in this data.
- ***Hospitals and specialties have different ratings of urgency.*** The number of outpatient urgency categories hospitals use varies. Hospitals typically used between one and 3 urgency categories, but in at least one case they had 9 categories[1]. Most of the larger hospitals with higher patient throughput had 3 urgency categories for their outpatient clinics. Smaller hospitals and clinics with lower patient volumes often had one or 2 urgency categories.
- ***Some urgent patients may be seen as an overbooking.*** We asked hospitals to report on the next available appointment for each triage category. All hospitals indicated that they manage their patient appointments to ensure that the most urgent patients are seen as soon as possible. This is frequently done by including urgent patients in clinics, as an "overbooking" without taking into account appointments.
- ***Grouping data into specialties can mask wide variation within that specialty.*** Most hospitals run a number of clinics in each specialty area, and each broad specialty can include sub-specialties. For example, orthopaedics generally run fracture clinics and procedural clinics, and in large hospitals these may be further categorised, as each specialist runs clinics relevant to their particular area of expertise (for example, upper limbs, lower limbs, shoulders, hips or back). Demand for these clinics, and waiting time to the next appointment, can vary considerably.

  Where there were multiple clinics within a specialty, we asked outpatient managers to report the best-case appointment date. In at least one case, the hospital reported an average time for all clinics. This information is noted beneath each chart.
- ***This data includes DHS-funded clinics and MBS-billed clinics run under private practice or licence arrangements.*** All of the clinics reported in this survey are located in public hospital outpatient departments. Hospital staff manage all bookings for all clinics.

---

[1] For example, Goulburn Health advised that it uses a 1 to 9 grading purely because in the past its visiting medical officers felt that they needed to grade patients within each category so as to prioritise them further. They advised that in practice, 1 to 3 are "urgent", 4 to 6 are "semi-urgent" and 7 to 9 "non urgent".

Validating and adjusting the data

We visited 18 hospitals (72 per cent of the survey sample) to confirm the validity of survey responses. We asked the hospitals to provide waiting time data for selected specialties on the date we visited to validate the reasonableness of the data. This provided us with an indication of whether the data reported in December 2005 was broadly consistent with the new data, taking into account possible differences due to clinic closures over the Christmas holiday period.

Where validation responses indicated waiting times greater than the initial survey, we have reported the lower survey results. Where the validation responses were significantly less than the survey results, we have reported the lower validation results.

The issues identified in this appendix mean that the following data needs to be considered carefully. However, as there is currently little publicly available data on overall performance in Victoria's outpatient clinics, we believe it is important to report the information we gathered from hospitals. Taking into account the qualifications we have noted above, it provides a snapshot of data at a point in time.

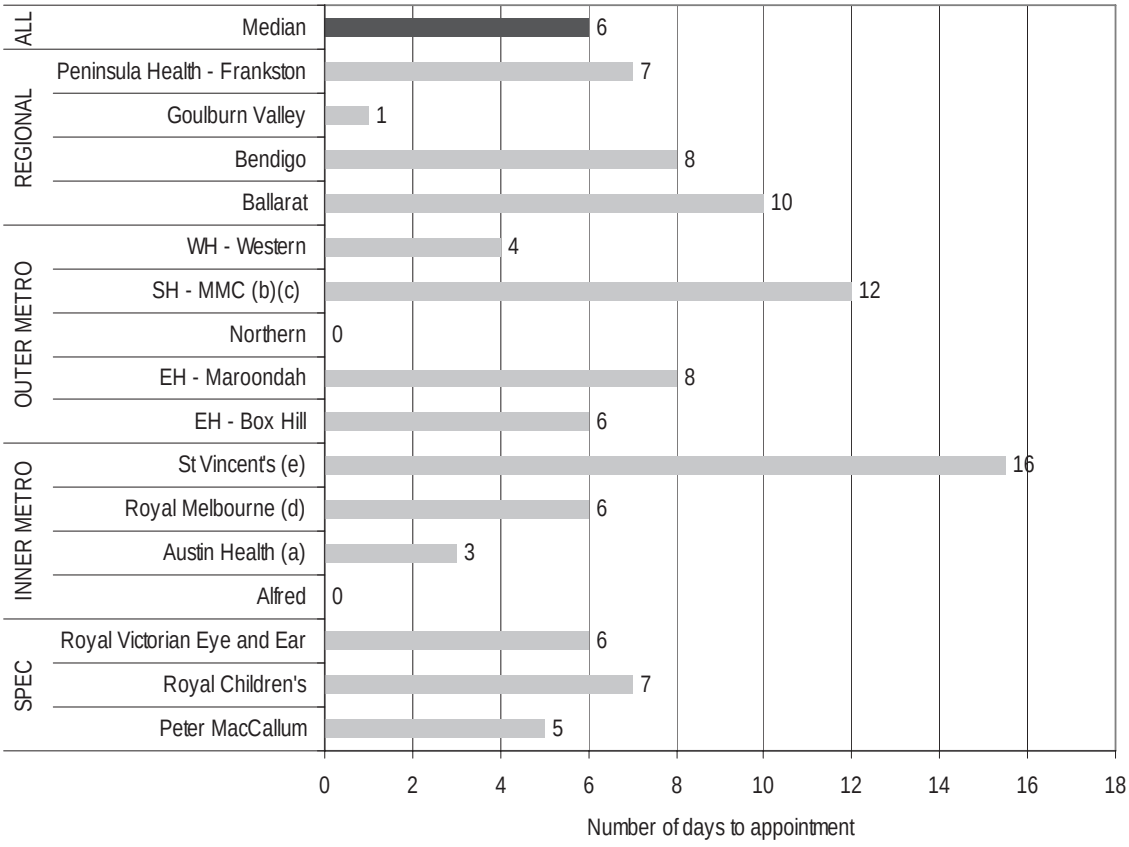
Next appointment by specialty

General medicine

Patients may be referred to a general medicine specialist in outpatient clinics for conditions such as complex hypertension, cardiovascular risk factors, angina, respiratory disorders, chronic pain, obesity, gastrointestinal and post-natal complications. Comparability of waiting times and activity for general medicine across hospitals is difficult because different hospitals categorise a varying range of sub-specialties under the general medicine clinic label.

At least one hospital advised that general medicine specialist consultations are often lengthy, taking up to one hour in contrast to surgical consultations which typically take only 15 minutes. This can contribute to a build-up in wait times for general medical consultations.

FIGURE C1: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE GENERAL MEDICINE APPOINTMENT FOR NEW PATIENTS WHO ARE *"URGENT"*?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) Austin Hospital advised that general medicine data does not include hypertension or pain clinics.

(b) Monash Medical Centre advised that it can accommodate urgent appointments at any time, as the centre tends to reschedule non-urgent patients.

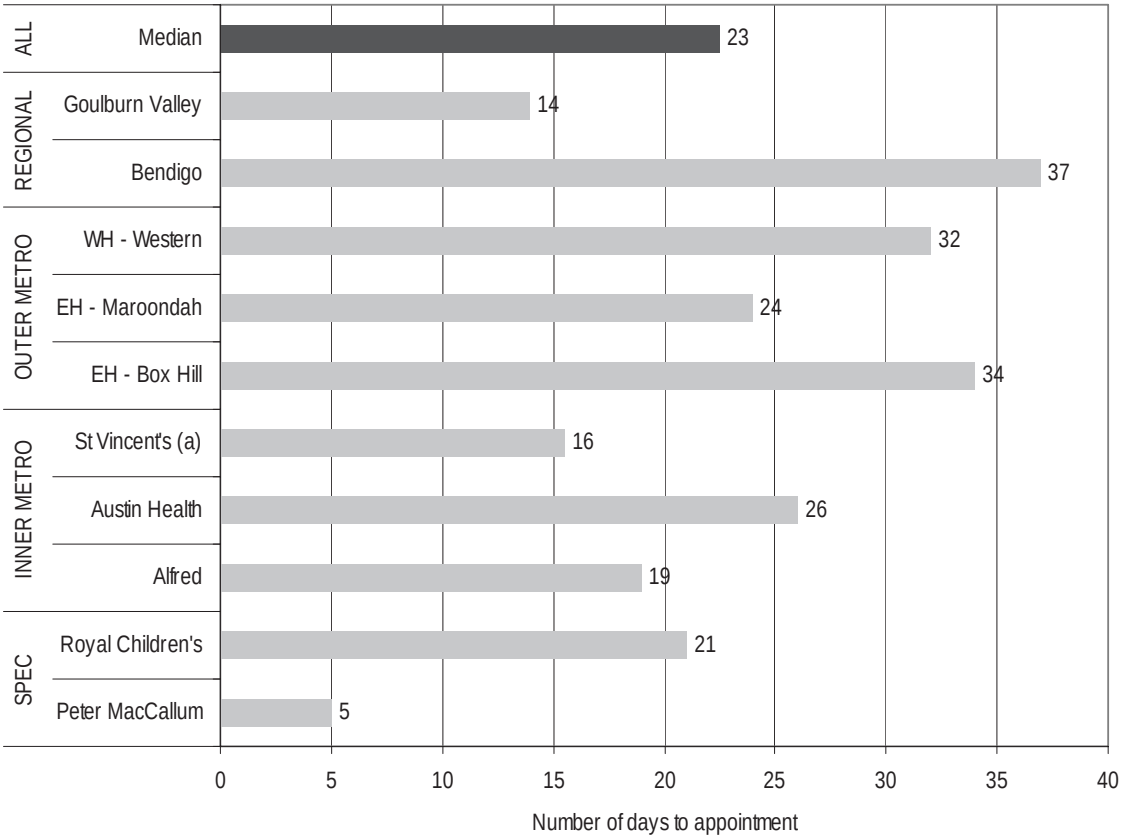
(c) We asked for data from Casey Hospital, which is part of Southern Health. Of the 6 specialties we surveyed, Casey Hospital provided 2. For these 2 specialties, appointments were review patients, which the survey did not request.

