



PUBLIC HOSPITAL
REPORT CARD
2011

AN AMA ANALYSIS OF AUSTRALIA'S
PUBLIC HOSPITAL SYSTEM





CONTENTS

INTRODUCTION	2
1 NATIONAL PUBLIC HOSPITAL PERFORMANCE	4
Introduction.....	4
Bed numbers and occupancy rates	5
Emergency department waiting times	8
Elective surgery waiting times	11
Hospital efficiency and productivity.....	14
Funding.....	17
2 STATE-BY-STATE PUBLIC HOSPITAL PERFORMANCE	18
Key Findings	18
NSW.....	19
Victoria.....	22
Queensland.....	24
Western Australia.....	27
South Australia	29
Tasmania.....	31
ACT.....	33
Northern Territory.....	36

INTRODUCTION

We have seen a very interesting political climate since the AMA's last Public Hospital Report Card. A minority Labor government had a tough time negotiating health reform with State and Territory Governments. The Labor Government's original and ambitious plans for health reform have slowly been whittled away by State Governments unwilling to concede ground on financing or responsibility.

Consequently, there is a new set of health care agreements that set out the funding and financing arrangements for public hospital services.

We have agreement that the Commonwealth and State and Territory Governments are jointly responsible for funding public hospital services, as they have always been.

We have affirmation that the State and Territory Governments are the managers of the public hospital system, as they have always been.

The agreements offer more certainty about future funding and transparency. The Commonwealth has committed to paying for 50 per cent growth in hospital services by 2017-18. What remains uncertain today is the quantum of Commonwealth funding that will flow to public hospitals under the agreements, and whether that amount will actually cover 45 per cent of efficient growth funding on 1 July 2014, and 50 per cent from 1 July 2017. This Report Card shows that the Commonwealth's share of total public hospital spending in 2008-09¹ was 42.1 per cent.

The State and Territory Governments have committed to arrangements that provide greater transparency of the flow of funding to hospitals and on hospital performance. As the managers of the public hospital system, the State and Territory Governments are squarely responsible for ensuring that public hospitals receive sufficient funding so that they have the capacity to meet access and quality targets set by the Council of Australian Governments (COAG).

This Report Card shows that public hospital performance in every State and Territory is currently well below the COAG targets for access to emergency departments and elective surgery.

The AMA repeats its message – straight from its members who work in public hospitals – that public hospitals currently do not have the capacity to meet the demands of an ageing population – a population that is also experiencing chronic conditions that inevitably require acute care.

This Report Card shows that the number of public hospital beds per capita, which is the strongest measure of capacity, continues to decline. Fewer beds means longer waiting times in emergency departments and longer waiting times for elective surgery.

The AMA welcomes the new COAG funding and financing arrangements, coupled with the transparency and accountability measures, that should ensure that every precious health dollar is spent on health care services. It is a good start.

But there is unfinished business with health reform.

¹ The latest publicly available data as at 31 August 2011.

The managers of the public hospital system must understand that real health reform will only occur when local doctors and nurses who work in the public hospitals can actively and genuinely participate in service planning and resource allocation decisions at the hospital level. This is the only way to ensure that health dollars are spent caring for patients and providing the safe, quality services that local communities need.

We cannot have history repeat itself whereby the latest public hospital investments and commitments to administrative arrangements make little or no sustained difference.

Now that three years of bureaucratic wrangling are behind us, it is time to make the real changes on the ground. It is time to make a real difference to patient access to services. It is time to make a real difference to the environments in which our hard working doctors, nurses and other health practitioners struggle to provide the care they are trained to provide – because they are working in public hospitals that are overcrowded, under resourced, and poorly managed.

We look forward to measuring the performance of the public hospital system with accurate and current data.

We look forward to real measures of access, such as counting waiting times for public elective surgery from when a general practitioner refers a patient to a specialist for assessment, and not from when the patient is booked for surgery.

We look forward to accurate information on the number of available hospital beds so that we can be sure that funding is flowing to hospitals and increasing their capacity to treat patients.

There has been a concerted effort by the Federal Government to increase organ and tissue donor rates.

The media campaign appears to be having an effect with increases this year in rates of tissue and organ donation and transplants compared to last year.

It is gratifying that the message to donate is getting through. The effort by the Australian people to increase donor rates must be matched by increased public hospital capacity to allow the timely provision of this life-saving surgery and lengthy and critical after care.



Dr Steve Hambleton
President

November 2011

1. NATIONAL PUBLIC HOSPITAL PERFORMANCE

This Report Card provides information about the performance of Australia's public hospitals in 2009-10.

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

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

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

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

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

We used the following sources for statistical data:

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2009-10*;
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2009-10: emergency department care and elective surgery waiting times*; and
- Council of Australian Governments Reform Council, *National Healthcare Agreement: Performance Report for 2009-10*.

As *The State of Our Public Hospitals* report was not published by the Commonwealth in 2011, we obtained the percentage of Category 2 elective surgery patients admitted within the recommended time of 90 days for each State and Territory under the *Freedom of Information Act*.

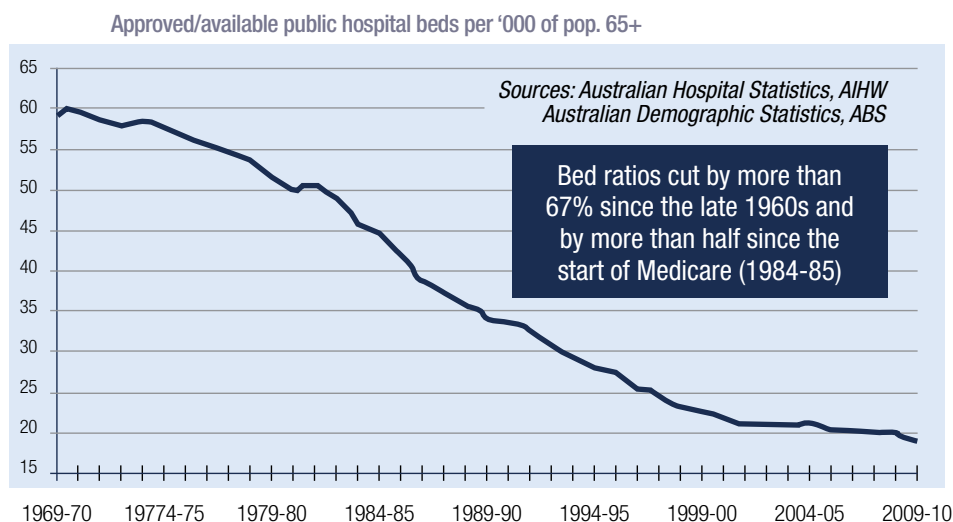
Bed numbers and occupancy rates

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 more than 67 per cent since the 1960s, and by more than half since the start of Medicare. There are now only 19.2 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 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 Commonwealth Government provided an extra \$4.8 billion to State and Territory Governments for public hospitals, and a one-off injection of \$750 million in 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 2012-13.²

Over the two-year period from July 2008 to June 2010, only 433 new beds were opened across the country.

In 2009-10, there were only 2.6 public hospital beds per 1000 population, down by 3.5 per cent from 2008-09.

² Media Release, Prime Minister Rudd, 29 November 2008.

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

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

Why this is important

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

The private hospital system has picked up more of the load. It currently performs 64 per cent of all elective surgery. This has eased the impact of previous cuts to public hospital capacity but the cut in bed numbers has been too deep to meet the current demands for public hospital services.

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,³ and leave little room for hospitals to cope with extra demand, such as when there are viral outbreaks or natural disasters.

What needs to be done

Beds

In *Australian hospital statistics 2009-10*, the Australian Institute of Health and Welfare revised the bed numbers for 2008-09 up by 44. Consequently, only 378 new beds were opened in 2009-10, well short of the potential number that could have been achieved with the additional Commonwealth funding provided to the State and Territory Governments.


This constant adjustment of bed numbers highlights the need for a robust, transparent reporting mechanism on bed numbers and average bed occupancy rates by individual hospitals. A rule of 85 per cent average bed occupancy rate should apply in every hospital.⁴

The Performance and Accountability Framework⁵ should include bed numbers and average bed occupancy rates as indicators of public hospital capacity. The National Health Performance Authority can track the bed numbers to ensure that 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 we achieve average bed occupancy rates of no more than 85 per cent.

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

⁵ National Health Reform Agreement, pgs 44-45, Schedule C



State and Territory Governments must also be required to report the number of available beds for each public hospital, and the occupancy rates, to the National Health Performance Authority, similar to the reporting that is required for subacute beds.⁶

A hospital bed is considered available if it is in a suitable location and is sufficiently staffed to deliver appropriate care.

Medical workforce

Governments have acknowledged the need to address workforce shortages and to ensure Australia's health workforce can meet increasing demands for services.

By 2014, the total number of domestic and international graduates from Australian medical schools will be 3786 per year, which compares to 1425 graduates in 2004. This growth presents Australia with a real opportunity to not only reduce overall medical workforce shortages, but to also address more specific workforce issues such as the lack of access to medical care in rural and remote areas. However, there are currently not enough pre-vocational and specialist training places available in our public hospitals to match the current expansion in medical graduate numbers.

The Commonwealth and State and Territory Governments have agreed to deliver more resources to support medical workforce training in our public hospitals and create a framework that delivers the right number of medical practitioners to the community, working disciplines, and regions where they are needed so that the community's health needs are properly served. This will require significant commitments and funding, along with better planning and coordination to deliver the promised increase in medical post-graduate training places.

⁶ National Partnership Agreement on Improving Public Hospital Services, 2011, pg 44, Clause E8

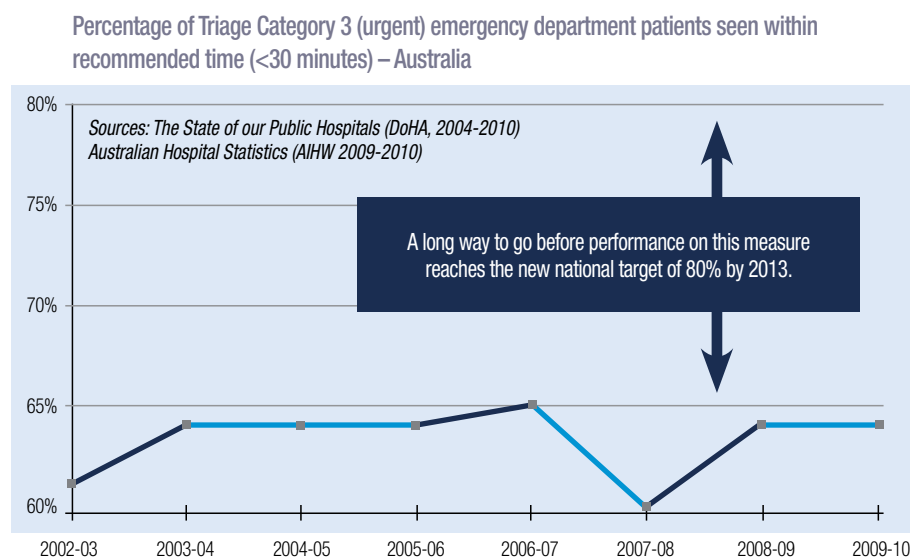
Emergency department waiting times

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

The National Partnership Agreement on Hospital and Health Workforce Reform signed by COAG in 2009 committed all States and Territories to a performance benchmark that, by 2012-13, 80 per cent of emergency department presentations will be seen within clinically recommended triage times as recommended by the Australasian College for Emergency Medicine (ACEM).⁷

In 2009-10, 64 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes. This is well below the target of 80 per cent.

