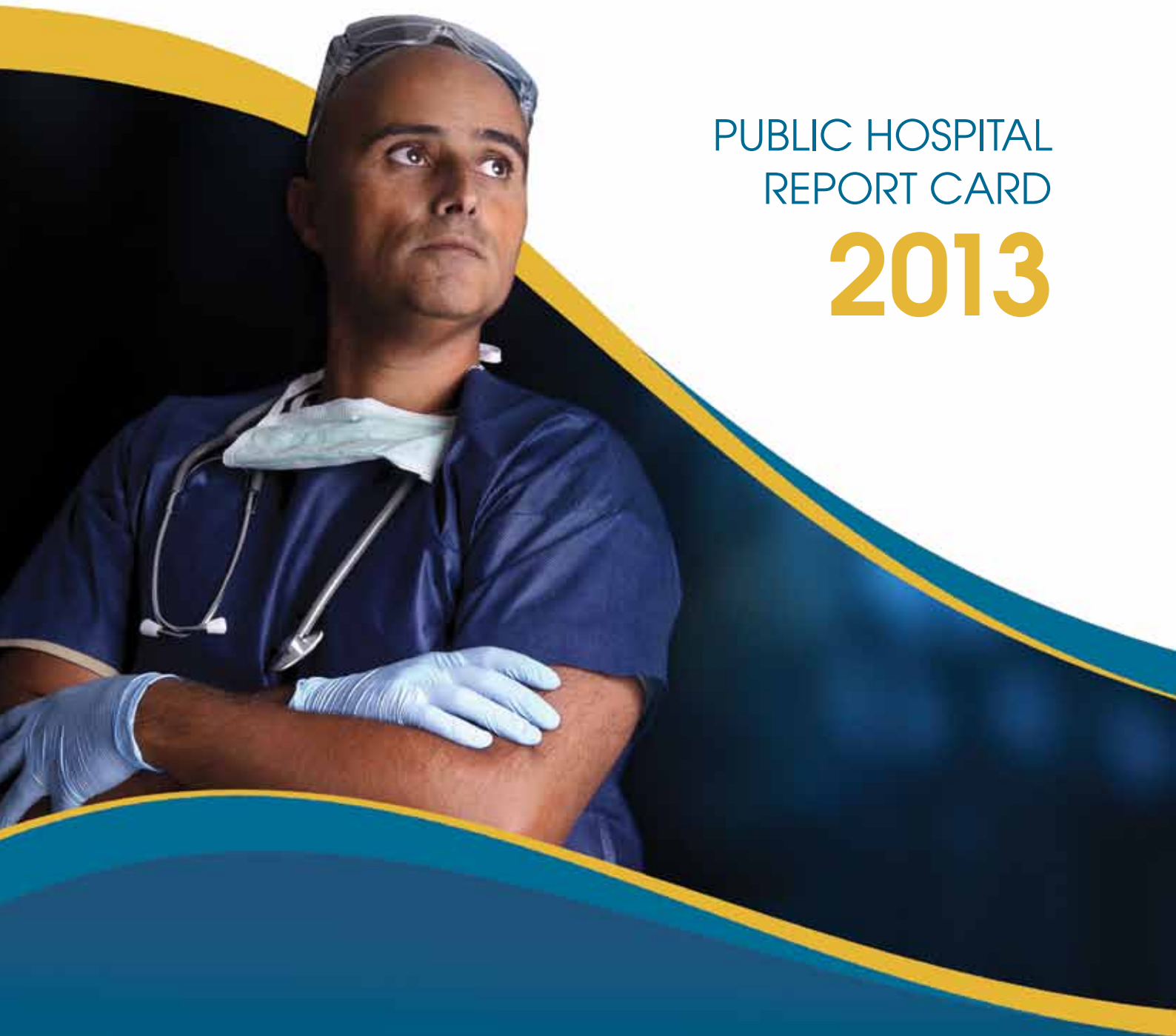


PUBLIC HOSPITAL REPORT CARD 2013

AMA

AN AMA ANALYSIS OF AUSTRALIA'S PUBLIC HOSPITAL SYSTEM

CONTENTS

INTRODUCTION

The *AMA's Public Hospital Report Card* provides the medical perspective on core measures of public hospital performance, using data published by the Commonwealth. The AMA report card is the only document that provides a clear picture of performance year-on-year.

The clear message of this report is that there is no evidence of substantial progress towards achievement of any of the national targets that have been agreed by the Council of Australian Governments (COAG) as part of health reform.

Despite Commonwealth Government expenditure on public hospitals increasing by 10 per cent over the two years preceding the National Health Reform Agreement, there has been no real change in the key performance measures.

Bed numbers, waiting times in emergency departments and waiting times for elective surgery are basically unchanged - and still a long way short of the COAG targets.

This report has been prepared in a context of new organisations established under the National Health Reform Agreement also providing reports on public hospital performance, from different perspectives and at different times. The AMA Public Hospital Report Card is the only report that presents a time series of the core measures of hospital performance.

The national health reforms overall have focused on backroom issues such as how governments split funding responsibilities and the development of the efficient price for hospital services. They haven't focused on the system's overall capacity for service delivery. This is confirmed by the publicly available Commonwealth hospital data, currently covering different aspects of hospital performance for 2010-11 and 2011-12.

The reforms haven't stopped the blame game and funding reductions.

In 2012-13, Commonwealth payments to State and Territory Governments for public hospital services will be less than expected. State and territory governments have also announced Budget cuts for public hospitals.

With little progress towards COAG targets, the AMA believes that it is unacceptable for any government to reduce funding to public hospitals, as it will only further reduce the capacity of the system to meet demand.

We will carefully monitor and report on how the new arrangements affect hospital performance and the Federal Government share of public hospital funding compared with State and Territory Government funding.

And we will keep a very close eye on high-risk issues such as funding for teaching, training and research. There is a very real risk that this activity will be under-funded at a time when increased funding is needed to provide quality training places for the increased numbers of medical graduates coming through the universities.

This report clearly shows that, in relation to our public hospitals, the dream of health reform that began in 2007 has not been realised.

Health reform, as defined and constructed by governments, has failed to deliver direct improvements in the capacity of public hospitals to meet the clinical demands and performance targets placed on them. This is sobering given the energy and money that has been spent by governments and the health care sector to implement the reforms.

Real health reform for patients, doctors, nurses, and allied health professionals means more resources at the hospital bedside to deliver timely, safe and quality health care.

Dr Steve Hambleton
President

February 2013

1. NATIONAL PUBLIC HOSPITAL PERFORMANCE

This Report Card provides information about the performance of Australia's public hospitals in 2011-12.

Consistent with previous AMA Public Hospital Report Cards, this Report Card measures capacity and performance using three indicators:

- bed numbers and occupancy rates;
- emergency department waiting times; and
- elective surgery waiting times.

This report card also includes the first full year of performance against the National Emergency Access Target.

These measures give us information about the capacity of the public hospital system to meet the demands being placed upon it.

We have also examined the efficiency and productivity of public hospitals using the following measures:

- average length of stays;
- percentage of same-day separations;
- cost per casemix-adjusted separations; and
- percentage of administrative and clerical staff compared to all hospital staff and funding.

We used the following sources for statistical data:

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2010-11*;
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2011-12: emergency department care;*
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2011-12: elective surgery waiting times*; and
- Australian Institute of Health and Welfare, *Health expenditure Australia 2010–11*.

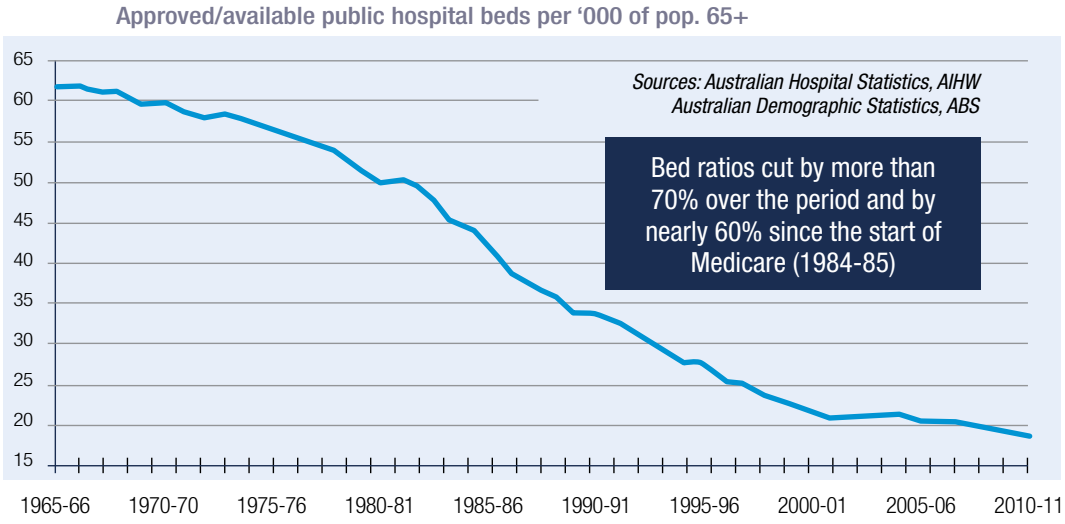
Bed numbers and occupancy rates

One of the strongest measures of hospital capacity is to compare the number of available beds with the size of the population.

The population aged 65 and over is a useful way to measure the hospital-using population because older people have more hospital episodes with longer admissions than young people.

Graph 1 shows that the number of public hospital beds has been slashed by almost 70 per cent since the mid-1960s, and by more than half since the start of Medicare. In 2010-11, there were only 18.9 hospital beds for every 1,000 people over the age of 65 - a decrease of 1.6 per cent since 2009-10.

Graph 1: Number of approved/available public hospital beds per 1000 population aged 65 and over



While 872 new beds were added in 2010-11, the total public hospital beds per 1000 of the total population held at 2.6 per cent, the same as in 2009-10.

Operating the hospital system with such a low number of available beds, at the same time that demand is increasing because the population is ageing and the prevalence of chronic disease is increasing, means that people needing to be admitted to hospital from emergency departments wait on trolleys in corridors and people needing elective surgery wait too long.

The continuing decline in bed numbers means that public hospitals, particularly the major metropolitan teaching hospitals, are commonly operating at an average bed occupancy rate of 90 per cent or above.

