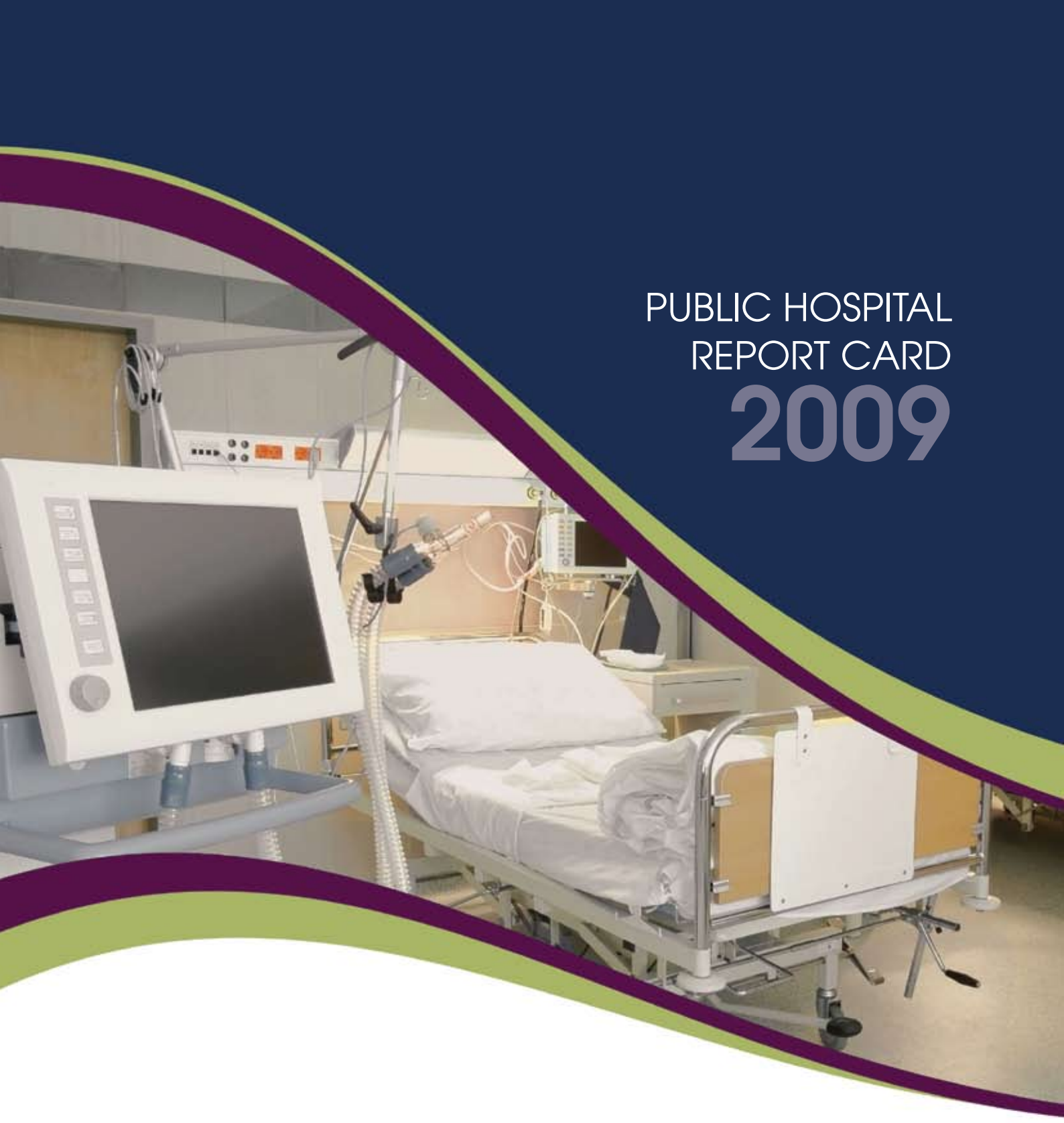

PUBLIC HOSPITAL REPORT CARD 2009

AN AMA ANALYSIS OF AUSTRALIA'S PUBLIC HOSPITAL SYSTEM

AMA


EMERGENCY
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INTRODUCTION

The performance of Australia's public hospital system continues to deteriorate. People still experience excessive waits in emergency departments and excessive waits for admission to a hospital bed. Waiting times for elective surgery have been getting longer.

These trends are the inevitable consequence of decisions taken by governments, over many years, to reduce the capacity of our public hospitals to meet the needs of Australians who require hospital treatment.

They are despite the hard work and dedication of doctors, nurses, and other health care workers who care for patients in public hospitals. I applaud all my colleagues who do their very best under increasingly difficult conditions.

More than half the Australian population depends on the public hospital system, yet the hospitals do not have the capacity (funds, workforce, or infrastructure) to adequately meet their needs.

A key indicator of capacity is bed occupancy rates. There is strong evidence that patient safety and quality of care are compromised when hospitals consistently run at average occupancy rates higher than 85 per cent. Major metropolitan teaching hospitals typically operate at average occupancy rates above 95 per cent. The outbreak of swine flu, and the consequential cancellation of elective surgery, has exposed the fragility of a hospital system that is already running at full capacity.

Any further increase in the rate of unemployment is likely to increase demand on public hospitals as private health insurance becomes less affordable.

The AMA wants Australian Health Ministers to make 85 per cent average occupancy a performance benchmark and to make public reporting of public hospital bed numbers and occupancy rates mandatory.

Delivering safe, high quality health care is a resource-intensive undertaking. High quality care, and avoiding adverse events, can only occur in an environment where the capacity of the hospital system matches demand.

Our doctors and nurses know what is needed to improve hospital performance and they should be involved in decisions on allocation of resources.

The AMA is encouraged to see governments making more effort to measure and report on the performance of public hospitals. That said, measuring and reporting will not of themselves make a difference to the capacity of public hospitals to provide care, or to the timeliness of quality of care the patient receives.

The 2009 AMA Public Hospital Report Card is issued as the Federal Government contemplates a huge health reform agenda, which includes the recommendations of the National Health and Hospitals Reform Commission.

It would be a grave mistake for governments to think that reform is simply about the hospital system doing more with less. All stakeholders benefit when resources are allocated and managed well, so that aim is not in dispute. We do, however, need to come to grips with the failures in the system. The quality of care needs to improve and it needs to improve now, not some years down the track after laboured reforms. The things that are needed to improve quality of care in hospitals are well known: appropriate resources, measures to make public hospitals rewarding places to work for all health professionals, rostering arrangements that provide safe working hours and minimise fatigue, high quality education and training of health professionals, and a strong commitment to research.

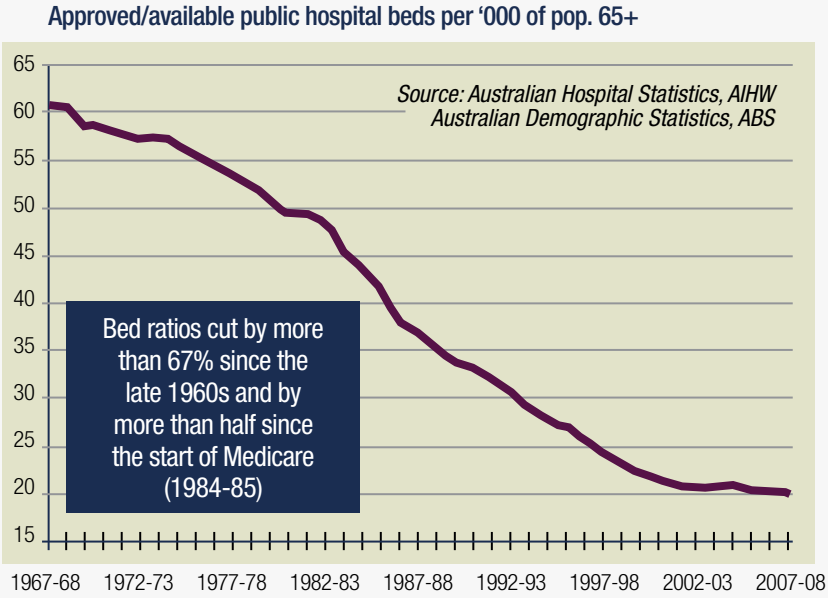
As Federal and State and Territory Governments debate the merits of different public hospital models, the AMA points to the constant deficiencies that have been identified in our public hospital reports year after year, and the need for governments to accept responsibility for actually addressing them, including providing adequate funding.

Regardless of who funds, governs, owns and operates public hospitals, the solutions that are set out in this report card stand. The Australian people will continue to hold all governments accountable for ensuring that public hospitals have sufficient capacity to meet the demands for their services. The Australian people rightly expect public hospitals to be resourced to meet community needs.

Dr Andrew Pesce
Federal President

1. CAPACITY

Hospital capacity is measured by relating the number of available beds to the size of the population. Population ageing reflects birth rates and the increase in longevity. Older people have more hospital episodes with longer admissions than younger people. The population aged 65 and over is a useful proxy measure for the hospital-using population. Graph 1.1 shows that the capacity of Australia's public hospitals has been slashed by 67 per cent over the past 20 years.



Graph 1.1: Available public hospital beds

Why is this important?

Advances in medical care and technology have reduced the average length of stay in hospital. The private hospital system has also picked up more of the load. These developments have blunted the impact of previous cuts to public hospital capacity.

However, the cuts in bed numbers have been too deep. While advances in health technology may continue to generate efficiency gains, there will be an offsetting increase in needs, reflecting the complexity of caring for an older population. Unless governments improve public hospital capacity, patient access to hospital care will worsen and safety will be put further at risk.

Bed occupancy rates in excess of 85 per cent are risky, leaving little room for systemic failures in equipment or systems and/or for periods of staff shortages. Overall, State averages are generally lower, influenced by rural and regional hospitals where occupancy rates can be 50 per cent or even lower.

Major metropolitan teaching hospitals commonly operate on a bed occupancy rate of 95 per cent or above. These rates are too high. Hospital overcrowding is the most serious cause of reduced patient safety in public hospitals. It can be reversed.

What needs to be done?

The 85 per cent rule should apply in every hospital. As part of their obligation to report against performance benchmarks, State and Territory Governments must also be required to report the number of available beds for each public hospital, and the occupancy rates.

A bed is considered available if it is in a suitable location and is sufficiently staffed to deliver appropriate care. Governments must urgently improve attraction and retention of appropriate workforce and provide more 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.

The Commonwealth has invested heavily to increase the number of medical student places to address workforce shortages. In 2007, there were 1,544 domestic medical graduates, an increase of 22 per cent from 2003. This is projected to increase to 2,920 graduates by 2012. The total number of medical graduates (domestic and international) is projected to increase to 3,437 by 2012.