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



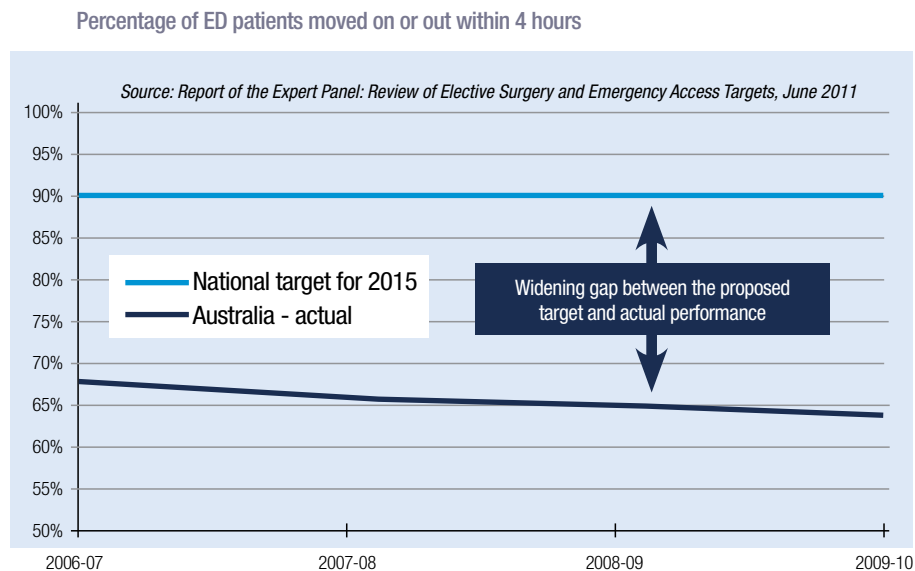
In addition to the 80 per cent target, COAG has also agreed to implement a National Emergency Access Target. Under this target, 90 per cent of all patients presenting to a public hospital emergency department will either physically leave the emergency department for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours.⁸ State and Territory Governments have committed to progressively achieve this target by the end of 2015.

In 2009-10, the proportion of emergency department patients whose length of stay was less than or equal to four hours was 64 per cent. Graph 3 shows a gradual decline in the performance of public hospitals against this measure since 2006-07.

⁷ National Partnership Agreement on Hospital and Health Workforce Reform, 2009, pg 28, clause D11

⁸ National Partnership Agreement on Improving Public Hospital Services, 2011, pg 30, clause C1

Graph 3: Percentage of emergency department patients treated, admitted or discharged within 4 hours



Why this is important

The ability of emergency departments to see patients within clinically recommended triage times and to treat, admit or discharge them within particular time periods is constrained by access block. Access block occurs when patients wait in the emergency department for more than eight hours for admission to a ward bed.

On 29 August 2011, the number of patients in emergency departments waiting for beds exceeded the number of patients waiting to be seen by a doctor. Caring for patients waiting for beds represents nearly one third of emergency department workload in major hospitals.⁹

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.¹⁰

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.

Triage Category 1 (resuscitation, patients need to be seen immediately), triage Category 2 (emergency, patients need to be seen within 10 minutes), and triage Category 3 (urgent, patients need to be seen within 30 minutes) together represent 43 per cent of emergency department presentations. The proportion of these highest triage category presentations has changed very little in the past few years, which is why it is critical that hospital capacity is sufficient to meet the needs of the local community.

⁹ Richardson, D, 2011 *Access Block Point Prevalence Survey – 2 August 2011* on behalf of the Australasian College for Emergency Medicine

¹⁰ 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

If the capacity of public hospitals is insufficient to meet genuine demand, patients will wait in emergency departments for admission to hospital beds. These patients will continue to overcrowd emergency departments, occupy beds and resources there, and limit the emergency department's capacity to deal with new urgent presentations.

What needs to be done

Waiting times in emergency departments can only be reduced, and access targets met, if there is sufficient investment in the capacity of the whole hospital to provide patients with safe, quality treatment.

The expert panel established by COAG to advise it on the implementation of emergency department and elective surgery targets acknowledged that *'to be successful, the targets must be used as a tool to drive clinical service redesign and whole-of-system change, ensuring that all obstacles to effective patient flow within a hospital are removed'*.¹¹

Imposing time-based targets or other performance benchmarks will be fruitless unless there are sufficient staff, beds, and other resources throughout the hospital, especially outside standard working hours, to respond appropriately to patient demand.

Performance targets for emergency care can be useful in driving improvements in whole-of-hospital service delivery, but they are no substitute for ensuring that public hospitals have sufficient capacity to meet the demands and needs of the local community.

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 Emergency Access Target will need to be carefully implemented with local doctor input. There needs to be independent and ongoing monitoring and reporting of the impacts of targets at the hospital level as they are being implemented to allow for modification of targets as evidence arises. In addition, there needs to be peer review of the evidence of the impact of the targets on patient care and health outcomes.

COAG has agreed that the expert panel will continue to have an ongoing role in reviewing the practical implementation, timing, phasing and safety and quality issues that may arise in implementing emergency department and elective surgery targets.

As a first step, an evaluation framework will be developed to assess the impact of the targets.¹² It remains to be seen whether this will extend to a comprehensive evaluation. At this stage, the extent of any monitoring of adverse events is limited to reporting against the number, source and percentage of emergency department attendances that are unplanned re-attendances within 48 hours of previous attendances.¹³

11 Expert panel review of elective surgery and emergency access targets under the National Partnership Agreement on Improving Public Hospital Services, COAG, 30 June 2011, pg xii

12 Expert panel review of elective surgery and emergency access targets under the National Partnership Agreement on Improving Public Hospital Services, 30 June 2011, page 58

13 National Partnership Agreement on Improving Public Hospital Services, pg 36, clause C43

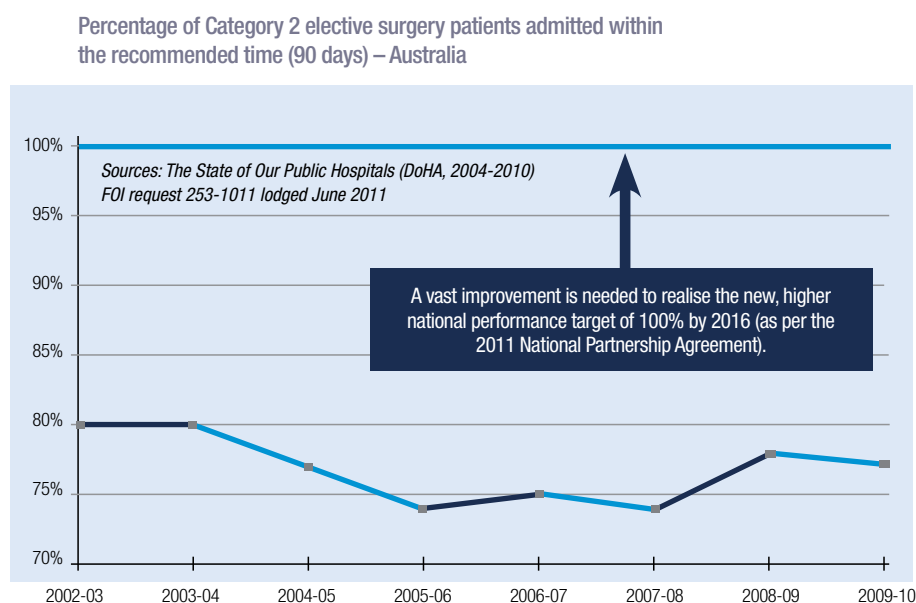
Elective surgery waiting times

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 39 per cent of elective surgery admissions nationally.

In 2009-10, there was a small decline in the percentage of Category 2 patients being admitted within 90 days.

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



In August 2011, COAG agreed to implement a National Elective Surgery Target of 100 per cent of all urgency category patients waiting for surgery to be treated within the clinically recommended times. The target will be progressively implemented from 1 January 2012 to 2016-17.¹⁴

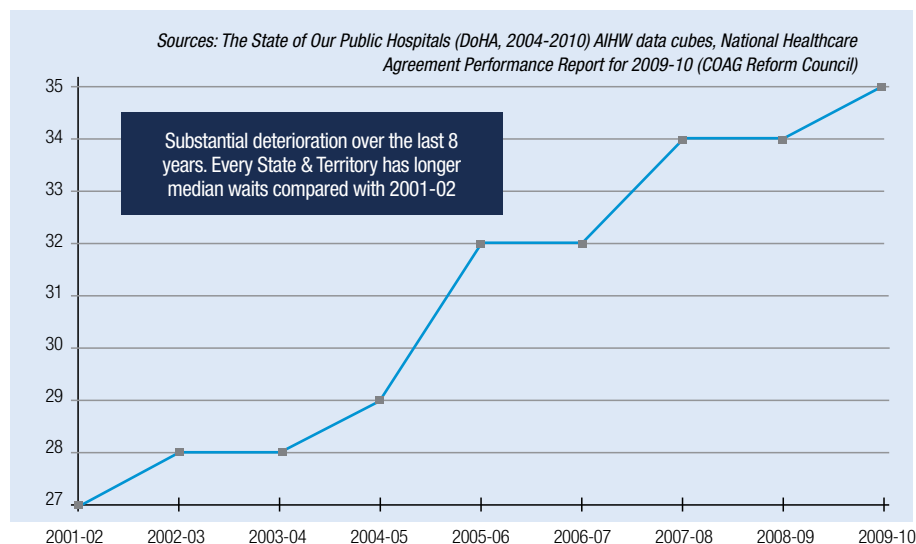
In 2009-10, 77 per cent of Category 2 elective surgery patients were seen within the clinically recommended time. This is well short of the COAG target.

Further, there has been an uninterrupted increase in the length of the median waiting times for all elective surgery in Australia over the last eight years. The national median waiting time is now 35 days.

