AMA

PUBLIC HOSPITAL REPORT CARD 2007

An AMA analysis of Australia's public hospital system

INTRODUCTION

More than half the Australian population depends on the public hospital system, yet hospitals have not been given sufficient resources (funds, workforce, or infrastructure) to meet their needs.

The lack of resources threatens the quality and the safety of the system. The degradation of the public hospital system is not acceptable and cannot be justified given the healthy state of Commonwealth and State/Territory budgets (boosted by resources boom revenues).

The 'blame game' does not fool the people. Both levels of government (Commonwealth and State/Territory) have fallen down on the job. Having sought — and failed — to foist the blame on each other, they now share the blame.

Annual publications on hospital activities and performance are released by both the Australian Institute of Health and Welfare and the Commonwealth Department of Health and Ageing.

This AMA Public Hospital Report Card 2007 provides an independent analysis of relevant hospital issues, including:

- capacity
- performance
- access and equity
- productivity
- funding.

These key issues best reflect hospital performance and are comparable over time and across States/Territories and on a national level.

The AMA has also identified areas where there is room for real action and improvement across all jurisdictions.

An opportunity exists for governments to set appropriate goals and achieve real progress through the development of the next Australian Health Care Agreements.

Australian voters also have an opportunity through the ballot box to demand improvements to their public hospital system.

The AMA Public Hospital Report Card 2007 aims to assist policymakers and the public with a relevant and useful contribution to the debate.

SUMMARY

In preparing this Report Card, the AMA has mostly used publicly available information which assesses public hospital performance against government-determined performance standards and criteria. The AMA does not endorse these performance standards and criteria and in many cases, even if the standards and criteria are fully met, they represent an unacceptable departure from good clinical practice. The AMA believes Australian public hospitals are in bad shape and are desperately in need of urgent recurrent and capital funding increases.

The AMA calls on all Australian governments to take immediate action to repair the public hospital system.

CAPACITY

CURRENT ISSUES Public hospital capacity has been slashed by nearly 60 per cent over the past 20 years.

Cuts to hospital bed numbers have been too deep and the risk of systematic breakdowns is too high.

RECOMMENDATIONS Governments reap financial savings by shifting admissions to the private sector for the privately insured and through productivity improvements. More of these savings should be reinvested in workforce and infrastructure to improve quality and reduce unmet needs.

PERFORMANCE

CURRENT ISSUES Less than two-thirds of urgent emergency department patients are currently seen within recommended times.

There is no compelling evidence that the decline in hospital performance is due to a rise in inappropriate patient presentations. Access block is occurring because insufficient resources have been made available to meet the genuine demand.

RECOMMENDATIONS All Australian governments should commit to more appropriate resourcing of public hospital emergency departments so that patients are seen within the recommended times in a high proportion of cases. A target of 100 per cent should be achievable.

The commitment to reaching acceptable targets must be a joint Commonwealth and State/Territory commitment and given expression in contractual form.

ACCESS AND EQUITY

CURRENT ISSUES There has been a distinct deterioration in the proportion of Australians being admitted for elective surgery within medically recommended times.

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

RECOMMENDATIONS All Australian governments should commit to an objective that at least 90 per cent of elective surgery patients are operated on within recommended times.

To achieve this objective, governments need to address comprehensively the resource limitations which currently result in poor access to elective surgery.

PRODUCTIVITY

CURRENT ISSUES Over the past 20 years, the average length of stay in public hospitals has fallen overall (in large part, reflecting the rise of same-day separations due to advances in medical care and technology). In the past few years, this reduction has slowed significantly and in-hospital episodes are becoming more intense and costly.

RECOMMENDATIONS Governments need to listen more carefully to what Australians are saying about their wants and needs for health care. The nation can afford to give its citizens access to modern health technologies, even though some are costly. Ultimately, this is a matter of choice.