Australia faces the prospect of wasting this significant extra investment if the States and Territories do not provide the necessary training places in their health systems. If they fail to do so, training bottlenecks will emerge and junior doctors will not get access to the breadth of clinical experience they require. This will inevitably impact on patient care, as we need every single one of these graduates to have a full and comprehensive medical education to ensure that the future demand for health services can be met. The Commonwealth should conduct a transparent review every two years of the States' and Territories' progress with providing extra clinical training places at undergraduate, pre-vocational, and specialist training levels. This would enable bottlenecks or training deficiencies to be identified and suitable solutions to be found.

States and Territories should be required to report on key workforce performance indicators such as increased intern positions and increased specialty training places in public hospitals.

Alongside the workforce shortages, public hospital infrastructure has been allowed to decay in many areas. Equipment, facilities and environment need updating, modernising and brought up to standard. Health infrastructure underpins safety and efficiency and is essential to produce the quality outcomes and meet the expectations that Australians deserve.

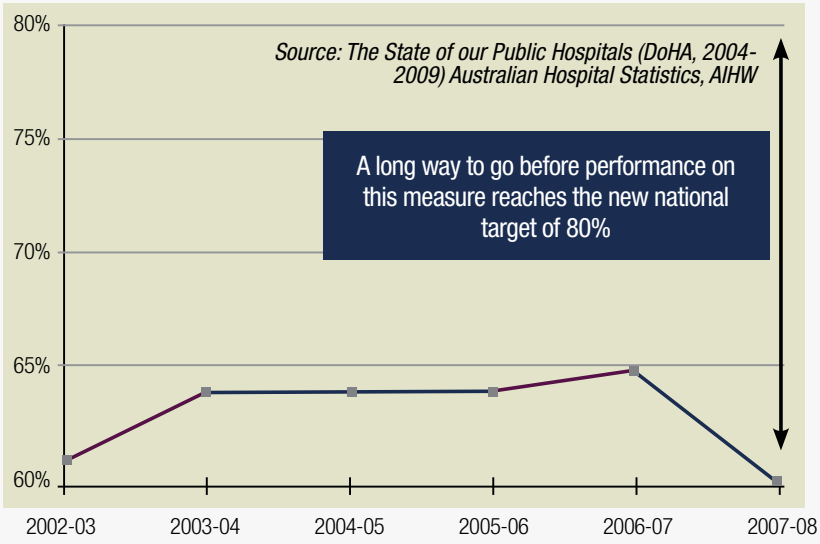
2. PERFORMANCE

The hospital system's ability to cope with emergency and urgent cases is a critical measure of performance. The declining performance on emergency cases is unacceptable.

The National Healthcare Agreement (signed by all governments in November 2008) set 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 (ACEM).

In 2007-08, only 60 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes, down from 65 per cent in 2006-07 (graph 2.1).

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



Graph 2.1: Urgent ED patients seen within recommended time

The ability of emergency departments to treat patients within clinically recommended triage times is constrained by access block. Access block is defined and measured by patients waiting for more than 8 hours in the emergency department for admission to a ward bed.

In June 2009, the Road Trauma and Emergency Medicine Unit at the Australian National University repeated its annual Access Block Prevalence Survey on behalf of ACEM. The Unit surveyed 79 Australian public hospitals in all States and Territories.

At the time of the survey, one third of patients under the care of the emergency department were waiting for admission to a ward. Of those patients, 70 per cent had been waiting more than 8 hours. In 22 hospitals, there were 44 patients who had been waiting more than 24 hours.

Commenting on the survey data, the President of ACEM noted that:

> "Even though politicians and health departments have been shown the facts and even though patients are still dying while waiting for beds, there has been no significant improvement in access block since this time last year."

Why is this important?

Because of 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 too far 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 42 per cent of emergency department presentations. The proportion of these highest triage category presentations — that is, patients who have the highest 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. Data from ACEM show that some 10 per cent of emergency department presentations are GP-type patients, and these presentations consume only 1 to 3 per cent of emergency department resources. Public hospitals have well developed protocols to divert patients to GP services when that is appropriate.

Access block is occurring because the capacity of our public hospitals is insufficient to meet genuine demand. Inability to admit patients to hospital beds means that they continue to reside in emergency departments, occupying beds and resources and limiting the hospital's capacity to deal with new urgent presentations. It is now essential that we achieve safe levels of hospital bed capacity to allow for timely admissions.

What needs to be done?

All Australian governments must commit to better resourcing of public hospital emergency departments and an increase in inpatient beds so that patients are seen within the recommended times in a higher proportion of cases. As previous AMA Public Hospital Report Cards have reported, the AMA estimates that an additional 3,750 beds are required across the country.

In November 2008, the Council of Australian Governments entered a 'landmark' deal for the National Healthcare Agreement, providing $64.4 billion over five years, including $4.8 billion in additional base funding. At the time, the Prime Minister stated that:

> "Together with the investments the Government has already made in hospitals, this could support an additional 3,750 beds in 2009-10, growing to 7,800 additional beds by 2012-13."

To date, there is no evidence to show that these new beds have been opened. All governments should publicly report on the new beds that have been made available from the additional funding provided under the National Healthcare Agreement. There needs to be a transparent and accountable process that includes a full stocktake of the actual number of beds required in each hospital, formal inter-governmental agreement of the timeframe for their establishment, and a transparent monitoring process. This is the only way to ensure that the new beds that are required are actually opened, that existing beds are not closed, and that additional funding is being provided at the hospital level to staff and operate the new beds.

In addition to transparent reporting on the actual number of beds in each hospital and bed occupancy rates, there should also be formal monitoring of access block in emergency departments, with a view to achieving ACEM's target of 10 per cent or fewer patients waiting more than 8 hours in emergency departments for admission to hospital.

Further, a target of 80 per cent of emergency department presentations seen within clinically recommended triage times is achievable in the short term, and 100 per cent should be the objective in the medium term.

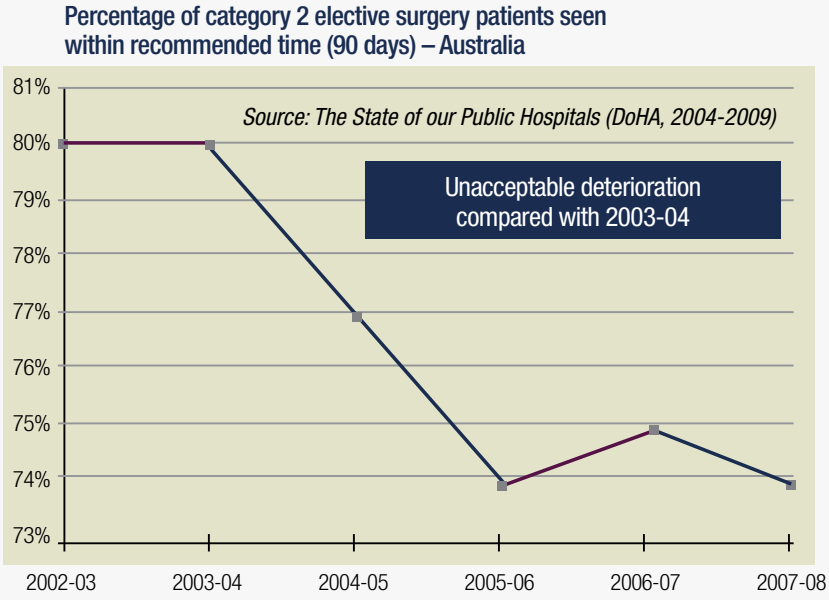
Australian governments have to be jointly and individually accountable for ensuring that the additional base funding in the National Healthcare Agreement is also used to improve outcomes significantly against these critical measures of public hospital performance.

3. ACCESS AND EQUITY

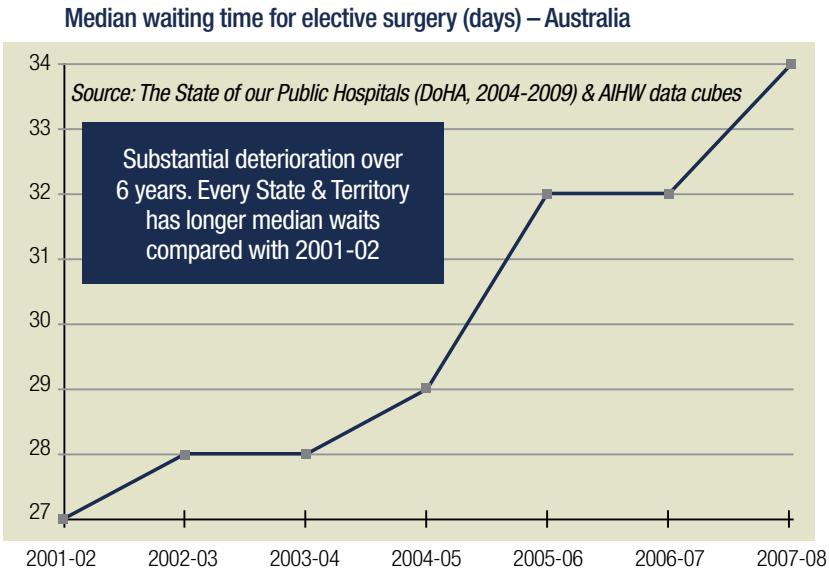
Elective surgery is not about non-essential or cosmetic procedures. It is any form of surgery considered medically necessary but which can be delayed for at least 24 hours.

In 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. Category 2 patients represent more than one-third of elective surgery admissions nationally.

The data show a decline in the proportion of patients who are able to access elective surgery within recommended times (graph 3.1) and a significant lengthening in the mean waiting time (graph 3.2).



Graph 3.1: Elective surgery patients (category 2) seen within recommended time



Graph 3.2: Median waiting time for elective surgery (days)

Why is this important?

When public patients are obliged to wait — for years in some cases — for a necessary 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 needs to be done?

All Australian governments should agree on and commit to an objective that at least 90 per cent of elective surgery patients receive their surgery within recommended times.

In January 2008, as part of a four-year plan to reduce the backlog of patients waiting for elective surgery, the Commonwealth provided States and Territories with $150 million for 25,000 procedures to carry out an "immediate national blitz on waiting lists". In a media release dated 30 June 2009, the Minister for Health and Ageing announced that this funding delivered 41,000 additional elective surgery procedures in 2008.

The 2007-08 data on which this report card is based show an increase of only 8,731 elective surgery procedures performed during that period compared to the previous year. The "blitz" did not occur in the first half of 2008. Notwithstanding this additional expenditure, waiting times are still increasing and waiting lists are still too long. For example, Victorian waiting list data for July to December 2008 show that the list reduced by only 218 people.