Hospital overcrowding is the most serious cause of reduced patient safety in public hospitals and the cause of waiting times in emergency departments and for elective surgery.

Unless governments improve public hospital capacity, patient access to hospital care will not improve and patient safety will be put further at risk.

A rule of 85 per cent average bed occupancy rate should apply in every hospital[1]. State and Territory Governments should be required to report the number of available beds for each public hospital, and the occupancy rates, to the National Health Performance Authority, similar to the reporting that is required for sub-acute beds[2].

1 Access Block and Overcrowding in Emergency Departments, Australasian College of Emergency Medicine, April 2004

2 National Partnership Agreement on Improving Public Hospital Services, 2011, pg 44, Clause E8

Emergency department waiting and treatment times

The hospital system's ability to cope with emergency and urgent cases is a crucial measure of performance.

Two performance indicators that measure the capacity of emergency departments to provide timely care are:

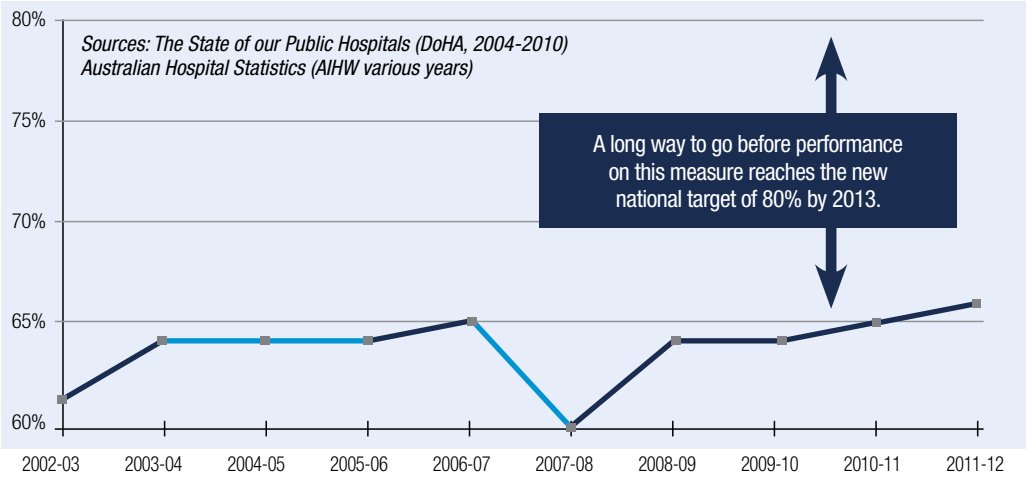
i. the percentage of emergency department presentations that are seen within clinically recommended triage times; and

ii. the percentage of patients leaving the emergency department within 4 hours.

The National Partnership Agreement on Hospital and Health Workforce Reform signed by COAG (February 2009) committed all States and Territories to a performance benchmark that, by 2012-13, 80 per cent of emergency department presentations will be seen within clinically recommended triage times as recommended by the Australasian College for Emergency Medicine.[3]

In 2011-12, 66 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes.

Graph 2: Percentage of Category 3 emergency department patients seen within recommended time



No substantial progress is being made towards the target of 80 per cent, despite $750 million having been provided to the States and Territories in 2008-09 to relieve pressure on emergency departments.

3 National Partnership Agreement on Hospital and Health Workforce Reform, 2009, pg 28, clause D11

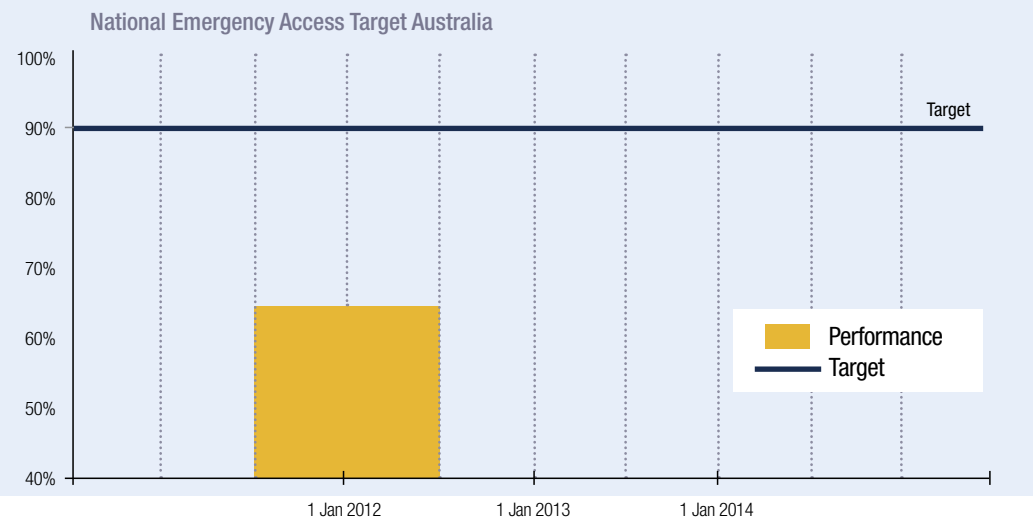
National Emergency Access Target

In the National Partnership Agreement on Improving Public Hospital Services (July 2011) COAG agreed to implement a National Emergency Access Target (NEAT). The Commonwealth provided additional funding of $250 million in capital funding to 2012-13 and $500 million in facilitation and reward payments to 2015-16.

Under this target, 90 per cent of all patients presenting to a public hospital emergency department will either physically leave the emergency department for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours[4]. State and Territory Governments have committed to progressively achieve this target by the end of 2015, with incremental targets over four years for each State and Territory.

In 2011-12, 64 per cent of all emergency department visits were completed in four hours or less, well short of the 90 per cent target to be achieved by the end of 2015.

Graph 3: Performance against the Four Hour National Emergency Access Target



Performance at the target level will only occur when there are sufficient beds, staff and other resources throughout the hospital, especially outside standard working hours, to respond appropriately to patient demand.

4 National Partnership Agreement on Improving Public Hospital Services, 2011, pg 30, clause C1

Elective surgery waiting times

Elective surgery is any form of surgery considered medically necessary but which can be delayed for at least 24 hours.

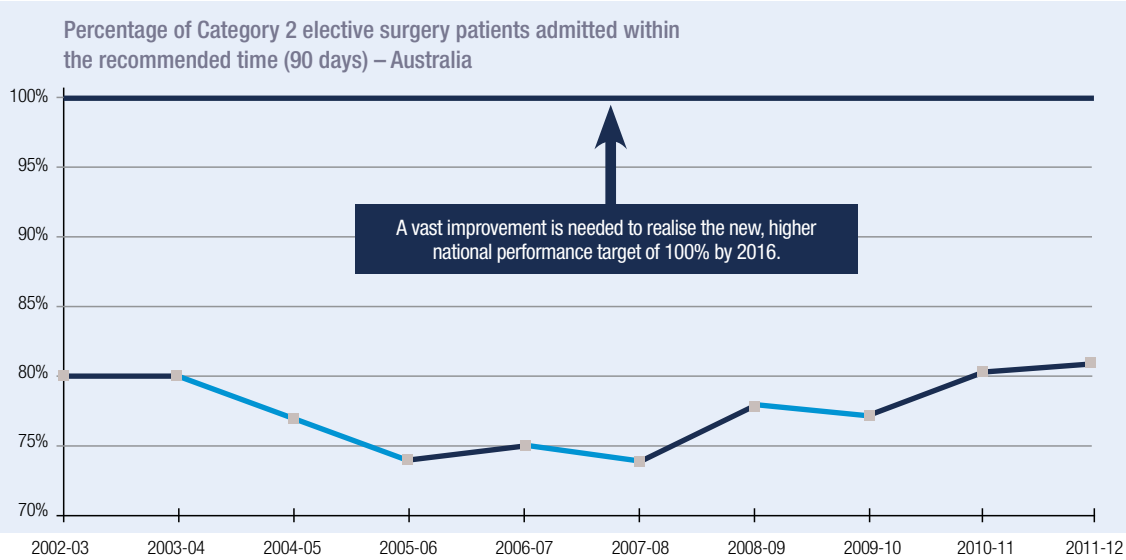
Category 2 elective surgery patients are those for whom admission within 90 days is desirable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency. In 2011-12, they represented 39 per cent of elective surgery admissions nationally.

The Australian Institute of Health and Welfare no longer reports the percentage of elective surgery patients admitted within clinically recommended times, citing an 'apparent lack of comparability of clinical urgency categories among jurisdictions'. Using individual State and Territory published hospital statistics, not all of which cover the entire 2010-11 or 2011-12 periods, the AMA estimates that a national average of 81 per cent of category 2 patients were admitted within the clinically recommended times.

In the National Partnership Agreement on Improving Public Hospital Services (July 2011), COAG agreed to implement a National Elective Surgery Target of 100 per cent of all urgency category patients waiting for surgery to be treated within the clinically recommended times. The Commonwealth provided additional funding of $150 million in capital funding to 2011-12 and $650 million in facilitation and reward payments to 2016-17. The target will be progressively implemented from 1 January 2012 to 2016.

Graph 4 presents performance over eight years to highlight the ambitious target that has been set for elective surgery performance.

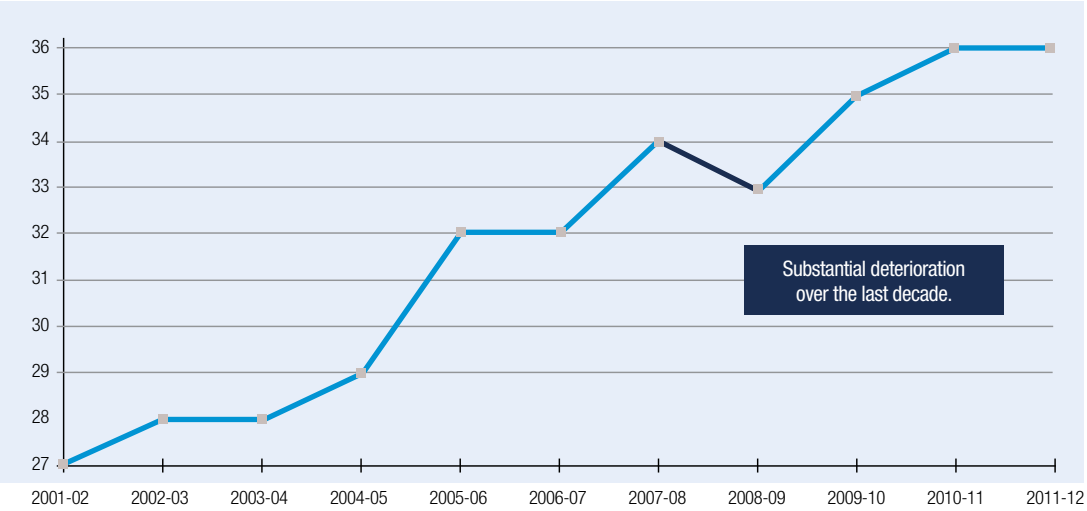
Graph 4: Percentage of Category 2 elective surgery patients admitted within the recommended time



**Sources: 2004-10 The State of Our Public Hospitals (DoHA); 2011 FOI request reference 253-1011 lodged June 2011; 2012 estimate based on State and Territory Government published data.*

Nationally, median waiting times for all elective surgery have increased over the last ten years. In 2011-12, the national median waiting time was 36 days.