FUNDING

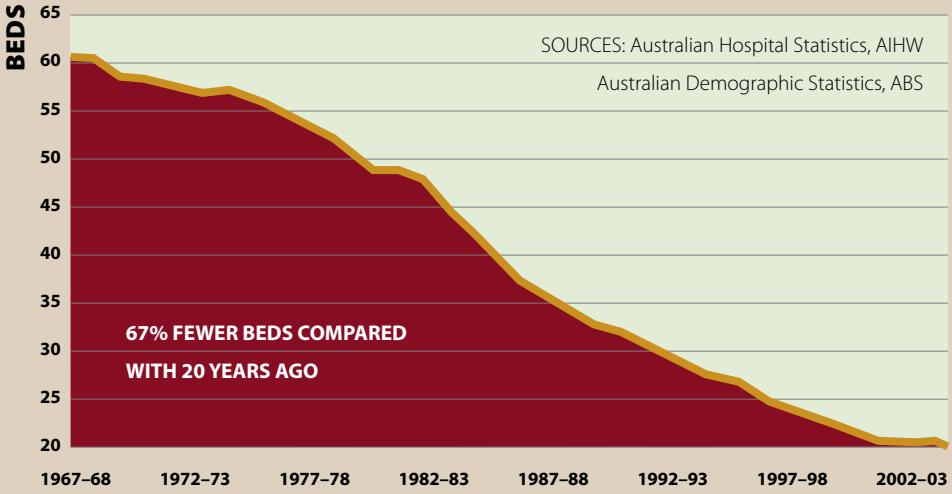
CURRENT ISSUES The hospital funding 'blame game' has lost its thrall and is a zero sum game anyway. The average contributions of governments since the 1980s are close to 50 per cent each but in recent years, the Commonwealth government effort has slackened off.

RECOMMENDATIONS All Australian governments need to remodel the Australian Health Care Agreements arrangements so that joint and individual responsibilities are clear and beyond dispute. The Commonwealth government needs to pull its weight with funding contributions that are more appropriate to the needs of the people.

1. CAPACITY

Hospital capacity is measured by relating the number of available beds to the size of the population. The capacity of Australia's public hospitals has been slashed by nearly 60 per cent over the past 20 years (graph 1.1).

Older people have more hospital episodes than younger people and typically have longer stays as well. The population aged 65 and over is a useful proxy measure for the hospital-using population. Graph 1.1 measures hospital capacity as the number of approved public hospital beds per thousand of population aged 65 years and over.



Graph 1.1: Approved/available public hospital beds per '000 of population 65+ nationally

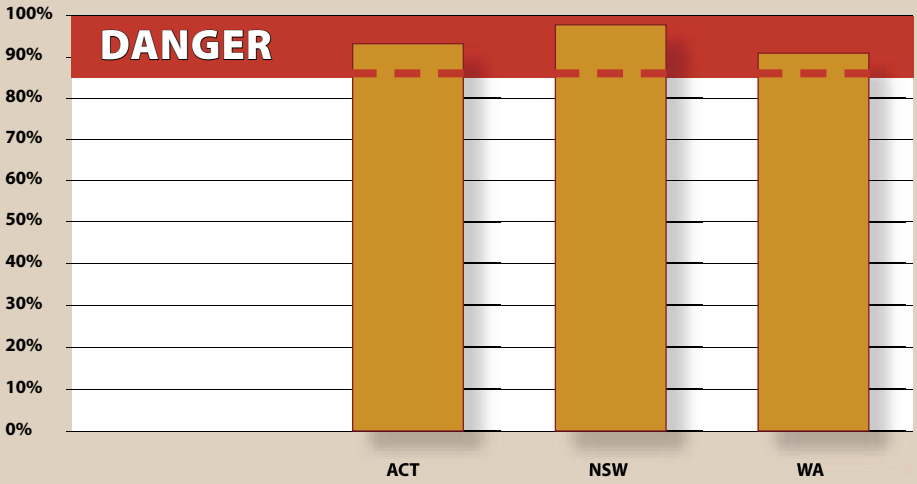
WHY IS THIS IMPORTANT?

Due to advances in medical care and technology, it has been possible to reduce the average length of stay in hospital. The private hospital system has also picked up more of the load. These developments have lessened the severity of previous cuts to public hospital capacity.

