



PUBLIC HOSPITAL  
REPORT CARD  
**2010**

AN AMA ANALYSIS OF AUSTRALIA'S  
PUBLIC HOSPITAL SYSTEM





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# INTRODUCTION

We have a new Labor Government – albeit a minority Government – and we have a new political dynamic in Canberra with the Greens and Independents now having power and influence in both Houses of the Federal Parliament.

Already, we have seen that power and influence on display.

This new dynamic presents great challenges for the Government in pushing on with the health reforms proposed by the Rudd Government and carried on by the first Gillard Government.

At the heart of that reform agenda is the original pledge to ‘fix our hospitals’. It is important to note that the Greens and the Independents broadly support the Government’s health reform program.

We are yet to know the specifics of that support, but we can be confident that they support improving the performance of our public hospitals. We can be more confident that the Australian public supports public hospital reform.

A 2009 Research Australia opinion poll found that 94 per cent of Australians rated improving hospitals and the health care system as the highest priority for the Government.

While the reform process must ensure that all health care resources are used efficiently and effectively, the rejuvenation of our public hospitals with greater and better targeted funding and better governance arrangements must be a priority.

Our public hospitals must have the capacity to meet the demands of a rapidly expanding population, which is ageing and which is experiencing chronic conditions that inevitably require acute care.

Under new COAG agreements, governments will introduce new rewards and penalties payment systems, which will be based on performance monitoring and reporting against targets. But these targets will be meaningless unless public hospitals have the resources that are required to meet them, as well as the flexibility to use resources to the greatest clinical effect.

The AMA has strongly advocated expanding public hospital capacity with new beds, more doctors and nurses, and new and improved infrastructure to support the hardworking health care professionals in our public hospitals.

To their credit, governments have acknowledged the problems and, before and during the period covered by this report card, increased funding to expand hospital capacity to meet immediate and medium term demand. Any real, substantial improvement in access to public hospital services as a result of that funding is yet to appear.

This report card covers the 2008-09 financial year – the latest year for which nationally consistent data are available. We report on:

- The number of beds per 1,000 population and occupancy rates;
- The percentage of emergency department triage patients seen in the recommended time; and
- Elective surgery waiting times.

We note the most recent attempts by governments to improve the performance of the public hospital system.

We highlight that total bed numbers increased by only 11 beds across the whole country.

This falls well short of the AMA's estimate that 3,870 additional beds are needed for the public hospital system to operate at a safe 85 per cent average bed occupancy rate.

The report shows that there have been slight improvements in the percentage of emergency department patients being seen within recommended times, but that the system is still light years away from reaching the targets set by COAG in April 2010.

Public hospitals will continue to struggle to meet emergency department targets unless capacity in all areas of public hospitals is expanded to allow patients in emergency departments to be admitted more quickly.

We conclude that the additional funding of \$150 million for the elective surgery 'blitz' did not achieve its objective. From our analysis, it did not result in significant numbers of additional elective surgery procedures above the numbers that would normally have been expected to be performed. In our view, the additional Commonwealth funding may have only had the effect of compensating State and Territory Governments for the increasing costs of providing elective surgery services.

We welcome the commitment of governments to move to activity-based funding and commit to national standards for their performance monitoring.

We welcome new governance arrangements that allow greater local clinician engagement in decisions about the management of hospitals and the delivery of health care to the local community. However, much needs to be done in each State and Territory to ensure that the commitment to 'central funding, local control' becomes a reality.

The AMA now wants an accountability framework that will hold governments to account for their role in funding and supporting hospitals into the future.

We maintain that the 60/40 funding split between the Commonwealth and the States does not end the blame game. Only a single funder will deliver on that commitment.

This report card shows clearly that there is still a lot of work to be done before the Federal Government can declare that its promise to 'fix the hospitals' has been met. That promise will need the full commitment and cooperation of all our governments.

It will also require greater support for mainstream general practice to reduce the demands of acute and chronic disease on the public hospitals.

The AMA acknowledges the dedicated and hardworking doctors, nurses and other health professionals who care for patients in public hospitals. They hold the system together.

In recent times, though, they have been faced with increasing incidents of violence against them in the workplace. The AMA urges all governments to take strong action to make our public hospitals safe places in which to work and in which to receive care.



Dr Andrew Pesce  
Federal President

# 1. NATIONAL PUBLIC HOSPITAL PERFORMANCE

This report card provides information about the performance of Australia's public hospitals in 2008-09.

Consistent with previous AMA public hospital report cards, it measures capacity and performance using three indicators:

- Bed numbers and occupancy rates;
- Emergency department waiting times; and
- Elective surgery waiting times.

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

We have also examined the efficiency and productivity of our 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.

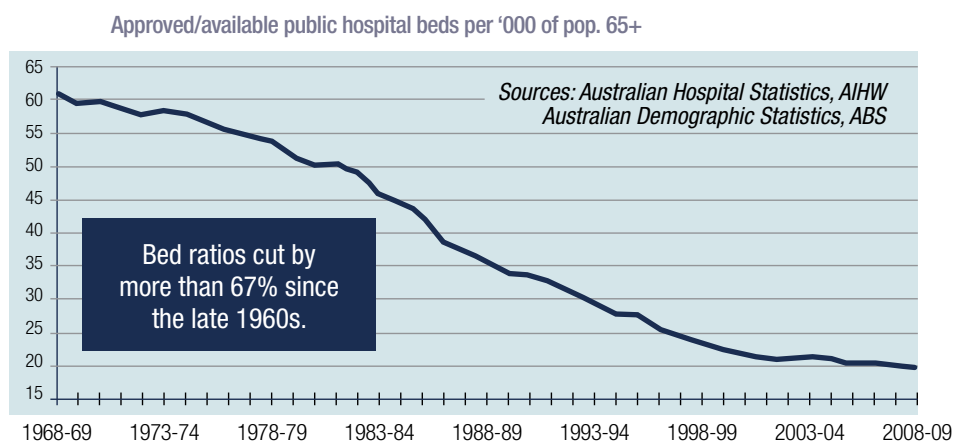
## Bed numbers and occupancy rates

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 45 per cent over the past 20 years and by more than 67 per cent since the late 1960s. There are now only 19.6 public hospital beds for every 1,000 people over the age of 65.

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



Retaining 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.

In November 2008, the Federal Government provided an extra \$4.8 billion to State and Territory Governments for public hospitals, and a one-off injection of \$750 million for 2008-09. The then Prime Minister said that the funding could support an additional 3,750 beds in 2009-10, growing to 7,800 additional beds by 2012-13<sup>1</sup>.

The Federal Government's *The State of Our Public Hospitals – June 2010 Report* recorded 56,478 available public hospital beds in 2008-09, an increase of only 11 beds across Australia compared to the number of available beds in 2007-08<sup>2</sup>.

This 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.

These occupancy rates are too high. 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.

## Why this is important

Unless governments improve public hospital capacity, patient access to hospital care will continue to worsen and patient safety will be put at further risk.

The private hospital system has picked up more of the load, which has eased the impact of previous cuts to public hospital capacity. But the cut in bed numbers has been too deep and this is now starting to be acknowledged by governments.

Advances in technology may continue to generate efficiency gains, but these are offset by the complexity of caring for an older population and for those with chronic conditions.

Regular bed occupancy rates in excess of 85 per cent are risky<sup>3</sup>, and leave little room for hospitals to cope with extra demand, such as during viral outbreaks.

## What needs to be done

The Federal Government must introduce a *Bedwatch* scheme to provide a transparent mechanism for tracking that the additional funding provided to State and Territory Governments actually results in the opening of new beds. This should start with a stocktake of the actual number of beds needed in each hospital to ensure average bed occupancy rates of no more than 85 per cent.

A rule of 85 per cent average bed occupancy rate should apply in every hospital<sup>4</sup>. 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. Currently, only the ACT, Queensland, and Western Australia publicly report on average bed occupancy rates in their jurisdiction.

1 Media Release, Prime Minister Rudd, 29 November 2008.

2 *The State of Our Public Hospitals Report* June 2010, p 46 and June 2009, p 12

3 McCarthy S, *Medical Journal of Australia* 2010, 193: 252-253

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

A hospital bed is considered available if it is in a suitable location and is sufficiently staffed to deliver appropriate care. Governments must do more to improve the training, attraction and retention of an appropriate workforce.

Federal and State and Territory Governments need to plan well ahead to ensure that we have the right number and types of training places needed in the future and in the right places. There are currently too few clinical training places for medical students, interns, prevocational and vocational trainees nationally for the growing number of medical school graduates coming through the system. Unless this bottleneck is addressed, the Australian community will be under-served by locally trained doctors. We will continue to have a shortage of doctors and will have to rely on bringing doctors from other countries to work in Australia.

On 29 September 2010, the AMA issued a joint statement with the Australian Medical Students' Association, Medical Deans Australia and New Zealand and the Confederation of Postgraduate Medical Education Councils setting out the action that must be taken on medical training in Australia to address these problems.

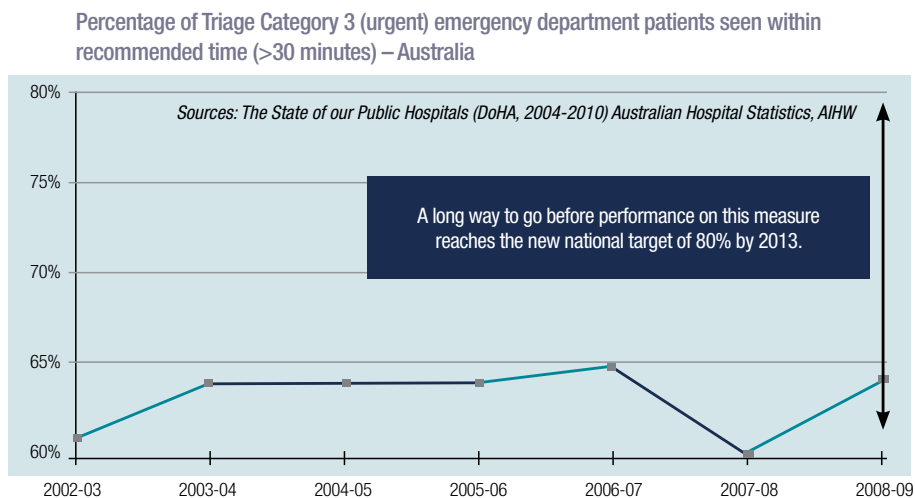
### Emergency department waiting times

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

The National Healthcare Agreement signed by all governments in November 2008 committed to a performance benchmark that, by 2012-13, 80 per cent of emergency department presentations would be seen within clinically recommended triage times as recommended by the Australasian College for Emergency Medicine (ACEM).

In 2008-09, 64 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes (see graph 2). This is a four per cent improvement on 2007-08 but is well short of the new target of 80 per cent.

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





## Why this is important

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 eight hours in the emergency department for admission to a ward bed.

In a literature review, Forero and Hillman found that:

*It has been estimated, by different authors and different methods, that there is a 20–30 per cent excess mortality rate every year that is attributable to access block and emergency department overcrowding in Australia<sup>5</sup>.*

Everyone realises that it is not possible for public hospitals to achieve short waiting times all the time because of the unpredictable demand for emergency care. That said, hospital performance indicators are too often falling too far short of what should be a minimal standard.