Graph 5: Median waiting time for elective surgery (days)



Sources: AIHW elective survery data cubes (2001-02 to 2006-07),AIHW Australian Hospital Statistics 2011-12: elective surgery watiting times (2007-08 to 2011-12)

Patients waiting more than one year

In 2011-12, 17,866 people (2.7 per cent) waited more than a year for their surgery.

The hidden waiting list

The elective surgery waiting list data hide the actual times patients are waiting to be treated in the public hospital system.

The time patients wait from when they are referred by their general practitioner to a specialist for assessment is not counted. It is only after patients have seen the specialist that they are added to the official waiting list. This means that the publicly available elective surgery waiting list data actually understate the real time people wait for surgery. Some people wait longer for assessment by a specialist than they do for surgery.

Long waits for access to treatment can impair quality of life, reduce work productivity, and reduce the contributions that older Australians can make to the community.

Public waiting lists must be nationally consistent and provide clear and accurate information about the number of people who have been referred by a general practitioner for assessment (who are currently not counted), the number of people who are waiting for elective surgery, and the number of elective surgeries performed.

Unfortunately, COAG does not consider the hidden waiting list a priority –consideration will be given to developing a measure of surgical access from general practitioner referral to surgical care for future agreements[5]. This delay is unacceptable given that this measure reflects the actual waiting time for patients and demand for elective surgery. This data must be collected and monitored now in time for reporting in 2013-14.

The AMA looks forward to this data being publicly available to give Australians a full and accurate picture of waiting times for elective surgery.

5 National Partnership Agreement for Improving Public Hospital Services, 2011, pg 25, clause A54(c)

Hospital efficiency and productivity

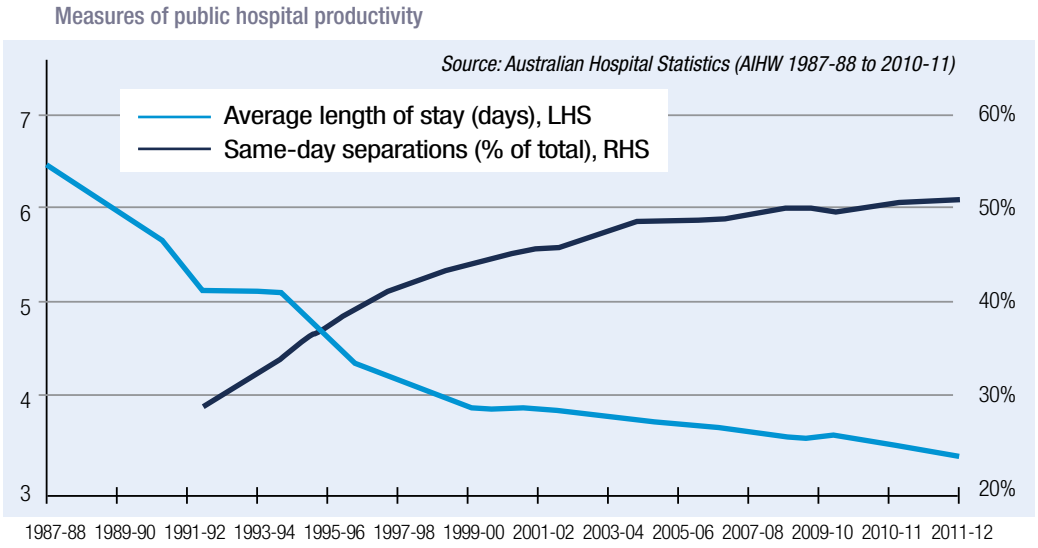
Commonwealth and State and Territory Government funding of public hospitals has long rested on assumptions of very strong growth in productivity. Two key and inter-related measures of efficiency and productivity are the average length of stay of patients and the percentage of all same-day separations.

Over the past 20 years, advances in medical care and technology have progressively lifted the proportion of same-day separations. At the same time, average length of stay has fallen for separations that are not same-day.

However, average length of stay and the percentage of same-day separations are both reaching a plateau, with only minor gains for both measures (see graph 6). The cost of hospital care per casemix separation increases each year.

These measures do not suggest significant gains in hospital efficiency or productivity over recent years. Neither do they indicate a strong trend to such gains in the future that would allow hospitals to provide more services with existing resources.

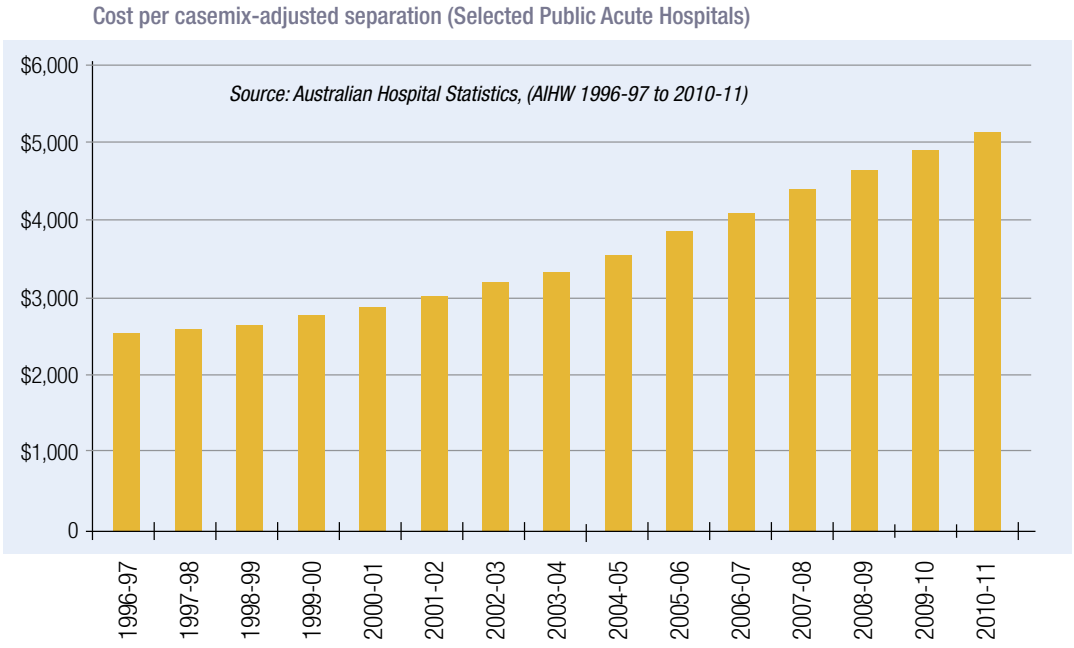
Graph 6: Average length of stay (days) and percentage of same-day separations



Graphs 6 and 7 indicate that hospitals have eked out efficiencies where they can, with no obvious or substantial capacity for hospitals to provide more services through further efficiency measures.

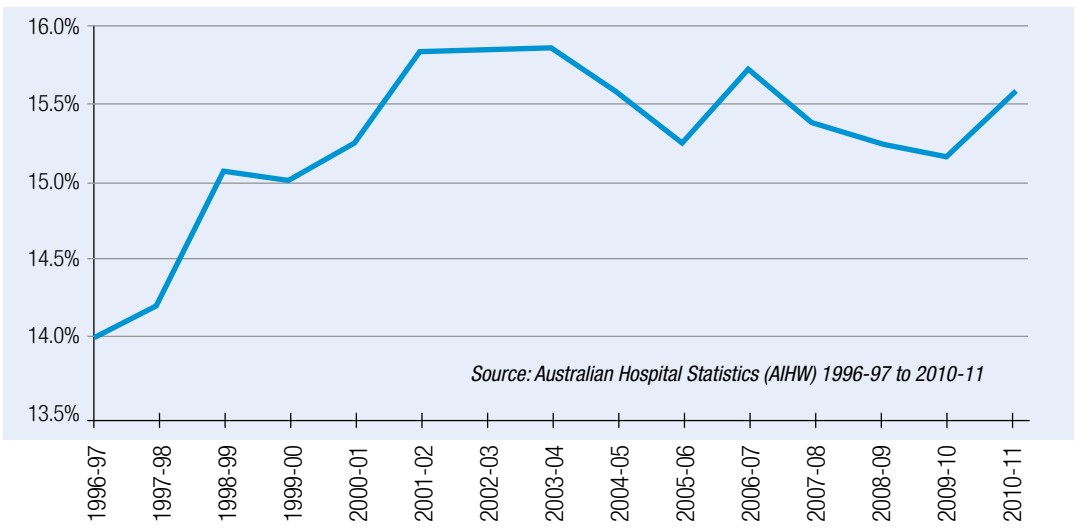
The Government has claimed that the introduction of new hospital pricing arrangements, based on activity based funding and a National Efficient Price, will enable more services through efficiencies. We will watch this issue carefully as the new funding arrangements roll out.

Graph 7: Measures of public hospital productivity



The National Health Reform Agreement agreed by COAG commits all governments to deliver reforms with no net increase in bureaucracy across the Commonwealth and State Governments as a proportion of the ongoing health workforce[6]. Graph 8 shows that the number of administrative staff as a percentage of total public hospital staff has actually increased, which appears to be inconsistent with the COAG commitment.