However, the cuts in bed numbers have been too deep. While advances in health technology will continue to generate efficiency gains, there will be an offsetting increase in needs that reflects the complexity of caring for an older population. Governments will not be able to keep cutting public hospital capacity without imposing further inappropriate restrictions on access to hospital care.

A shortage of beds manifests itself in a dangerously high bed occupancy rate. An Australasian College for Emergency Medicine study has shown that an occupancy rate of more than 85 per cent (on average over the year) risks systematic breakdowns and extended periods of 'code red', which put patient safety at risk.

Teaching hospitals commonly operate on a bed occupancy rate of 95 per cent (graph 1.2). Furthermore, some jurisdictions set a target bed occupancy rate of more than 90 per cent. These rates are too high. They risk systemic failure and compromise patient safety. The 85 per cent rule should apply in every hospital.



Graph 1.2: Median bed occupancy rate for teaching hospitals in selected States (%) 2005 (Data not available from Vic, Qld, SA and Tas)

WHAT NEEDS TO BE DONE?

A bed is considered available if it is in a suitable location and is sufficiently staffed to deliver appropriate care. All Australian governments must lift their efforts to improve workforce and infrastructure resources.

Workforce shortages continue to bedevil the public hospital system. Overseas trained doctors have helped avert even greater problems. However, Australia is just one of many countries to have failed to train enough health professionals for the needs of their population. Worldwide competition for health professionals is increasing.

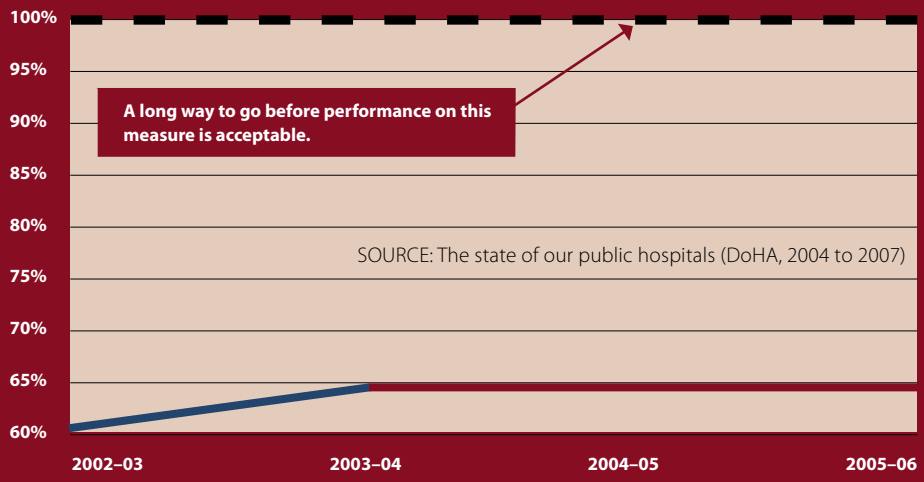
At the same time, public hospital infrastructure has been allowed to decay in some areas. Unless health infrastructure is modernised and brought up to standard, it will be difficult to produce the quality health outcomes that Australians expect.

Governments reap financial savings by shifting admissions to the private sector for the privately insured and through productivity improvements. More of these savings should be reinvested in workforce and infrastructure to improve the quality of the public hospital system and reduce unmet needs.