Triage categories 1 (resuscitation, patients need to be seen immediately), 2 (emergency, patients need to be seen within 10 minutes), and 3 (urgent, patients need to be seen within 30 minutes) together represent 42 per cent of emergency department presentations. The proportion of these highest triage category presentations has changed very little in the past few years.

Further, there is no compelling evidence that the decline in hospital performance is the result of a rise in inappropriate patient presentations. Data from ACEM show that only around 10 per cent of emergency presentations are GP-type patients, and these consume only 1–3 per cent of emergency department resources<sup>6</sup>.

Access block happens because the capacity of public hospitals is insufficient to meet genuine demand. Inability to admit patients to hospital beds mean that they continue to overcrowd emergency departments, occupying beds and resources there, and limiting the emergency department's capacity to deal with new urgent presentations.

## What needs to be done

In April 2010, COAG agreed to implement a National Access Target whereby people presenting to a public hospital emergency department will be either admitted to hospital, referred for treatment or discharged within four hours where it is clinically appropriate to do so. This will be implemented progressively from 1 January 2011.

We welcome the additional funding for facilitation, reward and capital that the Federal Government has committed to address the key pressure points in the public hospital system. Waiting times in emergency departments can only be improved, and access targets met, if there is sufficient investment in staff, beds, and other resources needed throughout the hospital, especially outside normal working hours, to respond appropriately to patient demand.

All Australian governments must ensure the additional funding is used to resource public hospitals better and increase inpatient beds. The AMA's most recent estimate is that an additional 3,870 public hospital beds are needed across the country.

<sup>5</sup> Forero, R & Hillman, K, *Access Block and Overcrowding: a literature review, prepared for the Australasian College for Emergency Medicine, Simpson Centre for Health Services Research, South Western Sydney Clinical School, University of NSW, 2008, p 1*

<sup>6</sup> ACEM 2009 Access Block Point Prevalence Survey, Executive Summary, p 2

As previously stated, the number of public hospital beds increased by only 11 beds in 2008-09.

The *Bedwatch* scheme proposed by the AMA could monitor the number of new and existing beds that are available in public hospitals and monitor access block in emergency departments. This would help determine if public hospitals have the capacity to meet demand.

Further, as there is no evidence to demonstrate that any specific time-based target is an appropriate benchmark or that patient care or health outcomes improve as a result of setting time-based targets, the National Access Target will need to be carefully implemented and monitored with local doctor input.

## Elective surgery waiting times

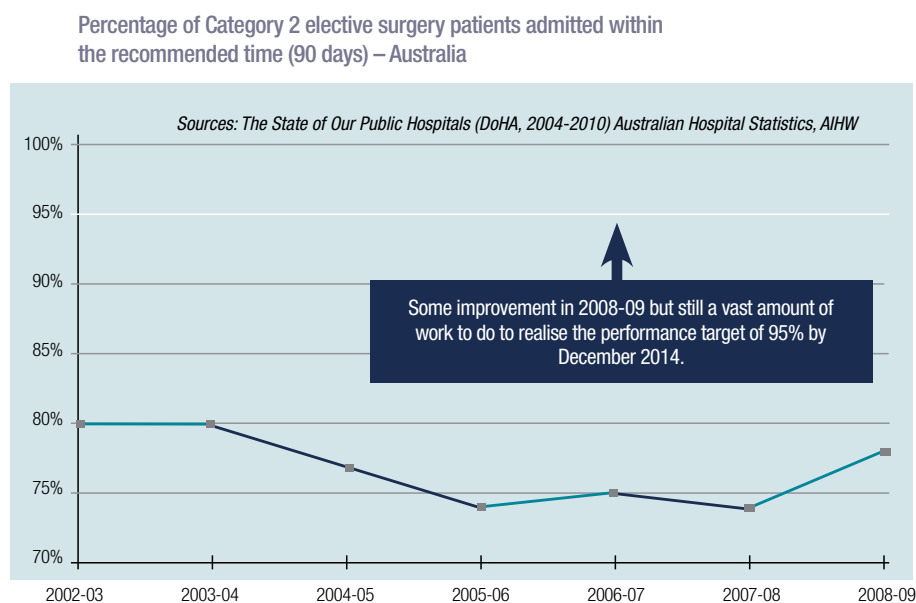
Elective surgery is any form of surgery considered medically necessary but which can be delayed for at least 24 hours.

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. They represent 38 per cent of elective surgery admissions nationally.

Previous AMA public hospital report cards reported a marked deterioration in access for category 2 elective surgery patients.

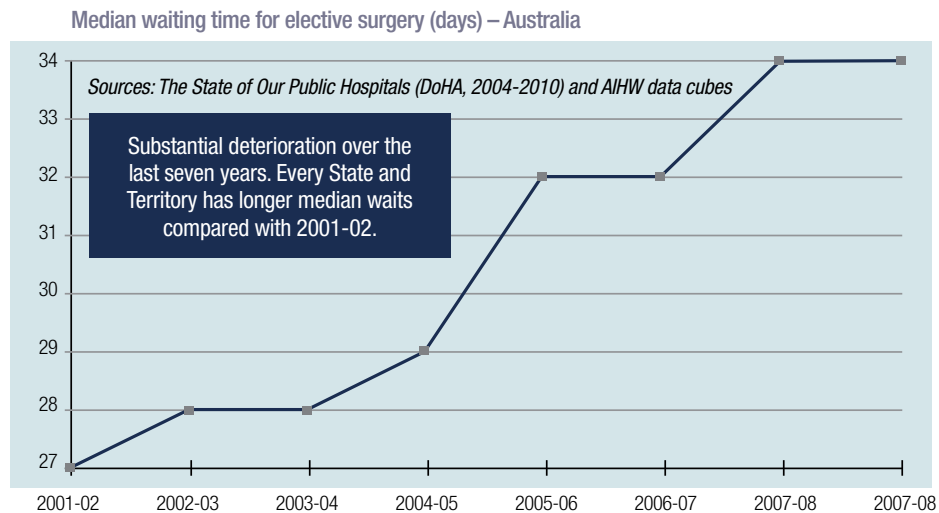
In 2008-09, there was a small improvement: 78 per cent of category 2 elective surgery patients were seen within the recommended time of 90 days, up from 74 per cent in 2007-08. However, this falls well short of the new target of 95 per cent by 2014, set by COAG under the National Health and Hospital Network reforms.

**Graph 3: Percentage of Category 2 elective surgery patients admitted within recommended time**



Further, there has been an uninterrupted increase in the length of the median waiting times for all elective surgery in Australia over the last seven years.

**Graph 4: Median waiting time for elective surgery (days)**



These data hide the actual times that patients are waiting to be treated in the public hospital system. There are 'ghost' waiting lists for those people who are referred by their general practitioner for assessment by a specialist for a public hospital procedure or treatment. 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.

## The waiting list 'blitz'

In 2008, the Federal Government provided \$150 million in additional funding to the States and Territories for "an immediate national blitz on waiting lists"<sup>7</sup>. As part of the 'blitz', the States and Territories committed to maintaining their current efforts in undertaking elective surgery procedures while conducting an additional 25,000 procedures.

On 5 March 2009, the Australian Health Ministers' Conference announced that there were 41,584 more elective surgery procedures in 2008 than in 2007 – exceeding the 'blitz' target by 64 per cent. In December 2009, the Health Minister announced that an additional 62,000 elective surgeries had been completed since 2008<sup>8</sup>.

The AMA has analysed the publicly available data to determine whether or not the States and Territories maintained their current elective surgery efforts and conducted the additional elective surgeries to 'blitz' their waiting lists, as had been agreed.

The AMA Public Hospital Report Card 2009 reported an increase of only 8,731 elective surgery procedures performed during 2007-08, compared with 2006-07. At that time, there was no evidence that the 'blitz' occurred in the first half of 2008, and we expected that the additional surgeries would appear in the 2008-09 data. Now we have the full public data for this period.

7 Communiqué, Ministerial Council Meeting, Brisbane, Monday 14 January 2008.

8 Hansard Questions on Notice, 3 February 2010, p 114 and Minister Roxon Media Release, 7 December 2009.

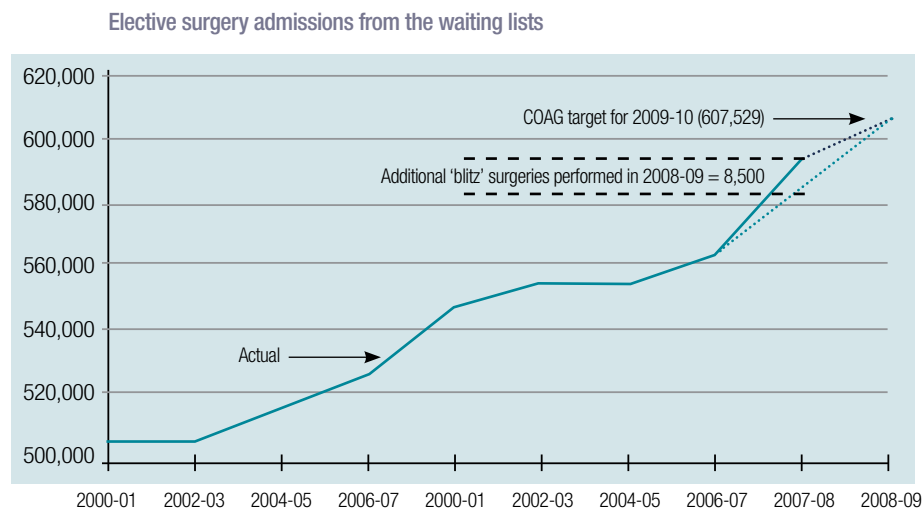
In 2008-09, 595,009 patients were admitted from waiting lists and received elective surgery, which is 29,508 more than in 2007-08. This is well short of the 41,589 additional elective surgeries that were reportedly undertaken in 2008.

Recognising that the Government's 'blitz' figures are for calendar years, while historical elective surgery data<sup>9</sup> are by financial year, in order to substantiate the reported 'blitz' figures we used two methods to attempt to identify what would have been the elective surgery effort of the States and Territories in 2008-09.

First, we applied trend growth of 1.3 per cent per annum over the four years to 2007-08, to arrive at an expected 572,852 elective surgeries for 2008-09. However, this is only 22,157 fewer than the actual number of elective surgery admissions in 2008-09.

Second, in order to estimate the 'current elective surgery effort' for 2008-09, we plotted the actual number of elective surgeries performed in 2007-08 directly to the Federal Government's performance target of 607,529 elective surgeries in 2009-10<sup>10</sup>. Graph 5 shows this by a green dotted line. It indicates that the current elective surgery effort for 2008-09 should have been around 586,515 – around only 8,500 fewer than the actual number of elective surgeries performed in 2008-09.

**Graph 5: Estimated current elective surgery effort for 2008-09**



We can only conclude from this analysis that it is more likely that the Commonwealth's \$150 million 'blitz' funding did not support any substantial increase in performance on elective surgery.