Graph 8: Administrative & clerical staff as a percentage of total public hospital staff



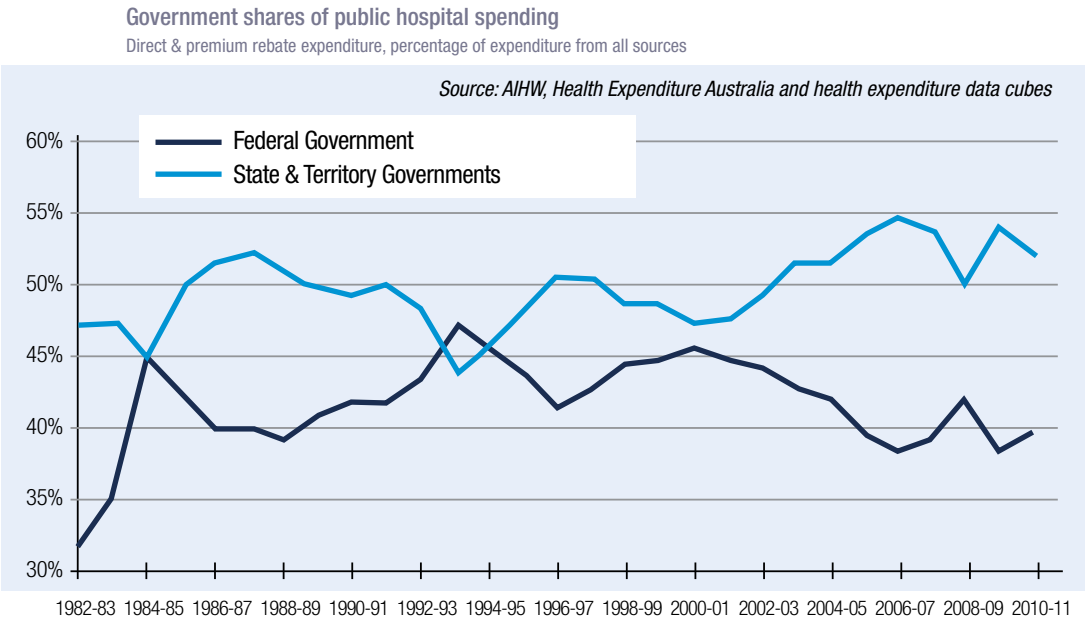
6 National Health Reform Agreement, August 2011, page 9, clause 17

Funding

The National Health Reform Agreement signed in August 2011 commits the Commonwealth to increase its share of public hospital funding to 45 per cent of efficient growth of activity based services from 1 July 2014, increasing to 50 per cent from 1 July 2017.

Graph 9 shows the changing history of the respective government shares of public hospital spending.

Graph 9: Government shares in public hospital spending



The AMA will continue to monitor this information into the future, assisted by the public information of the funding flows through the National Health Funding Pool.

2. STATE-BY-STATE PUBLIC HOSPITAL PERFORMANCE REPORT

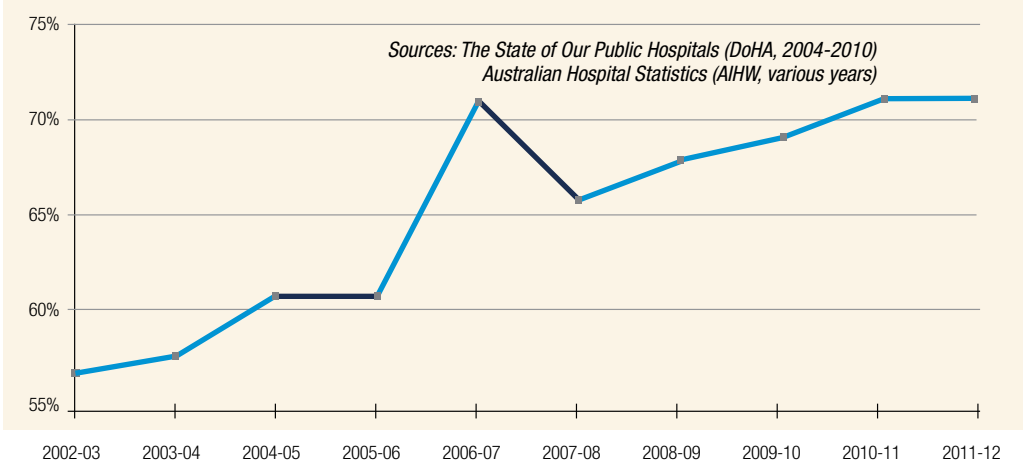
This section includes performance information for each State and Territory using available data sources.

NEW SOUTH WALES

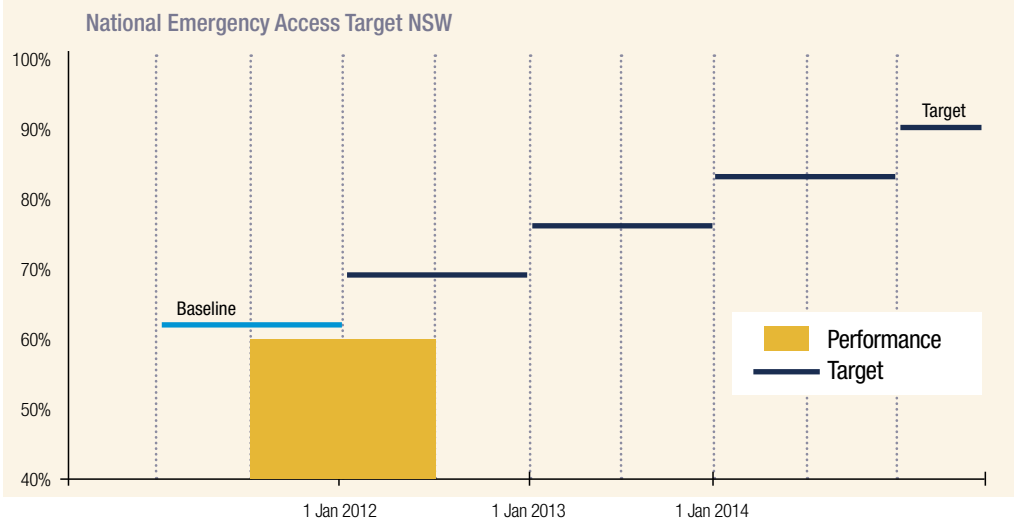
There has been no improvement in NSW emergency department performance in 2011-12, with 71 per cent of Category 3 patients seen within the recommended time. Emergency department access is below the baseline and interim target under the National Emergency Access Target (NEAT). Waiting times for elective surgery increased by two days.

Emergency departments - *no change*

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – NSW

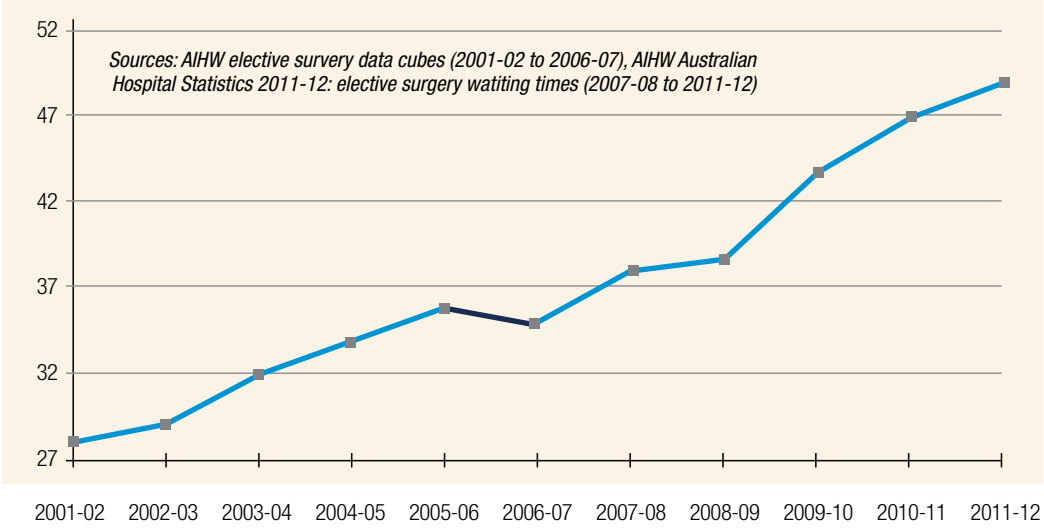


Emergency departments – NEAT – *below baseline and interim target*



Elective surgery waiting times – *increased (by two days)*

Median waiting time for elective surgery (days) – NSW

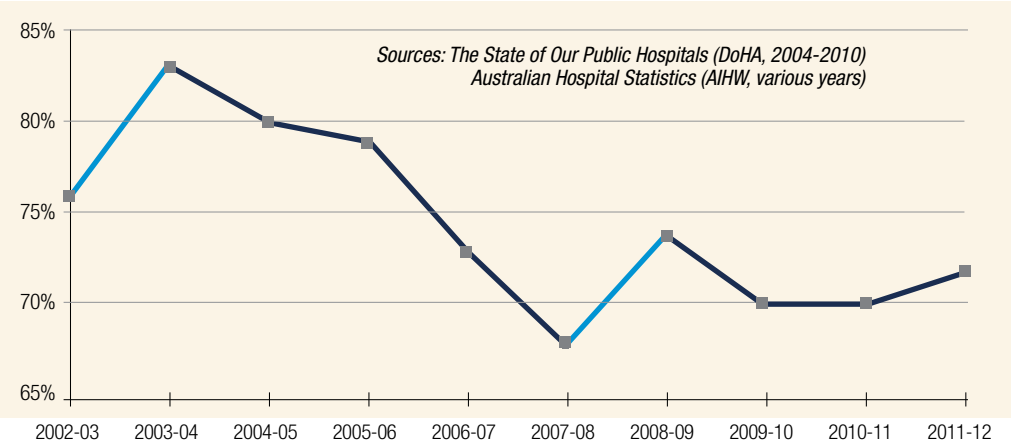


VICTORIA

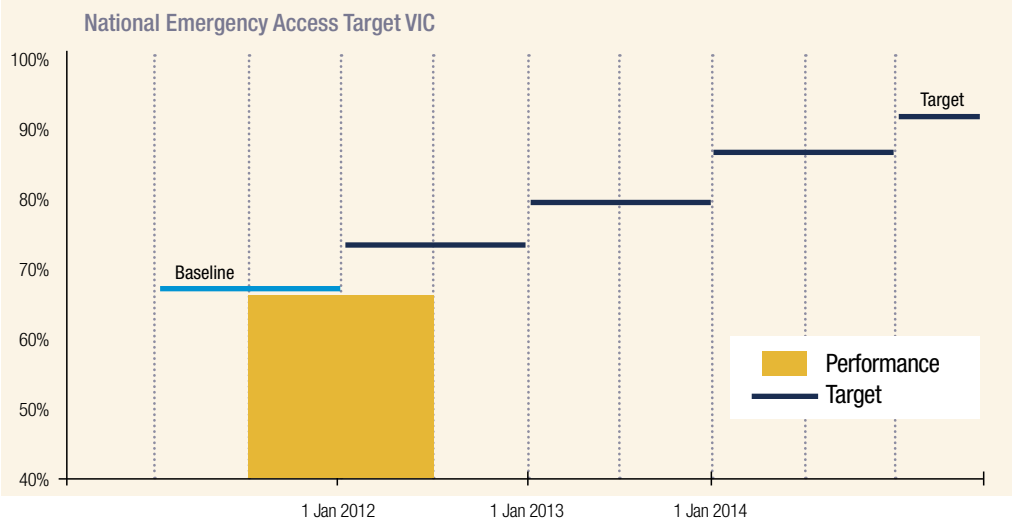
Victorian emergency department performance improved marginally in 2011-12, with 72 per cent of Category 3 patients seen within the recommended time, up from 70 per cent in 2010-11. Emergency department access is below the baseline and interim target under NEAT. Waiting times for elective surgery were unchanged in 2011-12.