2. PERFORMANCE

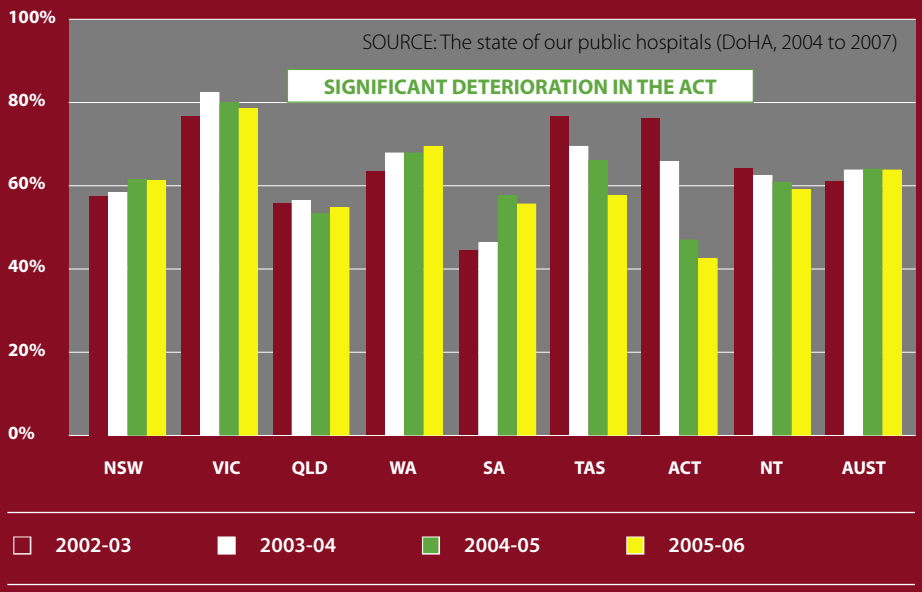
The hospital system's ability to cope with emergency and urgent cases is a critical measure of performance and any decline in recommended emergency admission rates is unacceptable.

Less than two-thirds of emergency department patients classified as urgent are currently seen within the recommended 30 minutes and there is no evidence of recent improvement (graphs 2.1 and 2.2).



Graph 2.1: Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) nationally.

In 2004 and again in 2007, the Australasian College for Emergency Medicine (ACEM) surveyed 70 Australian public hospitals in the five biggest States. The 2007 survey reveals a significant deterioration in access block, with a third more patients waiting more than eight hours for their hospital bed compared with 2004. The survey showed a 30 per cent decrease between 2004 and 2007 in the number of patients affected by access block in NSW. For the other four large states, therefore, the number of patients affected by access block more than doubled.



Graph 2.2: Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) state/territory.

The ACEM data were analysed by the Road Trauma and Emergency Medicine Unit of the Australian National University. The survey leader noted that:

"These figures are most consistent with a system which has passed the point of maximum efficiency and is now in a situation where even small changes in demand cause large changes in the number waiting."

WHY IS THIS IMPORTANT?

Due to the peaks and troughs in the demand for health care, everyone realises that it is not possible for public hospitals to achieve short waiting times 24 hours a day, 365 days a year. There will always be busy times. That said, hospital performance indicators are falling far too short of what is a minimal standard on too many occasions.

Triage categories 1 (resuscitation, patient needs to be seen immediately), 2 (emergency, patient needs to be seen within 10 minutes), and 3 (urgent) together represent 41 per cent of emergency department presentations.

The proportion of these highest triage category presentations — that is, patients who need to be there — has changed little in the past few years. There is no compelling evidence that the decline in hospital performance is due to a rise in inappropriate patient presentations. Public hospitals have well developed protocols to divert patients to GP services when that is appropriate. Access block is occurring because insufficient resources have been made available to meet the genuine demand.

WHAT NEEDS TO BE DONE?

All Australian governments should commit to more appropriate resourcing of public hospital emergency departments so that patients are seen within the recommended times in a high proportion of cases. A target of 100 per cent should be achievable.

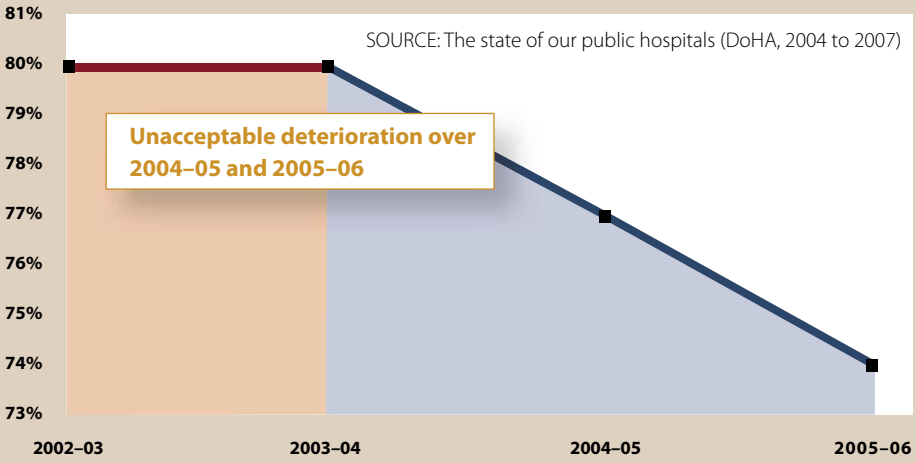
The government cost- and blame-shifting culture *must* change. The commitment to reaching acceptable targets must be a joint Commonwealth and State/Territory commitment and be given expression in contractual form (in the Australian Health Care Agreements). Australian governments have to be jointly and individually accountable for outcomes against this critical measure of public hospital performance.