In addition, there are regular reports about how unreliable current State and Territory waiting list data are and concerns about the processes used in hospitals and by State governments to manipulate the public reporting of the number of people waiting for elective surgery. A nationally consistent, robust and transparent report is needed that provides clear and accurate information about the number of people on waiting lists and the number of elective surgeries performed on patients, by category, in each jurisdiction.

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.

Commonwealth and State/Territory funding of public hospitals has long rested on assumptions of very strong growth in productivity. Two key (and obviously inter-related) measures of this are the average length of stay (which has fallen) and the percentage of all separations that are same-day (which has risen). 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). Both measures are reaching a plateau (graph 4.1). The easy yards have been made. Although productivity itself continues to improve, it is being offset by the rising complexity of the casemix, reflecting an ageing population with higher co-morbidities. Governments have had unrealistic expectations that large productivity gains would offset those factors.

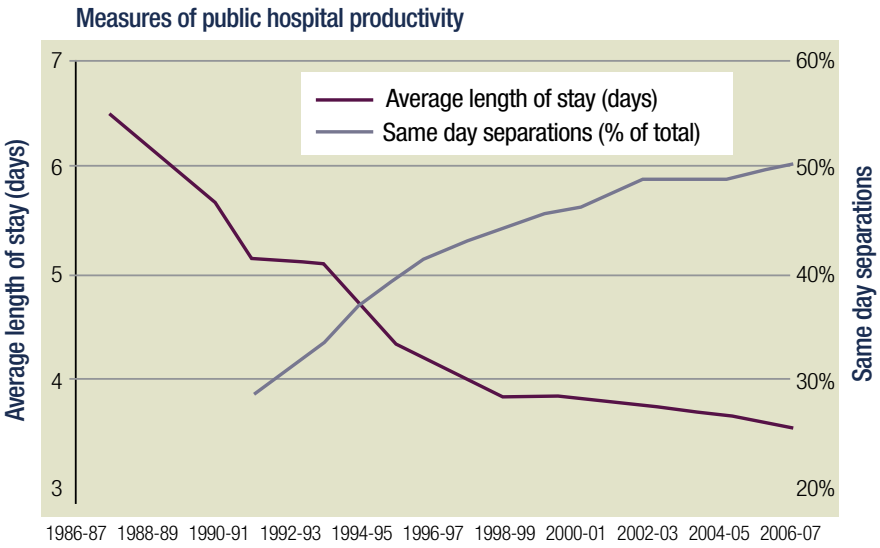
However, hospitals operating at full capacity for most of the time in fact create inefficiencies. Busy nursing staff are forced to attend to patients when they can, rather than when care guidelines say they should.

Public hospitals are served by a high-quality, dedicated and hard-working medical workforce. Unfortunately, there is no doubt that insufficient investment by governments in areas such as recruitment, retention and training has resulted in unsafe hours of work and excessive workloads, and this has led doctors to feel compromised as they endeavour to care for their patients. This issue is not being dealt with effectively by health departments in any State or Territory.

In 2008, the AMA conducted a national survey of junior doctors, who are a key part of the public hospital workforce. Fifty-four per cent reported that their workload had been excessive, 31 per cent believed that they regularly worked unsafe hours, and 41 per cent believed that their workload compromised patient safety.

The current reliance on medical officers undertaking prolonged periods of work results in unacceptably high costs both to the individual doctor and the standard of patient care.

Similarly, hospitals are less productive when staff have to rely on infrastructure and equipment that are old and not properly maintained.

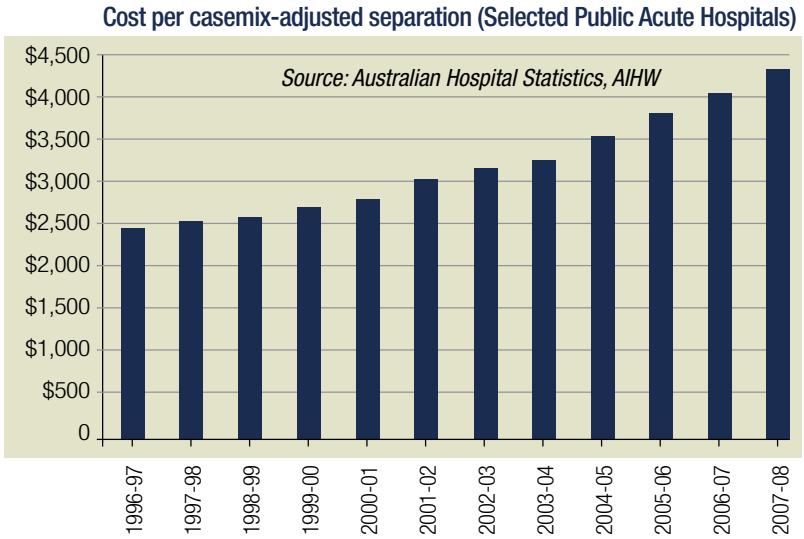


Graph 4.1: Public hospital average length of stay and same-day separations

Why is this important?

It is imperative that governments at all levels 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 4.2).

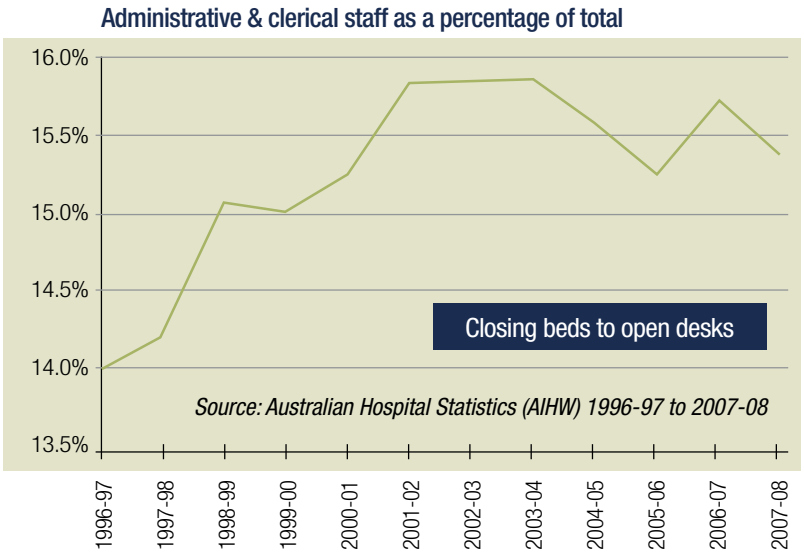
As a result, it is not an option to continue slashing the capacity of the system and place undue pressure on the individuals who provide care, and yet expect to deliver the same quality of care.



Graph 4.2: Cost per casemix-adjusted separation

In a world of scarce dollars, we need to make sure that money is not wasted needlessly on bureaucracy, but is directed to care of patients. The public hospitals employ 240,000 people.

Doctor and nurse numbers have been boosted but not to the levels needed. And the number of administrative and clerical staff remains high in proportion to the staff directly involved in the care of patients. Had administrative and clerical staff been maintained at 14 per cent of the public hospital workforce as it was in 1996-97, there would be 3,315 fewer jobs of that nature and scope to employ some 2,500 additional health workers today. Australia should not be closing beds to open desks. The recent reduction in the administrative and clerical staff as a percentage of total hospital staff since the last report card (graph 4.3) is a small step in the right direction and must continue over the coming years.



Graph 4.3: Index of bureaucracy

What needs to be done?

Doctors and nurses at the coalface know what is needed to optimise hospital performance. They must be involved in decisions about allocation of resources. Public hospitals are beset by tight resource constraints set by the bureaucracy, high levels of demand, workforce shortages, capital equipment issues and intermittent political crises. Our doctors and nurses work extraordinarily hard in this environment to deliver safe, quality healthcare and they must have a say in how hospital resources are allocated.

There needs to be better planning and infrastructure funding for new technologies. In times of resource constraints, governments often seek to restrain the growth in costs by delaying access to new health technologies. This is a counter-productive strategy. It stymies the productivity gains that have allowed the public hospital system to deliver more for less year after year. Initial cost outlays for modern health technologies often return efficiencies and better clinical outcomes.

Safe systems of work need to be developed and hospital management must commit to them. Rosters must minimise prolonged periods of work for doctors. Standard operating procedures for safe work practices must be put in place.

We need to measure the productivity of our hospitals simply, sensibly and realistically. Too often we have seen hospital data manipulated to cast a better light on achievement of benchmarks for political purposes. This year it has been more difficult to analyse how our public hospitals have fared compared to previous years because previously publicly available data are now not available.

5. FUNDING

In previous report cards, the AMA has provided commentary on the relative contribution of Commonwealth and State/Territory Governments for public hospital services.

The 2009 AMA Public Hospital Report Card is released at a time when there is significant debate on health care financing in Australia, and governments are contemplating their response to the recommendations of the National Health and Hospitals Reform Commission to transform the Australian health care system.

In that context the AMA acknowledges the importance of the additional base funding and increased indexation formula that the Federal Government provided under the National Healthcare Agreement. Given the reporting lags, it may be another two years before we can assess the impact that this additional funding has had on access to public hospital services. It will take several years of data to see if the State and Territory Governments have directed the additional funding to improve the capacity of public hospitals, and not reduced their own contributions to health care. The AMA will keep a close eye on the data.

In the meantime, the AMA will be closely watching private health insurance participation to see if recent changes to government policies have had a negative impact. If a fall in participation increases the need and demand in the public hospital system in the future, States and Territories will need financial compensation. Conversely, if people lose faith in public hospitals and seek treatment in the private sector, we could see the viability of public hospitals further undermined as the workforce moves to the private sector to meet demand.

6. STATE-BY-STATE PUBLIC HOSPITAL PERFORMANCE REPORT

Opening comments

As each year goes by, the Federal Government's *The state of our public hospitals* report provides less information on the performance of each State and Territory public hospital system. It is disappointing that the Federal Government fails to provide this information given its and COAG's commitment to develop and publish performance benchmark material.