(d) General medicine is general medicine only, and does not include any specialty medicine (e.g. gastroenterology).

(e) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

Source: Victorian Auditor-General's Office.

FIGURE C2: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE GENERAL MEDICINE APPOINTMENT FOR NEW PATIENTS WHO ARE "*SEMI-URGENT*"?

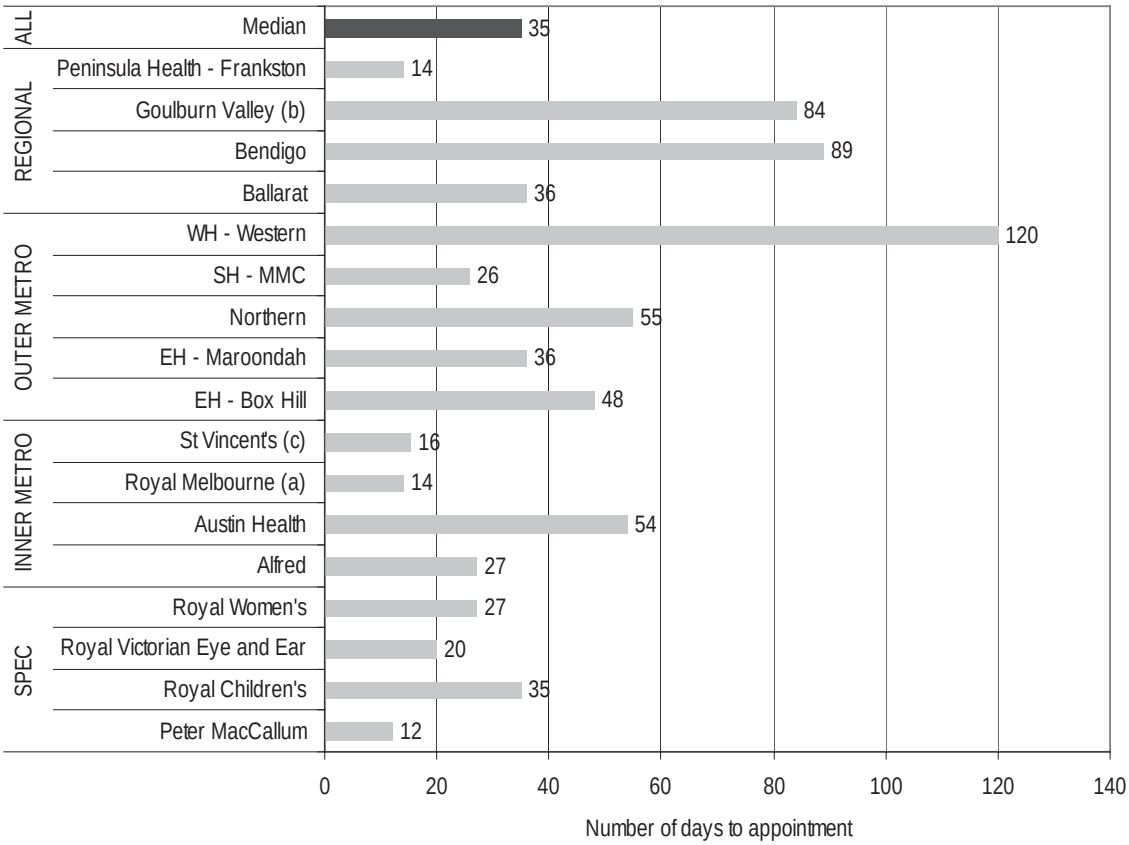


Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

Source: Victorian Auditor-General's Office.

FIGURE C3: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE GENERAL MEDICINE APPOINTMENT FOR NEW PATIENTS WHO ARE "*NON-URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) General medicine is general medicine only, and does not include any specialty medicine (e.g. gastroenterology).

(b) The time to "next available" appointments was prolonged due to planned leave by medical staff at the time of the survey. Waiting times for a "next available" appointment for all specialties are now much less.

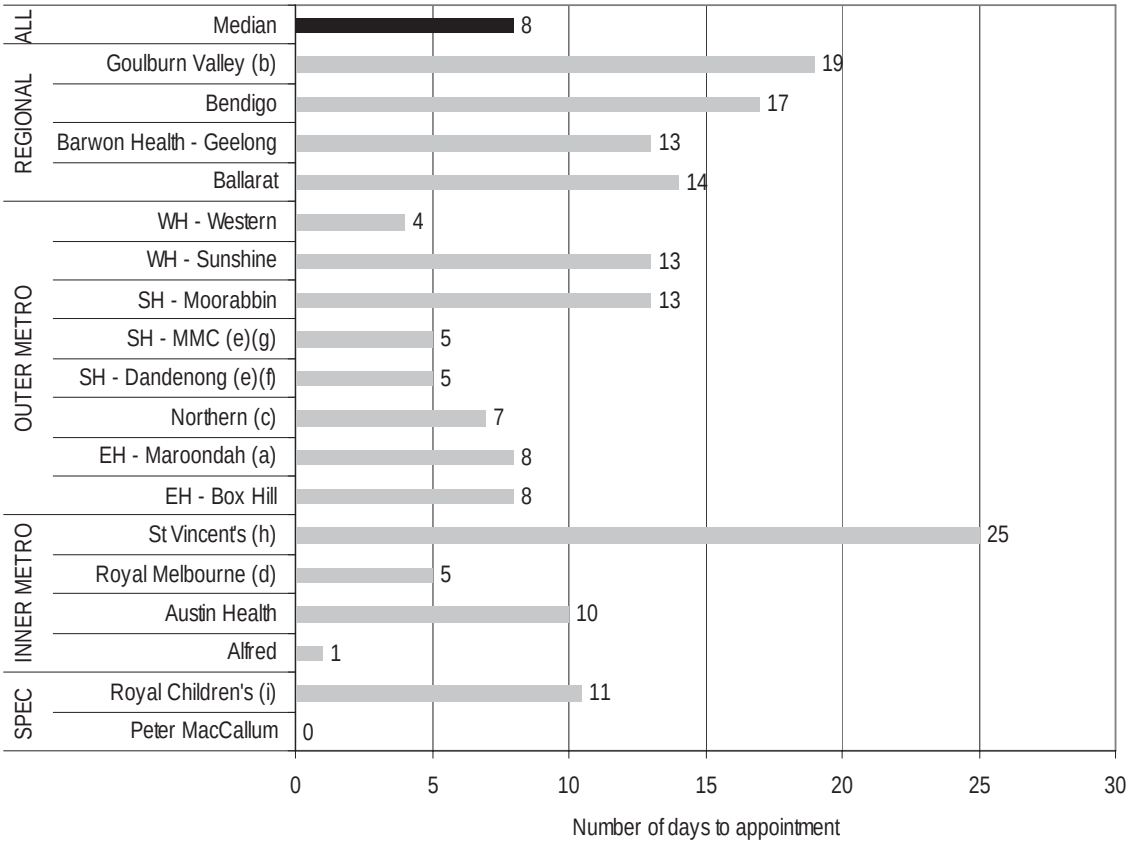
(c) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

Source: Victorian Auditor-General's Office.

Orthopaedics

Patients are referred to an orthopaedic clinic for conditions such as fractures, soft tissue injuries, gait disorders, limb deficiency, scoliosis, cerebral palsy, complex knee disabilities, arthritis, orthopaedic disabilities, reconstructive surgery of joints, joint replacements and chronic spinal conditions.

FIGURE C4: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE ORTHOPAEDICS APPOINTMENT FOR NEW PATIENTS WHO ARE "*URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) Maroondah Hospital advised that urgent appointments for orthopaedic clinics are always over-bookings. Normally the wait is 7 -10 days.

(b) Goulburn Valley Health advised that a GPs referral letter may cause the health service to modify urgent and non-urgent appointment times. For example, a GP referral for non-specific back pain, with no alteration in response to mobility, or neurological changes is more likely to result in the health service referring the patient to the fast-track system of physiotherapy assessment and treatment before any referral to the orthopaedic surgeons.

(c) Northern Hospital advised that patients for the orthopaedic specialties are seen the same day, while fracture and plaster clinics will see patients within one week.

(d) Royal Melbourne Hospital advised that 7 different orthopaedic specialists look after particular specialisations. All have different appointment slots to book into. Data reported is according to the best first available slot.

(e) Dandenong Hospital and Monash Medical Centre advised that it accommodates urgent appointments at any time because both hospitals reschedule non-urgent patients.

(f) Dandenong Hospital advised that they do not include fractures for waiting times.