### Why this is important

When public patients must 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 treatment can impair quality of life, reduce work productivity, and reduce the contributions that older Australians can make to the community.

<sup>9</sup> National Elective Surgery Waiting Times Data Collection.

<sup>10</sup> National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan: Period 1 assessment report. Report to the Council of Australian Governments, 30 June 2010, p 18.

## What needs to be done

The Federal Government must ensure that State and Territory Governments use additional Federal funding for the intended purpose. There must be a transparent reporting mechanism that allows the Australian people to identify exactly what health funding has been used for.

Accordingly, a nationally consistent reporting system is needed to 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 on elective surgery waiting lists, and the number of elective surgeries performed on patients, by category, in each jurisdiction.

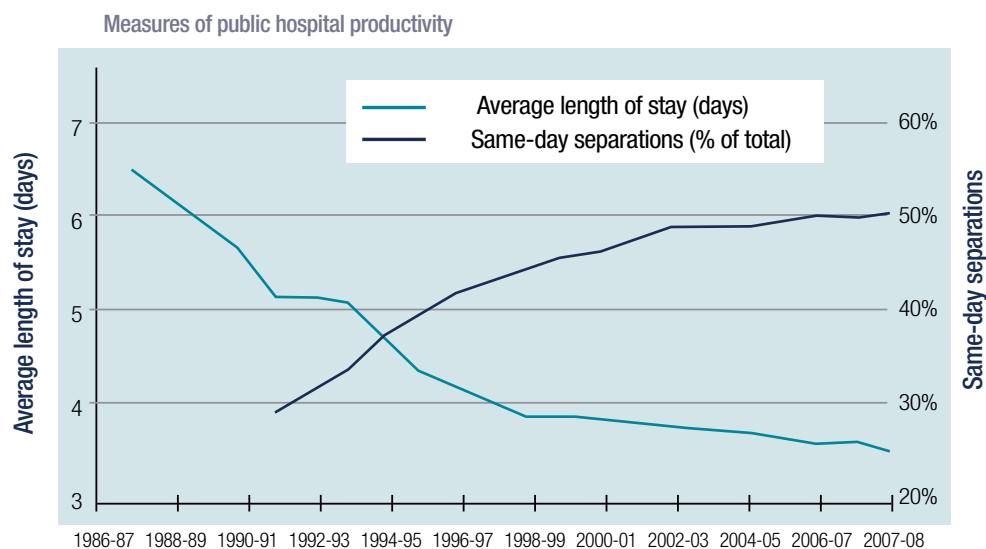
## Hospital efficiency and productivity

Federal 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, both measures are reaching a plateau (see Graph 6) because the easier productivity improvements have already been made in previous years. 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.

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



Governments have had unrealistic expectations that large productivity gains will continue to offset these factors. However, hospitals that operate at full capacity for most of the time in fact create inefficiencies. For example, busy nursing staff are forced to attend to patients when they can, rather than when care guidelines recommend that they should, and there is a higher risk of errors.

Public hospitals are served by a high-quality, dedicated and hardworking medical workforce. Unfortunately, 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 in their ability to care for their patients.

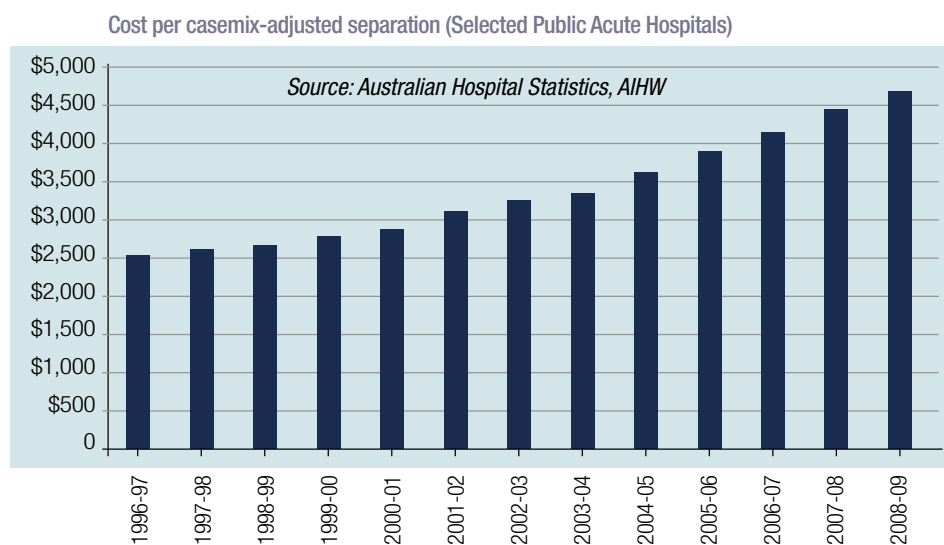
The current reliance on medical practitioners undertaking prolonged periods of work results in unacceptably high costs both to the individual doctor and the standard of patient care. Similarly, hospitals are less productive when staff have to rely on infrastructure and equipment that are old and not properly maintained.

## Why this is important

Governments at all levels need to 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 7).

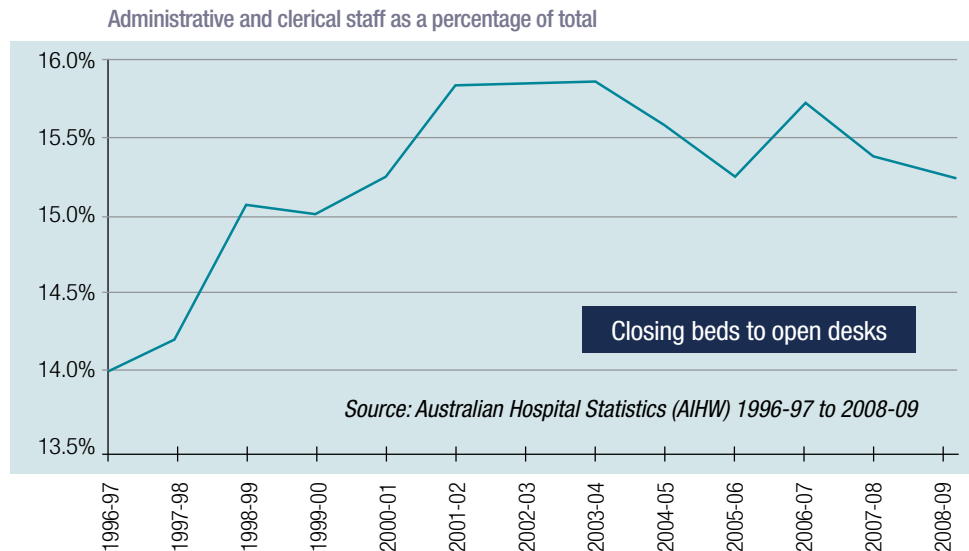
As a result, it is not an option to continue slashing the capacity and funding of the system and placing undue pressure on the individuals who provide care, and yet expect to deliver the same quality of care.

**Graph 7: Measures of public hospital productivity**



We also need to ensure that money is not wasted needlessly on bureaucracy and red tape, but directed to the care of patients. Graph 8 shows that administrative and clerical staff, as a percentage of total hospital staff, have declined for the second year in a row.

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



Continuing to lower the percentage of administrative and clerical staff could free up funds that can be used to create new medical intern places urgently, along with the extra medical training places required to ensure that all graduates can proceed to, and complete, specialist training. This would help address the shortage of prevocational and vocational training positions for medical school graduates. For example, if the percentage of administrative and clerical staff is returned to 14 per cent of the public hospital workforce, as it was in 1996-97, this would free up 3,100 jobs of that nature and provide scope to employ around 2,300 health workers today, some of whom would be medical trainees.

## What needs to be done

Under the National Health and Hospitals Network Agreement, the Commonwealth Government has agreed to fund 60 per cent of the efficient price of every public hospital service. From 1 July 2011, funding of many public hospitals will therefore be based on their activity. The AMA supports the development of activity-based funding, except for small rural and remote hospitals where block funding more appropriately covers the fixed costs of providing services in these areas. Although activity-based funding provides transparency for government funding, it is important that the amount of the funding covers the effective cost of care, and not be the cheapest price for care.

Doctors involved in the care of patients at the coalface can make a significant contribution to the effective and efficient management of hospitals to optimise their performance. Doctors can contribute to better management of health costs while ensuring quality patient care and outcomes by being involved in decisions about allocating resources and purchasing services for the provision of patient care, including decisions at the local hospital level. The management of hospitals works best when doctors are engaged in clinical and corporate governance. We welcome the reform measures that will see the return of doctors being involved in the governance of hospitals and the health system.

## 2. STATE-BY-STATE PUBLIC HOSPITAL PERFORMANCE REPORT

### Comments

As in last year's report, we have assembled performance information for each State and Territory using available data sources.

In relation to emergency care, all States and Territories have a long way to go to meet the National Healthcare Agreement performance benchmark of 80 per cent of emergency department presentations seen within clinically recommended triage times by 2012-13.

Data on elective surgery show that most jurisdictions have improved the percentage of elective surgery patients admitted within the recommended time from the waiting lists. However, we remain concerned that the accuracy of the waiting list data is uncertain, and that they do not report the time that people wait to be seen by a specialist for assessment. The elective surgery data only report on the waiting times for people who are booked for surgery.

It is also concerning that median waiting times for elective surgery for nearly all States worsened, sometimes considerably, over the period of additional Federal Government funding. Only South Australia and the Northern Territory reduced the median number of days that people wait for elective surgery.

Only the ACT, Queensland, and Western Australia publicly report on bed occupancy rates. It is disappointing that the other jurisdictions will not publish this information.

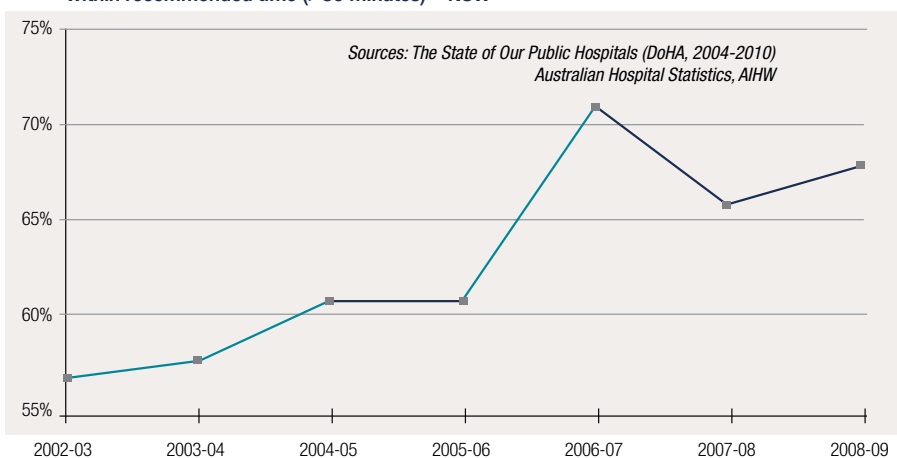


# NEW SOUTH WALES

## Emergency departments

There has been marginal improvement in NSW emergency department performance in 2008-09, with 68 per cent of Triage Category 3 patients seen within the recommended time of 30 minutes, but it has not been sufficient to reverse completely the disappointing decline in performance in 2007-08.

**Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (>30 minutes) – NSW**

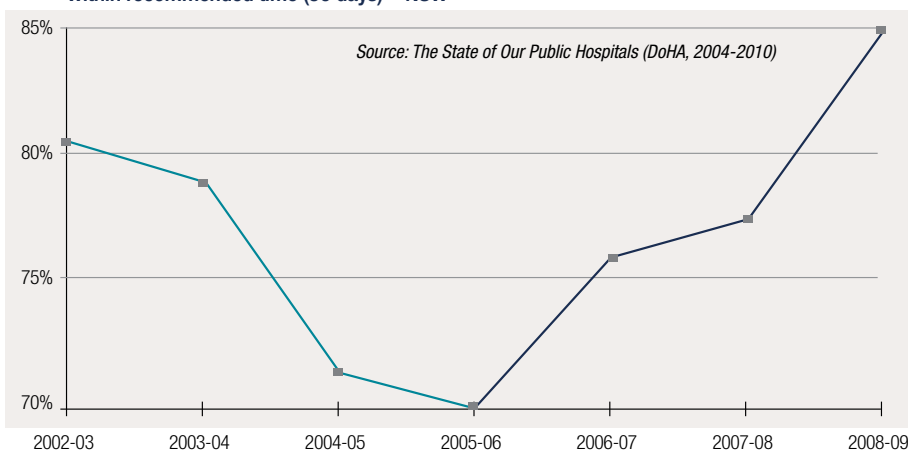


More recent data available from the NSW Bureau of Health Information for April to June 2010 quarter show that performance lifted to 74 per cent during that period<sup>11</sup>.

## Elective surgery waiting times

There has been a sharp improvement in the percentage of Category 2 elective surgery patients seen within the recommended time of 90 days in NSW since 2007-08.

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

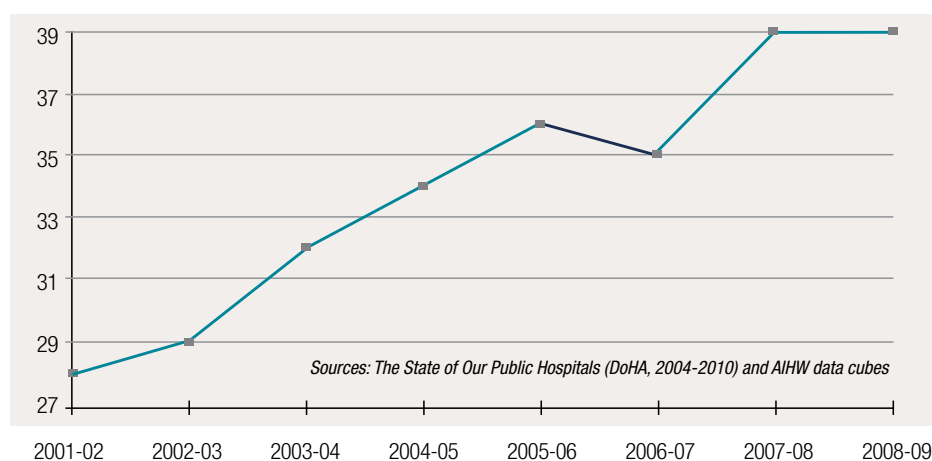


<sup>11</sup> Bureau of Health Information report: *Hospital Quarterly: Performance in NSW Public Hospitals, July 2009 to June 2010*, [www.bhi.nsw.gov](http://www.bhi.nsw.gov), p 28

More recent data available from the NSW Bureau of Health Information for the April to June 2010 quarter show that this performance is 85 per cent for this period<sup>12</sup>.

However, this performance improvement is marked by fewer elective surgeries performed in NSW in 2008-09 (199,384) than in 2007-08 (199,578) and no improvement in median waiting times.

Median waiting time for elective surgery (days) – NSW



No improvement in the median waiting time may reflect endeavours to provide services to those who have been waiting for a very long period of time.

## The elective surgery 'blitz'

It is difficult to confirm from publicly available data that NSW provided an additional 12,153 elective surgeries<sup>13</sup> in 2008-09 under the elective surgery waiting list 'blitz'. In 2008-09, there were 199,384 admissions from the elective surgery waiting list – 194 fewer admissions than in 2007-08. AMA (NSW) has written to the NSW Health Minister requesting an explanation of the difference between these figures.

## Bed numbers

The total number of available public hospital beds in 2008-09 was 19,805, which equates to 2.6 beds per 1,000 population in NSW. This continues a downward trend from 2.7 beds in 2007-08 and 2.8 beds in 2006-07, providing no growth to meet considerable unmet demand in NSW.

## Occupancy rates

Recent data on the bed occupancy rates of NSW public hospitals are difficult to obtain. However, information provided recently in the NSW Parliament in answer to a question during budget estimates revealed very high occupancy rates – between 89 per cent and 95 per cent for major Sydney hospitals. Anecdotal evidence from AMA members is that occupancy rates in the high 90s are not unusual.

## Comments

The data suggest that, overall, NSW public hospitals do not have the capacity to meet demand. Declining bed numbers correspond with declining elective surgeries. NSW is witnessing a decline in public hospital services to patients, which must be turned around.

<sup>12</sup> Bureau of Health Information report: *Hospital Quarterly: Performance in NSW Public Hospitals, July 2009 to June 2010*, www.bhi.nsw.gov, p 13

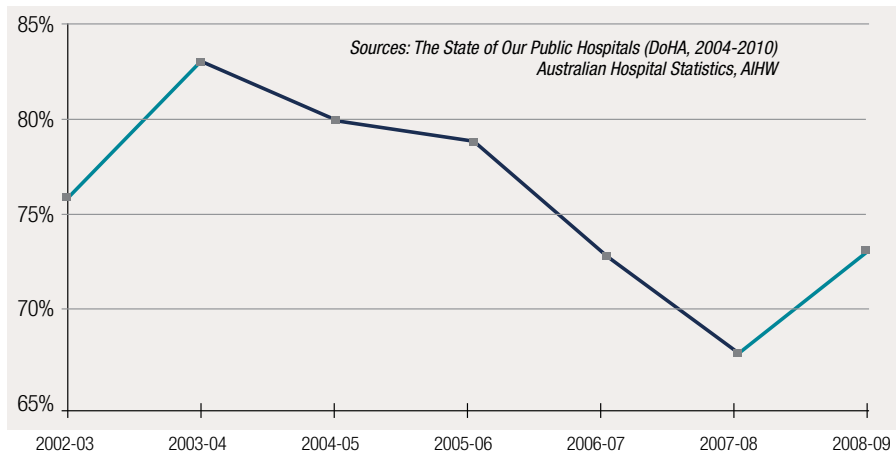
<sup>13</sup> Communiqué, Australian Health Ministers Conference, 5 March 2009

# VICTORIA

## Emergency departments

In 2008-09, Victorian emergency department performance improved, with 74 per cent of Triage Category 3 patients seen within the recommended times, up from 68 per cent in 2007-08.

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

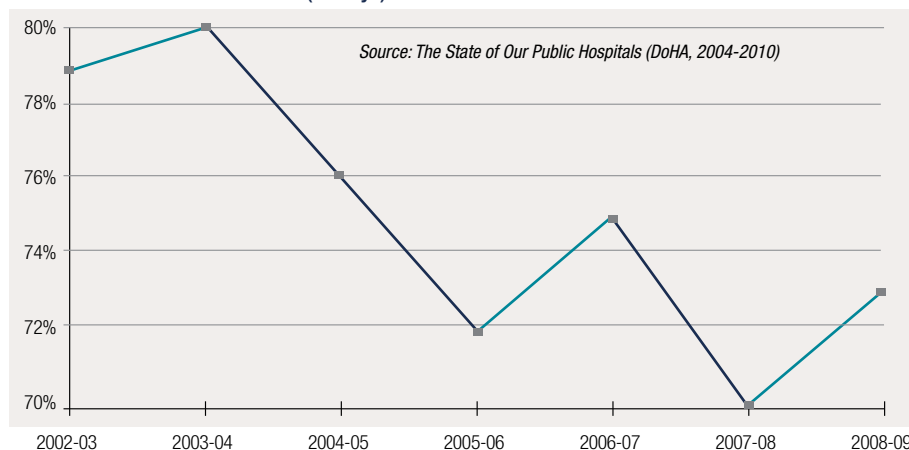


However, more recent Victorian Government data for 2009-10 show that only 69 per cent of Category 3 emergency patients were seen within the clinically appropriate time. More than 105,000 patients were not treated on time, an increase of 16,000 from the previous year<sup>14</sup>.

## Elective surgery waiting times

With 73 per cent of Category 2 elective surgery patients admitted within the clinically appropriate time, Victoria is currently performing under the national average of 78 per cent.

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

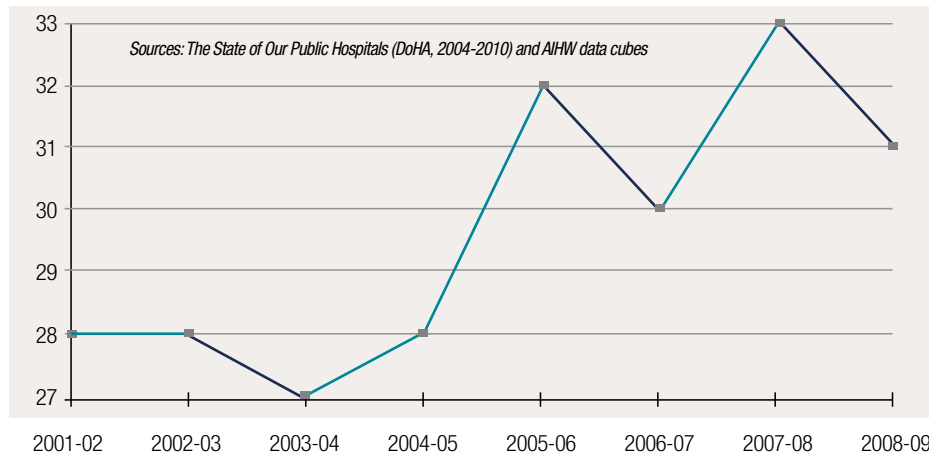


<sup>14</sup> *Your Hospitals: A report on Victoria's public hospitals July 2009 to June 2010 State of Victoria, Department of Health 2010.*

The latest Victorian Government data covering 2009-10 show that the improvement that started in 2008-09 has stalled, with still only 73 per cent of Category 2 elective surgery patients admitted within the recommended time. Around 20,000 Victorian Category 2 patients missed out on timely elective surgery.

Median waiting times for elective surgery in Victoria improved by two days compared to 2007-08.

Median waiting time for elective surgery (days) – VIC



In past years, Victoria removed patients from the waiting list and counted them as new patients if they had been prepped for an operation but the operation was cancelled at the last minute (as happens from time to time). It is possible that some of the see-sawing effect shown in the data is caused by changing administrative practices in the recording of waiting lists.