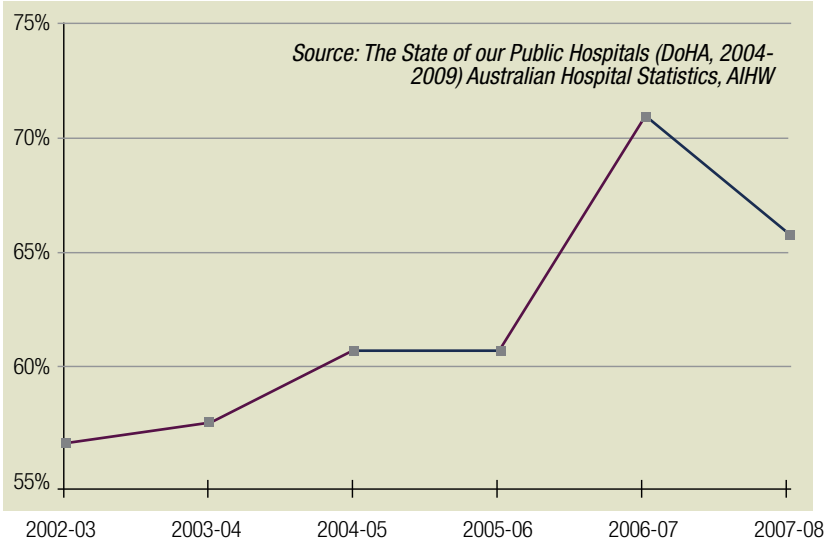
This year we have assembled performance information for each State and Territory, and included commentary on what AMA doctors who work in the public system are experiencing.

NEW SOUTH WALES

Emergency departments

While there was some improvement in NSW emergency department performance between 2005-06 and 2006-07, this was not sustained in 2007-08.

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

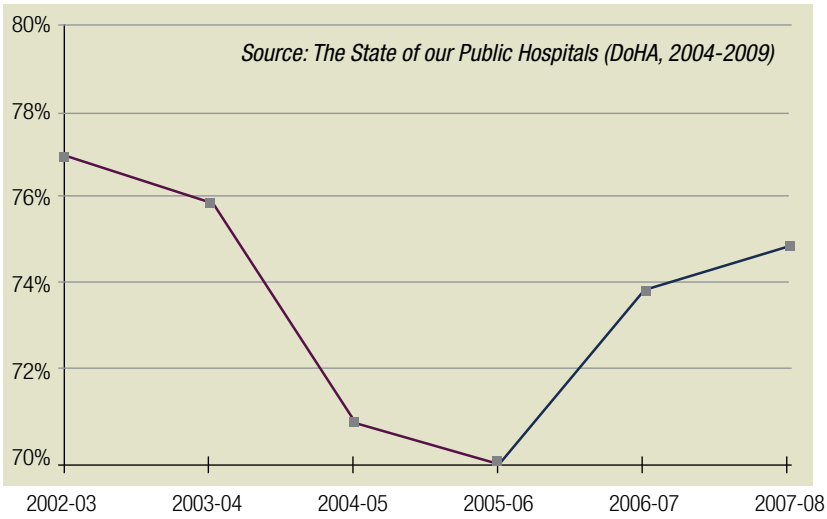


More recent data in the NSW Health Quarterly Performance Report show that for the period January to March 2009 there were 1.6 per cent fewer attendances at emergency departments than in the corresponding period a year earlier. At the same time, the data confirm that the percentage of patients seen within the recommended time is continuing to worsen and is well below the National Healthcare Agreement target of 80 per cent of emergency department presentations seen within clinically recommended triage times.

Elective surgery waiting times

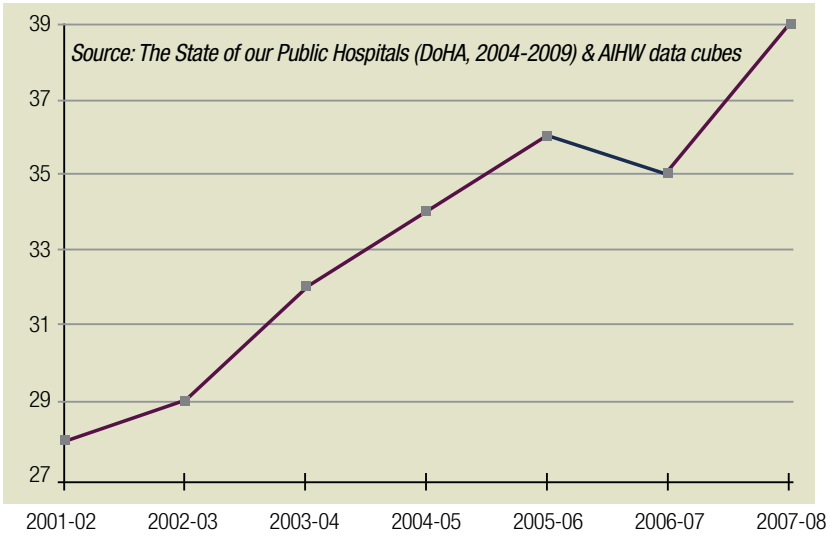
The percentage of category 2 elective surgery patients seen within the recommended time of 90 days has only increased by 1 per cent, up to 75 per cent for the year ending June 2008, and is still below the AMA's national target of at least 90 per cent of elective surgery patients seen within recommended times.

Percentage of category 2 elective surgery patients seen within recommended time (90 days) – NSW



Further, it is disturbing that the median waiting time for elective surgery increased significantly from 35 days in 2006-07 to 39 days in 2007-08.

Median waiting time for elective surgery (days) – NSW



Bed numbers

The total number of public beds for the year ending June 2008 is virtually identical to the previous year at 2.7 and 2.8 respectively per 1,000 weighted population, providing no real growth to meet considerable unmet demand in NSW.

Occupancy rates

Bed occupancy rates in Sydney hospitals continue to hover around an average of about 90 per cent. Fewer hospitals are publicly reporting their occupancy rates but on the information available it appears that major Sydney hospitals are often at the dangerous level of 95 per cent or higher.

Comments

The data suggest that emergency department performance is worsening while elective surgery performance has improved slightly, reflecting the additional COAG elective surgery funding, although it is still way below the agreed national target for patients receiving their surgery within the clinically recommended time. In 2008, $43.3 million was provided to NSW, resulting in an additional 12,153 procedures (approximately 6 per cent increase).

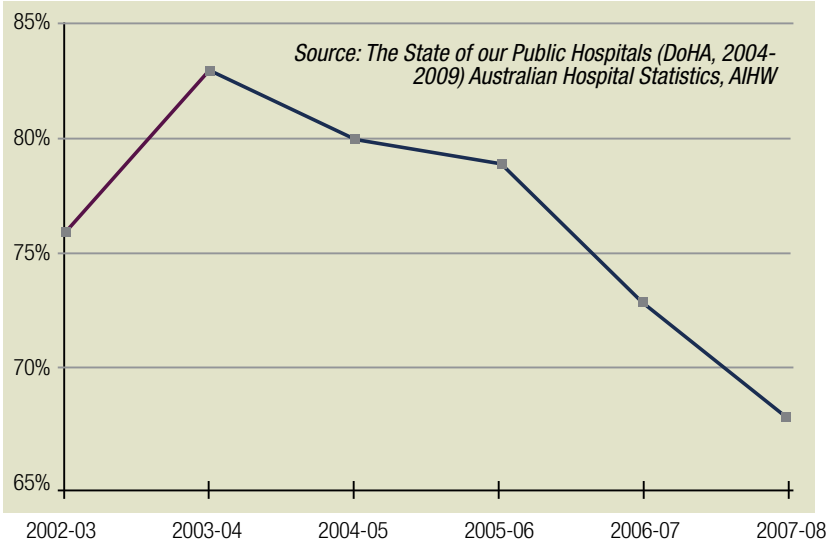
However, there is concern that these elective surgery performance and waiting time statistics do not accurately reflect the situation for patients who are waiting for elective surgery. There is regular feedback from AMA members that the official figures about waiting times are inconsistent with the time their patients have to wait for surgery. There are problems in getting patients on to official waiting lists in the first place because of the difficulty in gaining access to outpatient clinics, ie, there is a "waiting list to be on the waiting list" which is not reflected in the official statistics.

VICTORIA

Emergency departments

Victorian emergency department performance has been in decline since a peak of 83 per cent in 2003-04. The percentage of category 3 patients seen within the recommended waiting time of less than 30 minutes was reduced to 68 per cent in 2007-08.

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

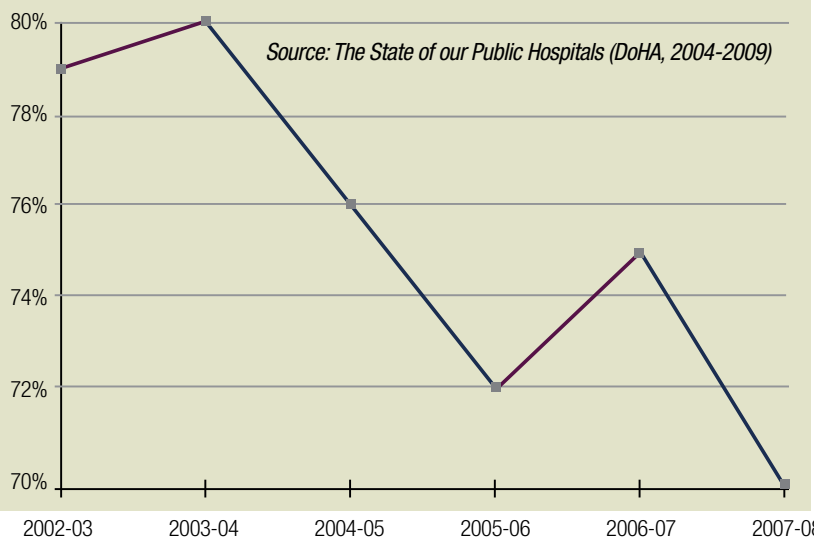


More recent public hospital data from the *Your Hospital Report* issued by the Victorian Government show that, for the period July to December 2008, there was a slight improvement, with 70 per cent of category 3 patients being seen within the recommended time. However the Victorian Government failed its target of 75 per cent for those patients and was well below the National Healthcare Agreement target of 80 per cent of emergency department presentations seen within clinically recommended triage times. In practice, this means that more than 47,000 Victorians suffering moderately severe symptoms over the six month reporting period missed out on care in the clinically appropriate time.

Elective surgery waiting times

The percentage of category 2 elective surgery patients seen within the recommended time of 90 days deteriorated from 75 per cent in 2006-07 to 70 per cent in 2007-08.