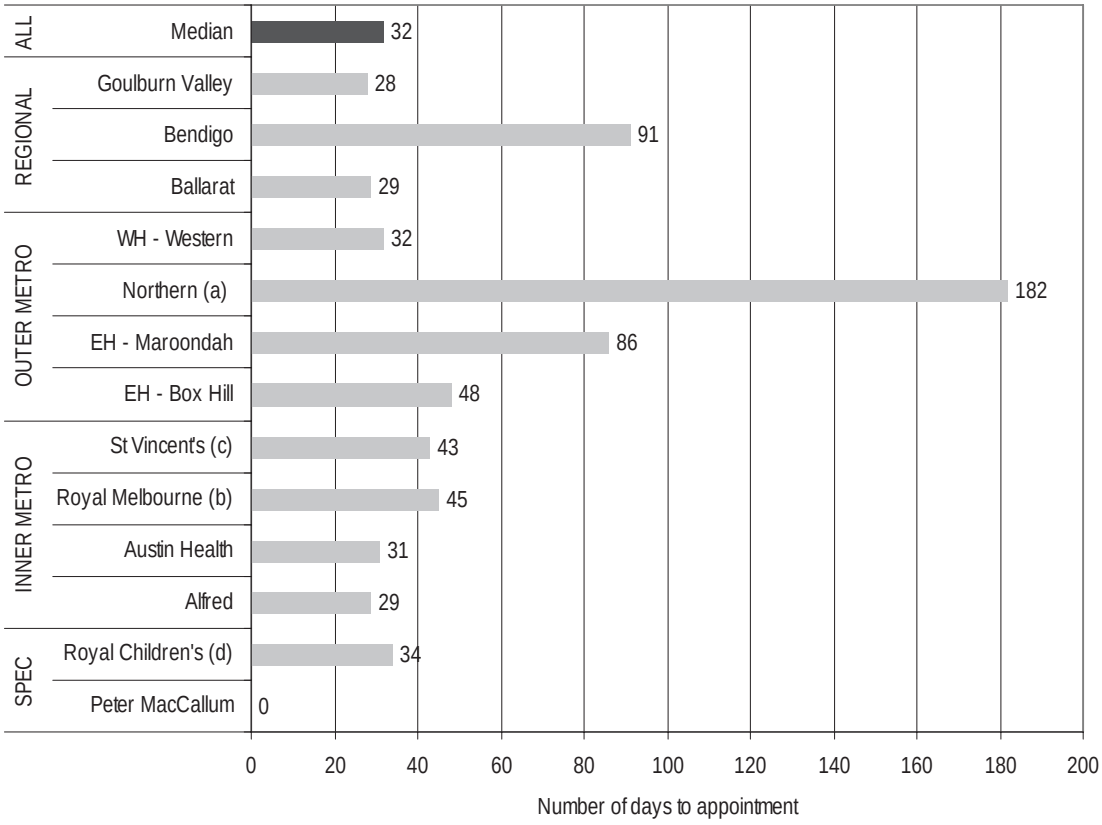
(g) Monash Medical Centre advised that it provides fracture and consultation services in one clinic. Several orthopaedic clinics are run in specialties, such as upper limb, lower limb, shoulder, hip, back etc. An average time is given.

(h) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

(i) Waiting times were provided in a range. We took the mid-point of that range.

Source: Victorian Auditor-General's Office.

FIGURE C5: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE ORTHOPAEDICS APPOINTMENT FOR NEW PATIENTS WHO ARE "*SEMI-URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) Northern Hospital advised that patients attend the orthopaedic specialty clinics within 6 months, while they will attend fracture and plaster clinics within 2 weeks.

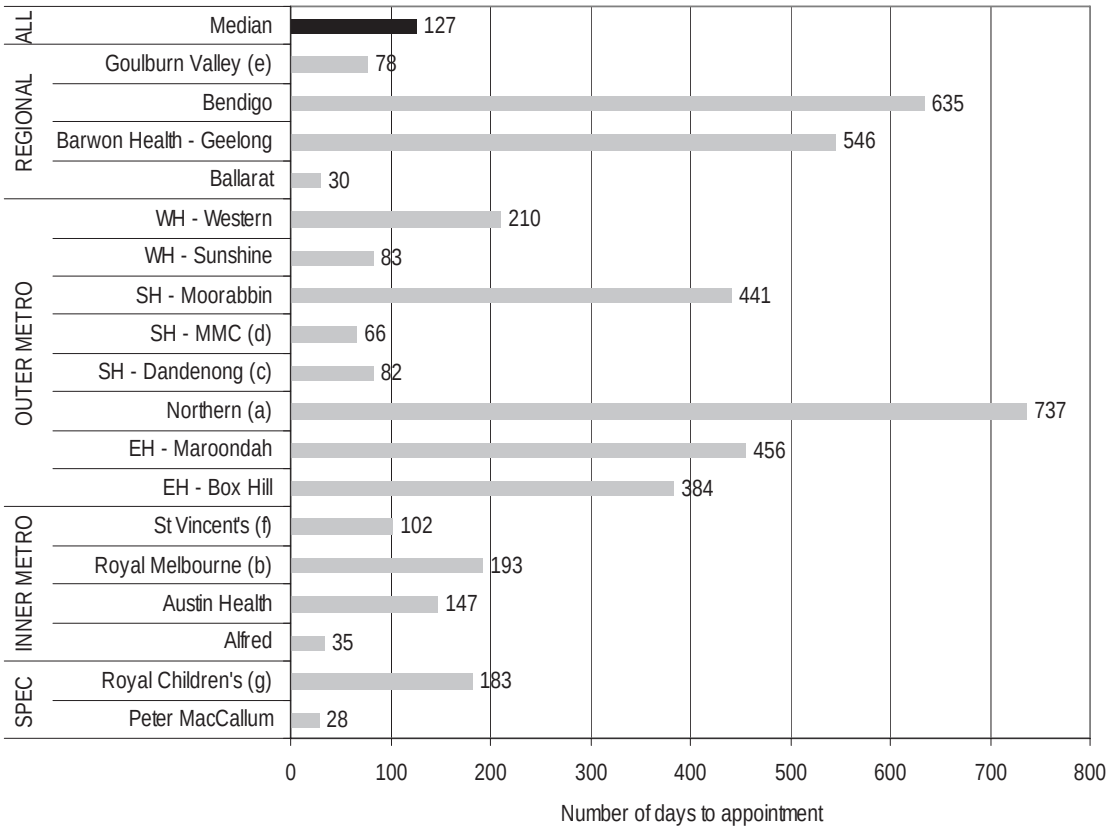
(b) Royal Melbourne Hospital advised that 7 different orthopaedic specialists look after particular specialisations. All have different appointment slots to book into. Data reported is according to the best first available slot.

(c) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

(d) Waiting times were provided in a range. We took the mid-point of that range.

Source: Victorian Auditor-General's Office.

FIGURE C6: INDICATIVE NUMBER OF DAYS TO THE NEXT ORTHOPAEDICS APPOINTMENT FOR NEW PATIENTS WHO ARE "*NON-URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

Note: Where health services have reported only waiting times for orthopaedic fracture clinics, the waiting time is likely to be shorter than for non-fracture clinics.

(a) Northern Hospital advised that its fracture and plaster clinics will see patients within 3 weeks.

(b) Royal Melbourne Hospital advised that 7 different orthopaedic specialists look after particular specialisations. All have different appointment slots to book into. Data reported is according to the best first available slot.

(c) Dandenong Hospital advised that its orthopaedic data does not include waiting times for fractures.

(d) Monash Medical Centre advised that they provide fracture and consultation services in one clinic. Several orthopaedic clinics are run in specialties, such as upper limb, lower limb, shoulder, hip, back etc. An average time is given.

(e) The time to "next available" appointments was prolonged due to planned leave by medical staff at the time of the survey. Waiting times for a "next available" appointment for all specialties are now much less.