¹⁴ Expert panel review of elective surgery and emergency access targets under the National Partnership Agreement on Improving Public Hospital Services, COAG, 30 June 2011, pg xii

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

Median waiting time for elective surgery (days) – Australia



The hidden waiting list

The elective surgery waiting list data hide the actual times patients are waiting to be treated in the public hospital system. The time that patients wait from when they are referred by their general practitioner to a specialist for assessment is not counted. It is only after patients have seen the specialist that they are added to the official waiting list. This means that the publicly available elective surgery waiting list data actually understate the real time that people wait for surgery. Some people wait longer for assessment by a specialist than they do for 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. In 2009-10, 21,927 patients admitted from public hospital waiting lists for elective surgery had waited for more than a year.

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.

What needs to be done

Given current performance, a target of 100 per cent of elective surgery patients being treated within recommended times is unrealistic. Such a target will only highlight the ongoing failure of State and Territory Governments to ensure public hospitals have the capacity to meet increasing demand.



The fact that patients have to wait significantly beyond the clinically recommended times for their surgery is an indicator of insufficient resourcing to meet demand of the local population. Public hospitals cannot meet elective surgery targets without adequate resources.

The Commonwealth Government must ensure that additional funding provided to State and Territory Governments for additional elective surgery makes a real difference to the waiting lists.

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

Unfortunately, COAG does not consider the hidden waiting list a priority – consideration will be given to developing a measure of surgical access from general practitioner referral to surgical care for future agreements.¹⁵ This delay is unacceptable given that this measure reflects the actual waiting time for patients and demand for elective surgery. It should be implemented now, in time for reporting in 2012-13.

¹⁵ National Partnership Agreement for Improving Public Hospital Services, 2011, pg 25, clause A54(c)

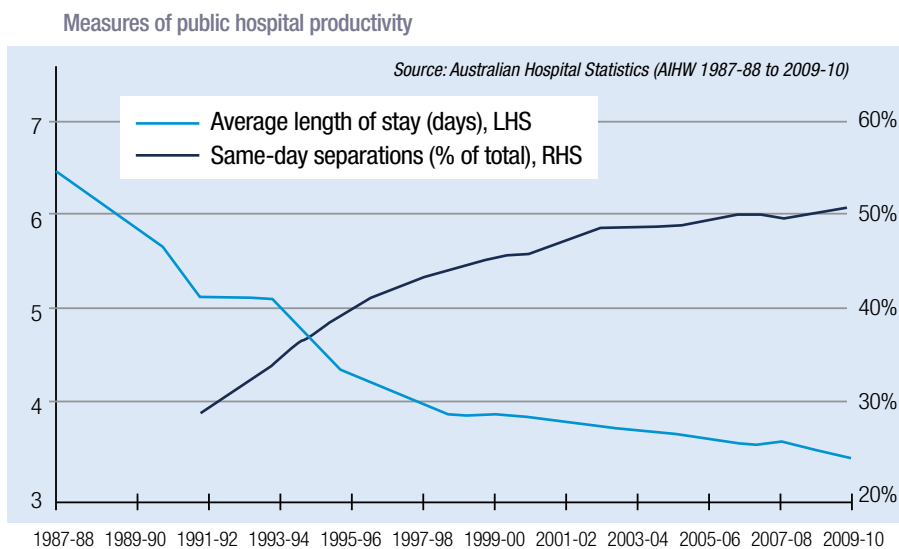
Hospital efficiency and productivity

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

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

However, average length of stay and the percentage of same-day separations are both reaching a plateau, with only minor gains for both measures (see graph 6) because the easier productivity improvements have already been made in previous years.

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



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.

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.

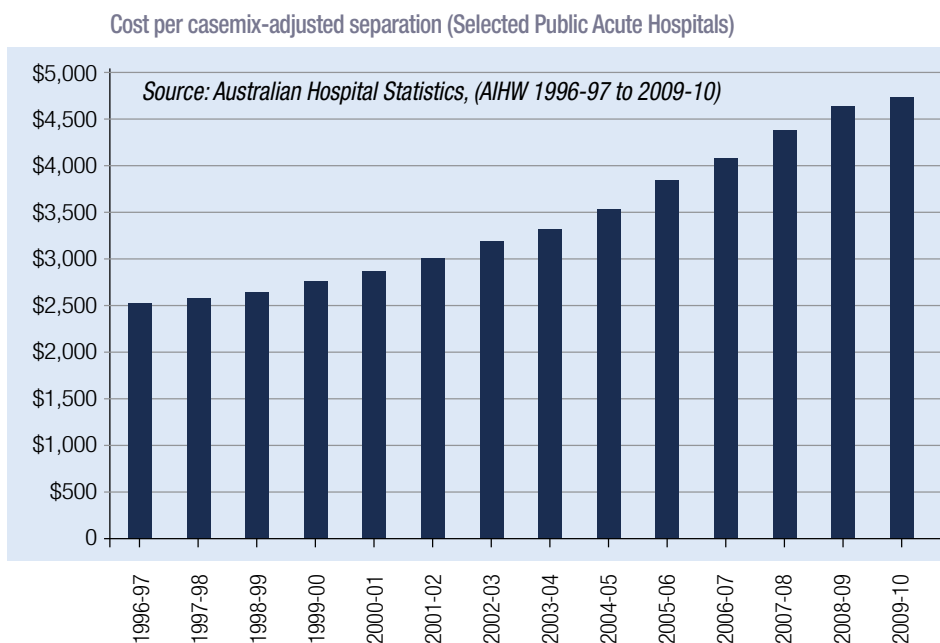
Public hospitals are served by a high-quality, dedicated and hard-working medical workforce. Unfortunately, insufficient investment by governments in areas such as recruitment, retention and training has resulted in unsafe hours of work and excessive workloads, and this has led doctors to feel compromised in their ability to care for their patients.

The continued reliance on medical practitioners to undertake 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 is this important?

The average length of stay is falling much more slowly than in previous years and, given the inexorable growth in chronic illness, in-hospital episodes are becoming more intense and costly as shown in graph 7. However, in 2009-10, the increase in the cost per casemix-adjusted separation was an unusually small 1.7 per cent compared to the average increase of seven per cent over the period 2003-04 to 2008-09.

Graph 7: Measures of public hospital productivity

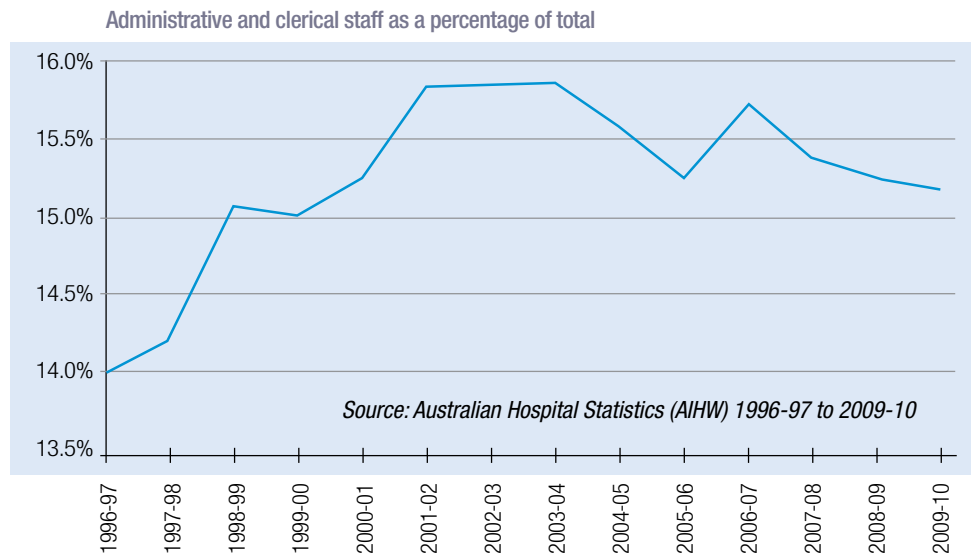


We also need to ensure that money is not wasted needlessly on bureaucracy and red tape, but directed instead to the care of patients. The National Health Reform Agreement agreed by COAG commits all governments to deliver reforms with no net increase in bureaucracy across the Commonwealth and State Governments as a proportion of the ongoing health workforce.¹⁶

¹⁶ National Health Reform Agreement, August 2011, page 9, clause 17

Graph 8 shows that administrative and clerical staff, as a percentage of total hospital staff, have declined for the third year in a row.

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



What needs to be done

The AMA has strongly advocated for medical practitioners to be engaged in the management and governance of local hospitals and health services. Our doctors and nurses know what is needed to improve hospital performance. Doctors should be consulted and involved in decisions on service planning and the allocation of resources to ensure safe and efficient care. Health care services cannot improve in a vacuum, with the doctors who play a pivotal role in every aspect of our health system sidelined from decisions on funding.

In addition, we need an overarching medical and health practitioner workforce plan for the next decade to ensure that adequate numbers of the next generation of healthcare providers are being trained to treat patients into the future.

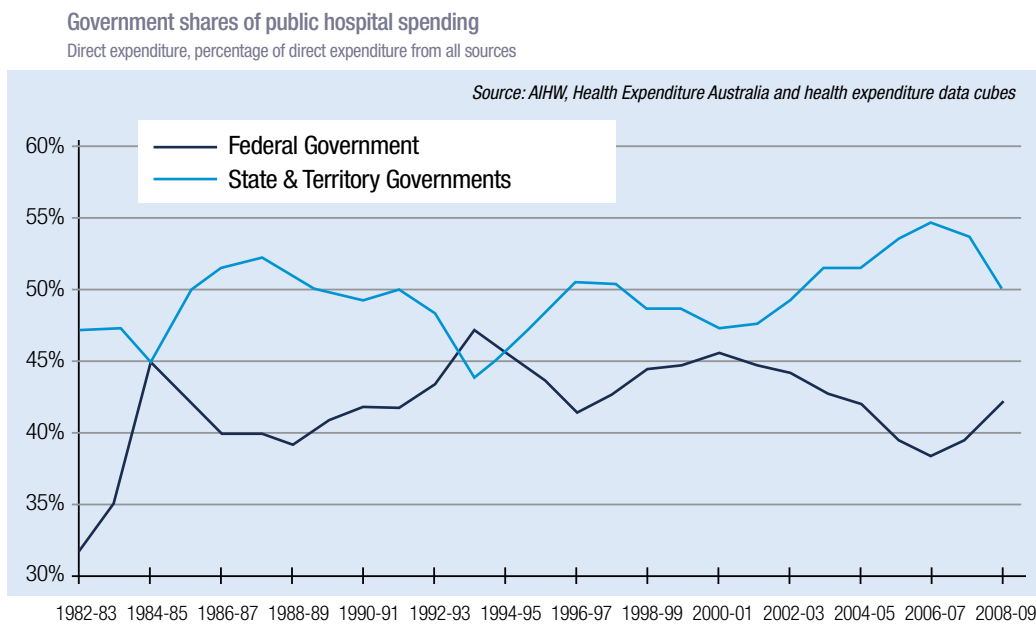
We need a primary care sector that is well placed to provide safe and appropriate care for people in the community when their acute care needs have been addressed.