Percentage of category 2 elective surgery patients seen within recommended time (90 days) – VIC

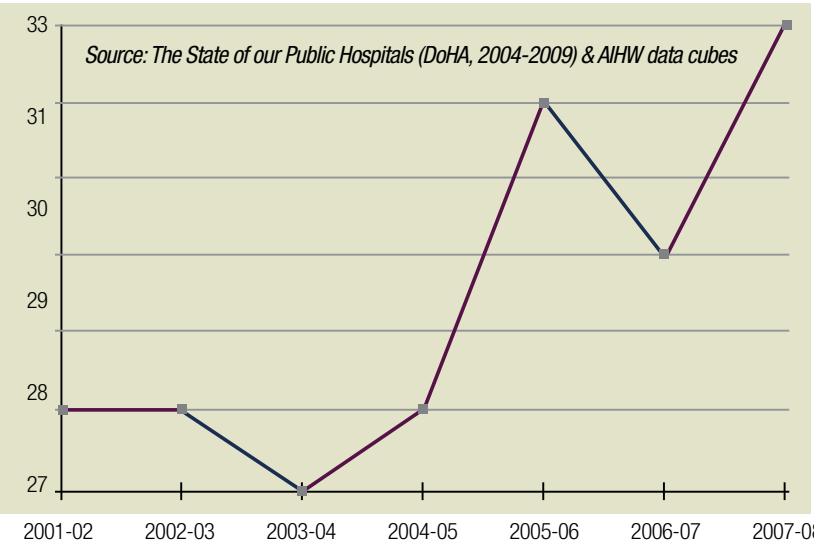


The *Your Hospital Report* for the period July to December 2008 shows that 74 per cent of category 2 elective surgery patients were seen within the recommended waiting time. However, the Victorian Government failed its target of 80 per cent for those patients and is still below the AMA's national target of at least 90 per cent of elective surgery patients receiving their surgery within recommended times.

At 30 June 2008, 37,311 patients were waiting for elective surgery and, at 31 December 2008, 37,379 patients were waiting for elective surgery. The Government has reported halving the number of category 1 patients waiting for elective surgery. There was an increase in the number of category 2 and 3 patients waiting. Overall, the elective surgery rate improved negligibly during the second half of last year, despite the additional funding blitz from the Commonwealth Government.

The median waiting time for elective surgery increased to 33 days in 2007-08.

Median waiting time for elective surgery (days) – VIC



Bed numbers

The average number of available hospital beds per 1000 Victorians is 2.3 (well below the national average of 2.6). While the State Government has funded an additional 400 beds during 2008-09, this falls short of the 600 required. Population growth in Victoria requires an additional 100-130 new beds per annum.

Occupancy rates

While the Victorian Government does not release data on bed occupancy, doctors report that public hospitals in Victoria continue to run at too high a capacity.

Comments

Victoria's public hospital system is failing too many people. Official government statistics do not show the full extent of patients waiting in the system, nor do they show the 'hidden' outpatient waiting lists. The AMA has called on the Government many times to make these data public.

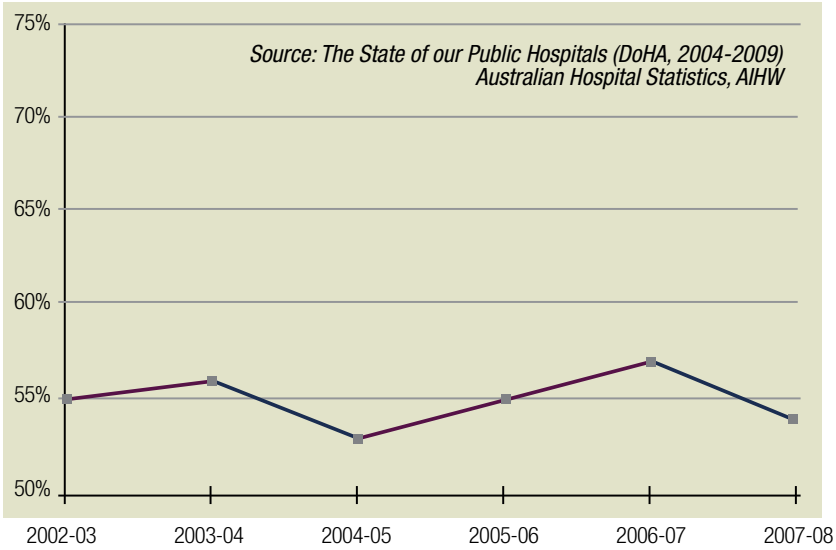
An Upper House inquiry into public hospital performance data is considering why and how data fraud has occurred and continues to occur in the system. Elective surgery figures are among those currently under scrutiny following announcements of the falsification and manipulation of performance data.

QUEENSLAND

Emergency departments

Queensland emergency department performance is well below the current Queensland performance benchmark of 70 per cent for category 3 patients. Other triage categories are also failing to meet the recommended waiting times and, throughout all triage categories, Queensland is nowhere near meeting the National Healthcare Agreement target of 80 per cent of emergency department presentations seen within clinically recommended triage times.

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

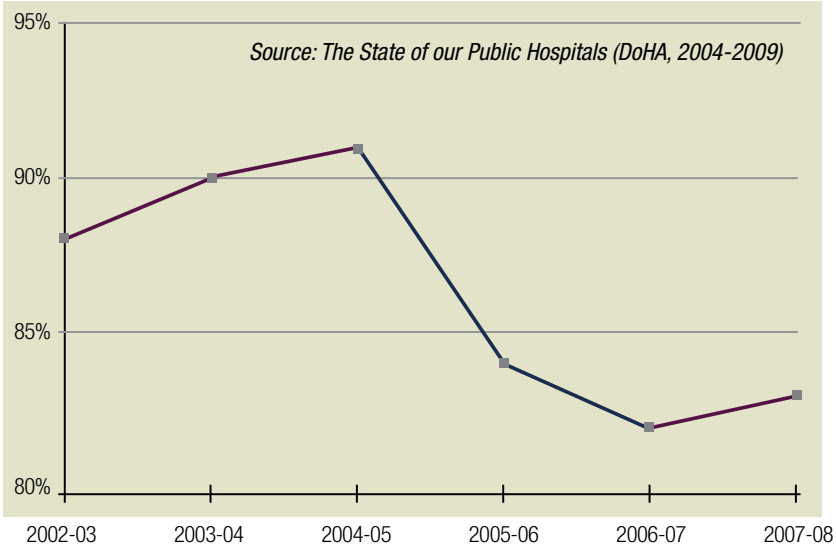


Data for the first eight months of 2008-09 show a significant increase in emergency admissions, putting further pressure on existing infrastructure and staff resources. Regional hospitals are struggling to cope with patient flow, with median waiting times for patient transfer from the emergency department to inpatient bed at Cairns Base Hospital and Logan Hospital reaching a totally unacceptable time of seven and eight hours respectively in the 2009 March quarter.

Elective surgery waiting times

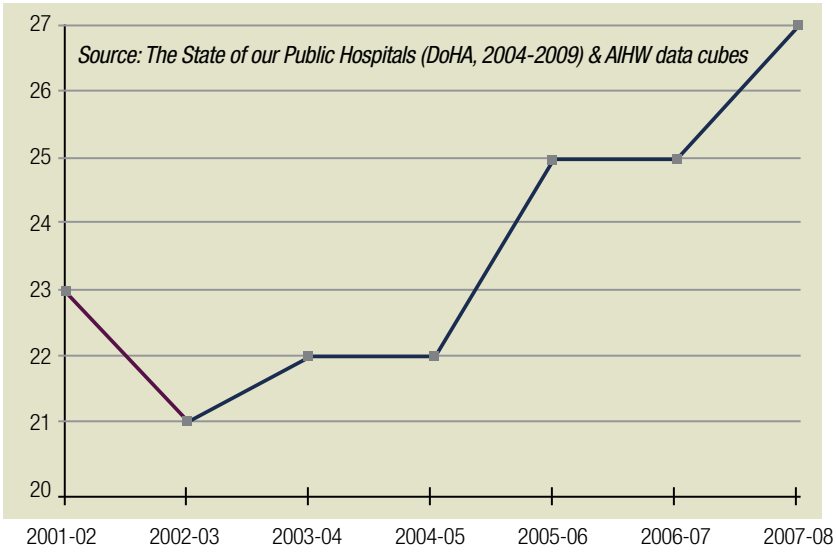
In mid to late 2007-08, more than 36,000 people were waiting for elective surgery. There has been a small improvement in the percentage of category 2 elective surgery patients seen within the recommended timeframe in 2007-08 to 83 per cent but it is still below the AMA's national target of at least 90 per cent of elective surgery patients receiving their surgery within recommended times.

Percentage of category 2 elective surgery patients seen within recommended time (90 days) – QLD



Notwithstanding this, the median waiting time for elective surgery increased to 27 days in 2007-08.

Median waiting time for elective surgery (days) – QLD



Timely access to outpatient services also remains inadequate, with many Queenslanders left on the 'waiting list' to get on the waiting list because they are still waiting for an initial public outpatient appointment. In the 2009 January to March quarter alone, 180,582 patients were waiting for a new specialist appointment, an increase of 13 per cent compared to the same time last year.

Bed numbers

Queensland had a total of 10,651 available public hospital beds during 2007-08. This equates to 2.5 available hospital beds for every 1,000 people. Since 1 July 2008, the total number of available beds Statewide increased by only 76. The severe shortage of beds in Queensland's public hospitals has contributed to the incidence of access block and hospital bypass, lengthy elective surgery and emergency department waiting times.

Occupancy rates

During 2007-08, almost half the 28 major pubic hospitals continued to operate regularly above the recommended 85 per cent occupancy level.

Comments

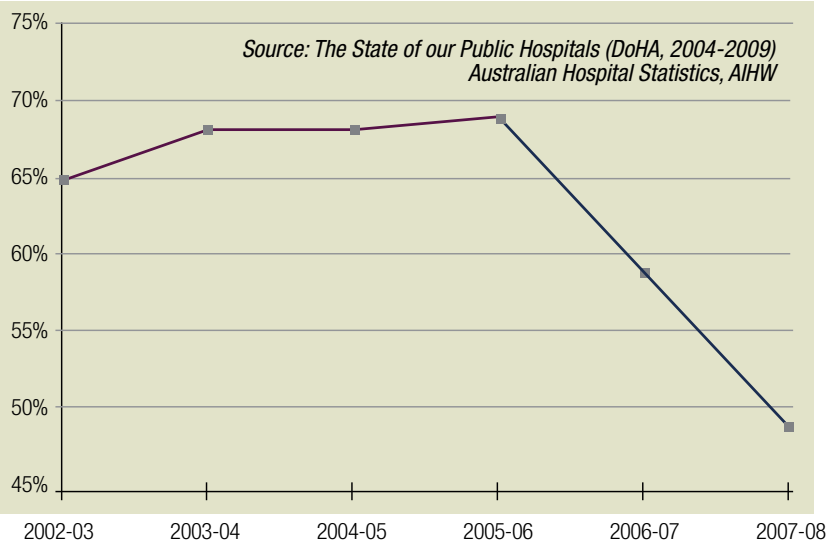
The Queensland Government is making progress to improve public hospitals through a $6.1 billion health infrastructure and capital works program. In the meantime, regions throughout the State suffer as a result of deficiencies that lead to a further breakdown in the delivery of health services for the entire community. In a State as decentralised as Queensland, and with its increasing and ageing population, interim measures must be provided to reduce pressures on hospital staff and ensure that high levels of patient care and safety are maintained now, and into the future.

