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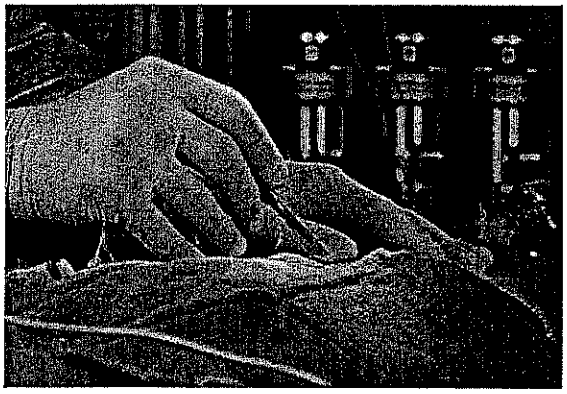
Issues Report – Waiting List Reduction Strategy



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By Medical Superintendents' Advisory Committee

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1.0 Background

There have been significant changes to the profile and provision of health care that will affect the role and function of hospitals. Advances in technology, minimally invasive procedures, day of surgery admission have resulted in providing more timely and effective treatment. Setting of targets, formulation of strategies and funding incentives all have an impact on outcomes from a corporate, organisational and patient perspective.

In order to maximise the potential of these developments, attention to the infrastructure must be a high priority. Recent workshops with the clinical and administrative personnel from Qld Health facilities have identified issues that warrant further exploration.

2.0 Introduction

The Medical Superintendents Advisory Committee – Working Party was formed as a response to the issues raised and recommendations made at recent workshops including:

The Elective Surgery Co-ordinators/ESLO combined workshop

The Combined workshop for Medical Superintendents and Elective Surgery Co-ordinators

3.0 The Issues

- The Elective Surgery Funding Model
- Communication
- Equity of Access
- Quality

4.0 Purpose of the Paper

To outline the issues which challenge the success of the strategies and aims of the *Waiting List Reduction Strategy.*

5.0 Issues in Detail

5.1 Elective Surgery Funding Model

5.1.1 Issue: Fairness of the business rules under the Elective Surgical Enhancement Initiative (ESEI) program.

The Medical Superintendents Advisory Committee (MSAC) do not agree with the current business rules and processes in place for determining elective surgery payments under the Elective Surgical Enhancement Initiative (ESEI) program.

Hospitals that have achieved elective surgery activity targets but have not achieved the target of no greater than 5% Category 1 and Category 2 'long waits' are not paid at the phase 7 price even though their performance has improved.

It should be recognised that the target of no greater than 5% 'long wait ' Category 2 patients has never been achieved on a state-wide basis. It should also be recognised that no scientific evidence has been provided that supports the target is reasonable or clinically relevant. Not withstanding working towards achieving the targets is considered useful as a benchmarking/quality initiative.

The reasons for not achieving the targets across facilities are multi factorial and are often complicated due to issues with human and physical resources, infrastructure costs and patients. Strategies to address these issues are not always successful due to non-availability of a number of surgical specialists and spare capacity in many of the States facilities.

Infrastructure costs must be met by each hospital even when the loss of a resource impacts on its ability to maintain an agreed level of service delivery.

The logistics of transporting either patients or medical team's long distances to address 'long waits' consumes significant hospital staff time and effort, which should be taken into consideration when determining payments.

Recommendations

- That the targets of no greater than 5% 'long waits' for Category 1 and 2 patients remain in place.
- That existing Category 1 and Category 2 targets are not utilised to determine differential payments in the 2002/2003 elective surgery-funding model.
- That elective surgery funding be provided on the basis of additional throughput (weighted separations).

5.1.2 Issue: Establishment of Elective Surgery Targets

The process of establishing elective surgery targets based on estimated historical elective surgery activity needs to be reviewed.

Elective surgery targets for some hospitals include a significant proportion of activity undertaken in 1996/97 and 1997/98 under the Hospital Access Bonus Program (HABP). Activity claimed under the HABP

- Was not restricted to 'elective surgery'
- Was funded at marginal rates as low as 30% of the casemix price at certain facilities.
- Has been funded at the same rate for the last 5 years of elective surgery program.

There has been no flexibility in terms of adjusting base elective surgery targets to reflect the current costs of undertaking procedures or adjust targets to represent current infrastructure costs.

Recommendations

- That the base elective surgery targets associated with the HABP are adjusted to represent current pricing on a state wide basis. This will result in a reduced base elective surgery activity target for those hospitals disadvantaged in the out years from 1997/98, as a result of the SAT rolling up all activity, claimed under the HABP in 1996/97 into elective surgery. Technically this is an adjustment for unfunded activity which will also reduce the need to roll over non-allocated elective surgery funds.

- To review the price paid for Elective Surgery activity to reflect the current operational costs

5.1.3 Issues: Requirement to meet total target prior to 2% tolerance. No Payment for over achieving elective surgery target.

The 2000/2001 business rules approved by the Queensland Health Procurement Council included:

- A total surgical target
- A 2% tolerance for the elective surgery component for hospitals exceeding the total surgical target.