Funding

The National Health Reform Agreement signed in August 2011 commits the Commonwealth to increase its share of public hospital funding to 45 per cent from 1 July 2012, and to 50 per cent from 1 July 2017.

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

Graph 9: Government shares in public hospital spending



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

2. STATE-BY-STATE PUBLIC HOSPITAL PERFORMANCE REPORT

Key findings

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 Partnership Agreement on Hospitals and Health Workforce Reform performance benchmark of 80 per cent of emergency department presentations seen within clinically recommended triage times by 2012-13.

In 2009-10, the only jurisdiction to show any material improvement in the percentage of triage Category 3 emergency department patients seen within the recommended time was the ACT, up from a very low base of 53 per cent to 60 per cent. NSW and South Australia were the only other States to show some improvement in emergency department performance.

Data on elective surgery show a mixed picture. In NSW, Queensland, the ACT, and the Northern Territory, performance in respect of Category 2 elective surgery patients being seen within the recommended time of 90 days has declined.

The median waiting time data paint a curious picture. The national median waiting time for elective surgery is 35 days, one day longer than in 2008-09. However, in NSW and Victoria, median waiting times lengthened by six and five days respectively. Given that both States account for 58 per cent of elective surgery admissions in public hospitals, it is difficult to comprehend how the national average could have increased by only one day.

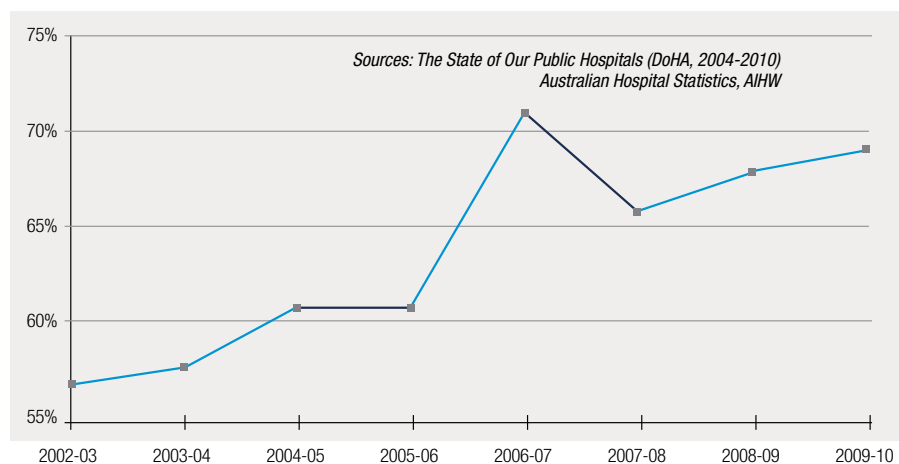
The significant improvement in Tasmania (down from 44 days to 36 days) combined with the marginal improvement in the ACT – which between them accounted for 4.3 per cent of elective surgery – is not enough to offset the significant increases in NSW and Victoria median waiting times.

NEW SOUTH WALES

Emergency departments

AIHW information released on an annual basis indicates a marginal improvement in NSW emergency department performance in 2009-10, with 69 per cent of Category 3 patients seen within the recommended time of 30 minutes, but not sufficient to reverse the 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 released on a quarterly basis are available from the NSW Bureau of Health Information (BHI). Information for the January to March 2011 quarter shows that 71 per cent of Category 3 patients were seen within the recommended time of 30 minutes during that period.¹⁷ This compares to 73 per cent for the same quarter in 2010. It is important to note that, because of seasonal fluctuations, quarterly data from one quarter should only be compared to the same quarter from previous years.

The BHI also releases information on 'Emergency Admission Performance', i.e. the percentage of patients who need admission who are admitted to a hospital ward within eight hours of the time they start to receive treatment in the emergency department (the NSW target performance is 80 per cent). This measure of performance is particularly important because of what it says about the capacity of public hospitals, i.e. if this target is not being achieved, it strongly suggests that there is not enough capacity within the public hospital system to admit patients within a reasonable timeframe.

The NSW Emergency Admission Performance measure has been worsening for a number of years. In relation to the January to March quarter, it has dropped steadily from 80 per cent in 2008 (on target) to 64 per cent in 2011 (well below target).¹⁸

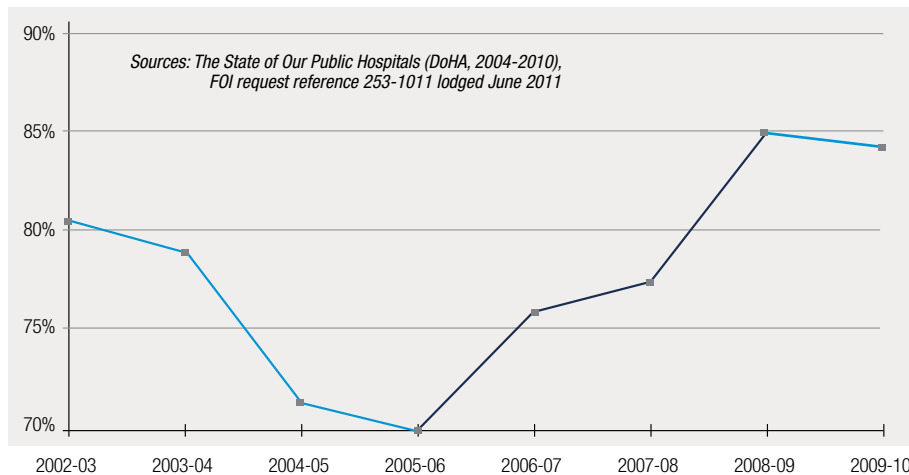
¹⁷ Bureau of Health Information report: Emergency Department Hospital Quarterly: Performance in NSW Public Hospitals, January to March 2011, www.bhi.nsw.gov

¹⁸ BHI information for emergency departments for the 2011 April to June quarter is not yet available because the BHI is seeking to improve the way it reports information to support fairer hospital comparisons.

Elective surgery waiting times

AIHW annual data indicate that, after a sharp improvement in the percentage of Category 2 elective surgery patients seen within the recommended time of 90 days from 2005-06 to 2008-09, performance declined in 2009-10.

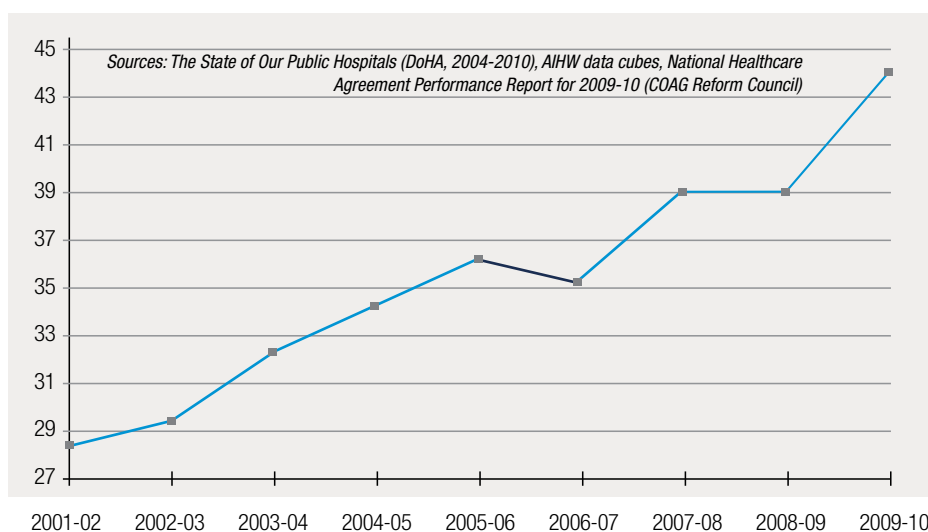
Percentage of Category 2 elective surgery patients seen within recommended time (90 days) – NSW



More recent quarterly figures released by NSW BHI suggest a significant improvement in performance in 2011. The percentage of Category 2 elective surgery patients admitted within the recommended time was 87 per cent for the January to March quarter and 91 per cent for the April to June quarter.

AIHW information shows the median waiting time for elective surgery dramatically increased by six days to 44 days between 2008-09 and 2009-10. This is the highest increase nationally.

Median waiting time for elective surgery (days) – NSW



More recent quarterly BHI information suggests that median waiting times are steady or improving for Categories 1 and 2, but worsening for Category 3.

Bed numbers

The total number of available public hospital beds for NSW in 2009-10 was 19,608, 197 fewer beds than the previous year. This continues a steady decline in the number of beds since 2007-08.

Occupancy rates

Recent data on the bed occupancy rates of NSW public hospitals are difficult to obtain. However, all the available data (including BHI information on the number of emergency department attendances, admitted patient episodes and occupied bed days) indicate that inpatient activity is steadily increasing. Taken together with the decline in bed numbers, it is reasonable to conclude that bed occupancy rates must be increasing. Doctors report that occupancy rates in the high 90s are not unusual for metropolitan hospitals.

The 2009-10 NSW Health Annual Report indicates that the total bed occupancy rates across NSW as at June was 88.3 per cent. Even this figure is above the 85 per cent average bed occupancy rate that the AMA believes is a safe level. However, this figure is an annual snapshot of all beds in all hospitals. What actually needs to be measured is the average acute care bed occupancy at 5 pm. It is only when we have achieved an average of 85 per cent acute care bed occupancy at 5 pm that we will see an end to emergency departments clogged with patients needing admission to the wards, cancellation of elective surgery because of lack of post-operative beds, and patients being accommodated in inappropriate (e.g. mixed gender) wards.

Comments

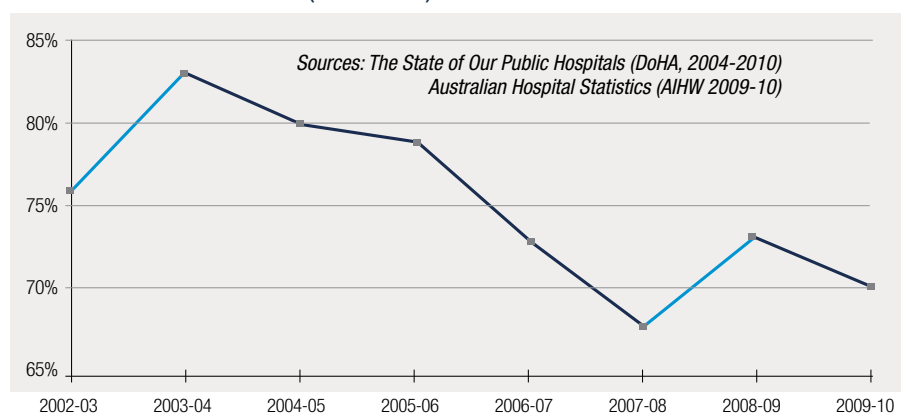
The data suggest that, apart from occasional bursts of activity to meet elective surgery targets, the performance of the NSW health system is worsening. It is to be hoped that recent developments at both State and Federal level will lead to significant improvements. We note, in particular, the NSW Government's unprecedented commitment to achieving average 85 per cent acute care bed occupancy at 5 pm and the implementation of the COAG targets for emergency department and elective surgery performance.