WESTERN AUSTRALIA

Emergency departments

Western Australia emergency department waiting time performance for category 3 patients has been in steep decline over the last 3 years and at 49 per cent is totally unacceptable.

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

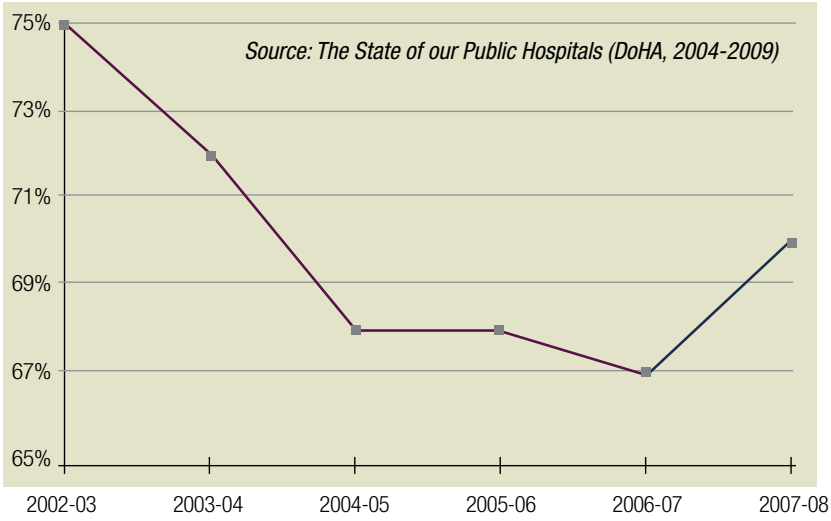


A two-year process of introducing the "4 hour rule" whereby 98 per cent of emergency patients would be dealt with within 4 hours commenced in April 2009. There have been no discernible improvements since its introduction but WA Health states that the process is still in the diagnostic/planning stage. WA clearly has a long way to go to meet the National Healthcare Agreement target of 80 per cent of emergency department presentations seen within clinically recommended triage times.

Elective surgery waiting times

While there has been an improvement in the percentage of category 2 elective surgery patients seen within the recommended timeframe to 70 per cent, it is still well below recognised clinical standards and current targets of at least 90 per cent of elective surgery patients receiving their surgery within recommended times.

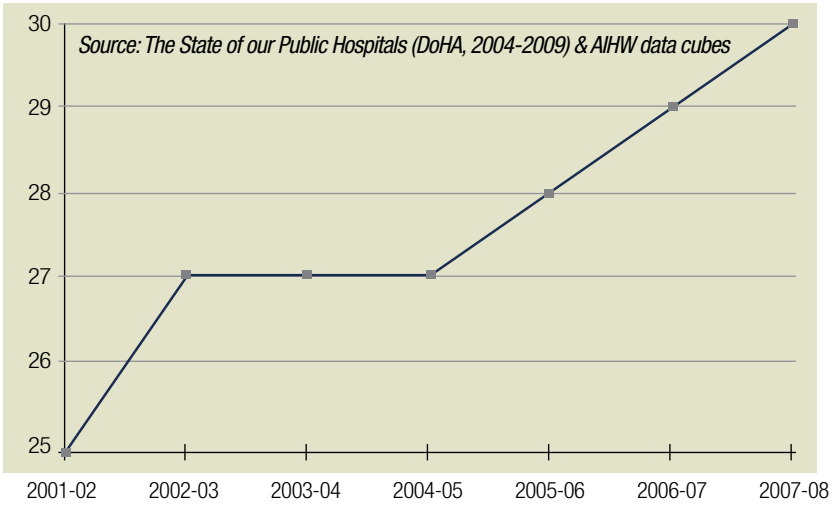
Percentage of category 2 elective surgery patients seen within recommended time (90 days) – WA



However, the number of people seeking first appointments for elective surgery has increased by 30 per cent. This suggests that more people are seeking elective surgery treatment at public hospitals but that they are waiting almost three months on average for their first outpatient appointment before they are recorded on the official elective surgery waiting list.

The median waiting time for elective surgery has steadily increased to 30 days in 2007-08.

Median waiting time for elective surgery (days) – WA



Bed numbers

It is difficult to obtain accurate figures about the average number of available beds in WA. WA Health has changed the definition of available beds, making it very difficult to compare with previous years and difficult to compare with the AIHW data. This reduces overall confidence in the reliability and transparency of WA's public hospital monitoring and reporting processes. With this qualification, longitudinal figures from WA Health Reports indicate that the number of overnight beds has not changed since 1990. This represents a dramatic decline in overnight beds relative to population growth and assists in explaining why WA has the worst reported levels of access block in Australia.

Occupancy rates

The quarter April to June 2008 had a realistically reported, but dangerously high, occupancy rate that averaged 93.5 per cent. However, the change in data definition for available beds led to the recalculation to a significantly lower occupancy rate of 84.5 per cent for the following quarter, July to September 2008. This is despite a similar number of hospital admissions. Again, we remain concerned about changes in data definitions and reporting which could hide the true WA picture over this period.

Comments

The WA public hospital system continues to decline despite the State Government's attempts to convince the public otherwise. There is no evidence available that demonstrates any significant enhancement to the public hospital system as a result of the additional Federal funding to improve elective surgery times or bed capacity.

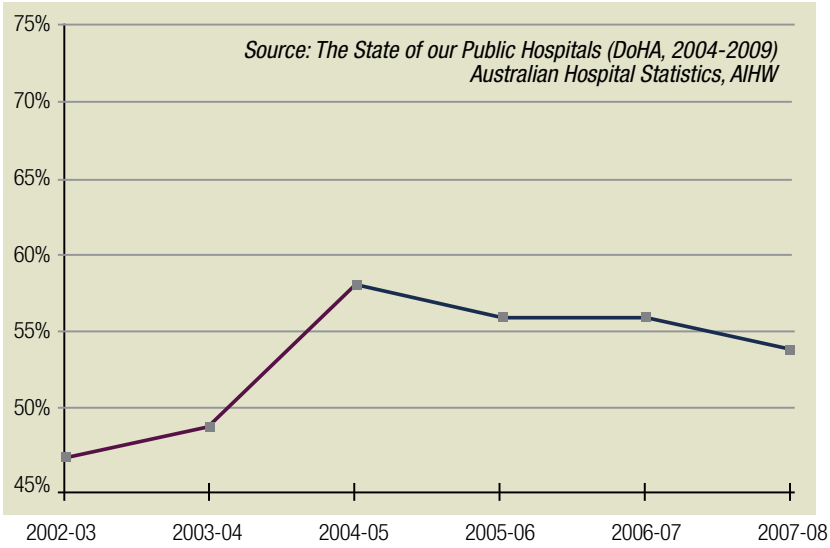
The media continue to highlight the deficiencies in the WA public health system by reporting long emergency waiting times, access block and failure to find a ward bed within eight hours. An article in the *Medical Journal of Australia* (MJA 2009; 190 (7): 362-363) said that this was leading to a significant number of deaths, which could be as high as the WA yearly road toll of 209 deaths in 2008.

SOUTH AUSTRALIA

Emergency departments

South Australia's emergency department performance for category 3 patients continues to decline and is well below the current performance benchmark of 70 per cent and the National Healthcare Agreement target of 80 per cent of emergency department presentations seen within clinically recommended triage times. In 2007-08, only 54 per cent of triage category 3 patients were seen within the clinically recommended time.

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



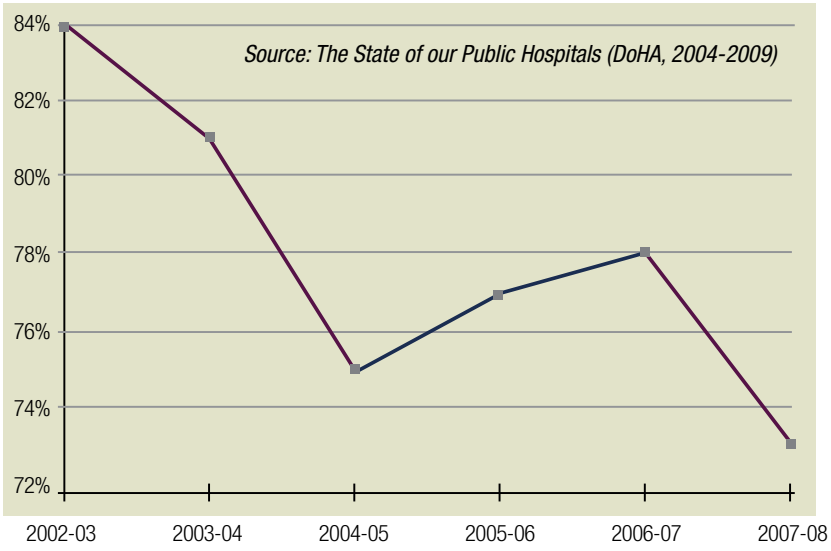
Across all triage categories in 2007-08, 544,439 patients presented to South Australian public hospital emergency departments, with only 61 per cent seen in the clinically recommended time (ie, 4 in 10 persons were not reviewed in a timely way relative to their triage category).

Elective surgery waiting times

In 2007-08, there was a decline to just 73 per cent of category 2 elective surgery patients receiving surgery within the clinically recommended time of 90 days, well below the AMA's national target of at least 90 per cent of elective surgery patients receiving their surgery within recommended times.

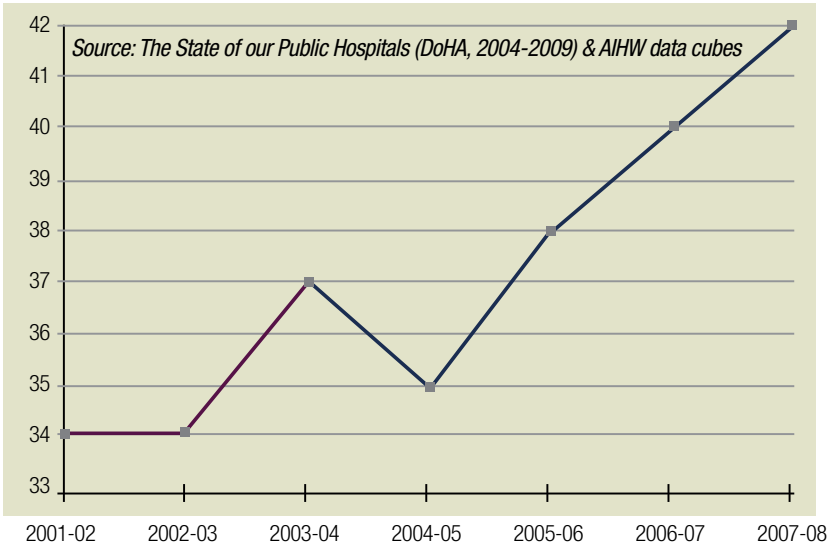
Of the 41,046 total elective surgery admissions in South Australia for 2007-08, one in five patients (19 per cent) was not operated on in the clinically recommended time. AMA(SA) anticipates the reporting of a reduction in SA's overdue elective waiting lists in 2008-09 because of increased clinical activity.