(f) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

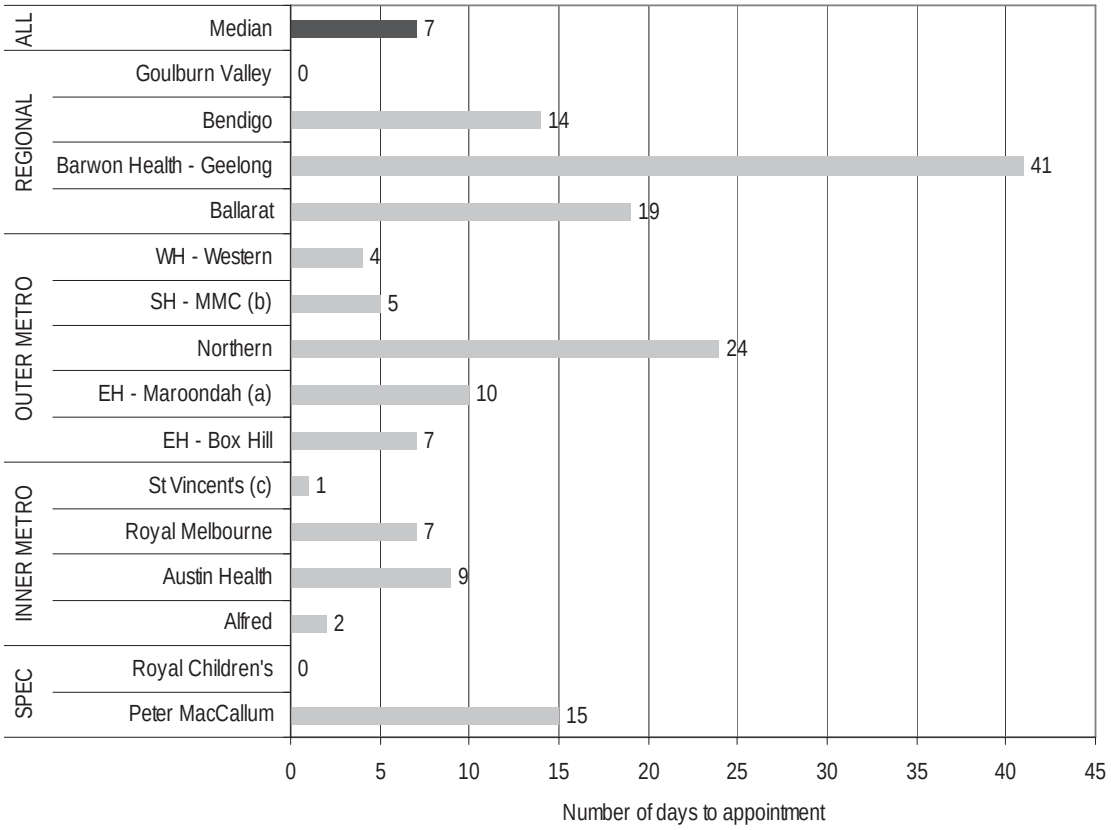
(g) Waiting times were provided in a range. We took the mid-point of that range.

Source: Victorian Auditor-General's Office.

Urology

Patients are referred to a urologist for a variety of problems such as urinary or faecal incontinence, prostatic cancer, stones and bladder disorders, urinary problems and gynaecological problems.

FIGURE C7: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE UROLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE "*URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

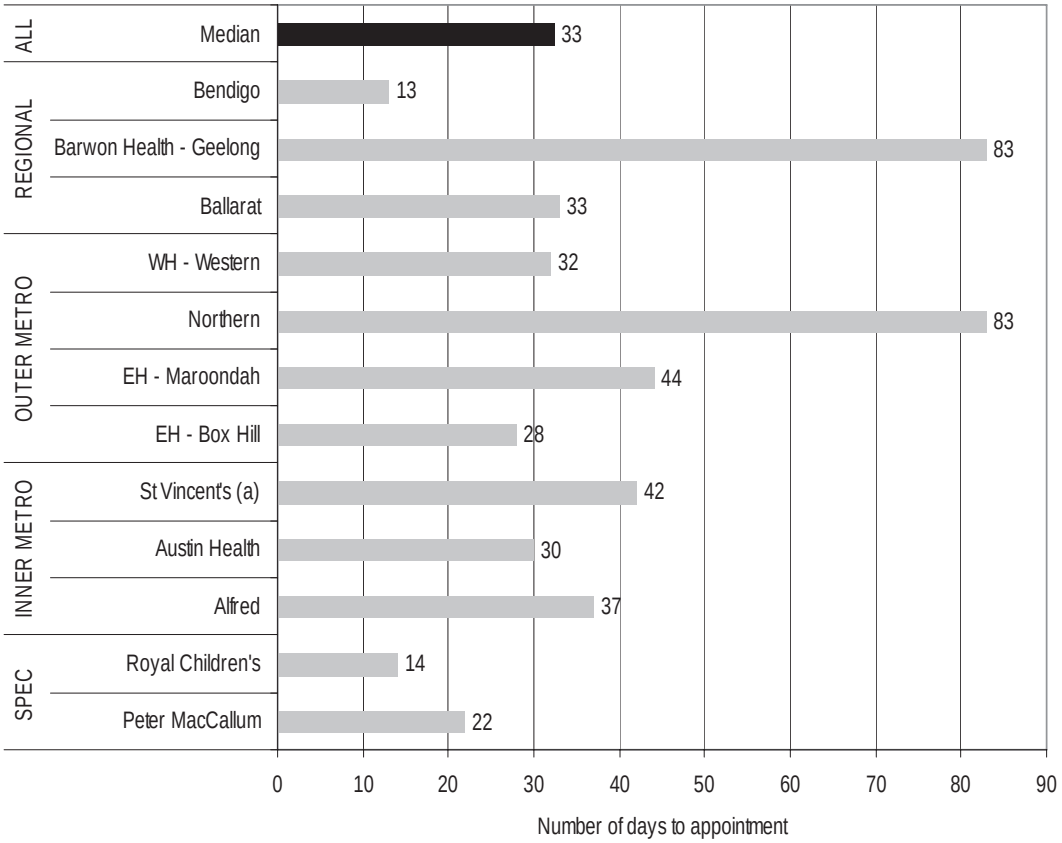
(a) Maroondah Hospital advised that urgent appointments for urology are always over-bookings. Normally, the wait would be 7 -10 days.

(b) Monash Medical Centre advised that it can accommodate urgent appointments at any time, as the centre tends to reschedule non-urgent patients.

(c) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

Source: Victorian Auditor-General's Office.

FIGURE C8: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE UROLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE *"SEMI-URGENT"*?

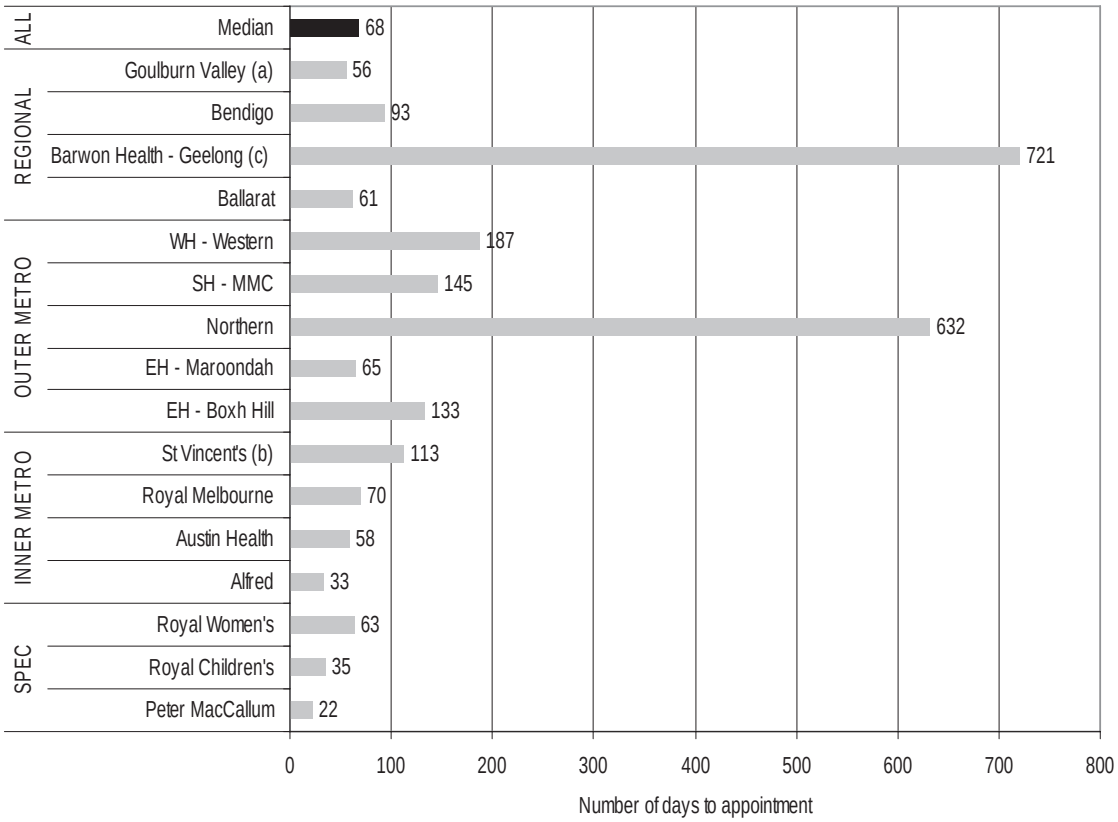


Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

Source: Victorian Auditor-General's Office.

FIGURE C9: INDICATIVE NUMBER OF DAYS TO THE NEXT UROLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE *"NON-URGENT"*?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) The time to "next available" appointments was prolonged due to planned leave by medical staff at the time of the survey. Waiting times for a "next available" appointment for all specialties are now much less.