VICTORIA

Emergency departments

In 2009-10, Victorian emergency department performance declined, with 70 per cent of Category 3 patients seen within the recommended time, down from 74 per cent in 2008 09.

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

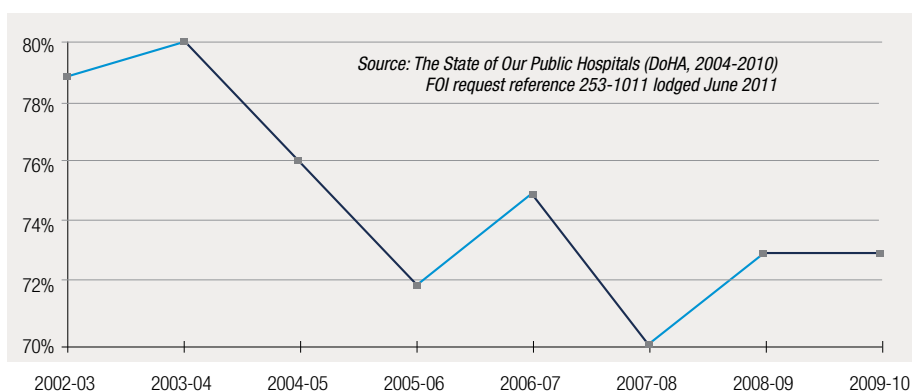


Victorian Government data¹⁹ for July to December 2010 show that 778 people waited more than a day for emergency treatment in 38 hospitals.

Elective surgery waiting times

With only 73 per cent of Category 2 elective surgery patients seen within the recommended time in 2009-10, Victoria is currently performing under the national average of 77 per cent.

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

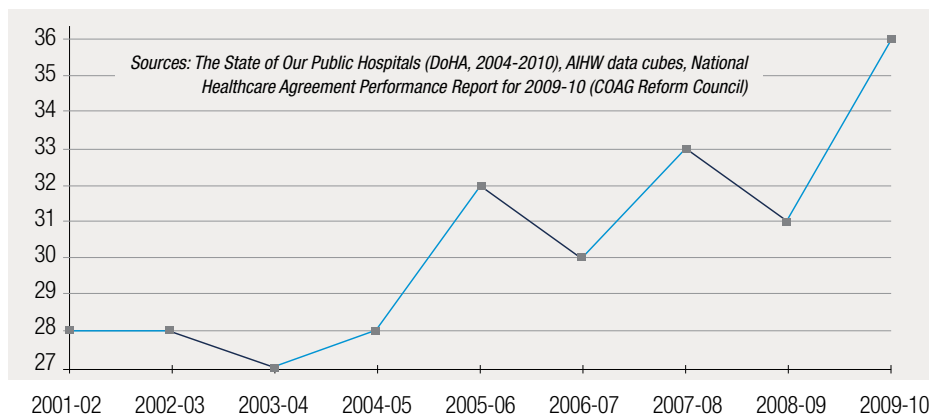


Victoria will have to make up a lot of ground to achieve its performance target of 79 per cent in 2012.

Median waiting times for elective surgery in Victoria have significantly increased by five days to 36 days, compared to 2008 09.

¹⁹ Victorian Health Services Performance Report March 2011 Quarter, page 10

Median waiting time for elective surgery (days) – VIC



The Victorian Government has funded an \$84.2 million waiting list reform package.²⁰ It has also committed to the release of outpatient appointment waiting times, which will help to provide a clearer picture of the true time that patients wait to receive elective surgery.²¹

Bed numbers

The total number of available public hospital beds in 2009-10 was 13,186, which represents an increase of 317 beds compared to the previous year. The number of available beds per 1,000 Victorians has increased to 2.4, but is still below the national average of 2.6.

Victoria has not added any new public psychiatric hospital beds since 2006-07. As of 20 June 2010, Victoria had 154 psychiatric beds available – fewer than 0.1 per 1000 Victorians.²²

The new Victorian Government committed to providing 800 new beds in its first term.²³ AMA Victoria is monitoring the release of these hospital beds and has urged the Government to disclose where these beds will be located.

Occupancy rates

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

Comments

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 recent change of Government has been accompanied by commitments and funding for more public hospital beds, waiting list reforms, and increased data transparency. The effect of these initiatives on public hospital performance will become apparent in the coming year.

²⁰ http://www.budget.vic.gov.au/domino/Web_Notes/budgets/budget11.nsf/d6e571e551bef80eca2572bb002bcea7/7b23ad429d0e6abbca257885000665a8!OpenDocument

²¹ <http://www.abc.net.au/news/2010-11-09/outpatient-waiting-list-figures-misleading/2329172>

²² Australian Institute of Health and Welfare, *Australian hospital statistics* reports

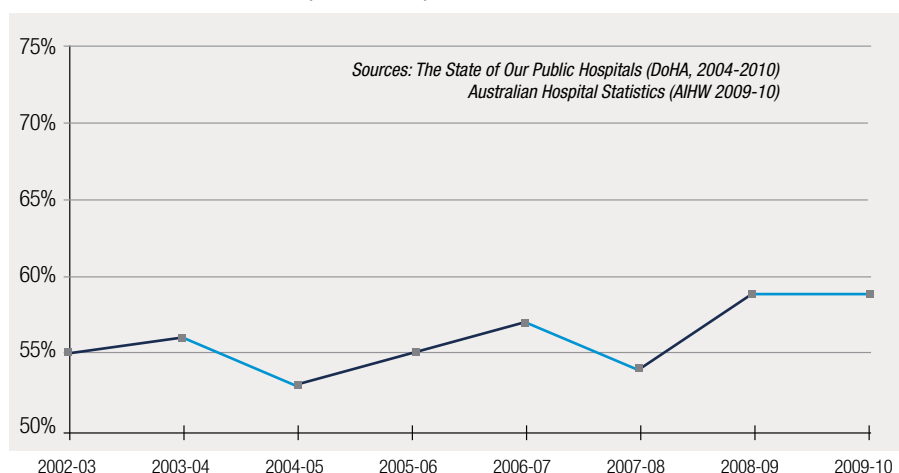
²³ http://www.budget.vic.gov.au/domino/Web_Notes/budgets/budget11.nsf/d6e571e551bef80eca2572bb002bcea7/7b23ad429d0e6abbca257885000665a8!OpenDocument

QUEENSLAND

Emergency departments

There has been no improvement in Queensland emergency department performance in 2009-10. Only 59 per cent of Category 3 patients were seen within the recommended time.

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

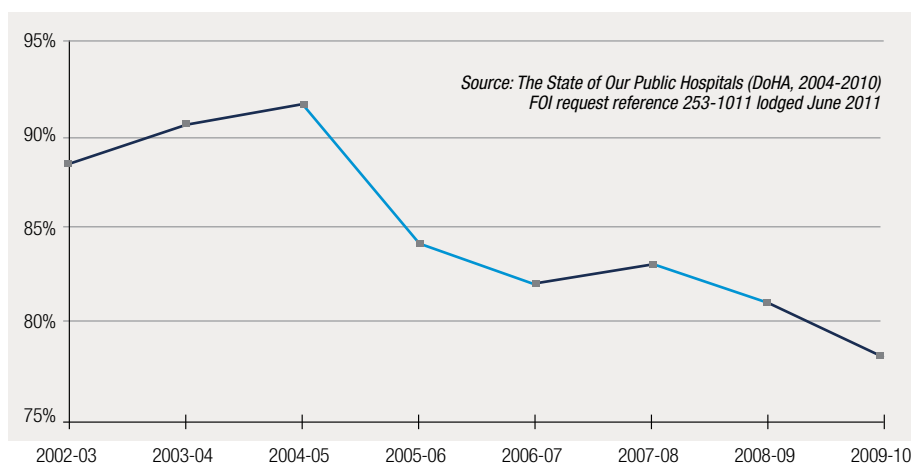


Queensland will find it difficult to meet the performance benchmark of 80 per cent by 2012-13.

Elective surgery waiting times

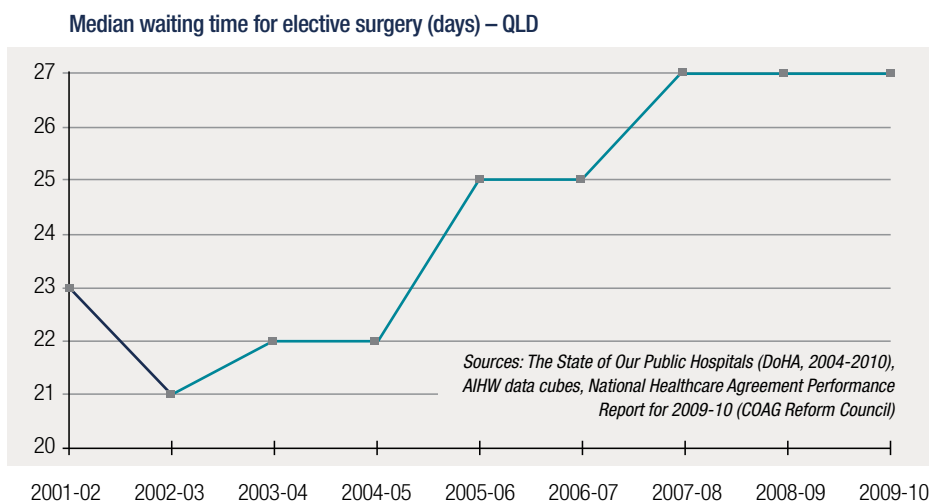
In 2009-10, the percentage of Category 2 elective surgery patients seen within the recommended time declined to 78 per cent, down from 81 per cent in the previous year. This continues an overall downward trend since 2004-05.

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



Queensland will need to reverse this downward trend to achieve its performance target of 81 per cent by 2012.

There has been no improvement in the median waiting times for elective surgery since 2007-08. However, median waiting times are still well below the national median waiting time of 35 days.



Under the Queensland Government's *Surgery Connect* program, elective surgery patients who wait longer than clinically recommended are treated in private hospitals. Almost four per cent of public patients who received elective surgery were treated under this scheme during the December 2010 quarter.²⁴

Bed numbers

The total number of available public hospital beds during 2009-12 was 10,911, an increase of only 106 beds from the previous year. The number of available hospital beds of 2.4 per 1,000 Queenslanders remains unchanged from 2008 09, and is below the national average of 2.6.