Percentage of category 2 elective surgery patients seen within recommended time (90 days) – SA



The median wait for elective surgery has continued to deteriorate and is now at 42 days, an extremely poor outcome.

Median waiting time for elective surgery (days) – SA



Nearly 4 per cent of patients waited for more than a year for admission to hospital for elective surgery.

Bed numbers

In 2007-08, there were 4,981 available public hospital beds in South Australia, equating to 2.8 beds per 1,000 weighted population, insufficient to meet unmet demand and population growth and ageing in South Australia.

Occupancy rates

During 2007-08, occupancy rates for teaching public hospitals remained consistently above the recommended rate of 85 per cent.

Comments

The South Australian Government continues to invest significant amounts in the health system. The current budget saw health expenditure exceed $4 billion for the first time, but growth in demand continues to nullify improvements in real terms.

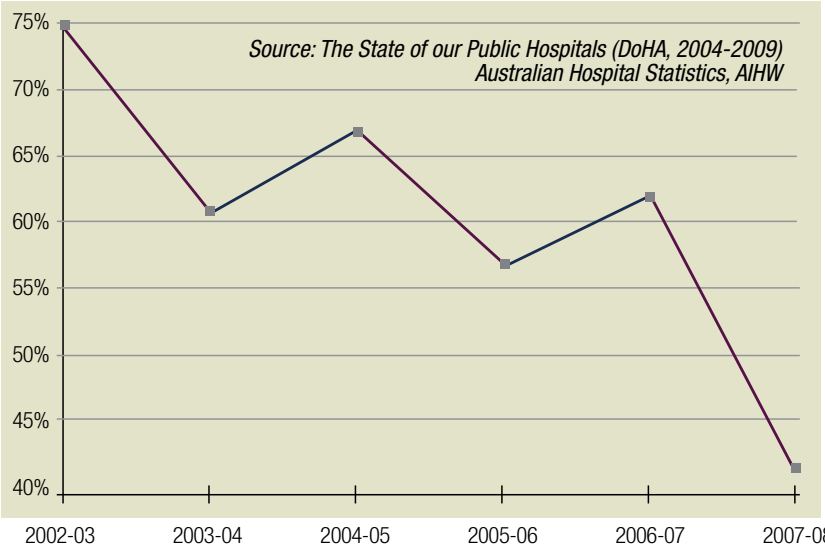
The length of time that some patients wait in order to receive an outpatient appointment before they are even put on the official elective surgery waiting list in South Australian public hospitals is of significant concern. While actual waiting times for initial outpatient appointments vary substantially from specialty to specialty and hospital to hospital, waiting times in excess of two years are not uncommon for some specialties. There are little data available on the 'waiting list to get on the waiting list'. These patients are not included in the official elective surgery waiting list data. This hidden health issue is the next frontier for the Government to tackle.

TASMANIA

Emergency departments

Tasmanian emergency department performance for category 3 patients has plummeted to only 42 per cent of patients being seen within the clinically recommended time. This is unacceptable.

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



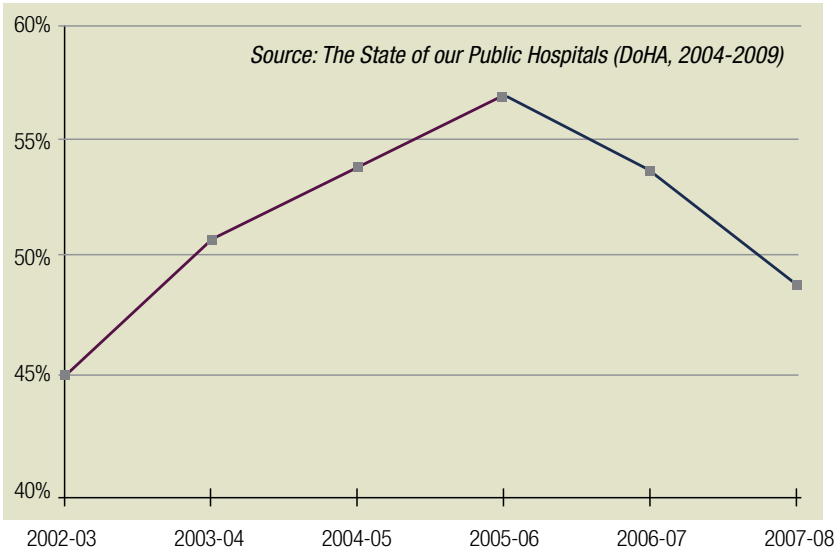
Tasmania has much ground to make up to meet the National Healthcare Agreement target of 80 per cent of emergency department presentations seen within clinically recommended triage times.

Elective surgery waiting times

The number of category 2 patients seen within the recommended time of 90 days for elective surgery has continued to decline. Only 49 per cent of category 2 patients on elective surgery waiting lists were seen within the recommended time of 90 days.

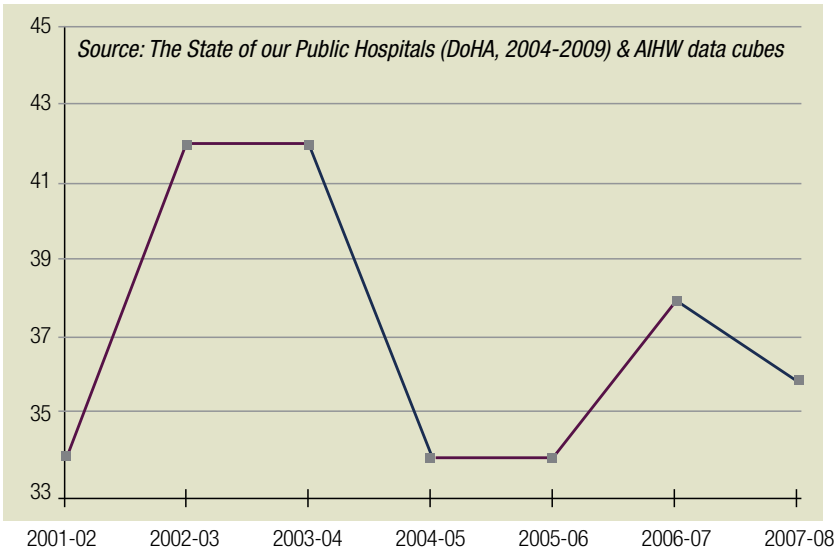
If the current downward trend continues, by next year the waiting time for category 2 elective surgery patients will be back to the unacceptable 2002-03 level of 45 per cent.

Percentage of category 2 elective surgery patients seen within recommended time (90 days) – TAS



The median waiting time for elective surgery has improved by 2 days, but is still too long at 36 days.

Median waiting time for elective surgery (days) – TAS



Despite the improvement, median waiting times for elective surgery in Tasmanian public hospitals remain longer than the national average of 34 days and are still below the AMA's national target of at least 90 per cent of elective surgery patients receiving their surgery within recommended times. More than 13 per cent of patients wait more than 365 days for admission.

Bed numbers

The total number of available beds for 2007-08 was 1,275, or an average of 2.3 available beds per 1,000 weighted population. There are 78 fewer available beds than in 2006-07. The State Government justifies the status quo by claiming that there is no need for more beds because of transition arrangements and shorter stays. This is despite ongoing severe problems in the State's emergency department clearly due to bed access block.

Occupancy rates

There are no available data on the average occupancy rates in Tasmania. It is extremely concerning that the Tasmanian government is not collecting, monitoring and making public data on this important indicator of the Tasmanian public hospital system's capacity to cope with demand.

Comments

In February 2009, the Tasmanian Government reported an increase of 20.3 per cent in elective surgery admissions for the period, July to December 2008, compared to the same period in the previous year. There was a focus on those elective surgery patients who had waited longer than the clinically recommended time.

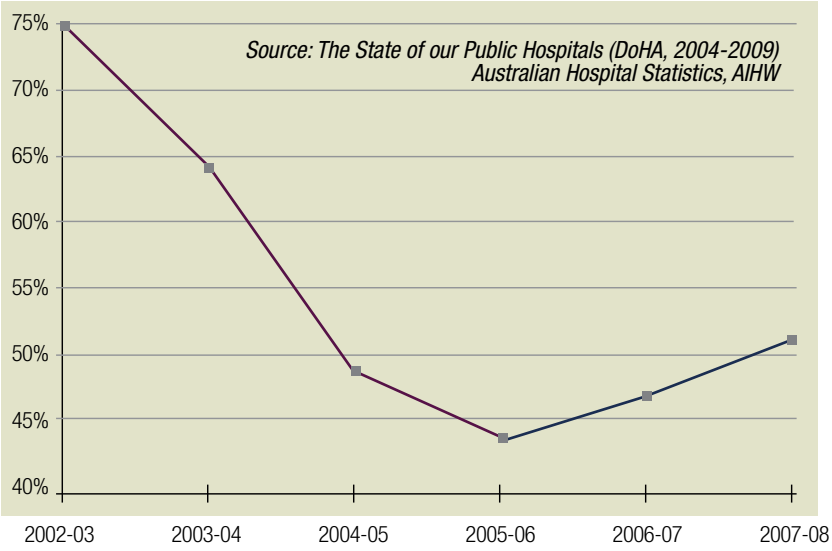
It would appear that this improvement comes as a result of the Tasmanian Government Elective Surgery Waiting List Improvement Plan and the additional funding by the Federal Government for the elective surgery "blitz".

AUSTRALIAN CAPITAL TERRITORY

Emergency departments

Australian Capital Territory emergency department performance for category 3 patients is improving from a very poor base in 2005-06. At only 51 per cent, the ACT has much ground to make up to meet the National Healthcare Agreement target of 80 per cent of emergency department presentations seen within clinically recommended triage times.