3. ACCESS AND EQUITY

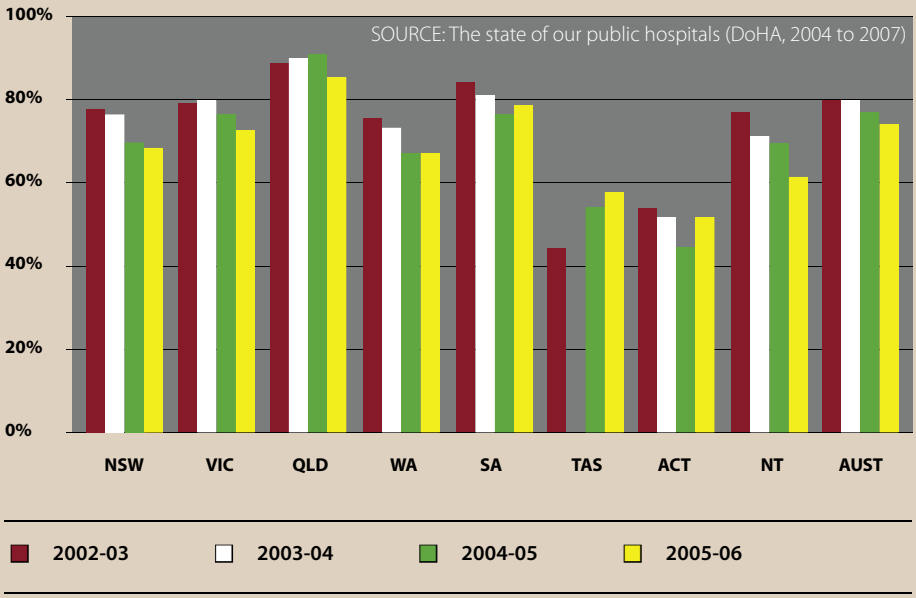
Elective surgery is not about non-essential or purely cosmetic procedures. It is any form of surgery considered medically necessary but which can be delayed for at least 24 hours.

Governments have dropped the ball with elective surgery as seen by the falling proportion of Australians being admitted for elective surgery in public hospitals within medically recommended times.

Over the past few years, there has been a marked deterioration in access for category 2 elective surgery patients — for whom admission within 90 days is desirable for a condition causing some pain, dysfunction or disability, but which is unlikely to deteriorate quickly or become an emergency (graphs 3.1 and 3.2). Category 2 patients represent more than one-third of elective surgery admissions nationally.



Graph 3.1: Percentage of elective surgery patients (category 2) seen within recommended time (90 days), nationally



Graph 3.2: Percentage of elective patients (category 2) seen within recommended time (90 days), state/territory

WHY IS THIS IMPORTANT?

When public patients are obliged to wait — for years in some cases — for an indicated procedure, it is no longer possible for governments to claim that access to health care is equitable.

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

WHAT CAN BE DONE?

All Australian governments should agree on and commit to a target that at least 90 per cent of elective surgery patients are seen within recommended times.