However, these statistics still do not show the full extent of patients waiting in the system to be assessed by a specialist before they are officially listed on the surgery waiting list. AMA Victoria has called on the Victorian Government many times to make these data public.


## The elective surgery 'blitz'

Victoria appears to have made some headway towards the reported additional 13,478 elective surgeries<sup>15</sup> under the elective surgery waiting list 'blitz'. In 2008-09, there were 147,690 admissions from the elective surgery waiting list – 17,384 more admissions than in 2007-08.

## Bed numbers

The total number of available public hospital beds in 2008-09 was 12,869. The number of available beds per 1,000 Victorians is 2.3, unchanged from 2007-08, and still below the national average of 2.5.

<sup>15</sup> Communiqué, Australian Health Ministers Conference, 5 March 2009



The Victorian Government announced around 1,000 new beds over the last two budgets. AMA Victoria is monitoring the release of these hospital beds and has urged government accountability to ensure that they are all funded and delivered as promised.

## Occupancy rates

Data on bed occupancy rates in Victoria are not publicly available. Hospitals should run at 85 per cent average capacity for peak efficiency and safety. The Victorian Government should fund hospitals accordingly.

## Comments

All of the publicly available data show that Victoria is unable to maintain consistent public hospital performance, and Victorians continue to face long waits for emergency care and elective surgery because of a shortage of serviced public hospital beds.

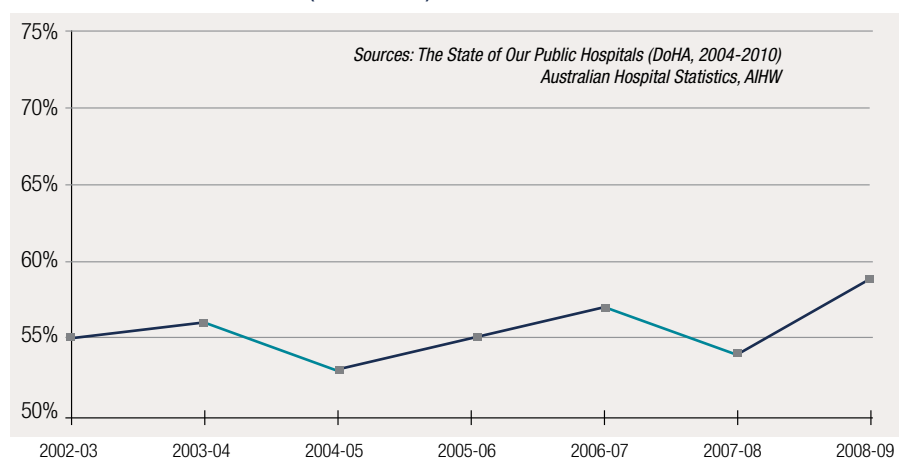
The Victorian Government funding of new beds is yet to catch up on the relative decline over the last seven years. AMA Victoria has called for a plan – a vision for the future – for Victoria’s public health services.

# QUEENSLAND

## Emergency departments

There has been a modest improvement in Queensland emergency department performance in 2008-09, with 59 per cent of Triage Category 3 patients seen within recommended times, up from 54 per cent in 2007-08.

**Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (>30 minutes) – QLD**

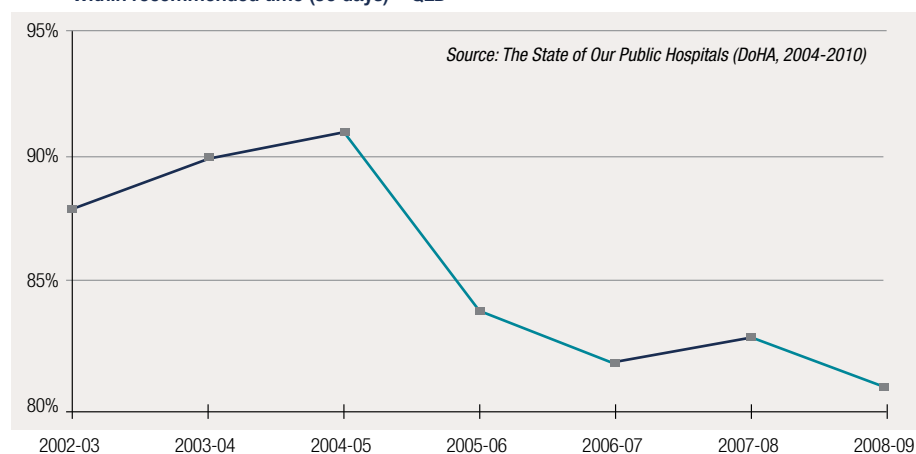


Emergency department attendances rose 2.7 per cent from the previous year and emergency admissions rose by 5.6 per cent<sup>16</sup>. Queensland will find it difficult to meet the National Healthcare Agreement performance benchmark of 80 per cent by 2012-13.

## Elective surgery waiting times

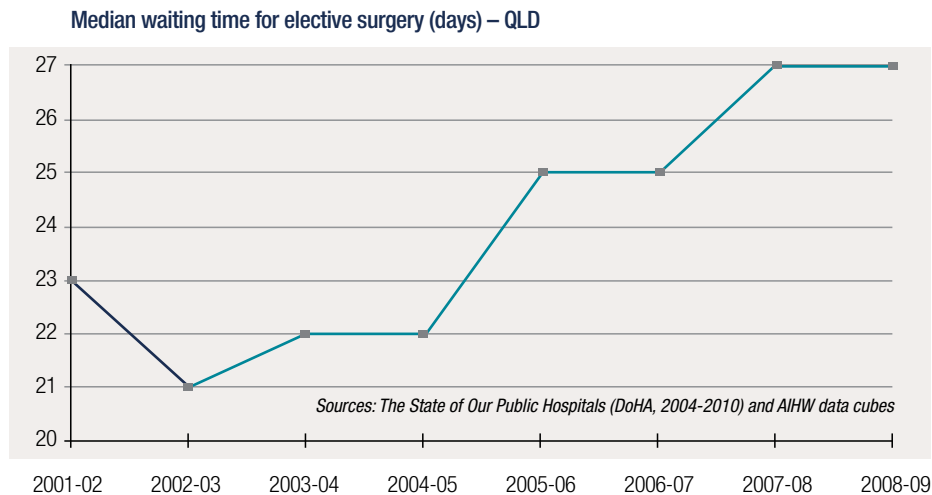
The percentage of Category 2 elective surgery patients seen within the recommended time declined to 81 per cent in 2008-09 and continues a downward trend from 2004-05.

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



<sup>16</sup> Quarterly public hospitals performance report June 2009 quarter Queensland Government, Queensland Health 2009

There has been no improvement in the median waiting times for elective surgery.



Although elective surgery waiting times in Queensland have continued to lengthen since 2002-03, they are well below the national median waiting time of 34 days.

The Queensland Government introduced 'Surgery Connect' to reduce the number of elective surgery patients who have been waiting longer than clinically recommended times by paying for them to be treated in private hospitals. The Queensland Government reported that 7,614 public patients were treated under this scheme by private hospitals in 2008-09<sup>17</sup>.

## The elective surgery 'blitz'

It is difficult to confirm from publicly available data that Queensland provided an additional 5,928 elective surgeries<sup>18</sup> in 2008-09 under the elective surgery waiting list 'blitz'. In 2008-09, there were 109,940 admissions from the elective surgery waiting list – only 2,317 more admissions than in 2007-08.

## Bed numbers

The total number of available public hospital beds was 10,805, an increase of only 154 beds from the previous year.

The number of hospital beds per 1,000 Queenslanders was 2.4, lower than 2.5 per 1,000 population in 2007-08. Although the number of beds per 1,000 population hovers around the national average of 2.5 beds per 1,000 population, Queensland's population is the second fastest growing population in Australia<sup>19</sup>.

Significant investment in hospital beds will be required to reduce access block from emergency departments and ensure that available elective surgery procedures meet demand.

<sup>17</sup> *Quarterly public hospitals performance report June 2009 quarter* Queensland Government, Queensland Health 2009, p 13

<sup>18</sup> Communiqué, Australian Health Ministers Conference, 5 March 2009

<sup>19</sup> ABS population growth statistics, [www.abs.au/ausstats](http://www.abs.au/ausstats)

## Occupancy rates

During 2008-09, more than half of Queensland's public hospitals with more than 100 beds continued to operate regularly above the recommended 85 per cent average bed occupancy level. Of these hospitals, Caboolture, Mackay Base and Redcliffe hospitals operated on average at over 100 per cent occupancy, showing significant overstressing of capacity.

## Comments

The various performance measures show a decline in elective surgery performance in Queensland over the past 5-6 years: fewer patients admitted within the clinically recommended times, longer median waits, and fewer admissions from the waiting list in 2008-09 than in 2003-04. This is despite the 'Surgery Connect' program, and this means that public hospital services are not meeting the needs of a population that is growing quickly and ageing even more quickly.

Public hospital bed numbers and bed occupancy rates are still too low to meet demand. AMA Queensland estimated that an additional 363 beds were required in 2008-09 to achieve 85 per cent average occupancy in overstressed hospitals<sup>20</sup>.

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<sup>20</sup> Figure provided by Qld AMA based on figures calculated from source 9 above

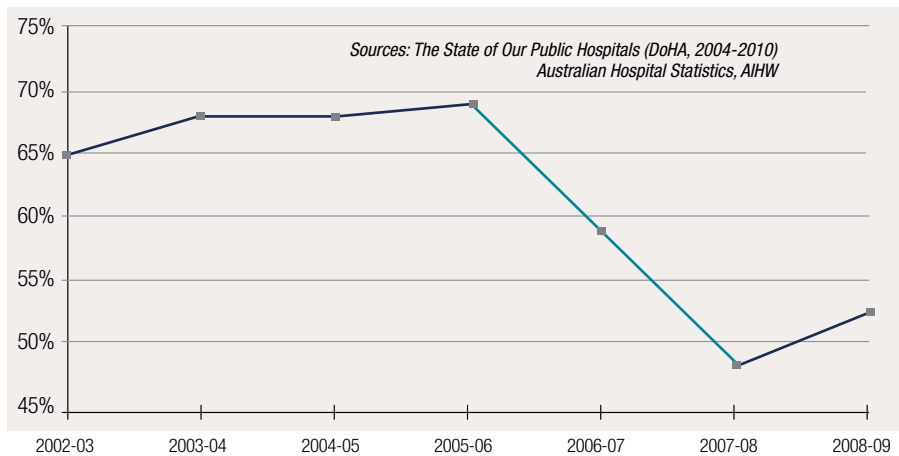


# WESTERN AUSTRALIA

## Emergency departments

In 2008-09, Western Australia has been able to make modest progress in turning around a sharp deterioration in emergency department performance over the preceding two years.

**Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (>30 minutes) – WA**

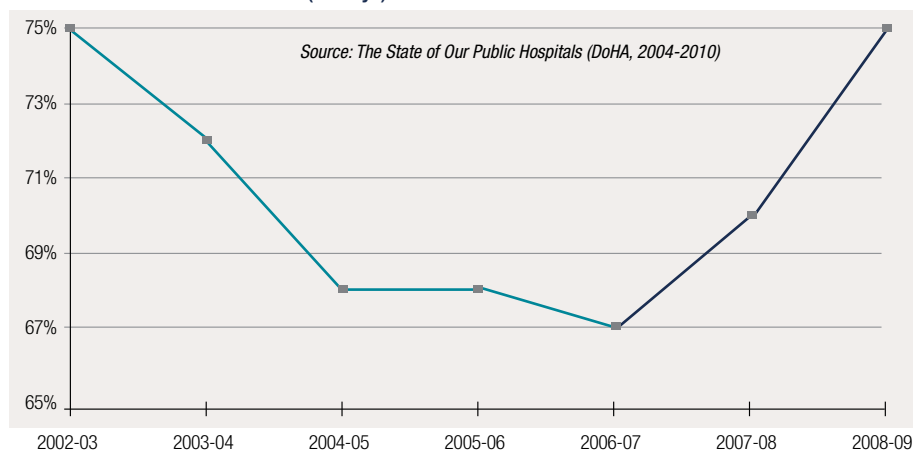


There will need to be significantly more effort and support for Western Australian public hospitals if they are to meet the performance benchmark of 80 per cent of emergency department patients being seen within clinically recommended times by 2012-13.

## Elective surgery waiting times

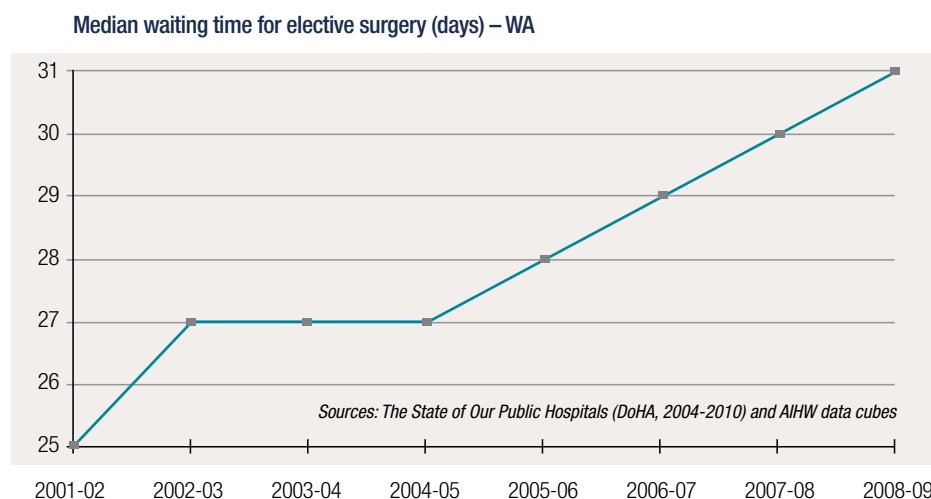
The deterioration in the percentage of Category 2 elective surgery cases seen within the recommended times since 2002 was reversed in 2006-07 and has continued to improve. Unfortunately, one in four – 25 per cent – of such patients are still not seen in recommended times.

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



However, patients waiting for assessment by a specialist are not recorded on the official elective surgery waiting list and, therefore, the time they wait for that appointment is not counted in these waiting list data.

In the meantime, the median waiting time for elective surgery in Western Australia continues to grow longer.



More recent data from 2010 reported in the WA Hospital Performance Report indicate that waiting lists have blown out by 14 per cent this year.

## The elective surgery 'blitz'

It is difficult to confirm from publicly available data that Western Australia provided an additional 3,727 elective surgeries<sup>21</sup> in 2008-09 under the elective surgery waiting list 'blitz'. In 2008-09, there were 60,398 admissions from the elective surgery waiting list – only 3,276 more admissions than in 2007-08.

## Bed numbers

The total number of available public hospital beds in 2008-09 was 5,369, which equates to 2.4 beds per 1,000 population in Western Australia. This is lower than the previous year's rate of 2.5 per 1,000 population.

It is difficult to obtain accurate figures about the number of available beds in Western Australia. WA Health changed the definition of available beds on 1 July 2008, making it difficult to compare with previous years and with Australian Institute of Health and Welfare hospital statistics. With this qualification, longitudinal figures from Western Australia Health Performance 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.

AMA WA has estimated that more than 400 extra beds are needed to meet current demands.

<sup>21</sup> Communiqué, Australian Health Ministers Conference, 5 March 2009

## 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 in July 2008 has led to a significantly lower reported average occupancy rate of 85.2 per cent in 2008-09 in metropolitan hospitals<sup>22</sup>. This is despite a similar number of hospital admissions and overnight available beds to the previous year.

AMA WA reports that Western Australian teaching hospitals regularly have occupancy rates of around 96 per cent.

## Comments

Western Australia has recently implemented a four-hour access target for public hospital emergency departments. Early reports from AMA members suggest that the measure has driven some one-off system improvements across the hospitals. The impact of this measure will probably not be seen until the first full year of data for 2010-11 becomes available in 2012.

Regarding elective surgery, the various performance measures show a mixed picture for Western Australia. Despite a significant increase in the number of elective surgery admissions from the waiting lists, the median waiting time has steadily increased and the percentage of patients admitted within the clinically recommended times has not been stable. Western Australia's population is also growing quickly, a factor that is not reflected in the aggregate performance measures.

Bed numbers are low and occupancy rates are difficult to interpret given the change in definition.

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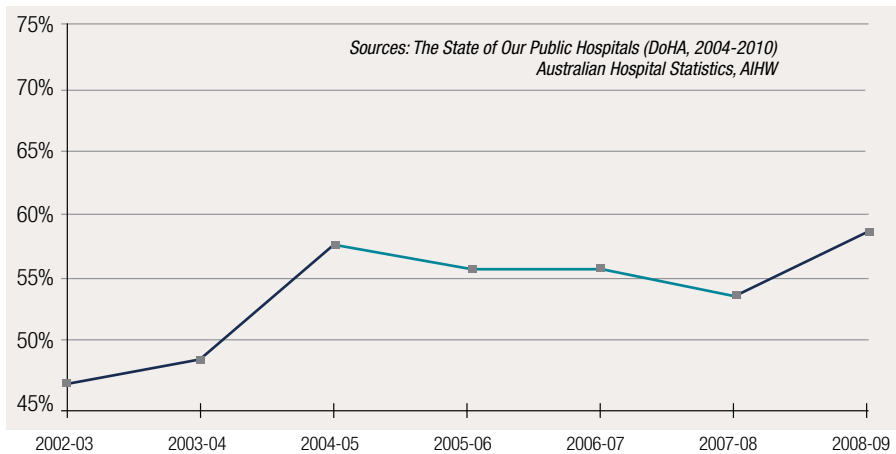
<sup>22</sup> WA Health Performance Report, January to March 2010 Quarter, pp 1, 2, 11, 12

# SOUTH AUSTRALIA

## Emergency departments

South Australian emergency department performance for Category 3 patients improved by five percentage points to 59 per cent of these patients being seen within the recommended time in 2008-09. However, this is only marginally better than the performance in 2004-05. South Australia has some way to go to reach the performance benchmark of 80 per cent in the National Healthcare Agreement.

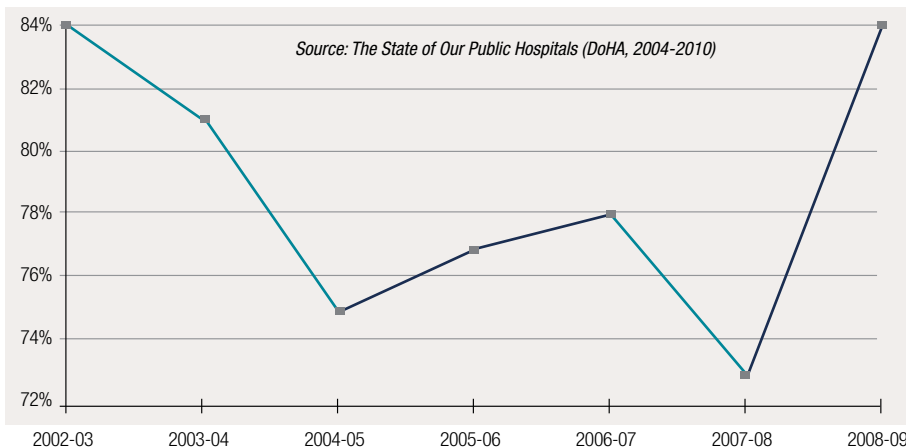
**Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (>30 minutes) – SA**



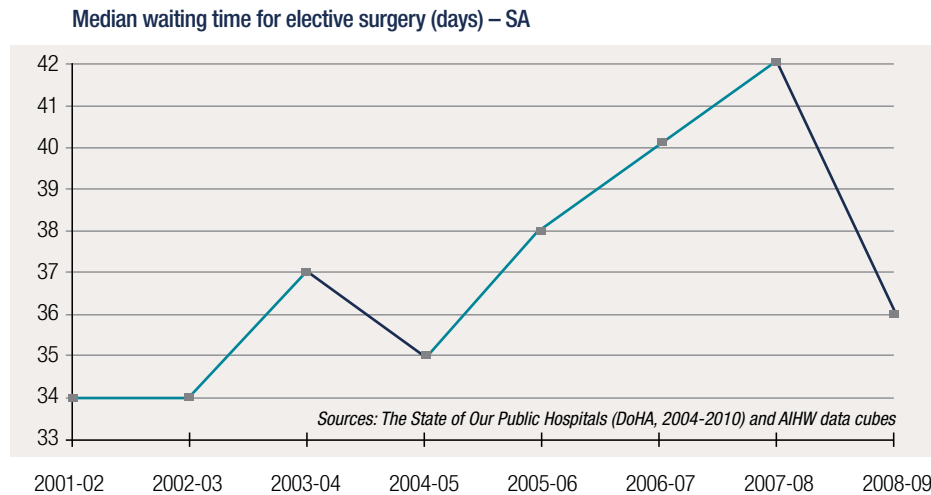
## Elective surgery waiting times

There has been a remarkable improvement in elective surgery performance by South Australia. In 2008-09, 84 per cent of Category 2 elective surgery patients were seen within the recommended time, compared to only 73 per cent of patients in 2007-08.

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



This improvement is also shown in a significant decline in the median waiting time for elective surgery. The median time in which patients waited for surgery in South Australian public hospitals was 36 days, almost a week less than in 2007-08.



## The elective surgery 'blitz'

It is difficult to confirm from publicly available data that South Australia provided an additional 3,196 elective surgeries<sup>23</sup> in 2008-09 under the elective surgery waiting list 'blitz'. In 2008-09, there were 44,152 admissions from the elective surgery waiting list – only 3,106 more admissions than in 2007-08, some of which should have included expected growth to meet increasing demand from an ageing population.

## Bed numbers

The total number of available public hospital beds was 4,874. The average number of available hospital beds per 1,000 South Australians was 2.7, but lower than the average of 2.8 beds in 2007-08<sup>24</sup>.