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

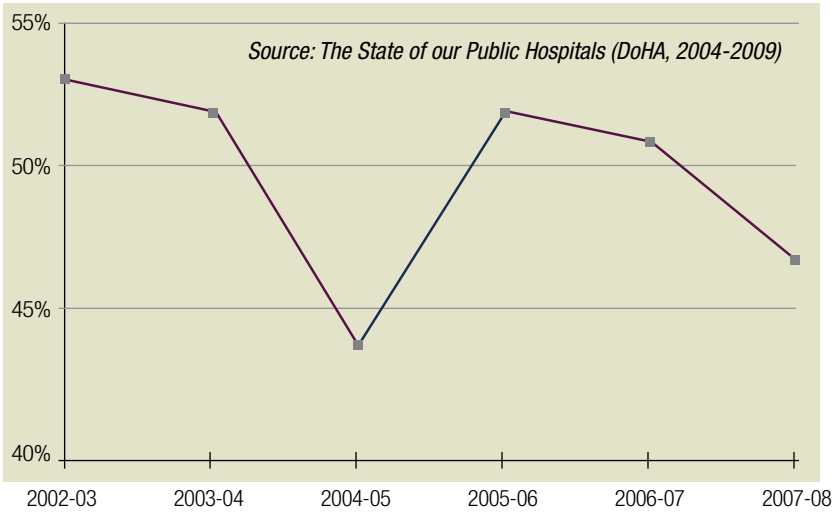


Emergency department waiting times for the most urgent categories (category 1 and 2 patients) continue to be too long to meet national targets. This has been exacerbated by an 18 per cent growth in more urgent category 1 and 2 admissions compared to the same period in 2007-2008.

Elective surgery waiting times

The number of category 2 elective surgery patients seen within the recommended time has declined to 47 per cent, well below the AMA's national target of at least 90 per cent of elective surgery patients receiving their surgery within recommended times.

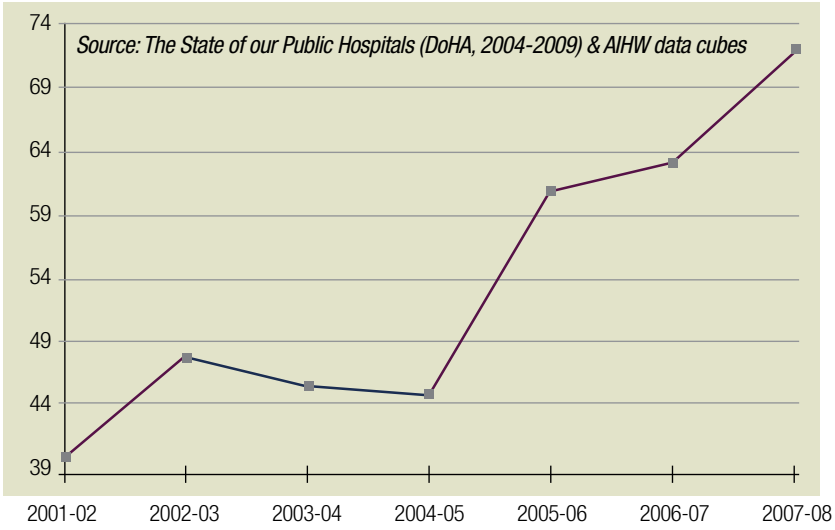
Percentage of category 2 elective surgery patients seen within recommended time (90 days) – ACT



In addition, elective surgery waiting lists in the ACT do not take into account the long delays in booking patients for non-urgent specialist assessments in outpatients and private rooms before they can be put on the official elective surgery waiting list.

The median waiting time for elective surgery in the ACT is 72 days, alarmingly higher than the national average of 34 days.

Median waiting time for elective surgery (days) – ACT



Bed numbers

In 2007-08, the ACT had a total of 851 available beds. This was an increase of 66 beds on the previous year's total bed numbers of 785 but is still insufficient to meet current and future demand in the ACT.

Occupancy rates

Unacceptably high bed occupancy of 90 per cent has not been improved over the past two years and is above the recommended 85 per cent occupancy rate.

Comments

An additional 858 patients had elective surgery in 2008, some as a result of additional Federal funding to enable extra elective surgery to be undertaken. A total of 250 additional surgical procedures were undertaken.

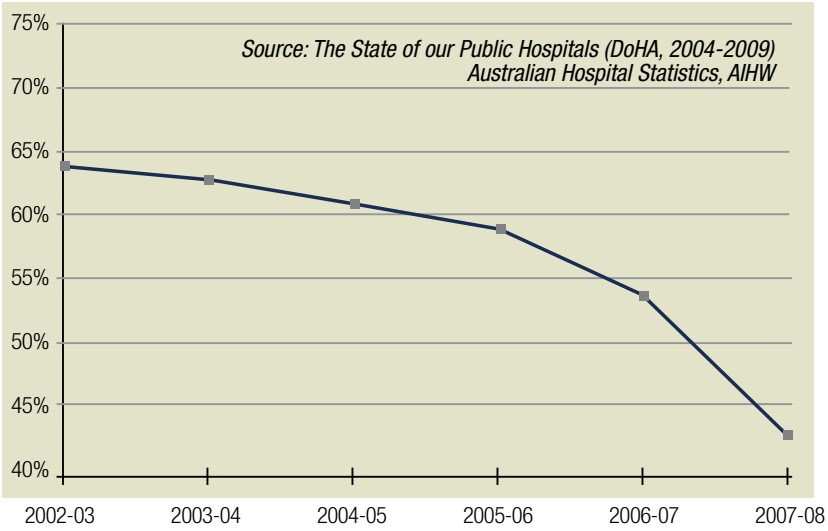
Notwithstanding this, at the end of March 2009, 638 people had been waiting longer than one year for elective surgery.

NORTHERN TERRITORY

Emergency departments

Northern Territory emergency department performance for treating category 3 patients within the recommended time has continued to deteriorate and is now totally unacceptable at 43 per cent. This is well below the National Healthcare Agreement target of 80 per cent of emergency department presentations seen within clinically recommended triage times and among the worst reported emergency department waiting times in the country.

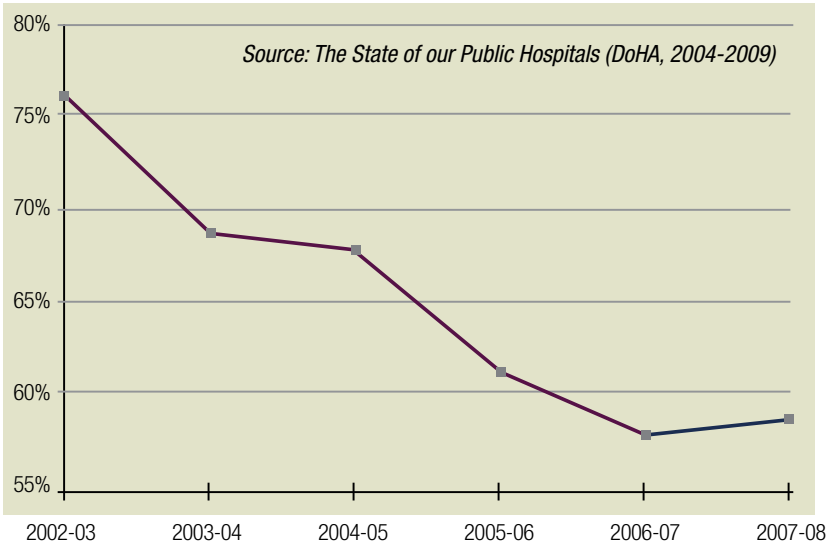
Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (>30 minutes) – NT



Elective surgery waiting times

The waiting times for category 2 elective surgery patients have improved only marginally on the previous year and remains far too low at 59 per cent, well below the AMA's national target of at least 90 per cent of elective surgery patients receiving their surgery within recommended times.

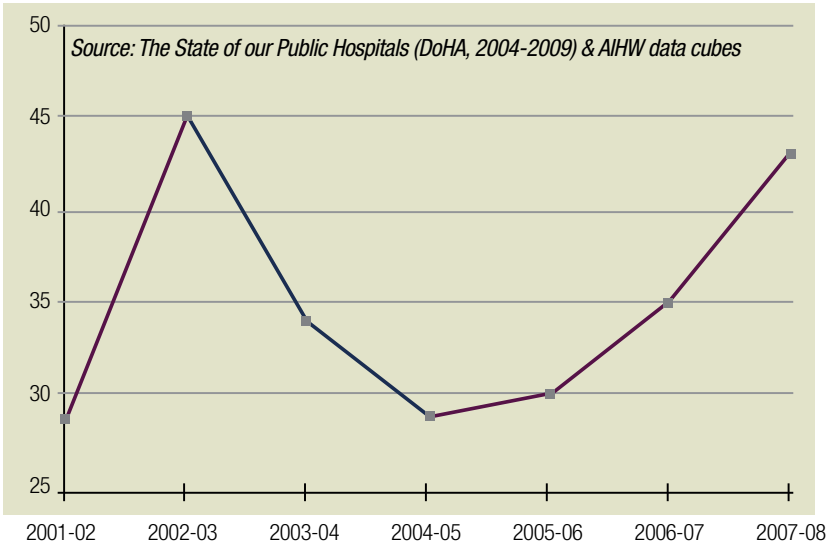
Percentage of category 2 elective surgery patients seen within recommended time (90 days) – NT



Waiting times for elective surgery have reached a crisis point in the NT, with the NT Government revealing a backlog of 700-900 people waiting for colonoscopies and endoscopies because of ward closures. Other elective procedures are also being postponed which risks patients' conditions becoming more urgent.

The median waiting time for elective surgery has continued to worsen and is now 43 days compared to the national average of 34 days.

Median waiting time for elective surgery (days) – NT



There is no evidence to indicate that the funding provided by the Federal Government for the elective surgery "blitz" has improved the waiting lists in the Northern Territory.

Bed numbers

In 2007-08, the total available public hospital beds in NT was 616. This was 134 fewer beds than in 2006-07. The Northern Territory Government must use the COAG funding to increase capacity and to provide additional beds.

Occupancy rates

It is very difficult to obtain any accurate statistics on occupancy rates as data tend to be collected at times of lowest occupancy, which distorts the real picture across the course of the year. Doctors in NT public hospitals report that occupancy rates are in the range of 110 per cent in the two major hospitals. This is dangerously high.

Comments

The NT hospitals are geographically isolated with the nearest bypass hospital being approximately 3,000 kms away. Every patient presenting to an NT hospital and requiring admission must be admitted – there is nowhere else for them to go.

The closure of the maternity ward at Nhulunbuy Hospital, forcing patients (70 per cent Indigenous) to travel long distances to either Katherine or Darwin hospitals, was a result of long-term problems with recruitment and retention of medical staff.

A report on the independent review of governance arrangements at Royal Darwin Hospital (and Department of Health and Families) was released in February 2009. It contained 26 recommendations on clinical and corporate governance affecting patient care, clinical risk, staffing, recruitment/retention and responsibilities for strategic and operational performance. These recommendations must be implemented quickly.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