(b) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

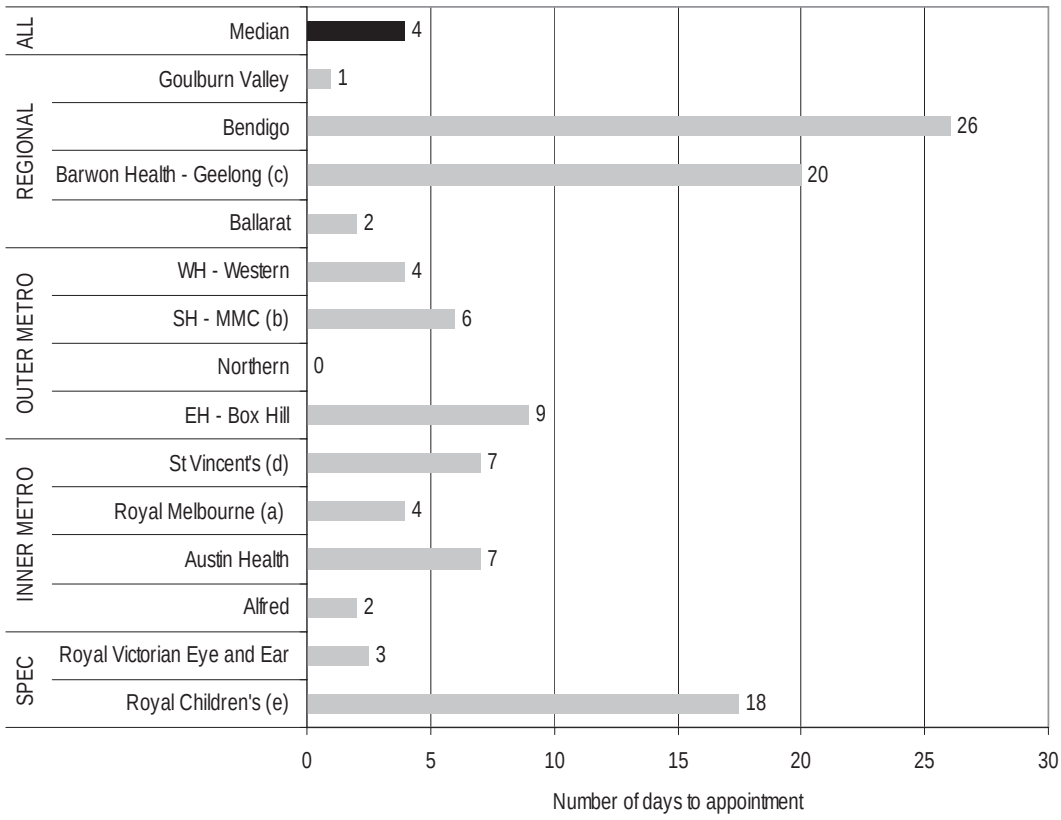
(c) Barwon Health advise that restraints in current capacity mean that waiting times for a new non-urgent appointment (currently in excess of 2 years) are continually increasing.

Source: Victorian Auditor-General's Office.

Ear, nose and throat

Ear nose and throat specialists treat conditions including voice disorders, disorders of speech (i.e. spastic dysphonia), hearing loss due to medical conditions and epistaxis.

FIGURE C10: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE EAR, NOSE AND THROAT APPOINTMENT FOR NEW PATIENTS WHO ARE "*URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) Royal Melbourne Hospital advised that data covers the 3 major clinics: Head and Neck, Nasal and Sinus & Otology. In addition to the 3 main clinics, there are 4 ENT sub speciality clinics that they have not included, as there are no waiting times and the volumes are low.

(b) Monash Medical Centre advised that it can accommodate urgent appointments at any time, as the centre tends to reschedule non-urgent patients.

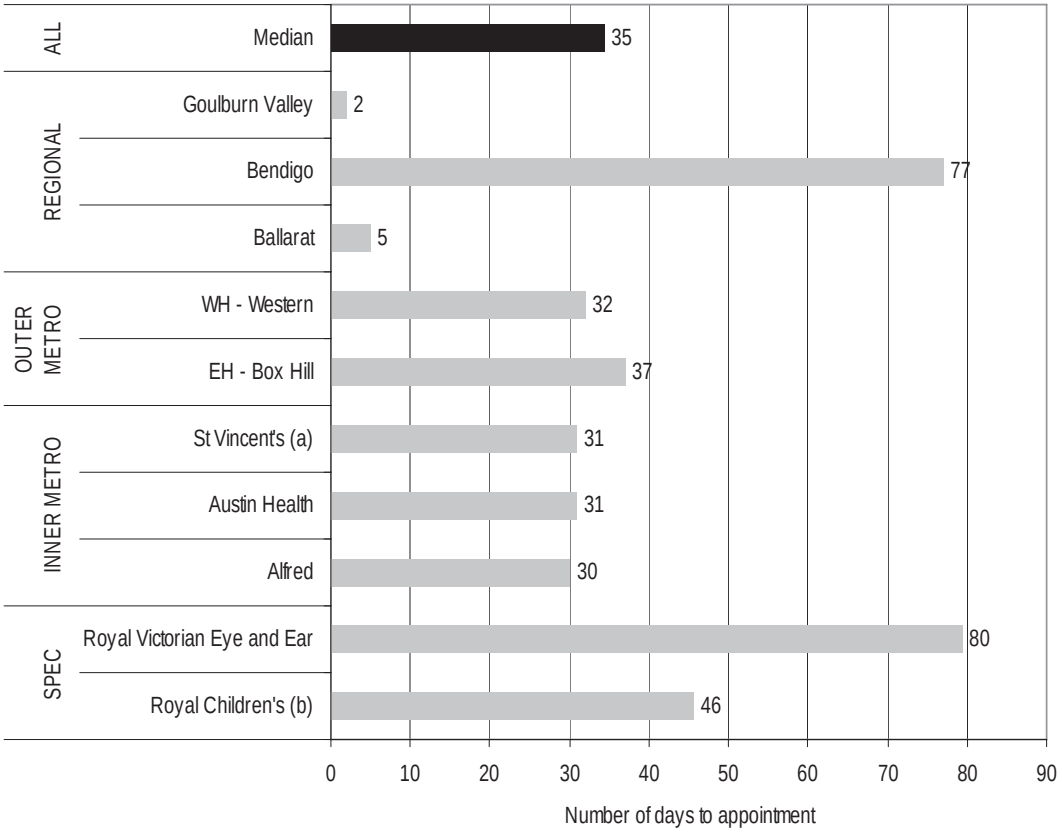
(c) For ear, nose and throat services, Barwon Health has 2 urgency categories: "urgent" and "semi-urgent". These categories are used for administrative purposes. In practice, Barwon Health uses "urgent" and "next available". Following discussions with Barwon Health, data presented here for ear, nose and throat has been categorised as "urgent" and "next available" to reflect actual practice.

(d) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

(e) Waiting times were provided in a range. We took the mid-point of that range.

Source: Victorian Auditor-General's Office.

FIGURE C11: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE EAR, NOSE AND THROAT APPOINTMENT FOR NEW PATIENTS WHO ARE "*SEMI-URGENT*"?



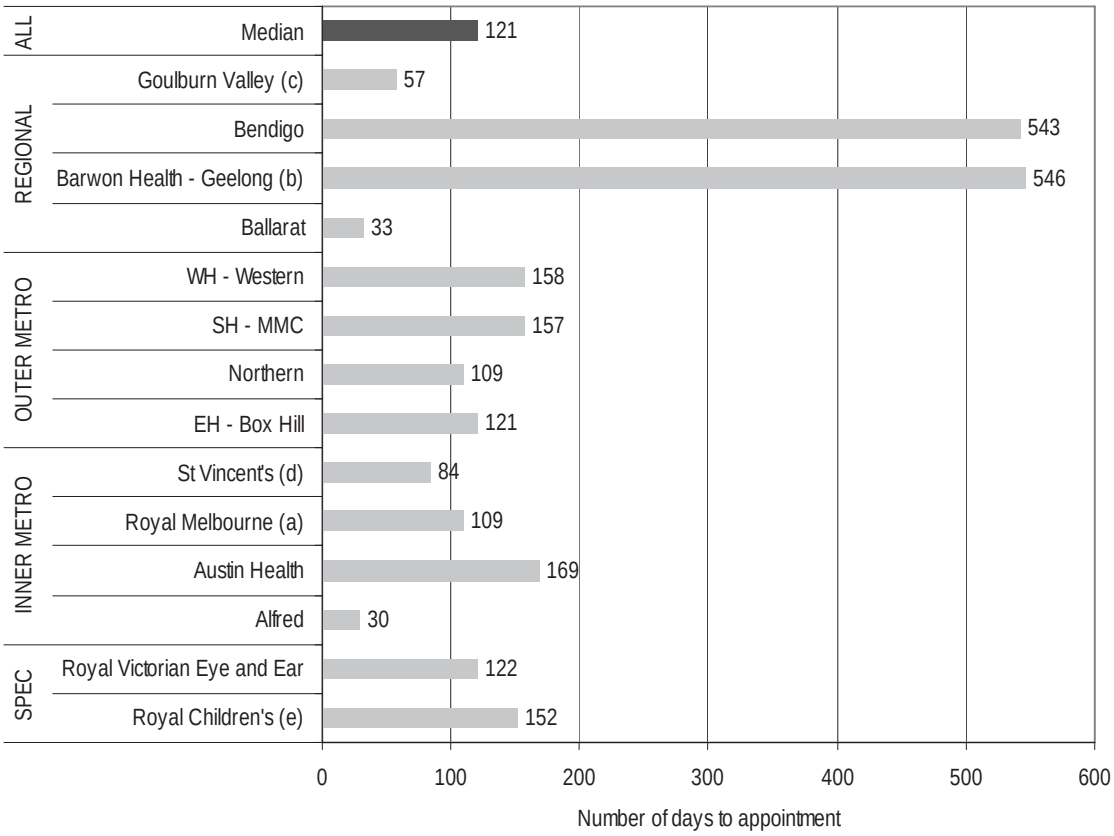
Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

(b) Waiting times were provided in a range. We took the mid-point of that range.