Emergency departments – *improved (by 2%)*

Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (<30 minutes) – VIC

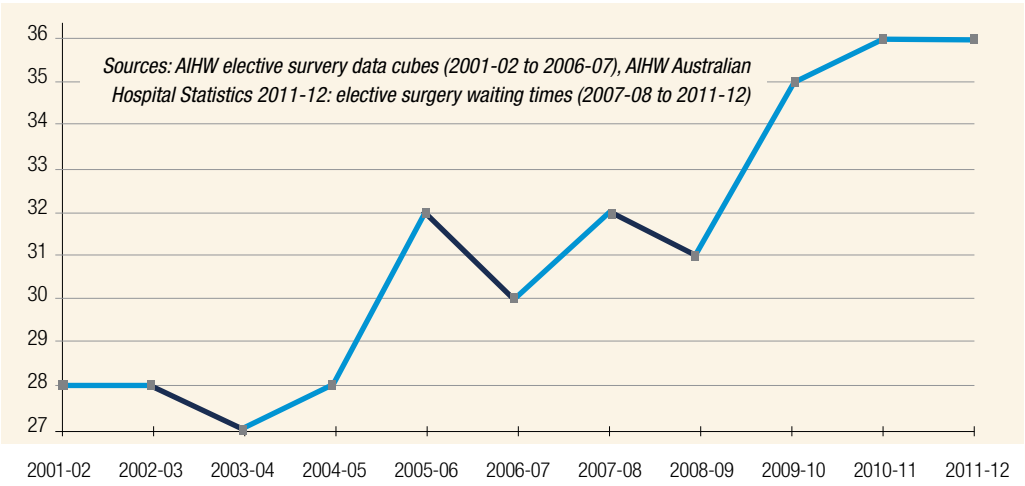


Emergency departments – NEAT target – *below baseline and interim target*



Elective surgery waiting times – *no change*

Median waiting time for elective surgery (days) – VIC

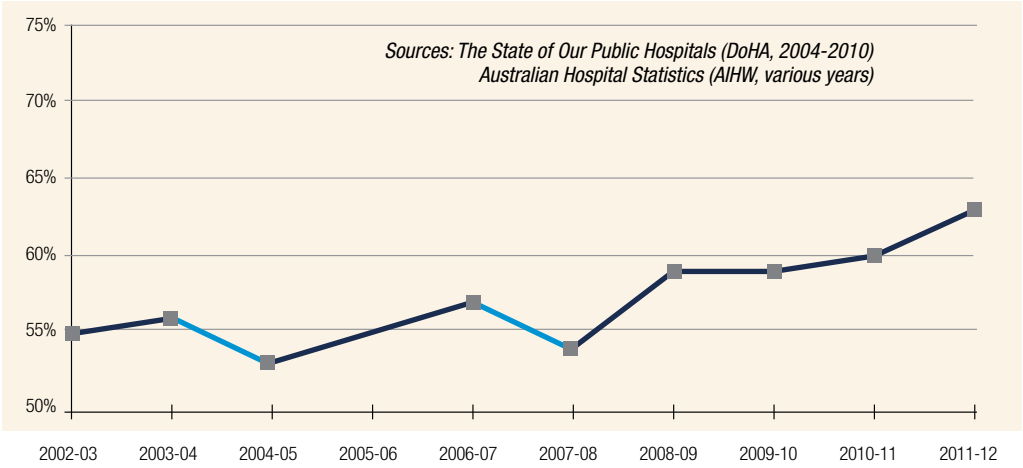


QUEENSLAND

In 2011-12, Queensland emergency department performance improved marginally, with 63 per cent of Category 3 patients seen within the recommended time, up from 60 per cent in 2010-11. Emergency department access is above the baseline but below the interim target under NEAT. Waiting times for elective surgery decreased by one day.

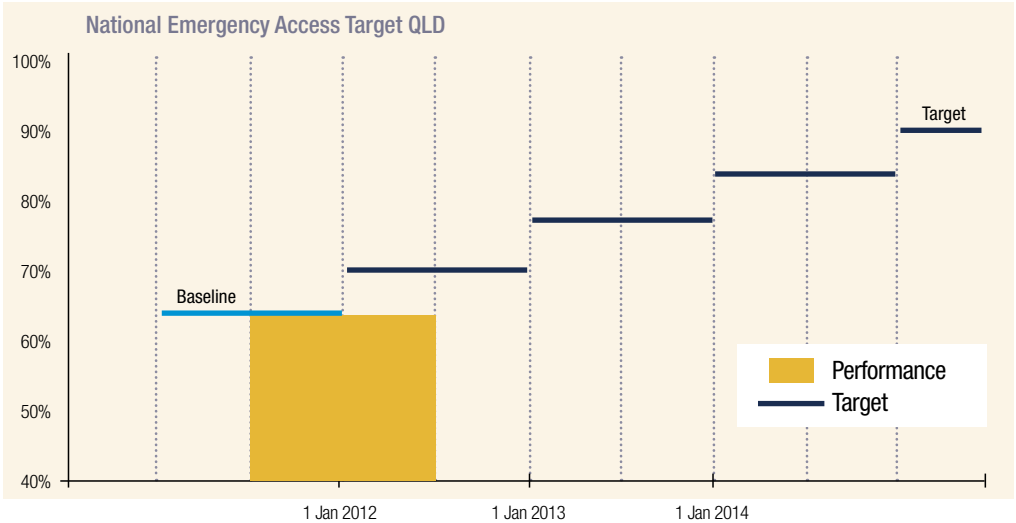
Emergency departments – *improved (by 3%)*

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – QLD



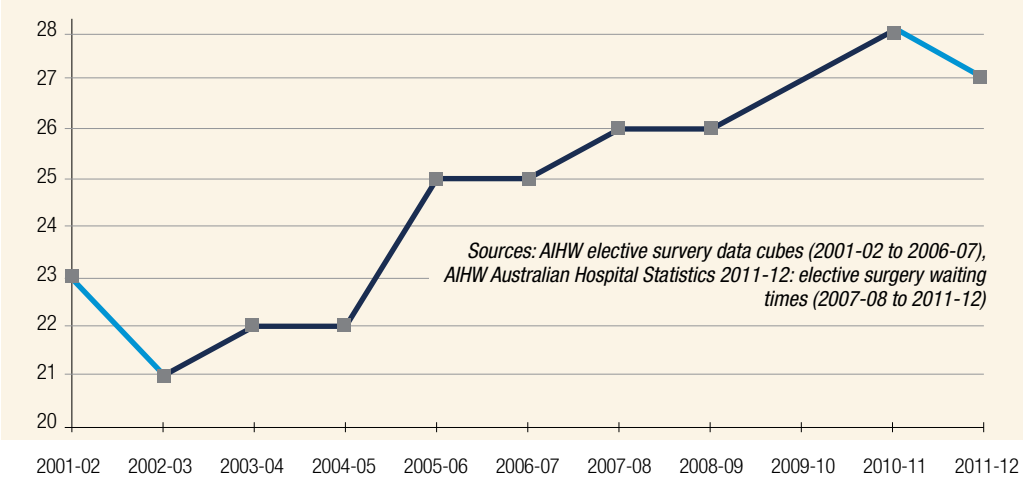
Emergency departments – NEAT target – *above baseline but below interim target*

National Emergency Access Target QLD



Elective surgery waiting times – *decreased (by one day)*

Median waiting time for elective surgery (days) – QLD

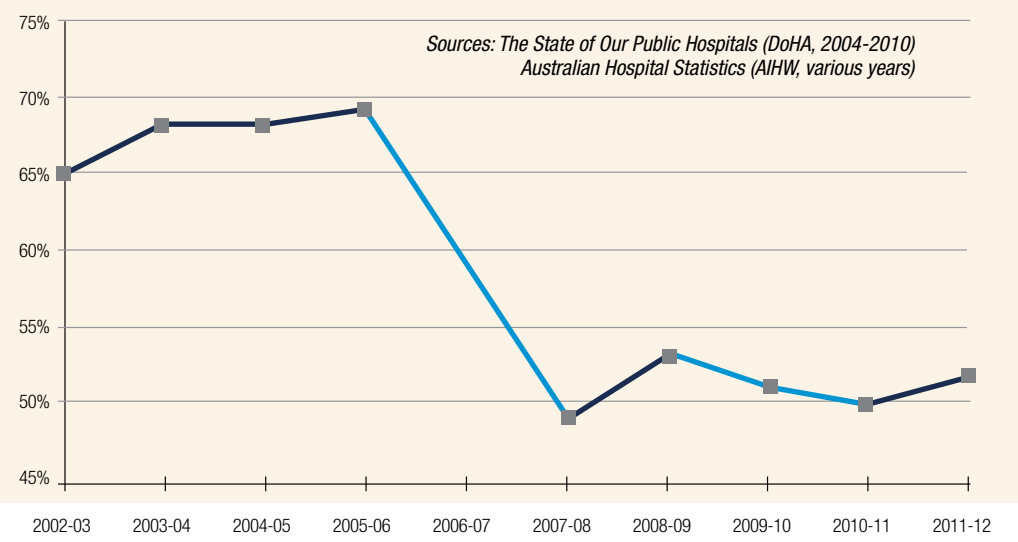


WESTERN AUSTRALIA

In 2011-12, emergency department performance in Western Australia improved marginally to 52 per cent, up from 50 per cent in 2010-11. Emergency department access is above the baseline and interim target under NEAT. Waiting times for elective surgery increased by one day.