To date the total surgical target has proved to be irrelevant, as the 2% tolerance for elective surgery payments has not been applied. Additionally hospitals have not received payment where elective surgery targets are over achieved despite the availability of unspent elective surgery funding.

Considering the Minister claims credit for over achieved activity under the elective surgery program it is unreasonable that it is not paid for with the available funds. The MSAC considers that expending the available the funds and avoiding roll overs can only be beneficial in political terms for the Government.

Recommendation

- That the General Manager, Health Services applies the business rules endorsed by the Queensland Health Procurement Council in approving payments for those hospitals not meeting their elective surgery target if their total surgical target is exceeded.
- Elective surgery funds to be utilised to reimburse hospitals that over achieve elective surgery targets. This will negate the need for rollovers of unexpended elective surgery funds.

5.1.4 Issue: No identified Elective Surgery Funding for Category 4,5 and 6 surgery

Under the Elective Surgery funding model only Category's 1, 2 and 3 attract funding. Demand for hospital services is much broader, with cases assigned Category 4,5 and 6. A high proportion of these procedures must be performed within the operating theatre environment or require operating theatre personnel to assist. In many instances these cases are investigative and diagnostic procedures that will lead to an open operative procedure at a later date or may result in a surgical procedure being performed at the time.

Recommendations

- Although patients assigned a Category of 4,5 or 6 don't qualify as Elective Surgery under Commonwealth definitions it is recommended that all Category 4 patients be included for payment under the Elective Surgery programme irrespective of a surgical or medical DRG being assigned.

- Funding should be accessible through the Elective Surgery funding rules for all elective patients who require operating theatre services and/or surgical team to perform the procedure.

- Elective Surgery funds have been under utilised for the last 3 years and this trend is likely to continue. Roll-over Elective Surgery funds should be allocated to hospitals for the performance of procedures in Categories 4,5 and 6. Procedures within these Categories utilising operating theatre services should also be recognised in the reported Queensland Health Elective Surgery activity.

- Rules within the *Waiting List Reduction Strategy* should be congruent with the Elective Surgery Funding Rules.

5.2 Communication

5.2.1 Issue: Lack of consultation in relation to negotiation of elective surgery activity targets.

- There is no uniform strategy in place across Queensland Public Hospitals in terms of a visible line of communication that encompasses the consultative and negotiation phases for the setting of elective surgery targets. The MSAC has had limited involvement in terms of decision-making, setting of targets and allocation of funds that will impact on achieving the goals of the *Waiting List Reduction Strategy*.

Recommendations

- Provide access for representation from MSAC (Chair or nominee) to participate at forums when formalised decisions are being made, addressing state-wide issues that will impact on equity of access to Elective Surgery and the *Waiting List Reduction Strategy*

- Ensure the inclusion and participation of MSAC representatives at forums that will determine state, zonal and organisational elective surgery targets

- Build on the current formal communication channels that are presently established between the Surgical Access Team (QH), Corporate Health, Zonal Units, Districts and executives at individual hospitals including the Medical Superintendent. This is critical to ensure that all practical and appropriate measures are identified that will assist with the management of Elective Surgery across the state.

- The Surgical Access Team to disseminate significant issues impacting on Elective Surgery activity/throughput as identified by the MSAC, Medical Superintendents and Elective Surgery Coordinators representing all reporting hospitals through to the General Manager, Health Services.

5.3 Equity of Access

5.3.1 Issue: Discrimination against Category 3 elective surgery patients

Current Waiting List Management Programs are focussed on Category 1 and Category 2 throughput from waiting lists. There is limited opportunity for an offer of a booking date for surgery to be provided to 'in time' and 'long wait' Category 3 patients in the foreseeable future.

Recommendations

- Investigate alternatives that could be promoted to address health needs of the public within the community setting, prior to referrals being directed to health facilities for consideration of surgery.

- Queensland Health on the advice of the Surgical Access Team and groups such as MSAC, to support a funding model that will initiate health promotion activities that will achieve clinical best practice.

5.4 Quality Management

5.4.1 Issue: There is a need to improve the way in which the performance and quality of surgical services are measured.

The current waiting list reports generated by the SAT identify performance in terms of the management of 'long wait patients'. The reports only measure the time that patients are on elective surgery waiting list and do not take into consideration the time that patients wait for their initial outpatient consultation. There are no reports generated that measure the quality of the services being provided.

Consistency in the application of the clinical urgency category from a statewide perspective is also questionable. In this regard there is minimal confidence in the categorisation system. The MSAC agree that the percentage of "long waits" can be manipulated to promote individual or specialty agendas. This does not promote a quality agenda, rather it promotes gaming to enable access to funding.

There are no established parameters to limit access to Specialist Outpatient services. For example; placement on Outpatient waiting lists for Category 3 patients and their management thereafter is reflective of the Elective Surgery waiting lists. The waiting list position of a hospital may be improved by reducing access to specialist outpatient services.