Occupancy rates

During 2009-10, 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, Caloundra and Cairns Base Hospitals operated on average at over 100 per cent occupancy, showing significant overstressing of capacity.²⁵

²⁴ *Quarterly public hospitals performance report December 2010 quarter* Queensland Government, Queensland Health 2010, p 10

²⁵ AMA Queensland *Your Hospital's Health* <http://yourhospitalshealth.com.au>

Comments

The various performance measures show a continued decline in elective surgery performance in Queensland over the past five years: there have been fewer patients admitted within the clinically recommended time and there are longer median waiting times. This is despite the 'Surgery Connect' program and this means that public hospital services are not meeting the needs of a population that is rapidly growing and ageing.

In Queensland, there is a 'waiting list' for the elective surgery waiting list, where patients are categorised by processing a referral letter from a general practitioner into Category 1, 2 or 3. For example, in the ear, nose and throat area, the waiting list for Category 3 can be more than five years because Category 1 cases go to the top of the list. This means that, effectively, there are Category 3 patients that may never actually get their surgery.

In June this year, AMA Queensland became aware that public hospitals in Queensland had been rejecting general practitioner referrals including Category 1 and Category 2 cases, with the admission that, if they were to accept the referral, the patient could not be seen within the clinically recommended time frame. The general practitioner's referral letter was sent back with a rejection letter stating that it was the general practitioner's responsibility to find alternative care when the patient's own local hospital had effectively rejected them.

AMA Queensland took this up with the Queensland Minister for Health and achieved a public statement from the Minister that this practice would cease immediately and that it would be the responsibility of the local public hospital to find alternative care for patients where the hospital could not provide the service.²⁶

Queensland Health is presenting new methods of bulk billing that are of considerable concern to AMA Queensland, in particular the Acute Primary Care Clinics. This is an area that AMA Queensland is monitoring closely.

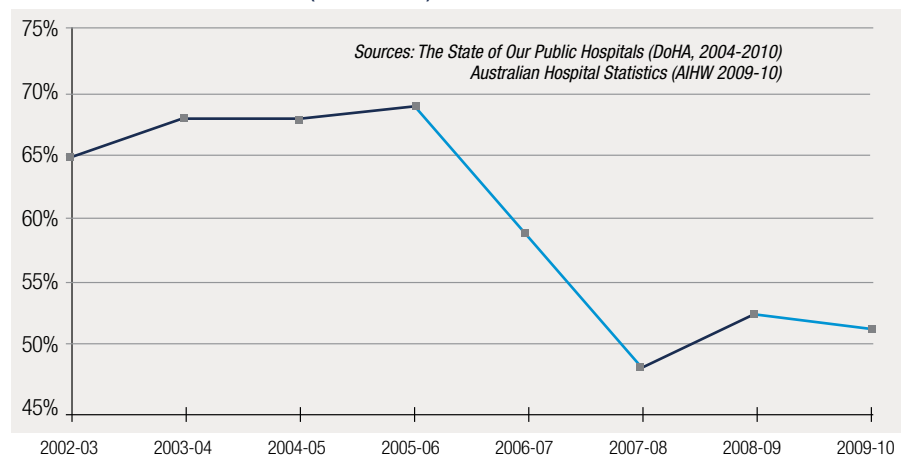
²⁶ Statement made by the Minister for Health in a meeting with AMA Queensland on 16 June 2011 and to a *Weekend Gold Coast Bulletin* journalist as reported on 11 June 2011.

WESTERN AUSTRALIA

Emergency departments

Emergency department performance in Western Australia has suffered a setback. Only 51 per cent of Category 3 patients were seen within the recommended time.

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

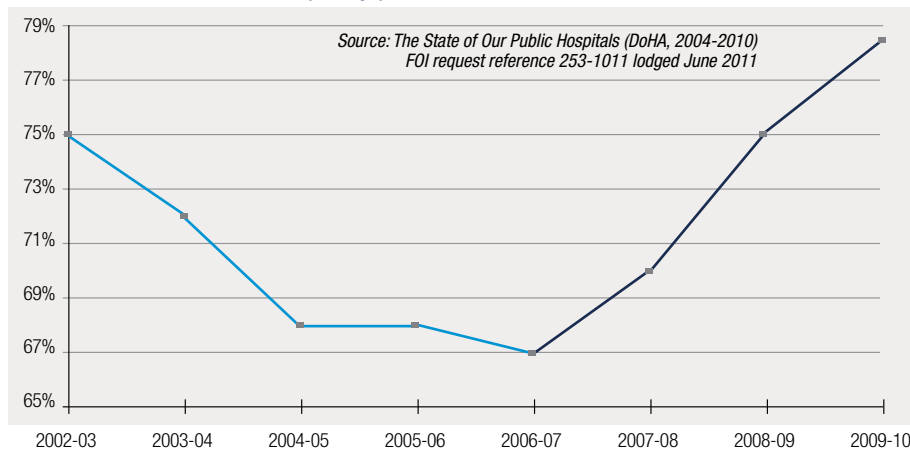


There will need to be significantly more effort and support for Western Australian public hospitals if they are to perform nearer to the national average of 64 per cent, let alone meet the performance benchmark of 80 per cent by 2012-13.

Elective surgery waiting times

There was a further improvement in the percentage of Category 2 elective surgery cases seen within the recommended time in 2009-10. Western Australia now has three consecutive years of improvement on this performance measure.

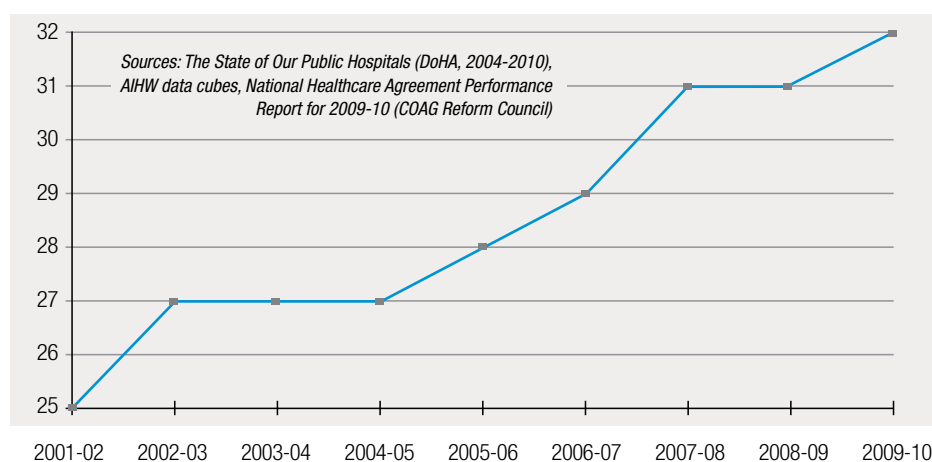
Percentage of Category 2 elective surgery patients seen within recommended time (90 days) – WA



Western Australia will have to maintain this upward trend to achieve its performance target of 84 per cent in 2012.

The median waiting time increased again in 2009-10, continuing a trend of longer waiting times for public elective surgery patients in Western Australia.

Median waiting time for elective surgery (days) – WA



Bed numbers

The total number of available public hospital beds in 2009-10 was 5,376, only seven more beds than in 2008-09, raising serious concerns over the capacity of the system to meet increasing demand – even with new beds coming on stream from 2013-14.

Occupancy rates

Western Australia data on average bed occupancy rates showed a drop after changes in the definition several years ago but major tertiary hospitals routinely report unsafe occupancy rates of over 90 per cent.²⁷

Comments

Western Australia implemented a four-hour access target for public hospital emergency departments in 2009.

Reports from AMA members suggest that the measure has driven some one-off system improvements across some hospitals such as reductions in access block and possibly improved patient mortality. Data from 2009-10²⁸ show a significant improvement in the percentage of patients who spend four or less hours in emergency departments and in access block (patients stuck in the emergency department awaiting a bed) in Western Australia compared to previous years and compared to other jurisdictions.

However, both senior and junior doctors working in WA have raised serious concerns that the four-hour-rule compromises their ability to care for patients properly. In response to representations from AMAWA and concerns from other sources, Western Australian Health Minister Kim Hames ordered a review of the program implementation.²⁹

²⁷ WA Health Performance Report, published quarterly, www.health.wa.gov.au/publications/subject_index/p/performance.cfm

²⁸ National Partnership Agreement on Improving Public Hospital Services, 2011, pg 35 clause C34

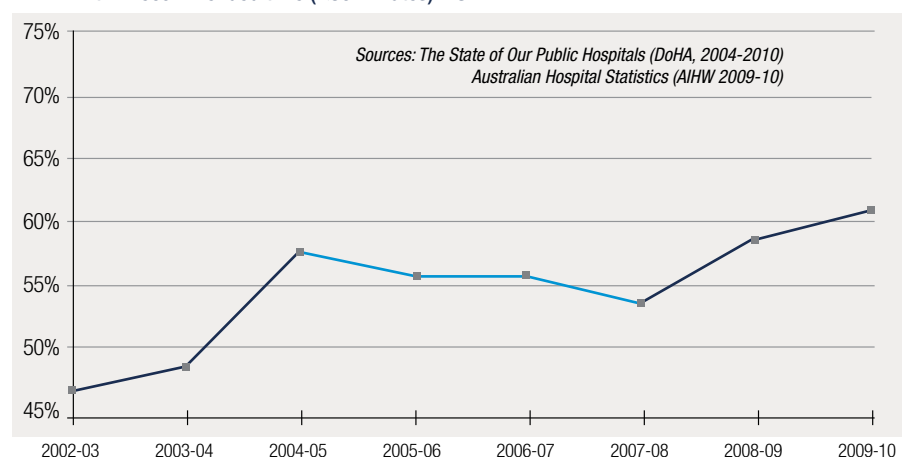
²⁹ WA Health Minister Kim Hames, press release, 21 July 2011, www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=142520&

SOUTH AUSTRALIA

Emergency departments

South Australian emergency department performance improved marginally in 2009-10 with 61 per cent of Category 3 patients being seen within the recommended time.

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

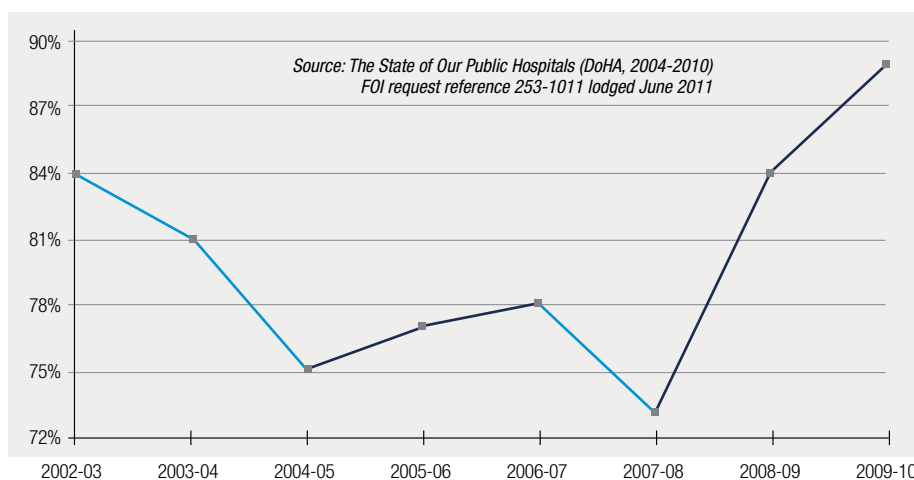


There will need to be more effort and support for South Australian public hospitals if they are to meet the performance benchmark of 80 per cent by 2012-13.