Source: Victorian Auditor-General's Office.

FIGURE C12: INDICATIVE NUMBER OF DAYS TO THE NEXT EAR, NOSE AND THROAT APPOINTMENT FOR NEW PATIENTS WHO ARE "*NON-URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) Royal Melbourne Hospital advised that data covers the 3 major clinics: Head and Neck, Nasal and Sinus & Otology. In addition to the 3 main clinics, there are 4 ENT sub speciality clinics that they have not included, as there are no waiting times and the volumes are low.

(b) For ear, nose and throat services, Barwon Health has 2 urgency categories: "urgent" and "semi-urgent". These categories are used for administrative purposes. In practice, Barwon Health uses "urgent" and "next available". Following discussions with Barwon Health, data presented here for ear, nose and throat has been categorised as "urgent" and "next available" to reflect actual practice.

(c) The time to "next available" appointments was prolonged due to planned leave by medical staff at the time of the survey. Waiting times for a "next available" appointment for all specialties are now much less.

(d) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

(e) Waiting times were provided in a range. We took the mid-point of that range.

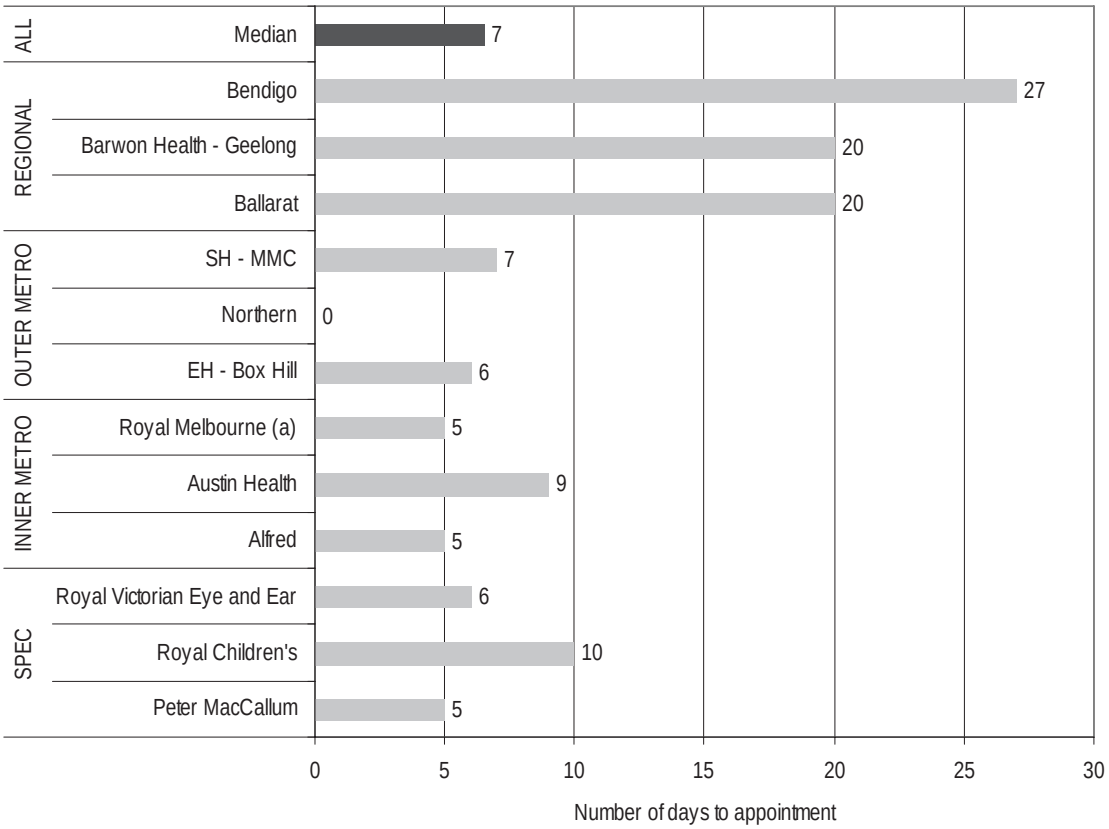
Source: Victorian Auditor-General's Office.

Ophthalmology

Patients are referred to an ophthalmologist for conditions including inflammatory disease of the eye, disease of eyelids and tear system, glaucoma, corneal grafting, retinal detachment, squint, pterygia, errors of refraction, cataracts, post-operative wound management, HIV-related problems, lid disorders, stroke and neurological conditions resulting in vision impairment.

Ophthalmology had the lowest number of hospitals reporting an outpatient service at their hospital.

FIGURE C13: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE OPHTHALMOLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE "*URGENT*"?

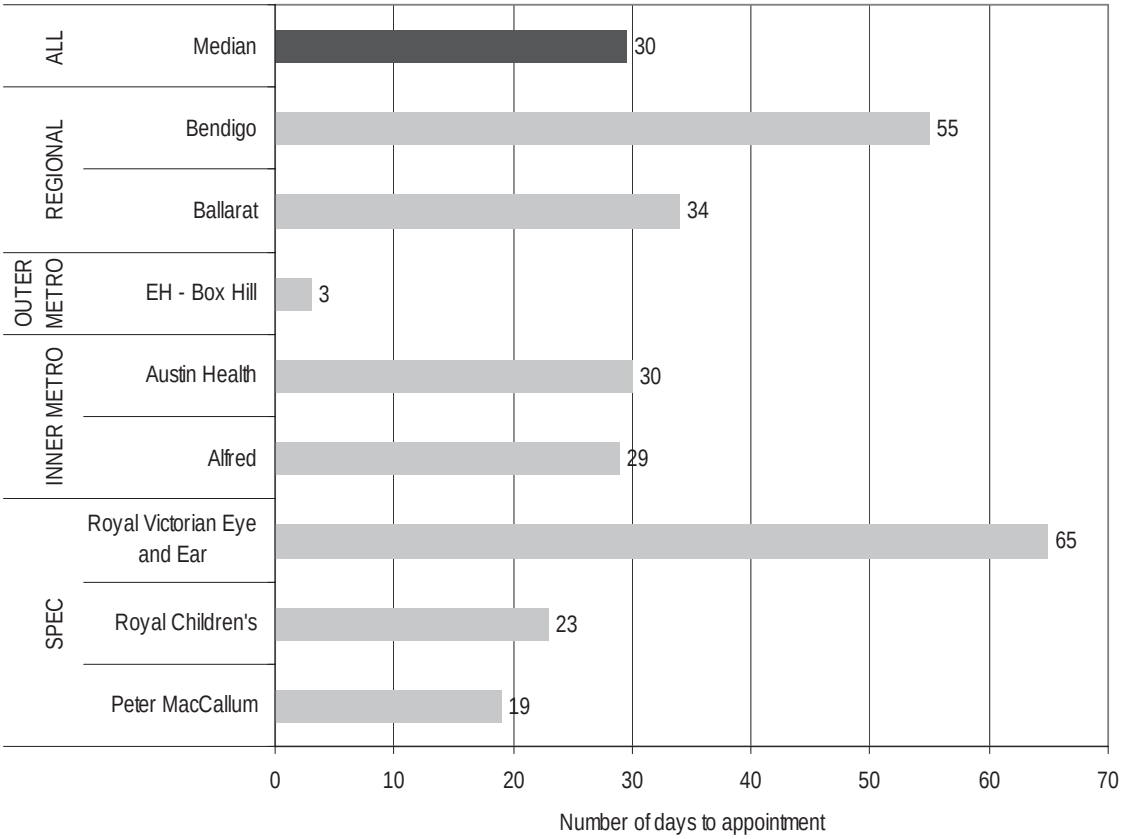


Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) Royal Melbourne Hospital advised that the data includes the General Eye Clinic only, as this is the largest volume. In addition, there are also 10 sub-speciality clinics and one "spoke" service, not included in this data.

Source: Victorian Auditor-General's Office.