## Occupancy rates

South Australia does not make information on occupancy rates publicly available. Major metropolitan hospitals are often running at 100 per cent occupancy, leading to blockages in emergency departments as well as regular unscheduled cancellations of elective surgery list patients.

## Comments

South Australia is only managing to return to emergency care performance levels of 2004-05, and will have difficulty meeting the performance benchmark of 80 per cent by 2012-13.

The various performance measures for elective surgery show that South Australia dramatically improved in 2008-09. South Australia's population is not growing as fast as some others and the performance needs to be seen in that light.

<sup>23</sup> Communiqué, Australian Health Ministers Conference, 5 March 2009

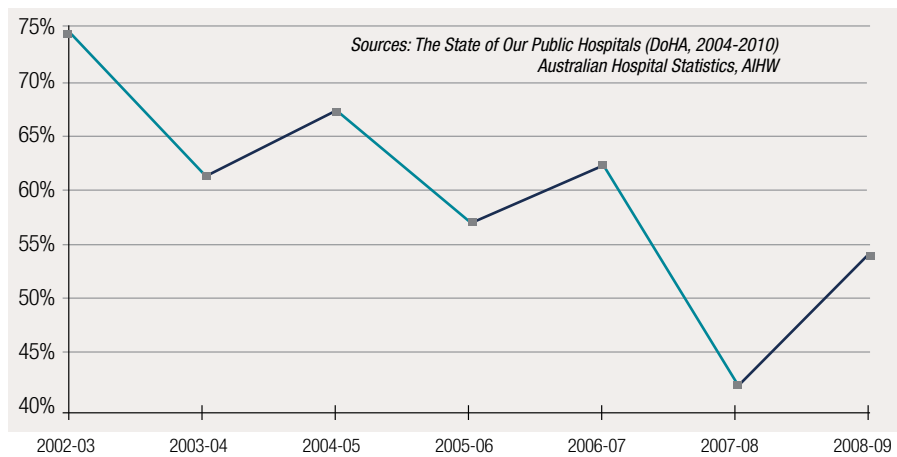
<sup>24</sup> *State of Our Public Hospitals June 2010*, p 46 and *June 2009*, p 12

# TASMANIA

## Emergency departments

Tasmania has managed to turn around a serious decline in emergency department performance but still has a long way to go to ensure that residents of Tasmania have timely access to emergency care.

**Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (>30 minutes) – TAS**

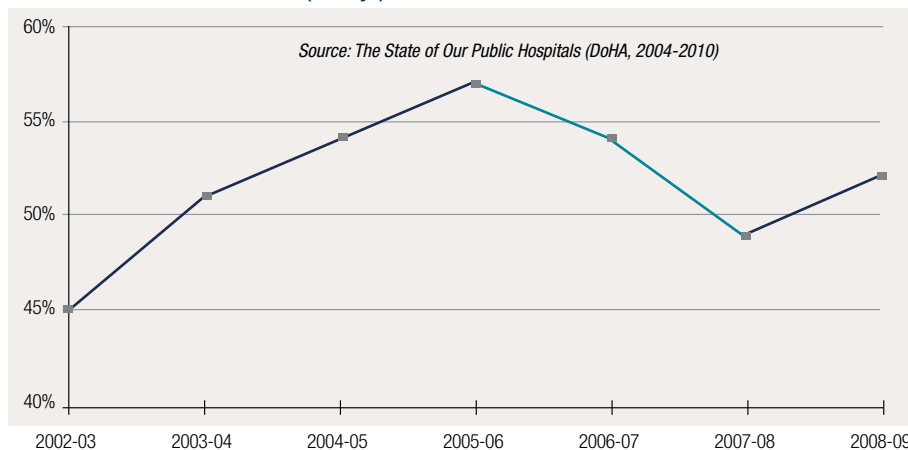


With only 54 per cent of Triage Category 3 emergency department patients seen within the recommended time, Tasmania is still 10 percentage points below the national average of 64 per cent.

## Elective surgery waiting times

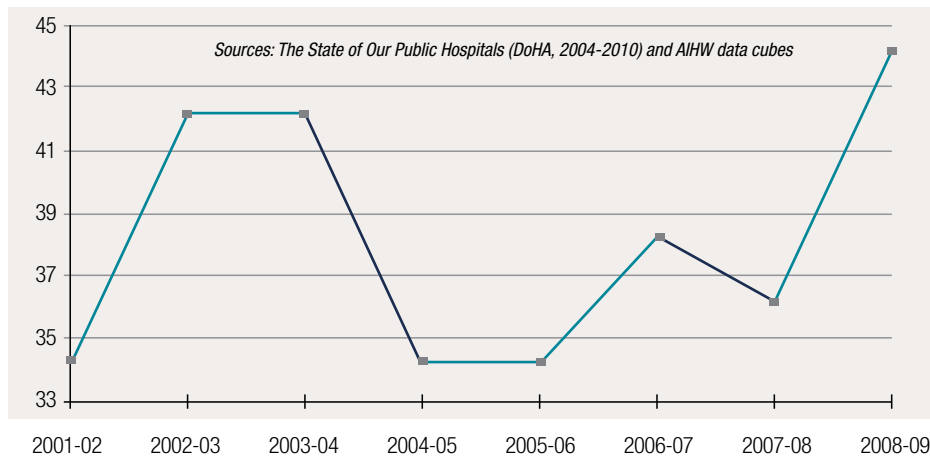
There was a small improvement in the percentage of Category 2 elective surgery patients seen within the recommended time. However, at 52 per cent, Tasmania is well below the national average of 78 per cent of these patients seen within the recommended times.

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



The median waiting time for elective surgery in Tasmania has blown out from 36 days in 2007-08 to 44 days in 2008-09. This is 10 days longer than the national median waiting time.

Median waiting time for elective surgery (days) – TAS



## The elective surgery 'blitz'

Tasmania is the only jurisdiction in which the data demonstrate that additional elective surgeries were performed under the elective surgery waiting list 'blitz'. Tasmania performed an additional 1,606 elective surgeries<sup>25</sup>. In 2008-09, there were 16,931 admissions from the elective surgery waiting list – 2,782 more admissions than in 2007-08.

## Bed numbers

The total number of available public hospital beds was 1,275. The average number of available hospital beds per 1,000 Tasmanians was 2.3, the same as in the previous year<sup>26</sup>.

## Occupancy rates

There are no publicly available data on average occupancy rates in Tasmania. The Tasmanian Government is still not collecting, monitoring and making public data on this important indicator of the Tasmanian public hospital system's capacity to cope with demand. However, doctors report hospitals running close to 100 per cent capacity much of the time. AMA Tasmania estimates that an additional 150 beds are required to meet capacity demands.

## Comments

Though improvements have been made in the number of elective surgeries provided in Tasmanian public hospitals, overall performance is poor compared to the national averages.

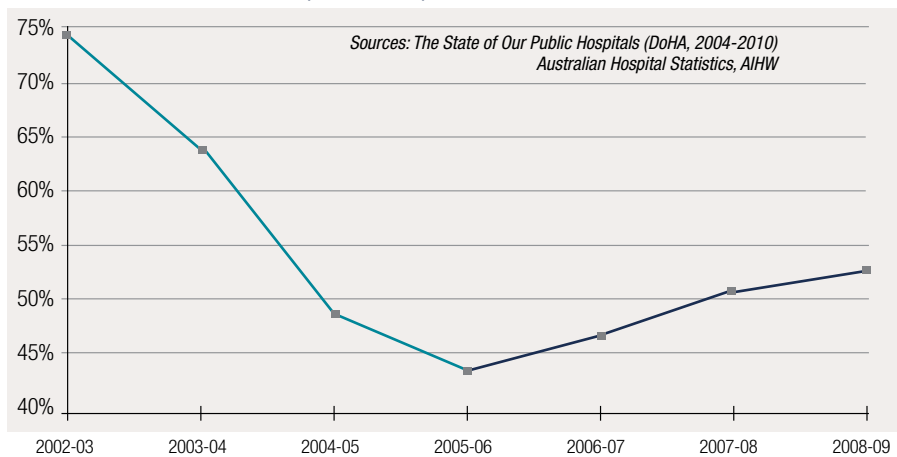
<sup>25</sup> Communiqué, Australian Health Ministers Conference, 5 March 2009  
<sup>26</sup> *State of Our Public Hospitals June 2010*, p 46 and June 2009, p 12

# AUSTRALIAN CAPITAL TERRITORY

## Emergency departments

Australian Capital Territory emergency department performance for Category 3 patients continues to improve from a very poor base in 2005-06. However, with only 53 per cent of these patients seen within the recommended time in 2008-09, the ACT remains well below the national average of 64 per cent.

**Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (>30 minutes) – ACT**



The ACT Government cited a 21 per cent increase in Category 1 and 2 patients during 2008-09 as impacting on its ability to provide more timely care for this category of patients<sup>27</sup>.

Data from the first three quarters of 2009-10 published by the ACT Government show a considerable improvement against this measure to 60.1 per cent.

Despite the improvement, it is likely that the ACT will still have difficulty meeting national targets for Triage Category 3 patients. It currently meets national targets for treating Triage Category 1 and 2 patients.

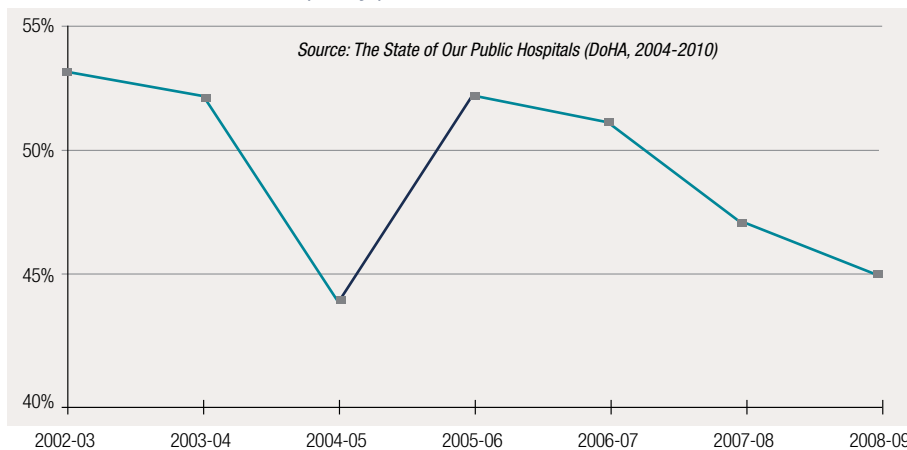
## Elective surgery waiting times

Against this measure, the ACT's performance continued to deteriorate in 2008-09, the 45 per cent result being significantly below the national average of 78 per cent.