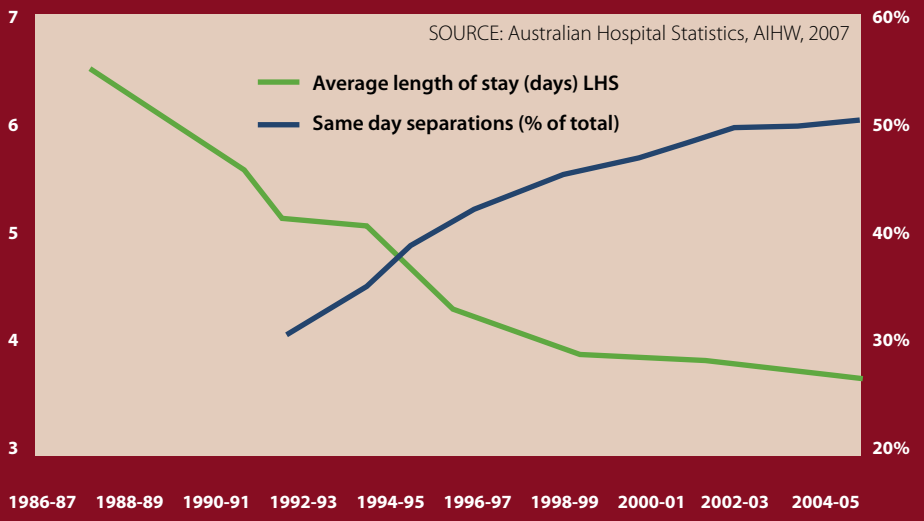
To achieve this objective, governments need to address comprehensively the resource limitations which currently result in poor access to elective surgery — available beds, workforce shortages, funding shortfalls and poor organisation.

4. PRODUCTIVITY

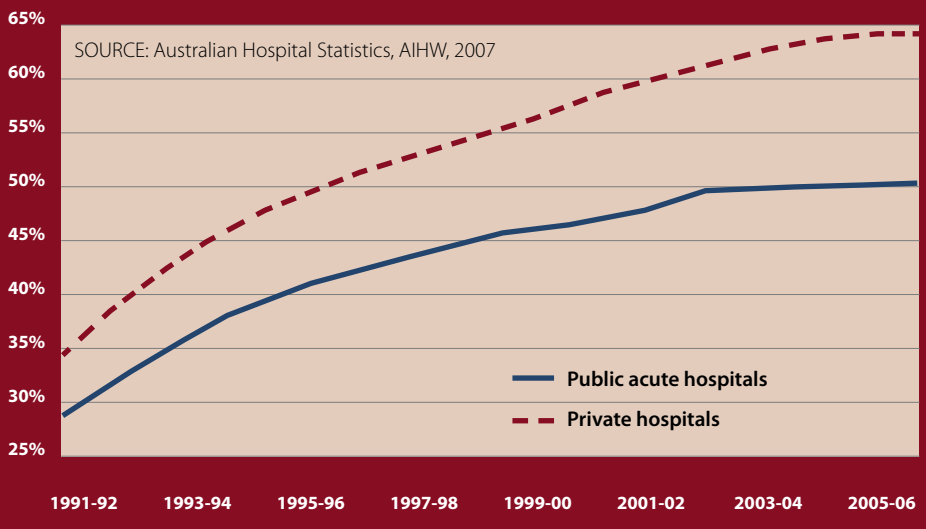
Average length of patient stay and the proportion of same-day separations provide an indication of hospital system productivity. Advances in medical care and technology have progressively lifted the proportion of separations that are same-day. Average length of stay has also been reduced for separations that are not same-day.

Over the past 20 years, the average length of stay in public hospitals has fallen overall (in large part, reflecting the rise of same-day separations). In the past few years, this reduction has slowed significantly (graph 4.1).

While the proportion of same-day services has grown to 50 per cent of public hospital separations, this growth has been much slower than in the private sector (graph 4.2).



Graph 4.1: Public hospital average length of stay and same-day separations, nationally