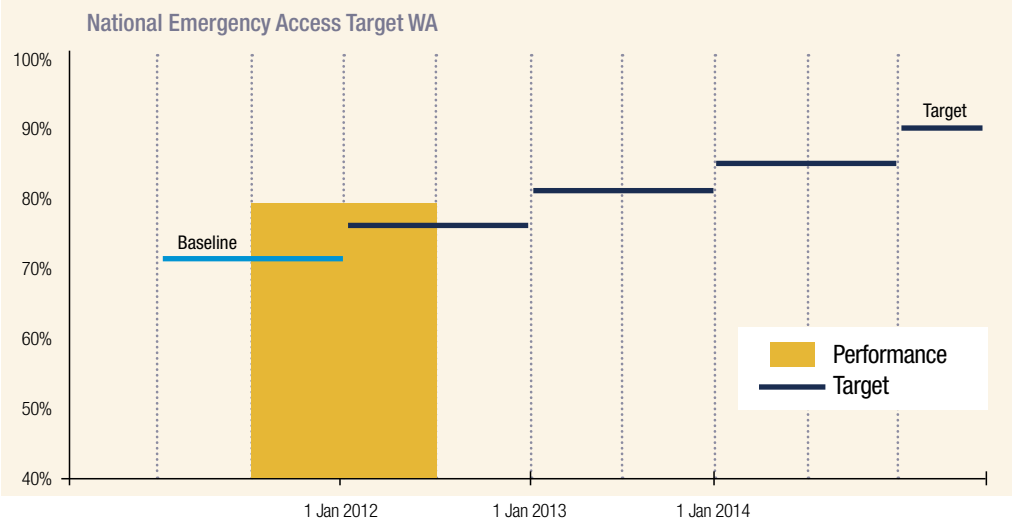
Emergency departments* – *improved (by 2%)*

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – WA



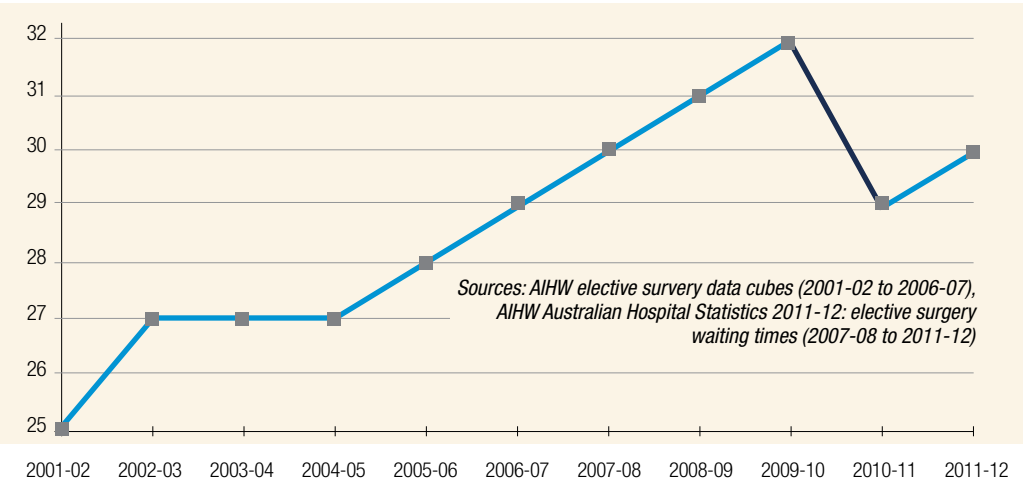
** WA reports this data differently and the % reflects the time taken by a patient to be seen by a doctor (and not another health professional, as is recorded in other State data).*

Emergency departments – NEAT target – *above baseline and interim target*



Elective surgery waiting times – *increased (by one day)*

Median waiting time for elective surgery (days) – WA

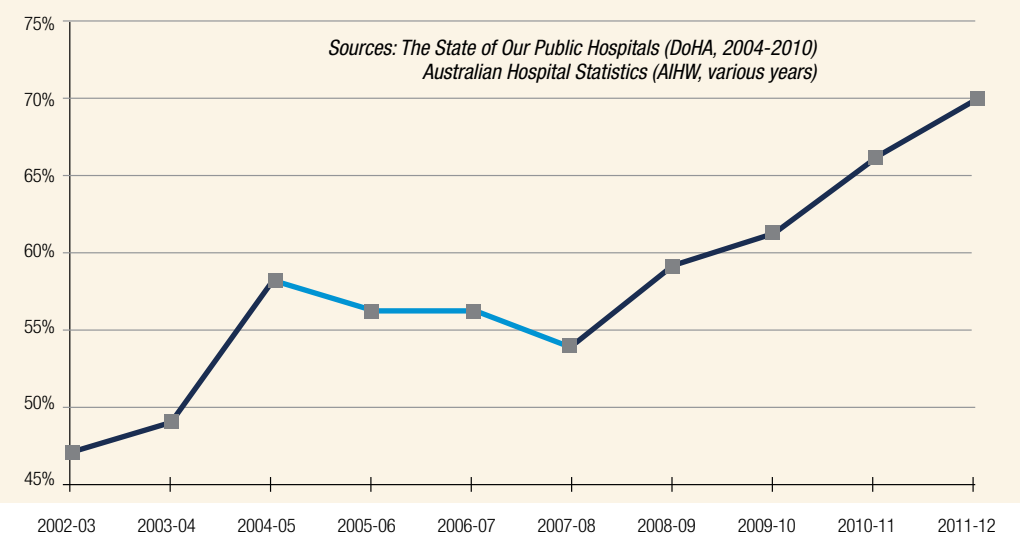


SOUTH AUSTRALIA

South Australian emergency department performance improved marginally in 2011-12 to 70 per cent, up from 66 per cent in 2010-11. Emergency department access is above the baseline but below the interim target under NEAT. Waiting times for elective surgery decreased by four days.

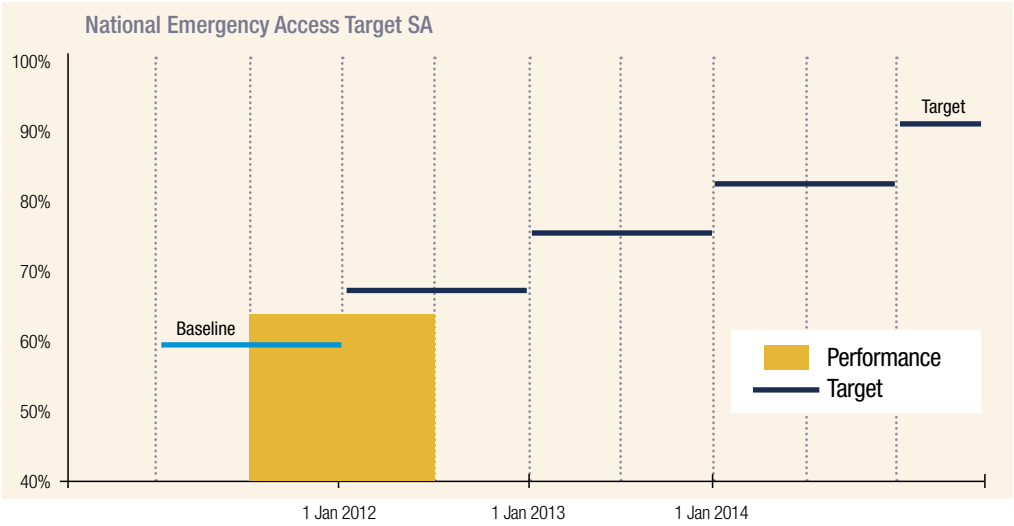
Emergency departments – *improved (by 4%)*

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – SA



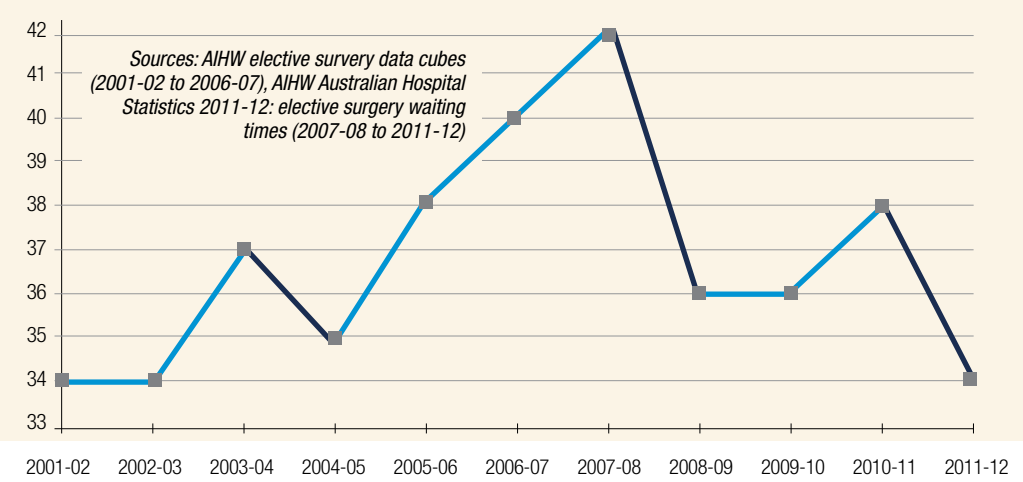
Emergency departments – NEAT target – *at baseline but below interim target*