Elective surgery waiting times

South Australia continued to improve its elective surgery performance with 89 per cent of Category 2 elective surgery patients seen within the recommended time in 2009-10.

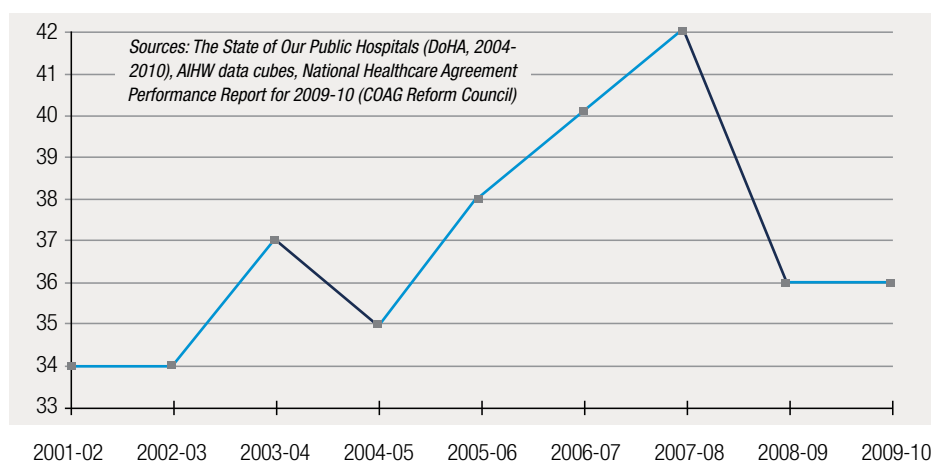
Percentage of Category 2 elective surgery patients seen within recommended time (90 days) – SA



South Australia will need to maintain this trend to achieve its performance target of 91 per cent in 2012.

In 2009-10, South Australia has managed to halt the significant decline in the median waiting time for elective surgery that occurred in 2008-09.

Median waiting time for elective surgery (days) – SA



Bed numbers

The total number of available public hospital beds in 2009-10 was 4,859, a decline of 15 beds compared to the previous year. The average number of available hospital beds per 1,000 South Australians was 3.0, above the national average of 2.6 beds.

Occupancy rates

The South Australian Government does not publish average bed occupancy rates. Doctors report that 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

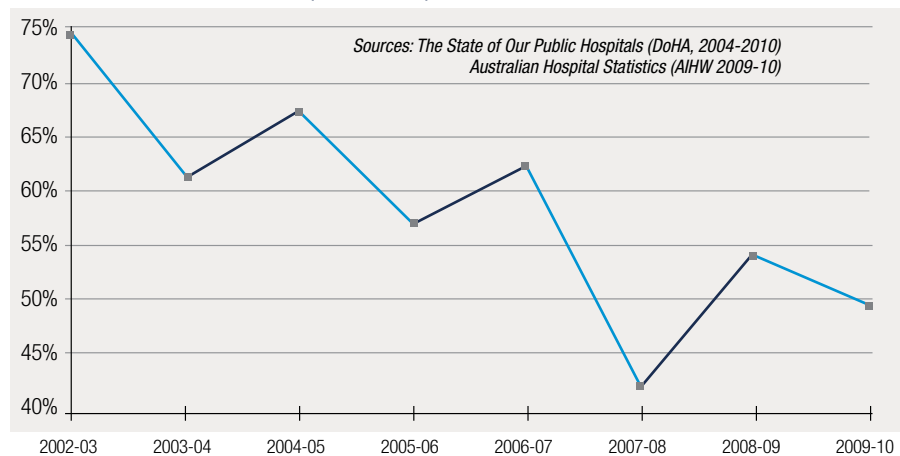
South Australia has been able to improve its performance. However, it will have difficulty reaching any of the performance targets set by COAG without additional government funding.

TASMANIA

Emergency departments

Tasmania has experienced another downward turn in performance on the percentage of Category 3 emergency department patients being seen within the recommended time of 30 minutes.

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



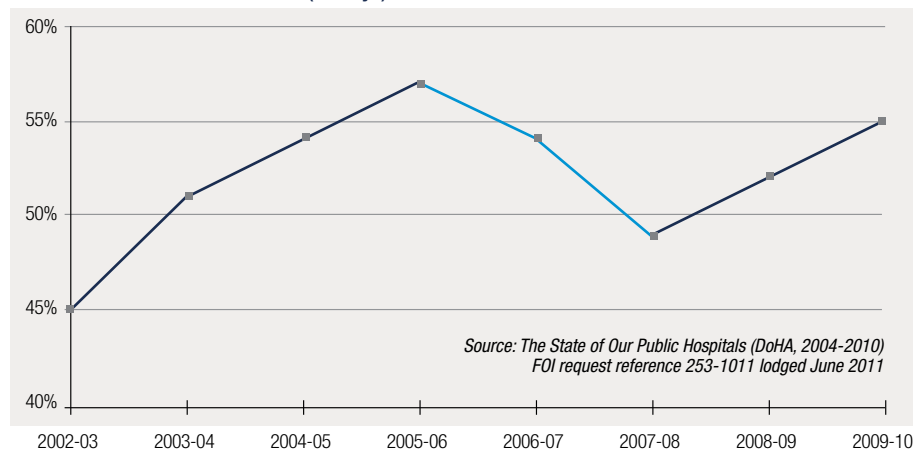
With only 49 per cent of Category 3 patients being seen within the recommended time, Tasmania is significantly below the national average of 64 per cent.

This see-sawing record of declining performance must be turned around to ensure that residents of Tasmania have timely access to emergency care.

Elective surgery waiting times

There was a continued improvement in the percentage of Category 2 elective surgery patients seen within the recommended time. However, at 55 per cent, Tasmania is well below the national average of 77 per cent.

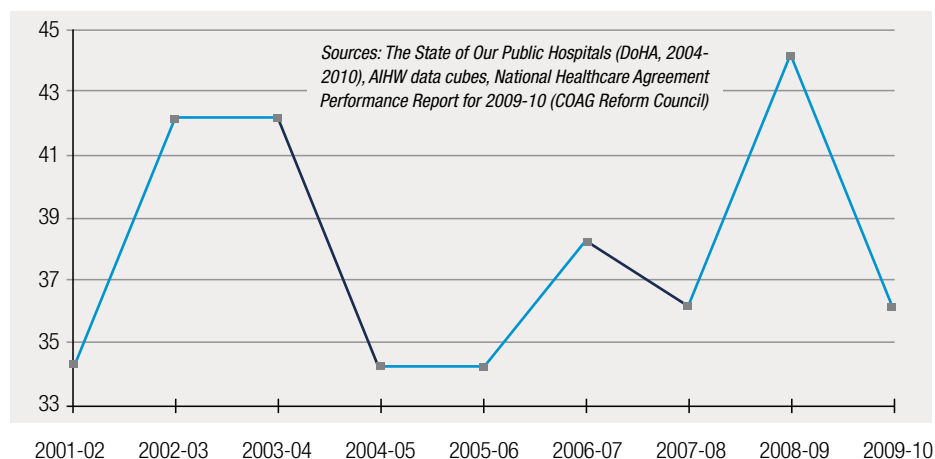
Percentage of Category 2 elective surgery patients seen within recommended time (90 days) – TAS



Tasmania will have to make significant gains to achieve its performance target of 67 per cent in 2012.

The median waiting time for elective surgery in Tasmania has dramatically reduced by eight days. Tasmania's performance on elective surgery is improving.

Median waiting time for elective surgery (days) – TAS



Bed numbers

The total number of available public hospital beds was 1,359. This is a reasonable increase of 84 beds for a small jurisdiction. The average number of available hospital beds per 1,000 Tasmanians is 2.7, making it slightly higher than the national average of 2.6 beds.

Occupancy rates

There is no publicly available data on average bed occupancy rates in Tasmania. Doctors report hospitals running close to 100 per cent capacity most of the time.

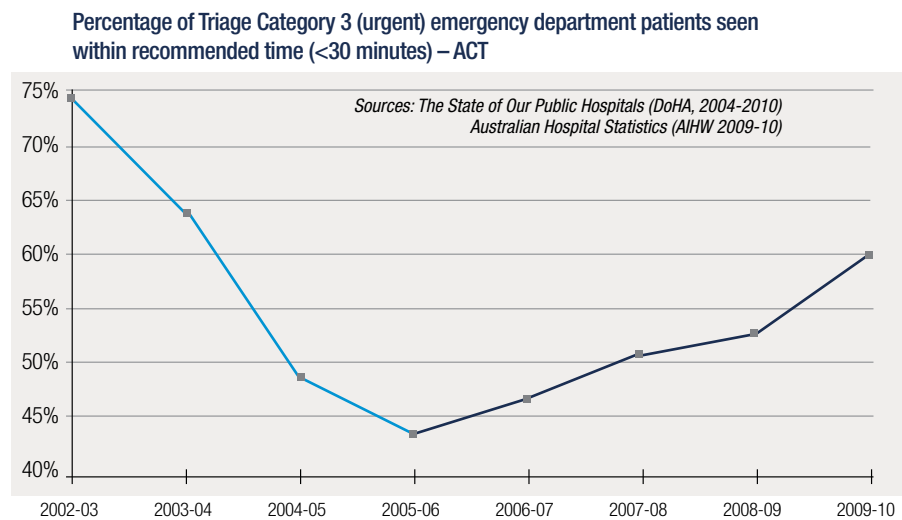
Comments

Though improvements have been made regarding elective surgery performance, overall performance is poor compared to other jurisdictions.

AUSTRALIAN CAPITAL TERRITORY

Emergency departments

The ACT emergency department performance for Category 3 patients continues to improve. In 2009-10, 60 per cent of these patients were seen within the recommended time of 30 minutes.