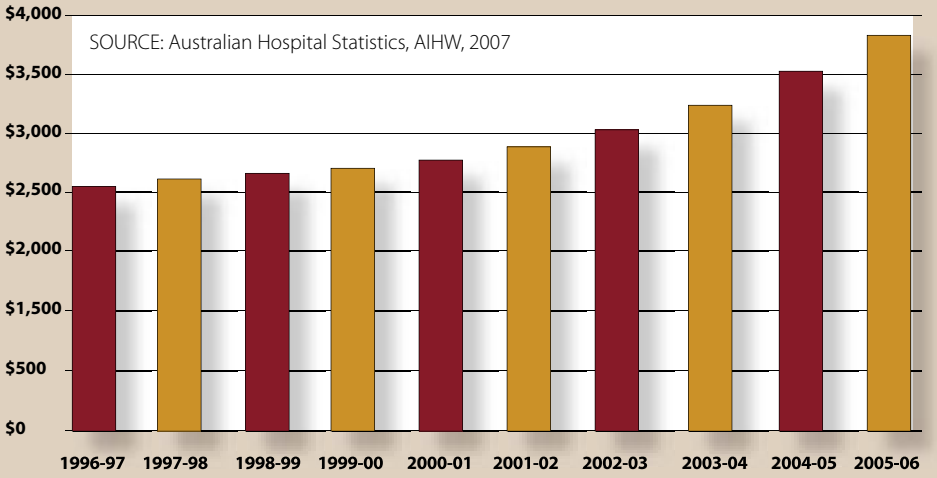


Graph 4.2: Same-day separations, public and private sectors, nationally

WHY IS THIS IMPORTANT?

It is imperative that all Australian governments understand that the average length of stay is falling much more slowly than in previous years and that, given the inexorable growth in chronic illness, in-hospital episodes are becoming more intense and costly (see graph 4.3).

As a result, it is not an option to continue slashing the capacity of the system to deliver quality care.



Graph 4.3: Cost per casemix-adjusted separation (selected public acute hospitals)

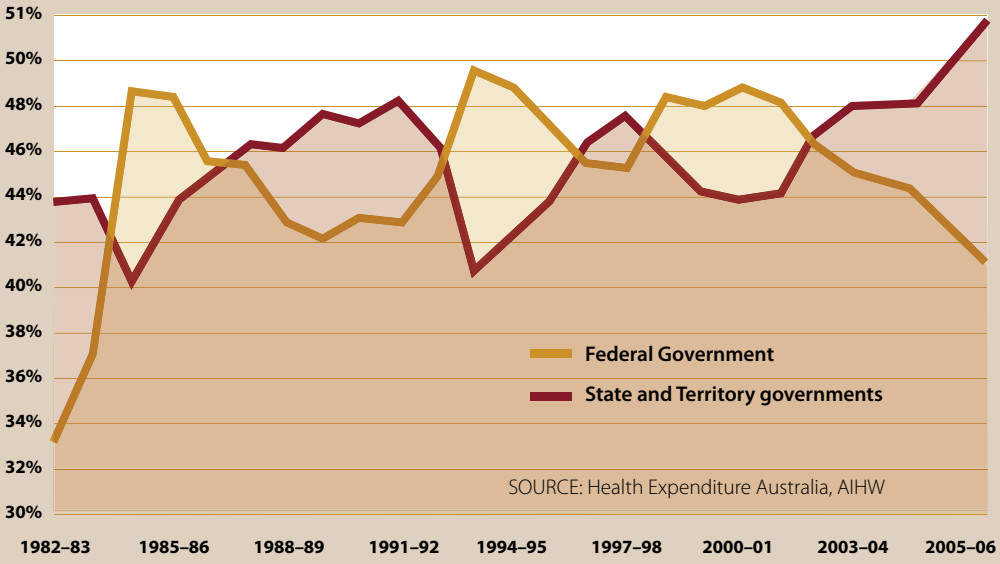
WHAT NEEDS TO BE DONE?

Governments often seek to restrain the growth in costs by delaying access to new health technologies. This is a counterproductive strategy. It stymies the productivity gains that have allowed the public hospital system to deliver more for less, year after year after year.

The nation can afford to give its citizens access to modern health technologies, even though some are costly. Ultimately, this is a matter of choice. Communities have a range of wants and needs, of which health care is one. Governments need to listen more carefully to what Australians are saying about their wants and needs for health care.

5. FUNDING

The hospital funding 'blame game' has lost its thrall. It is a zero sum game anyway given that, over time, the average contributions of the Commonwealth and State/Territory governments has been close to 50 per cent each (graph 5.1).