National Emergency Access Target SA



Elective surgery waiting times – *decreased (by four days)*

Median waiting time for elective surgery (days) – SA

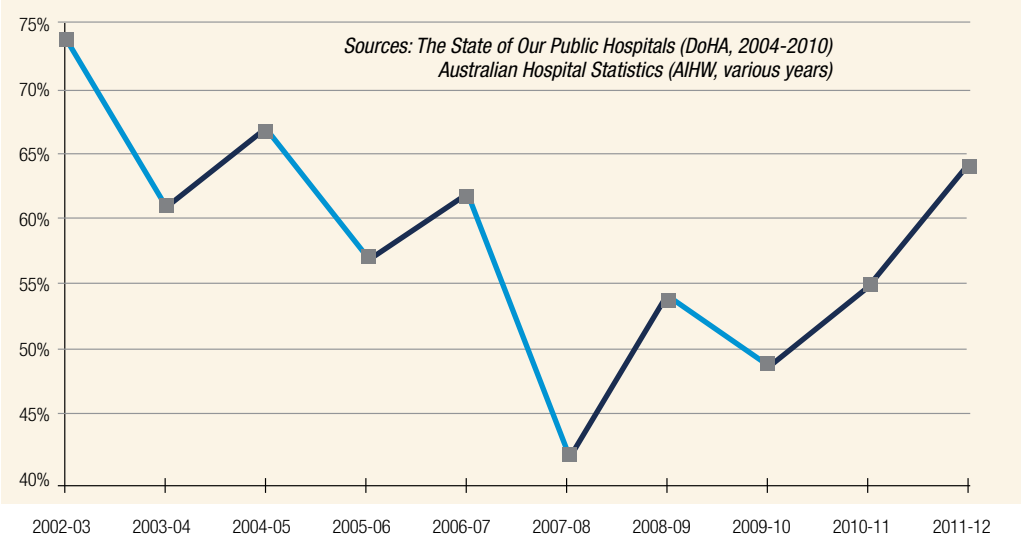


TASMANIA

In 2011-12, Tasmania's emergency department performance improved, with 64 per cent of Category 3 patients seen within the recommended time of 30 minutes, up from 55 per cent in 2010-11. Emergency department access is at the baseline but below the interim target under NEAT. Waiting times for elective surgery were unchanged.

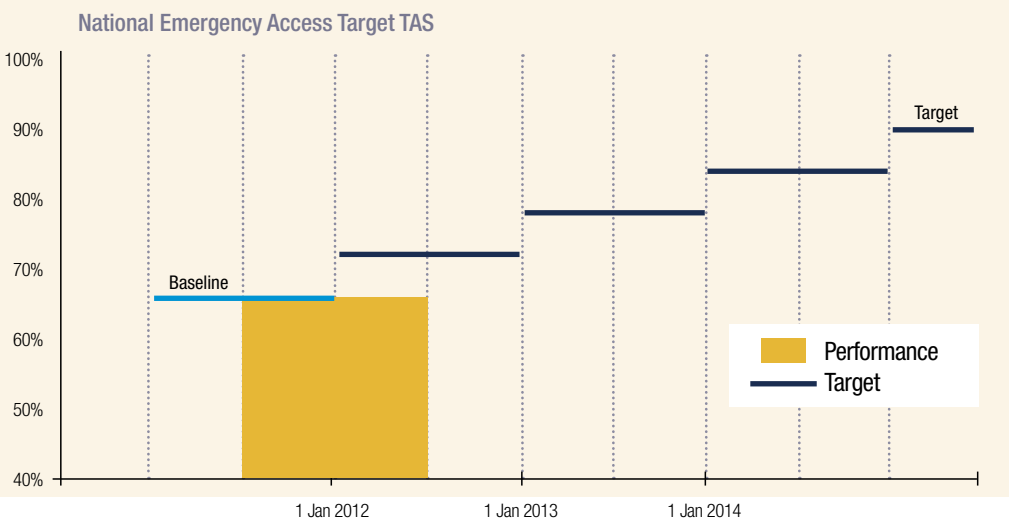
Emergency departments – *improved (by 9%)*

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – TAS



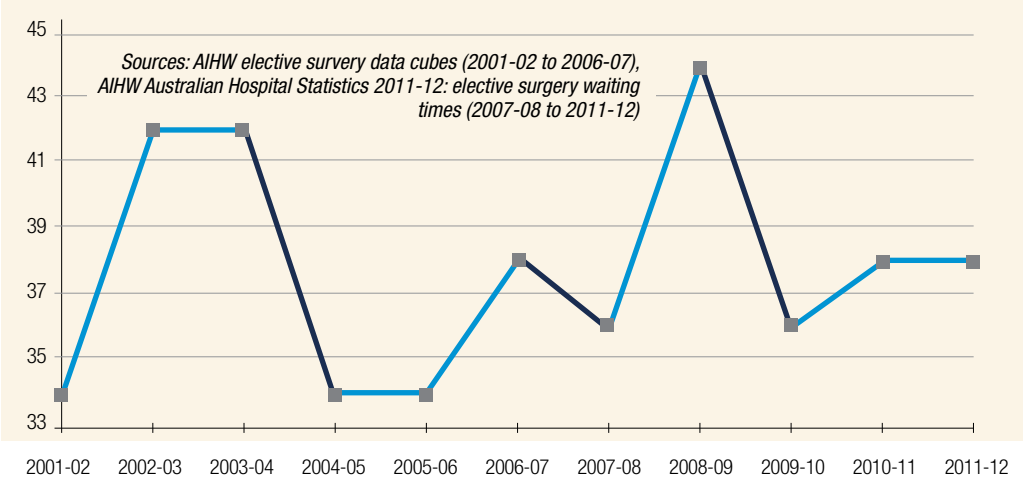
Emergency departments – NEAT target – *at baseline but below interim target*

National Emergency Access Target TAS



Elective surgery waiting times – *no change*

Median waiting time for elective surgery (days) – TAS

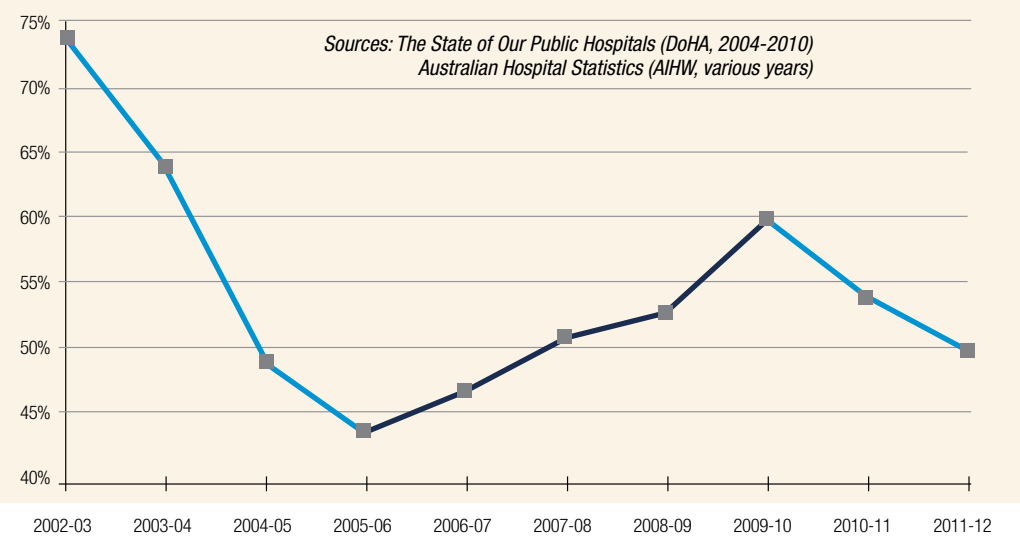


AUSTRALIAN CAPITAL TERRITORY

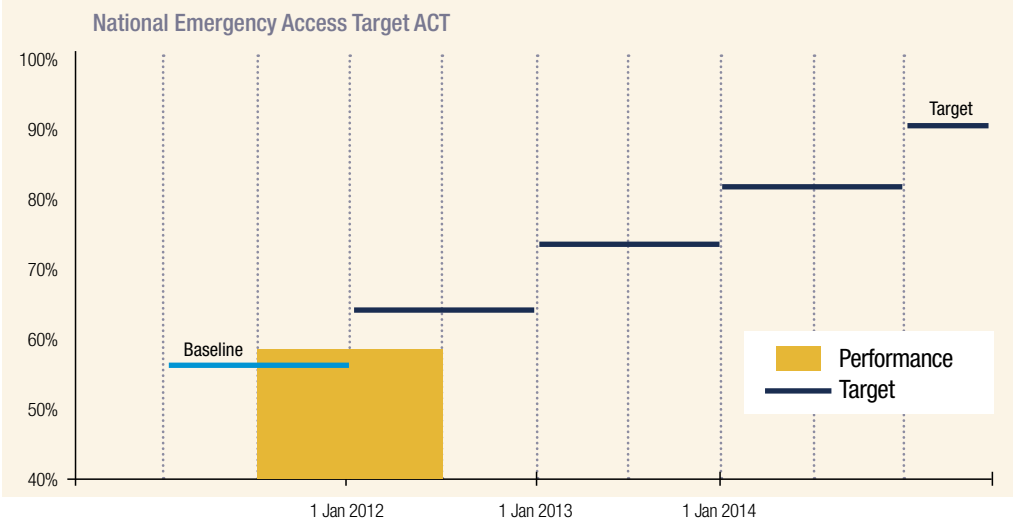
In 2011-12, the ACT emergency department performance for Category 3 patients declined from 54 per cent to 50 per cent. Emergency department access is above the baseline but below the interim target under NEAT. Waiting times for elective surgery decreased by 13 days.