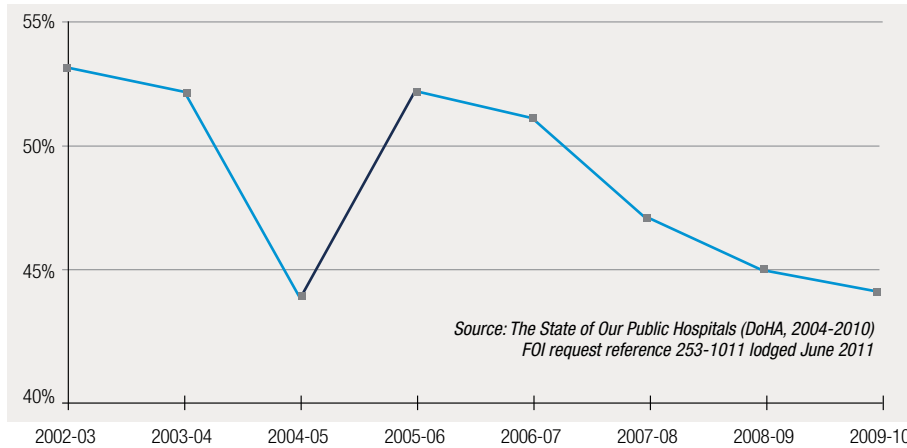
Despite the improvement in 2009-10, ACT Government data³⁰ show that this performance dropped in the period of July to December 2010.

Elective surgery waiting times

The ACT elective surgery performance continued to deteriorate in 2009-10 with a further fall to 44 per cent of Category 2 elective surgery patients being seen within the recommended time, well below the national average of 77 per cent.

³⁰ ACT Public Health Services Quarterly performance report December 2010, p10

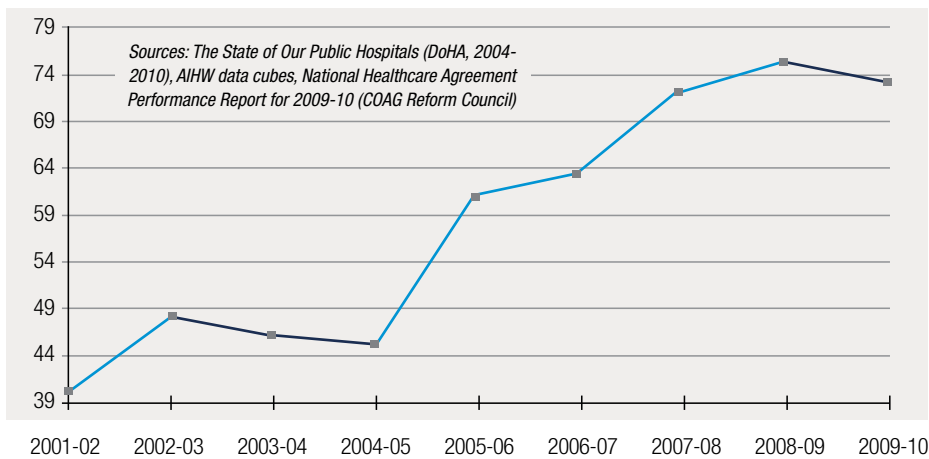
Percentage of Category 2 elective surgery patients seen within recommended time (90 days) – ACT



The ACT will have to make up a lot of ground to achieve its performance target of 55 per cent in 2012.

Waiting times for elective surgery in the ACT have improved for the first time in five years with median waiting time for elective surgery dropping to 73 days in 2009-10. This is still more than twice the national average of 35 days.

Median waiting time for elective surgery (days) – ACT



The ACT Government cites a continuing focus on patients with extended waiting times as the reason why overall median waiting times have not improved.³¹

Bed numbers

The total number of available public hospital beds in 2009-10 was 907, an increase of 32 from the previous year. In 2009-10, the average number of available hospital beds per 1,000 people in the ACT was 2.6.

Occupancy rates

The average bed occupancy rate in the ACT during 2009-10 was 89.6 per cent, a similar rate to the last three years and an improvement from 97 per cent in 2005-06.³² The ACT Government reported further improvements for the last quarter of December 2010, citing 83 per cent,³³ which is below the safe benchmark level of 85 per cent average bed occupancy rate.

Comments

While the ACT has achieved some improvement in emergency department performance for Category 3 patients, it will have to significantly improve performance from 60 per cent to meet the performance benchmark of 80 per cent by 2012-13.

The ACT's elective surgery performance is poor. However, we note that ACT hospitals are an important health resource for the wider southeast region of NSW.

31 ACT public health services quarterly performance report year to March 2010, p 6

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

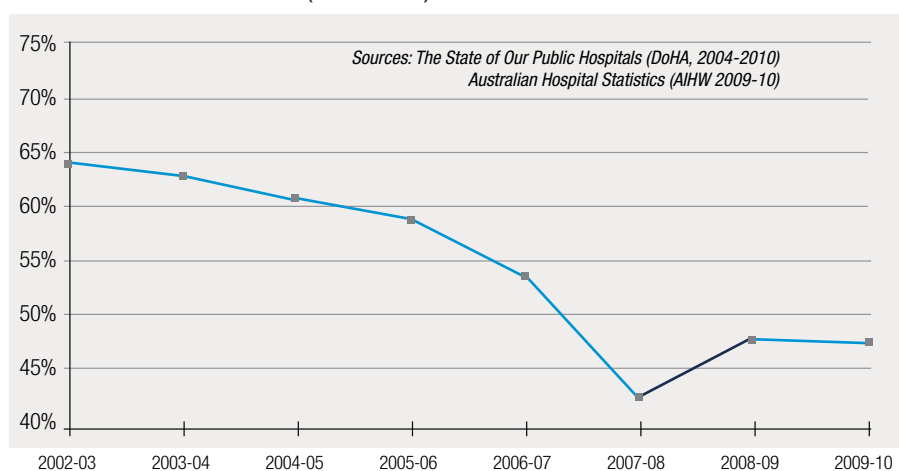
33 ACT Public Health Services Quarterly performance report for December 2010, p 5

NORTHERN TERRITORY

Emergency departments

Northern Territory emergency department performance remains unacceptably low.

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



With only 47 per cent of Category 3 patients being seen within the recommended time, the Northern Territory is well below the national average of 64 per cent and unlikely to succeed in turning around this performance to meet the performance benchmark of 80 per cent by 2012-13.

The number of Category 3 patients seen in one Northern Territory hospital has increased from around 18,000 in 2009 to 21,000 in 2010. AMA members have advised that there are continuously patients in overflow as occupancy levels have been over 100 per cent. Access block is the biggest issue.

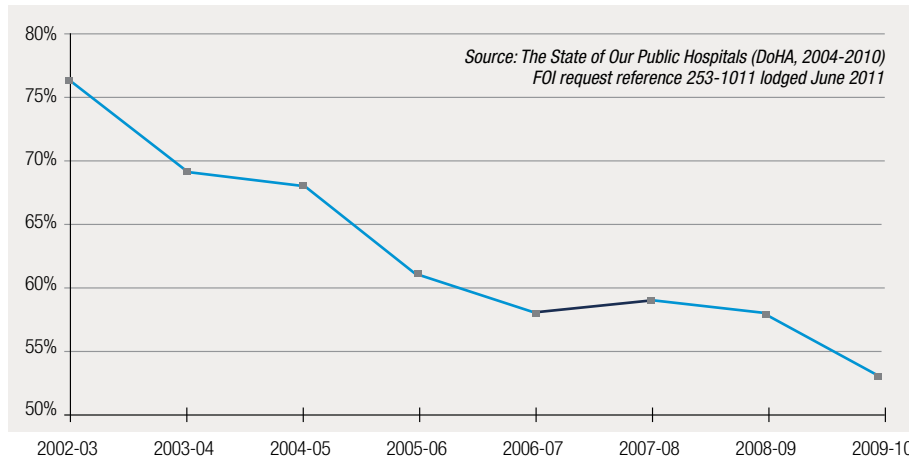
In some cases, there are patients waiting 90 hours for emergency surgery due to a shortage of emergency operating time and theatres. Staffing shortages, both medical and nursing, are also having a significant impact on throughput. Theatre throughput has increased by over 25 per cent in four years at one Territory hospital. AMA members advise they are operating in substandard conditions with out-dated equipment and technology.

Elective surgery waiting times

The Northern Territory's performance continues to decline with 52 per cent of Category 2 elective surgery patients seen within the recommended time. Over the past four years, throughput has increased by over 25 per cent.

The Northern Territory Government must make serious investments to upgrade infrastructure and attract medical practitioners to provide public elective surgery to the people of the Northern Territory.

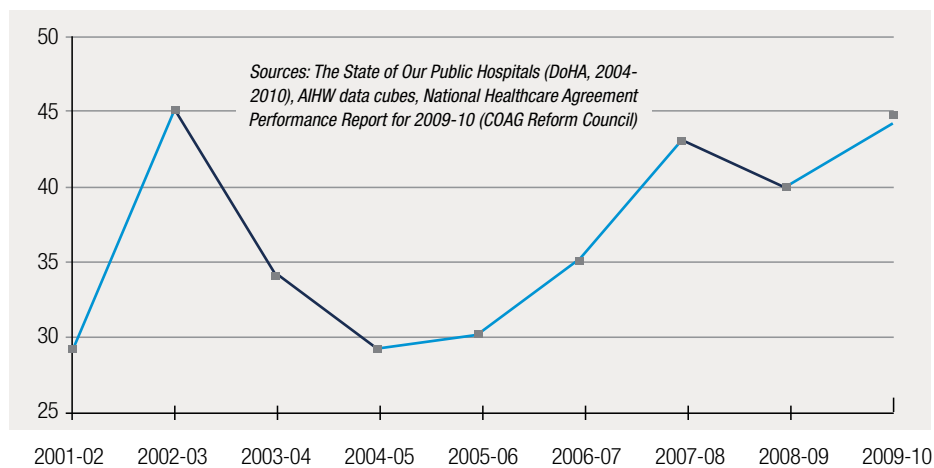
Percentage of Category 2 elective surgery patients seen within recommended time (90 days) – NT



Only 85 per cent of Category 1 urgency patients, and 61 per cent of Category 2 patients, received their surgery within the clinically recommended time. This is a long way from the National Health Reform Agreement target of 100 per cent. The Northern Territory will have to make up a lot of ground to achieve its performance target of 59 per cent in 2012.

There was a marked increase to 44 days in the median waiting time for elective surgery in 2009-10. It is disappointing that the improvement in 2008-09 was reversed in 2009-10.

Median waiting time for elective surgery (days) – NT



Bed numbers

After declining for the previous three years in a row, bed numbers have increased in 2009-10 by 88 beds to 694. However, there was a drop in the average number of available hospital beds per 1,000 Territorians, from 3.5 in 2008-09 to 3.0 in 2009-10.

Occupancy rates

The Northern Territory Government does not publish occupancy rates.

Comments

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 flow-on effect is that it can then take up to three days for various hospital departments to recover from this surge in presentations.

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

It also needs to ensure that transparent and publicly available data are collected and made available.









AMA

42 Macquarie Street Barton ACT 2600
Telephone: 02 6270 5400 Facsimile: 02 6270 5499
www.ama.com.au