Graph 5.1: Government shares in public hospital spending

State and Territory Governments are now having to 'put back in' after reducing their efforts when the Commonwealth lifted its own efforts.

WHY IS THIS IMPORTANT?

Electors expect governments to work together to ensure that the public hospitals are properly resourced. It is a joint responsibility. The shares of spending count for nought if the total resourcing is insufficient. The Commonwealth and State/Territory governments also share the blame about equally when they fail to sustain the public hospital system. The 'blame game' is a failed strategy.

WHAT NEEDS TO BE DONE?

The Commonwealth and State/Territory governments need to stop blaming each other and work together — without reserve — to make the public hospital system more responsive to the wants and the needs of the population. The funding arrangements need to be remodelled so that joint and individual responsibilities are clear and beyond dispute. There needs to be full accountability from all Australian governments.

6. ROOM FOR IMPROVEMENT, EVERYWHERE

The AMA believes Australian public hospitals are in bad shape and are desperately in need of urgent recurrent and capital funding increases. In addition to the specific matters raised below, there is a need for an across-the-board lift in performance which can only be achieved with significant increases in recurrent and capital funding.

NEW SOUTH WALES

- poor results for proportion of public hospitals that are accredited (77 per cent compared to 84 per cent nationally)
- poor results for the number of public patient admissions per 1,000 of weighted population (163 compared to 186 nationally)
- poor results for median waiting time for elective surgery (36 days compared to 32 days nationally)

VICTORIA

- poor results for the number of public hospital beds per 1,000 of weighted population (2.3 compared to 2.6 nationally) and runs the system dangerously close to 100 per cent of capacity
- comes last in recurrent expenditure per person ($588 compared to $665 nationally)

QUEENSLAND

- poor results for recurrent expenditure per person ($612 compared to $665 nationally)
- poor results for the number of public patient admissions per 1,000 of weighted population (173 compared to 186 nationally)
- poor results for emergency department performance (60 per cent of patients seen in recommended time compared to 69 per cent nationally, and 31 minutes median waiting time compared to 24 minutes nationally)

SOUTH AUSTRALIA

- poor results for recurrent expenditure per person ($597 compared to $665 nationally)
- poor results for median waiting time for elective surgery (rising to 38 days compared to 32 nationally)

WESTERN AUSTRALIA

- dangerously high result for median bed occupancy for teaching hospitals
- poor results for bed numbers (below NSW, Victoria, Queensland and national average)
- poor result on recurrent expenditure on public hospitals (below NSW, Victoria, Queensland and national average)
- some small room for improvement on proportion of public hospitals accredited

TASMANIA

- scores three last places:
  - the proportion of public hospitals that are accredited (19 per cent compared to 84 per cent nationally)
  - the number of public patient admissions per 1,000 of weighted population (155 compared to 186 nationally)
  - the percentage of elective surgery admissions within the recommended time (68 per cent compared to 81 per cent nationally)

AUSTRALIAN CAPITAL TERRITORY

- scores four last places
  - the percentage of elective surgery admissions that waited longer than one year (10.3 per cent compared to 4.6 per cent nationally)
  - the median waiting time for elective surgery (61 days compared to 32 nationally)
  - the percentage of emergency department patients seen within the recommended time (52 per cent compared to 69 per cent)
  - the median waiting time for emergency department patients (46 minutes compared to 24 nationally)
- little to show for spending that is well above average ($865 recurrent expenditure per person compared to $665 nationally)

NORTHERN TERRITORY

- poor results for elective surgery measures (73 per cent of patients seen in recommended time compared to 81 per cent nationally; 7.7 per cent of patients wait more than one year compared to 4.6 per cent nationally)
- poor results for emergency department measures (60 per cent of patients seen in recommended time compared to 69 per cent nationally; 35-minute median waiting time compared to 24 nationally)
- system running at dangerous over-capacity

Source: The state of our public hospitals June 2007, DoHA

AMA

Australian Medical Association Limited (ABN 37 008 426 793)
PO Box 6090 Kingston ACT 2604 TELEPHONE: 02 6270 5400
FACSIMILE: 02 6270 5499 WEBSITE: http://www.ama.com.au/