Emergency departments – *declined (by 4 %)*

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – ACT

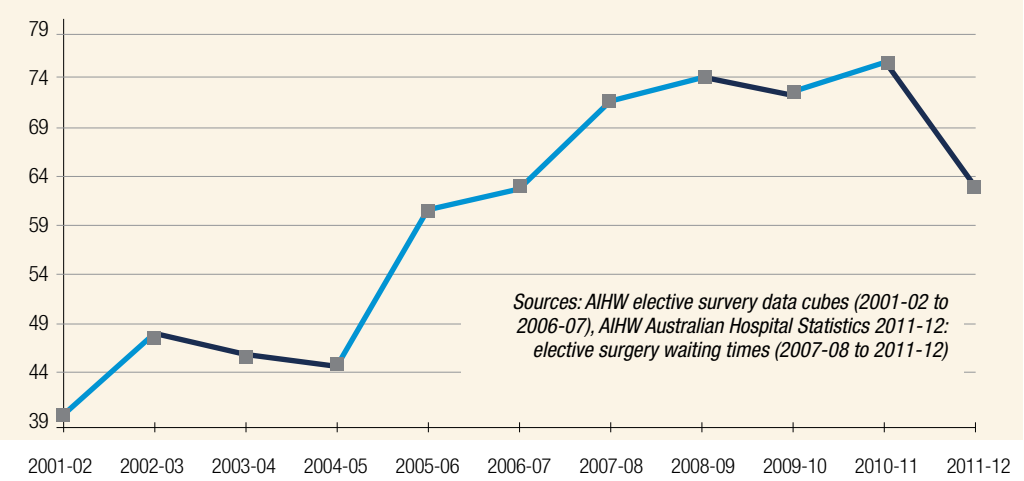


Emergency departments – NEAT target – *above baseline but below interim target*



Elective surgery waiting times – *reduced (by 13 days)*

Median waiting time for elective surgery (days) – ACT

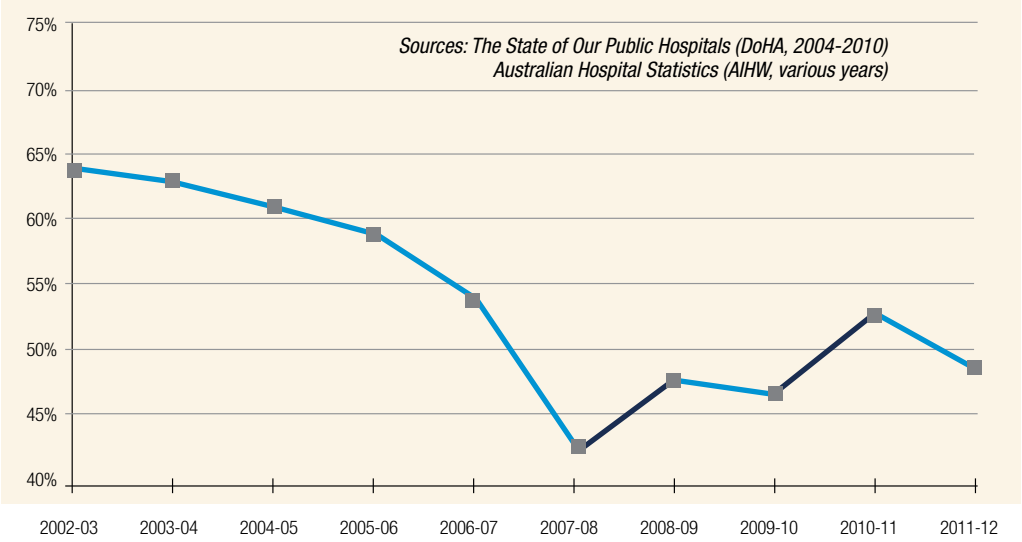


NORTHERN TERRITORY

In 2011-12, Northern Territory emergency department performance declined, with 49 per cent of Category 3 patients seen within the recommended time of 30 minutes, down from 53 per cent in 2010-11. Emergency department access is below the baseline and interim target under NEAT. Waiting times for elective surgery increased by six days.

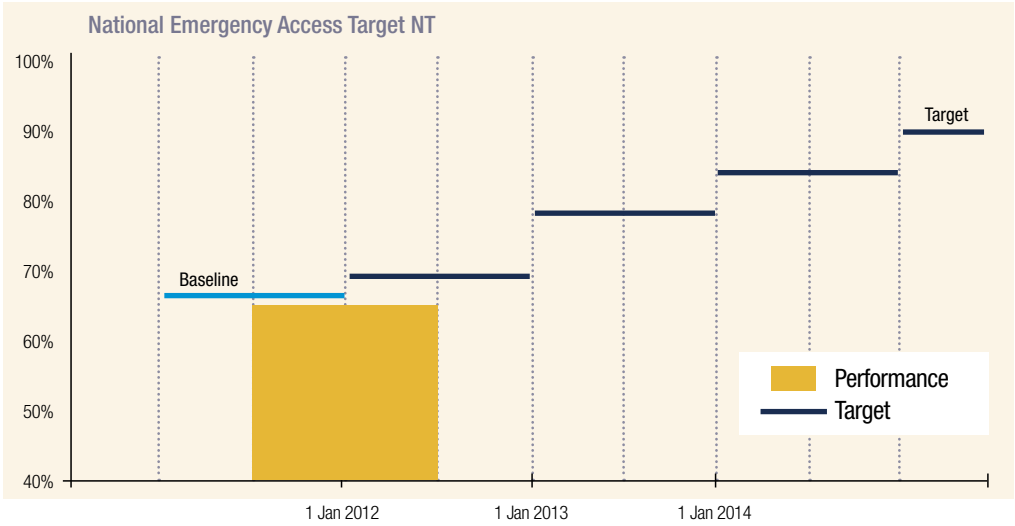
Emergency departments – *declined (by 4%)*

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – NT



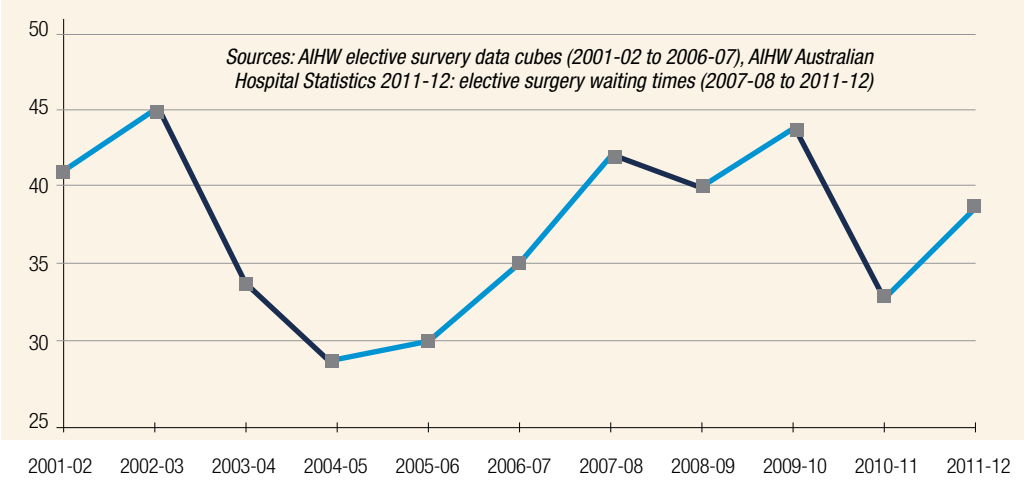
Emergency departments – NEAT target – *below baseline and interim target*

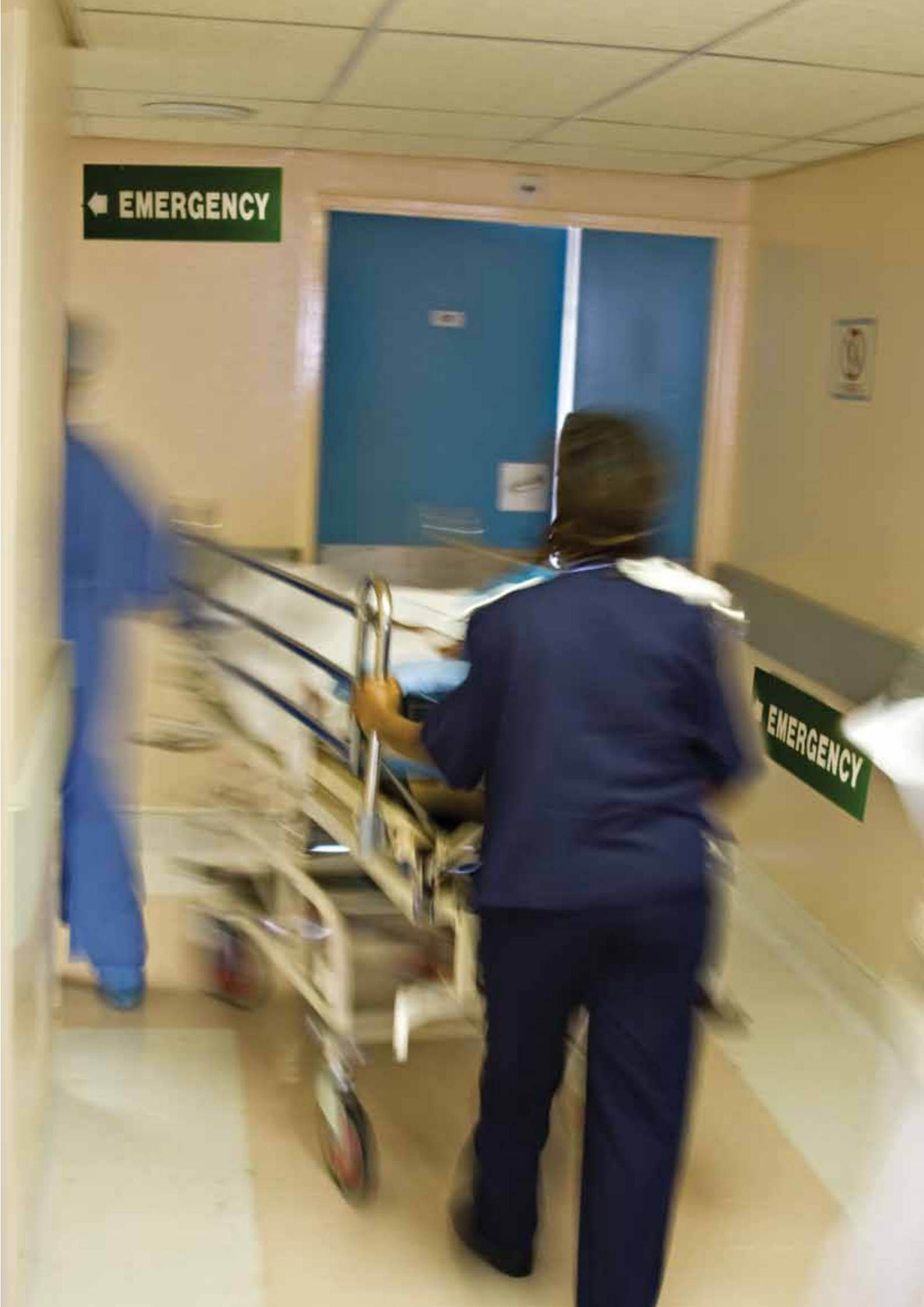
National Emergency Access Target NT



Elective surgery waiting times – *increased (by six days)*

Median waiting time for elective surgery (days) – NT

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