Recommendations

- The Surgical Access Team undertakes a detailed analysis of the application of clinical urgency category assignment at the specialty/doctor/procedure level. This information to be provided to the MSAC to assist in gaining consistency across urgency category application.

- Patterns of variation in specialty demand, and appropriateness of current services across districts should be examined to identify whether or not the needs of the community are being met.

- Funding models and incentive programmes should support the achievement of better value, integrated care and improved performance across health care facilities.

5.4.2 Issue: The elective surgery program has evolved to where the focus has become solely political. MSAC agree that there is little or no attention dedicated to research and promotion of new advances in clinical service delivery.

The impact of advances in technology, have resulted in significant changes across health care services, which in turn has affected the role and functions of hospitals. For example; minimally invasive surgery is providing more timely and effective treatment but has impacted greatly on infrastructure and hospital budgets.

Recommendations

- Initiate benchmarking activities to identify centres of excellence to enable districts to act as lead hospitals and achieve statewide best quality outcomes.
- Establish a process that will provide forums to discuss state wide operational issues impacting on the provision of elective surgery service
- Review consultative groups and consortiums that exist within Queensland Health involved in benchmarking activities. This will lead to the establishment of an information-sharing network.

6.0 Summary of Recommendations

- That the targets of no greater than 5% 'long waits' for Category 1 and 2 patients remain in place.

- That existing Category 1 and Category 2 targets are not utilised to determine differential payments in the 2002/2003 elective surgery-funding model.

- That elective surgery funding be provided on the basis of additional throughput (weighted separations).

- That the base elective surgery targets associated with the HABP are adjusted to represent current pricing on a state-wide basis. This will result in a reduced base elective surgery activity target for those hospitals disadvantaged in the out years from 1997/98, as a result of the SAT rolling up all activity, claimed under the HABP in 1996/97 into elective surgery. Technically this is an adjustment for unfunded activity which will also reduce the need to roll over non-allocated elective surgery funds.

- To review the price paid for Elective Surgery activity to reflect the current operational costs

- That the General Manager, Health Services applies the business rules endorsed by the Queensland Health Procurement Council in approving payments for those hospitals not meeting their elective surgery target if their total surgical target is exceeded.

- Elective surgery funds to be utilised to reimburse hospitals that over achieve elective surgery targets. This will negate the need for roll-overs of unexpended elective surgery funds.

- Although patients assigned a Category of 4,5 or 6 don't qualify as Elective Surgery under Commonwealth definitions it is recommended that all Category 4 patients be included for payment under the Elective Surgery programme irrespective of a surgical or medical DRG being assigned.

- Funding should be accessible through the Elective Surgery funding rules for all elective patients who require operating theatre services and/or surgical team to perform the procedure.

- Considering Elective Surgery funds have been under utilised for the last 3 years, and this trend is likely to continue, this is an opportunity to use unallocated Elective Surgery funds for Categories 4,5 and 6. This action to be recognised in the reported Queensland Health Elective Surgery activity.

- Rules within the *Waiting List Reduction Strategy* should be congruent with the Elective Surgery Funding Rules.

- Establishment of an effective communication strategy that clearly identifies the roles and responsibilities of those involved in the establishment of elective surgery targets.

- Build on the current formal communication channels that are presently established between the Surgical Access Team (QH), Corporate Health, Zonal Units, Districts and executives at individual hospitals including the Medical Superintendent. This is critical to ensure that all practical and appropriate measures are identified that will assist with the management of Elective Surgery across the state.

- The Surgical Access Team to disseminate significant issues impacting Elective Surgery activity/throughput as identified by the MSAC, Medical Superintendents and Elective Surgery Coordinators representing all reporting hospitals through the General Manager, Health Services.

- Provide access for representation from MSAC (Chair or nominee) to participate at forums when formalised decisions are being made, addressing state-wide issues that will impact on equity of access on Elective Surgery and the *Waiting List Reduction Strategy*

- Investigate alternatives that could be promoted to address health needs of the public within the community setting, prior to referrals being directed to health facilities for consideration of surgery.

- Queensland Health on the advice of the Surgical Access Team and groups such as MSAC, to support a funding model that will initiate health promotion activities that will achieve clinical best practice.

- The Surgical Access Team undertakes a detailed analysis of the application of clinical urgency category assignment at the specialty/doctor/procedure level. This information to be provided to the MSAC to assist in gaining consistency across urgency category application.

- Patterns of variation in specialty demand, and appropriateness of current services across districts should be examined to identify whether or not the needs of the community are being met.

- Funding models and incentive programmes should support the achievement of better value, integrated care and improved performance across health care facilities.

- Initiate benchmarking activities to identify centres of excellence to enable districts to act as lead hospitals and achieve statewide best quality outcomes.

- Establish a process that will provide forums to discuss state wide operational issues impacting on the provision of elective surgery service
- Review consultative groups and consortiums that exist within Queensland Health involved in benchmarking activities. This will lead to the establishment of an information-sharing network.