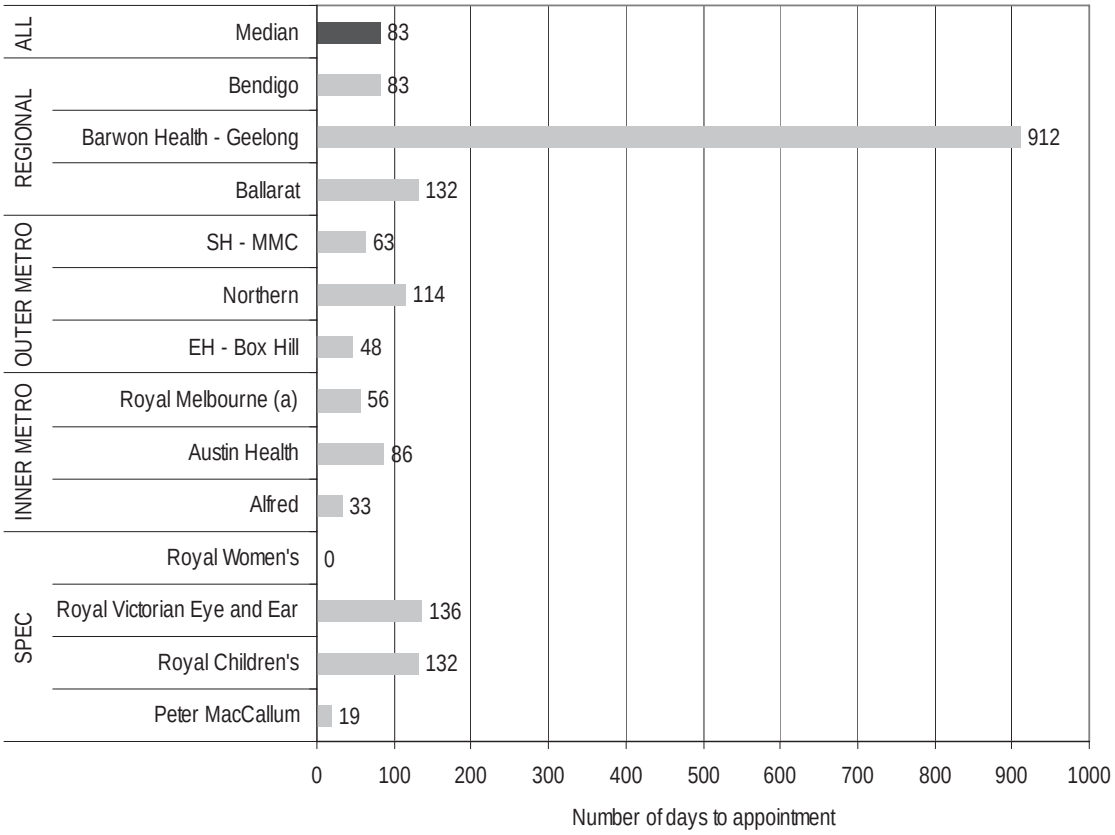
FIGURE C14: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE OPHTHALMOLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE *"SEMI-URGENT"*?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

Source: Victorian Auditor-General's Office.

FIGURE C15: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE OPHTHALMOLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE *"NON-URGENT"*?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

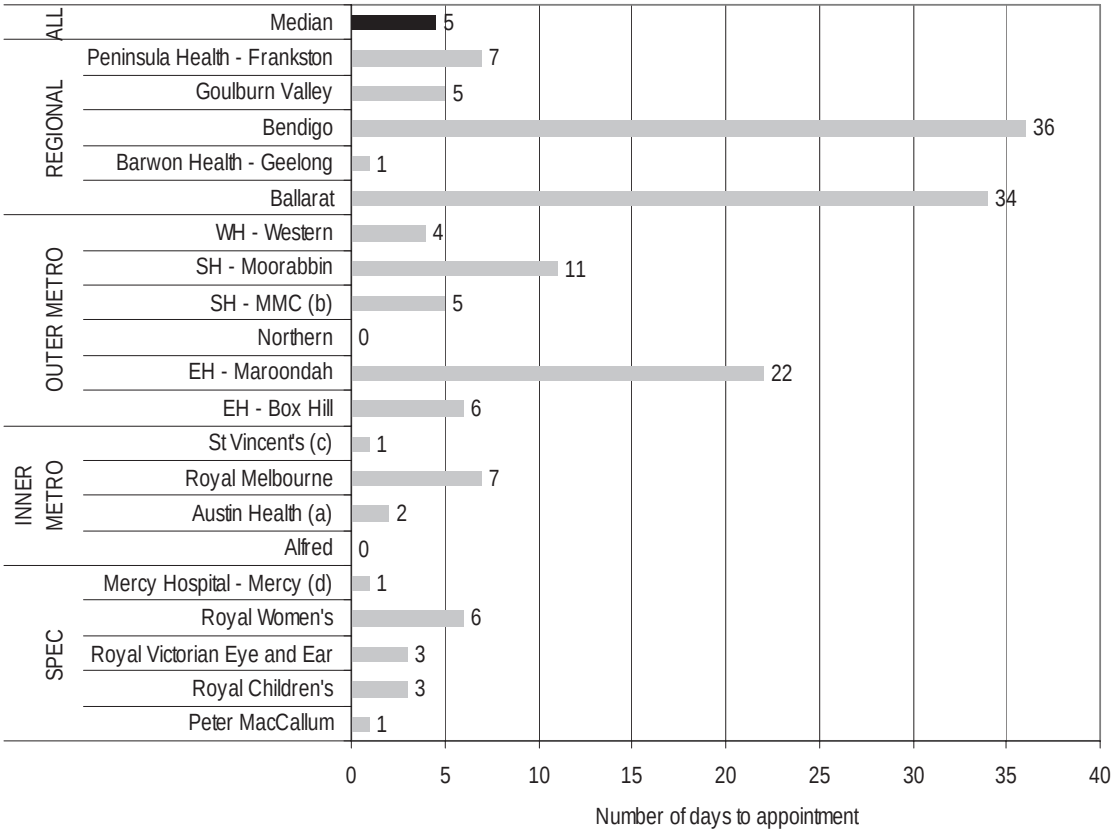
(a) Royal Melbourne Hospital advised that the data includes the General Eye Clinic only, as this is the largest volume. In addition, there are also 10 sub-speciality clinics and one "spoke" service, not included in this data.

Source: Victorian Auditor-General's Office.

Oncology

Oncology clinics see patients with conditions including hepatocellular cancer, breast cancer, hepatocellular carcinoma, leukaemia, orbital malignancies, lung cancer, known blood disorders, hepatoma, and lymphedema. They also see patients requiring genetic monitoring and investigation.

FIGURE C16: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE ONCOLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE "*URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) Austin Hospital advised that oncology data does not include Haematology or Radiation Oncology.

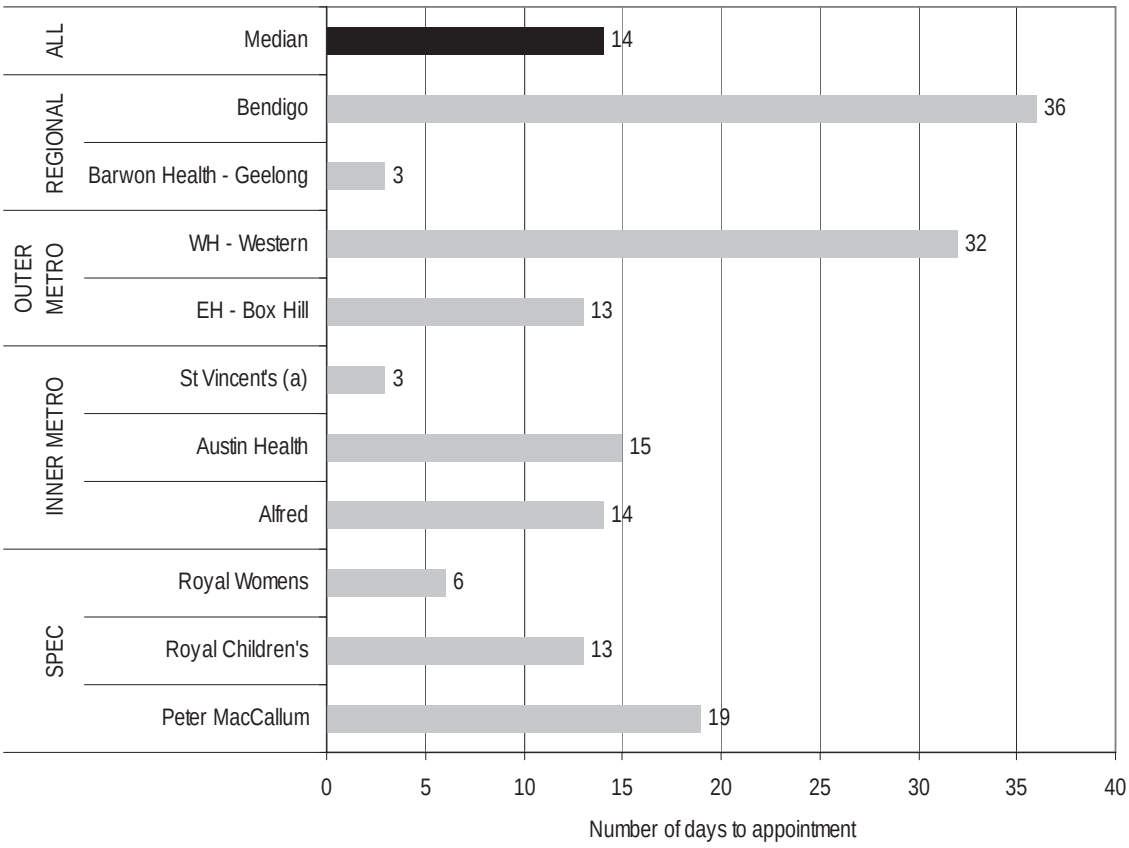
(b) Monash Medical Centre advised that it can accommodate urgent appointments at any time, as the centre tends to reschedule non-urgent patients.