<sup>27</sup> ACT Public Health Services Quarterly Performance Report, June Quarter 2009, p 10



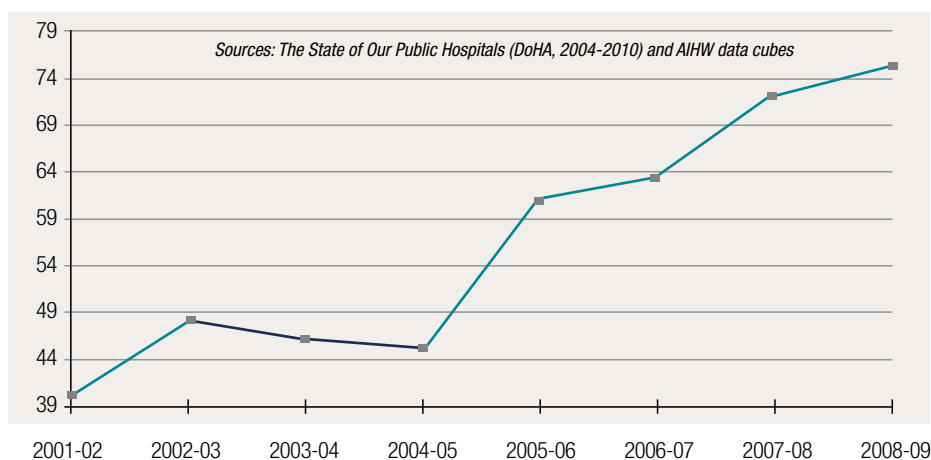
**Percentage of Category 2 elective surgery patients seen within recommended time (90 days) – ACT**



The ACT Government cited a need to reduce planned surgery in order to provide bed capacity in the event of an epidemic resulting from the H1N1 outbreak as one reason for difficulties against this measure<sup>28</sup>.

Waiting times for elective surgery in the ACT continue to grow.

**Median waiting time for elective surgery (days) – ACT**



In 2008-09, the median waiting time in the ACT was 120 per cent longer (75 days), compared to the national average (34 days). Data from the first three quarters of 2009-10 indicate only a marginal improvement. The ACT Government cites a continuing focus on patients with extended waiting times as the reason why overall median waiting times have not improved<sup>29</sup>.

The ACT has a high rate of participation in private health insurance (54 per cent) but the number of people on elective surgery waiting lists with undeclared private health insurance is unknown. This should be considered in any plans for waiting list management.

<sup>28</sup> ACT Public Health Services Quarterly Performance Report, Year to March 2010, p 7

<sup>29</sup> ACT Public Health Services Quarterly Performance Report, Year to March 2010, p 6

## The elective surgery 'blitz'

It is difficult to confirm from publicly available data that the ACT provided an additional 858 elective surgeries<sup>30</sup> in 2008-09 under the elective surgery waiting list 'blitz'. In 2008-09, there were 10,104 admissions from the elective surgery waiting list – only 527 more admissions than in 2007-08.

These data show that the ACT's elective surgery admissions from the waiting lists have grown steadily to be 48 per cent higher than in 2000-01.

ACT data show that the ACT has reduced the number of people waiting longer than one year from 1,085 in 2005-06 to 586 in 2008-09<sup>31</sup>.

## Bed numbers

In 2008-09, the average number of available hospital beds per 1,000 people in the ACT was 2.6. Though there was an increase in the total number of available beds from 785 in 2007-08 to 875 in 2008-09<sup>32</sup>, this did not change the number of beds per 1,000 people.

## Occupancy rates

The average bed occupancy rate in the ACT during 2008-09 was 91 per cent, a similar rate to the last two years and an improvement from 97 per cent in 2005-06<sup>33</sup>. The ACT Government reported further improvements for the first three quarters of 2009-10, citing an 85 per cent average bed occupancy rate – a safe level.

## Comments

Even though the ACT has achieved some improvement in emergency department performance for Category 3 patients, there is still a very large gap compared to the national performance.

Although elective surgery performance is poor, we note that ACT hospitals are an important health resource for the wider south-east region of NSW and elective surgery performance cannot be related simply to the characteristics of the ACT population.

The ACT should be commended for publicly reporting bed occupancy rates and the improvements that have seen safe levels of bed occupancy in the ACT.

30 Communiqué, Australian Health Ministers Conference, 5 March 2009

31 ACT Public Health Services Quarterly Performance Report, June Quarter 2009, page 8

32 *State of Our Public Hospitals June 2010*, p 46 and June 2009, p 12

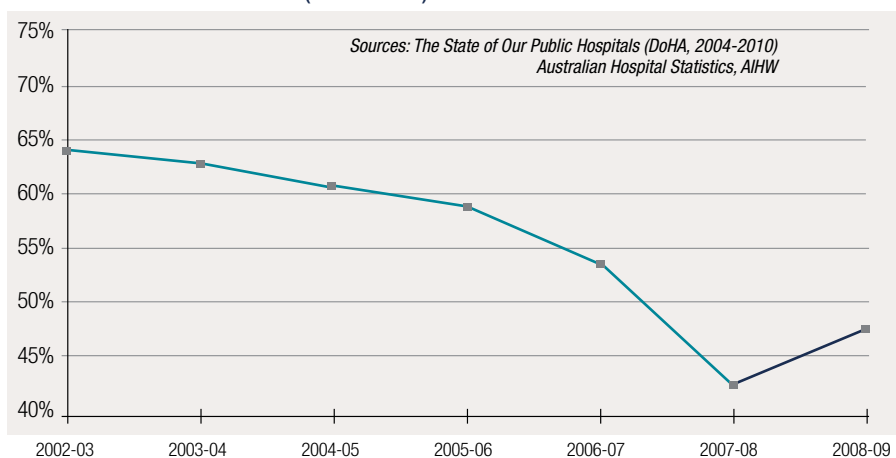
33 ACT Public Health Services Quarterly Performance Report, June Quarter 2009, p 7

# NORTHERN TERRITORY

## Emergency departments

The Northern Territory made a modest improvement in the percentage of Category 3 patients that were seen in the recommended time in 2008-09, but not sufficient to reverse the decline over the past five years.

**Percentage of Triage Category 3 (urgent) emergency department patients seen within recommended time (>30 minutes) – NT**

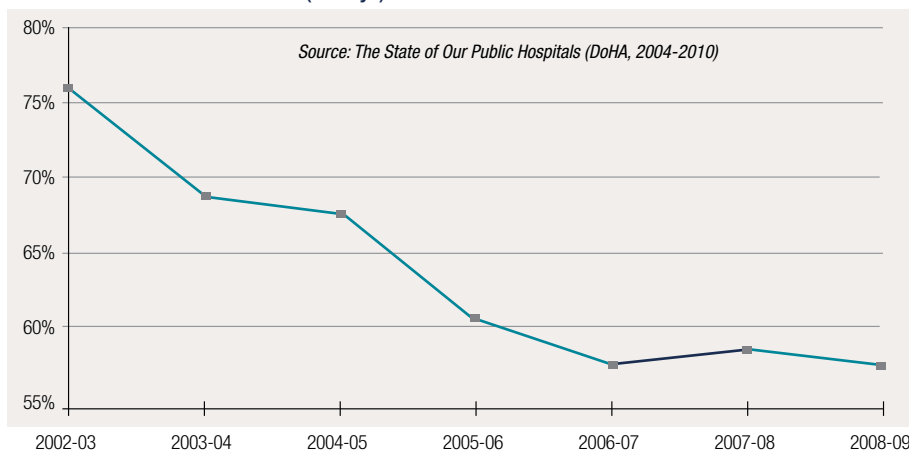


With only 48 per cent of these patients being seen within the recommended time, the Northern Territory is well below the performance benchmark of 80 per cent set by the National Healthcare Agreement.

## Elective surgery waiting times

The Northern Territory continues to make no headway in improving the percentage of elective surgery patients seen within the recommended time.

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



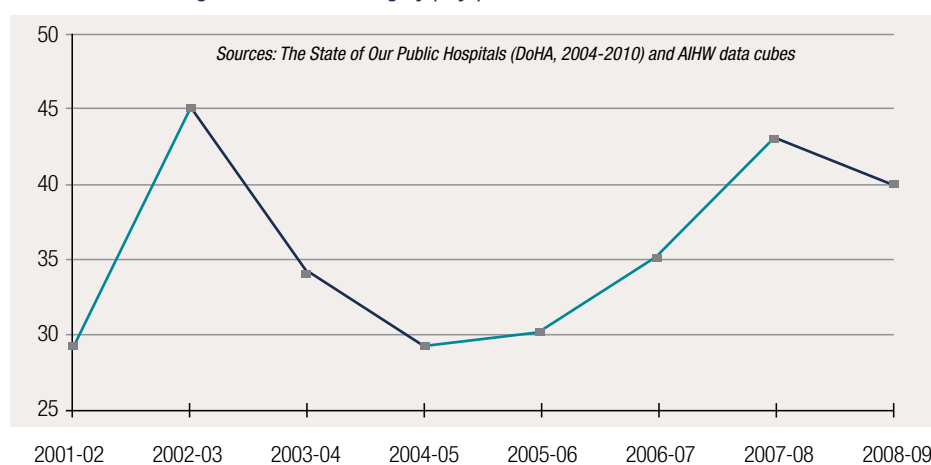
At Royal Darwin Hospital, there were 2,640 patients on the elective surgery waiting list in September 2009. By September 2010, this number had reduced to 1,165. This has been a direct result of more operating theatres becoming available and more surgical locums working in the Northern Territory.

However, a serious bottleneck was created in September 2010 because many elective surgeries had to be cancelled because of the lack of anaesthetists at Royal Darwin Hospital.

Across the Northern Territory, the waiting list numbers are increasing, caused by several factors. In Alice Springs, theatre time is limited because one theatre has been decommissioned while that area of the hospital is rebuilt. Gove and Katherine do not have enough surgeons to perform services. The Northern Territory continues to face a shortage of anaesthetists.

Though there was an improvement in the median waiting time for elective surgery in 2008-09, Territorians waited nearly 20 per cent longer for elective surgery than their fellow Australians.

Median waiting time for elective surgery (days) – NT



## The elective surgery 'blitz'

It is difficult to confirm from publicly available data that the Northern Territory provided an additional 638 elective surgeries<sup>34</sup> in 2008-09 under the elective surgery waiting list 'blitz'. In 2008-09, there were 6,410 admissions from the elective surgery waiting list – only 310 more than in 2007-08.

## Bed numbers

Bed numbers are declining in the Northern Territory: 750 in 2006-07; 616 in 2007-08; and 606 beds in 2008-09.

The average number of available hospital beds per 1,000 people in the Northern Territory was 3.5, down from 3.6 in 2007-08.

<sup>34</sup> Communiqué, Australian Health Ministers Conference, 5 March 2009

## Occupancy rates

The Northern Territory Government does not publish occupancy rates. Doctors in Northern Territory public hospitals continue to report that occupancy rates are in the range of 110 per cent in the two major hospitals. This is unacceptably high.

## Comments

This is a worrying picture, given that Northern Territory hospitals are geographically isolated. Every patient presenting to a Northern Territory hospital and requiring admission must be admitted: there is nowhere else for them to go.

The Northern Territory Government must use the additional funding provided by COAG to increase the capacity of the public hospitals.

Last year, this report noted that an independent review of governance arrangements at Royal Darwin Hospital released in February 2009 had made recommendations on issues such as clinical risk, staffing, strategic and operational performance, and clinical and corporate governance affecting patient care. AMA NT is not aware of any action yet to address these recommendations.







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