(c) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

(d) All confirmed oncology cases will normally be seen within one week. All non-confirmed cases, which may be classified as gynaecology at other hospitals, are seen within 8 weeks. Non-confirmed cases have been excluded from this data.

Source: Victorian Auditor-General's Office.

FIGURE C17: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE ONCOLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE "*SEMI-URGENT*"?

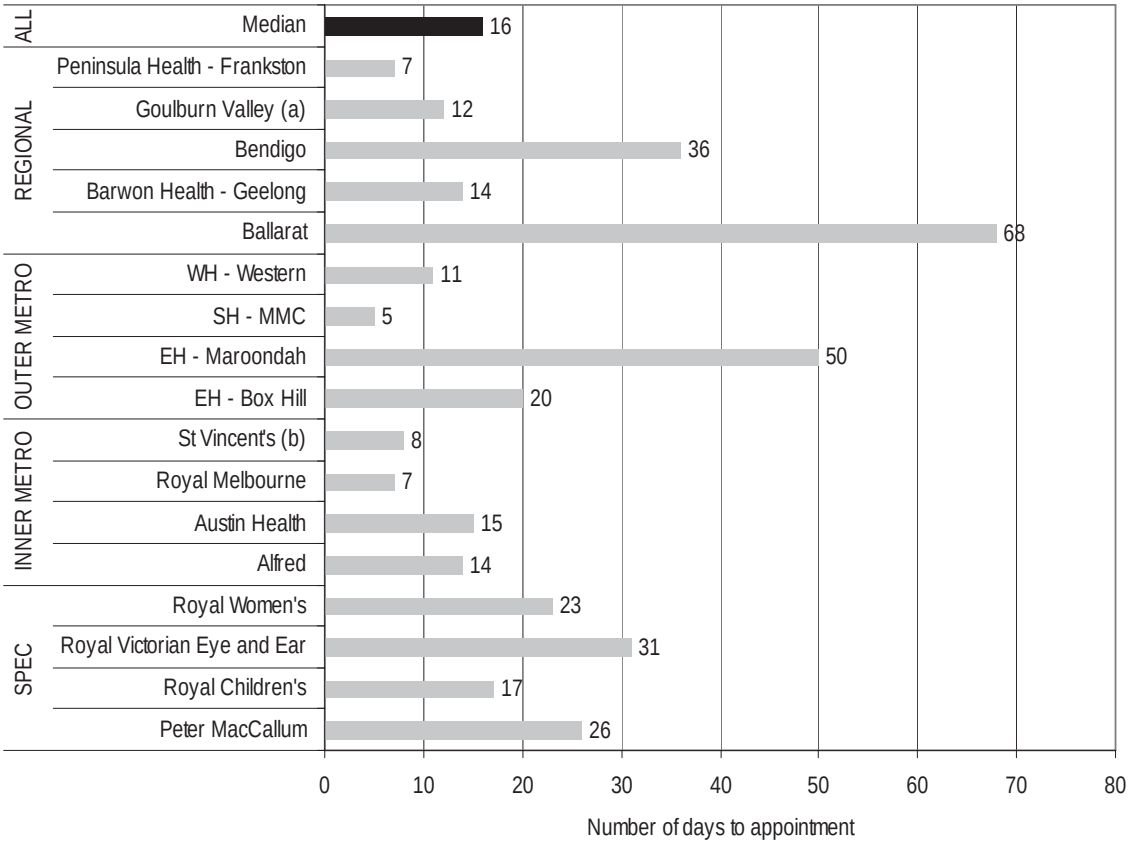


Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

Source: Victorian Auditor-General's Office.

FIGURE C18: INDICATIVE NUMBER OF DAYS TO THE NEXT AVAILABLE ONCOLOGY APPOINTMENT FOR NEW PATIENTS WHO ARE "*NON-URGENT*"?



Note: This data should be analysed in the context of the information at the start of Appendix C of this report.

(a) The time to "next available" appointments was prolonged due to planned leave by medical staff at the time of the survey. Waiting times for a "next available" appointment for all specialties are now much less.

(b) "Urgent" and "semi-urgent" patients are seen in accordance with St Vincent's Clinics prioritisation guidelines and over-bookings are made when both new appointments and over-booking appointments are unavailable: "urgent" - less than 1-2 weeks; "soon" - 2 - 4 weeks; "routine" - next available (aim 4-8 weeks).

Source: Victorian Auditor-General's Office.

Appendix D. Glossary

Glossary

Allied health
Services provided to non-admitted patients, including audiology, nutrition, optometry, physiotherapy and speech pathology.

Ancillary services
Services provided to the patient to assist in assessment, diagnosis and treatment. Such services include pathology, radiology and pharmacy.

Bulk-bill
When the doctor bills Medicare directly, accepting the Medicare benefits as full payment for a service.

Clinic
Outpatient areas in a hospital for the specialised treatment of particular conditions and diseases.

Clinic template
Appointment schedule for each clinic session with appointments allocated to new patients and review patients.

Continuity of care
The coordination of care received by a patient over time and across multiple healthcare providers.

Cost weight
The result of the average cost of a clinical category by the overall average cost (over 4 years), followed by scaling all weights.

Discharge
Discharge occurs when a patient leaves outpatient (hospital based) care.

Encounter
An encounter is defined as the clinic visit plus all ancillary services provided within 30 days either side of the visit.

Fail to attend (FTA)
A patient who does not attend their appointment and does not notify the outpatient department.

Health Information Services (HIS)
A health service department responsible for the maintenance and storage of patient files.

Inpatient
A patient who undergoes a hospital's admission process to receive treatment and/or care.

Investigations
Diagnostic tests performed on patients to assist in assessment, diagnosis and treatment, such as pathology and radiology.

Medical record
A file maintained by the hospital to record all patient contact, diagnosis and treatment.

Multi-disciplinary care
Where a patient has at most one appointment and more than one medical practitioner, allied health practitioner and/or specialist nurse practitioner assesses and/or treats them.

National peer-group A public hospital
Major city hospitals with greater than 20 000 acute casemix-adjusted separations/regional hospitals with greater than 16 000 acute casemix-adjusted separations each year and specialised acute women's and children's hospitals with greater than 10 000 acute casemix-adjusted separations each year.

National peer-group B public hospital
Major city hospitals treating greater than 10 000 acute casemix-adjusted separations each year/regional acute hospitals treating greater than 8 000 acute casemix-adjusted separations each year and remote hospitals with greater than 5 000 casemix-adjusted separations each year.

Non-admitted patient
A patient who does not undergo a hospital's formal admission process.

Outpatient
A non-admitted patient for whom a hospital accepts responsibility for treatment or care.

Overbooking
Appointments made on clinic templates where the appointment slots have already been filled.

Patient
A person for whom a hospital accepts responsibility for treatment or care.

Patient Administration System (PAS)
A central electronic system for recording patient details and the patient's contact with the hospital.

Picture Archiving and Communication System (PACS)
An electronic diagnostic imaging service for viewing radiology results.

Referral
A recommendation by a care or service provider to further care or alternative services.

Unit Record (UR) Number
A unique patient identifier used in medical records.

Victorian Ambulatory Classification System (VACS)
State funding allocated to health services based on the number of patient encounters and established annual throughput targets.

Visiting medical officer (VMO)
A visiting medical officer is a medical practitioner appointed by the hospital to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis.

Waiting list
The number of people referred to, and accepted by, the outpatient department who have yet to attend for an appointment.

Auditor-General's reports

2005-06

Report title	Date issued
Managing stormwater flooding risks in Melbourne (2005:8)	July 2005
Managing intellectual property in government agencies (2005:9)	July 2005
East Gippsland Shire Council: Proposed sale of Lakes Entrance property (2005:10)	July 2005
Franchising Melbourne's train and tram system (2005:11)	September 2005
Results of special reviews and other investigations (2005:12)	October 2005
Health procurement in Victoria (2005:13)	October 2005
Community planning services in Glenelg Shire Council (2005:14)	October 2005
Follow-up of selected performance audits tabled in 2002 and 2003 (2005:15)	October 2005
Auditor-General's Report on the Finances of the State of Victoria, 2004-05 (2005:16)	November 2005
Results of 30 June 2005 financial statement and other audits (2005:17)	December 2005
Planning for a capable Victoria Police workforce (2006:1)	May 2006

The Victorian Auditor-General's Office website at <www.audit.vic.gov.au> contains a more comprehensive list of all reports issued by the Office. The full text of the reports issued is available at the website. The website also features "search this site" and "index of issues contained in reports and publications" facilities which enable users to quickly identify issues of interest which have been commented on by the Auditor-General.

AUDITOR GENERAL
VICTORIA

Availability of reports

Copies of all reports issued by the Victorian Auditor-General's Office are available from:

- Information Victoria Bookshop
  356 Collins Street
  Melbourne Vic. 3000
  AUSTRALIA

  Phone: 1300 366 356 (local call cost)
  Fax: (03) 9603 9920
  Email: <bookshop@dvc.vic.gov.au>

- Victorian Auditor-General's Office
  Level 34, 140 William Street
  Melbourne Vic. 3000
  AUSTRALIA

  Phone: (03) 8601 7000
  Fax: (03) 8601 7010
  Email: <comments@audit.vic.gov.au>
  Website: <www.audit.vic.gov.au>