



**PUBLIC HOSPITAL
REPORT CARD**

2014



AMA

AN AMA ANALYSIS OF AUSTRALIA'S PUBLIC HOSPITAL SYSTEM



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DATA SOURCES

Australian Institute of Health and Welfare, *Australian Hospital Statistics 2011-12*

Australian Institute of Health and Welfare, *Australian Hospital Statistics 2012-13: emergency department care*

Australian Institute of Health and Welfare, *Australian Hospital Statistics 2012-13: elective surgery waiting times*

Australian Institute of Health and Welfare, *Australian Hospital Statistics: National emergency access and elective surgery targets 2012*

Commonwealth Budget, *Mid-Year Economic and Fiscal Outlook 2012-13*

Commonwealth Budget, *Budget Paper No. 3 2013-14*

Commonwealth Budget, *Mid-Year Economic and Fiscal Outlook 2013-14*

Council of Australian Governments (COAG) Reform Council, *National Partnership Agreement on Improving Public Hospital Services: Performance Report for 2012 (NEAT and NEST targets)*

National Health Funding Pool Administrator, *National Health Funding Pool Annual Report 2012-13*

INTRODUCTION

The AMA Public Hospital Report Card presents data published by the Commonwealth, year on year.

This year, the Report Card presents performance data reflecting the first year of activity based funding for public hospitals, as set out under the National Health Reform Agreement (NHRA).

It is also the first year that the AMA Report Card uses information about Commonwealth funding published by the National Health Funding Pool Administrator.

We have used this information to monitor the performance of the Commonwealth Government against the commitment in the NHRA that no State or Territory would be worse off in the short or long term as a result of the new funding arrangements under the NHRA.

Despite the structural reforms to health financing, the AMA is disappointed that there has been only marginal improvement in public hospital performance against the performance benchmarks for emergency care and elective surgery set by all governments.


In 2012-13, only 68 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes, compared with the nationally agreed target of 80 per cent. Only 67 per cent of all emergency department visits were completed in four hours or less, well short of the 90 per cent target to be achieved by the end of 2015. An estimated 79 per cent of elective surgery category 2 patients were admitted within the clinically recommended time, also well short of the target of 100 per cent to be achieved by 2016.

In relation to elective surgery, the real length of time that patients are waiting for elective surgery is much longer than the publicly reported data. The time patients wait from when they are referred by their general practitioner to a specialist for assessment is not counted. It is only after patients have seen the specialist that they are added to the official waiting list.

Some health commentators will say that the focus on public hospital capacity and performance is misdirected – that the focus for Australia's health care system should be on primary care to keep people well and out of hospital. That is true.

Under the NHRA, the Commonwealth Government has prime responsibility for general practice and primary health care. The AMA has made suggestions for investing in general practice, to build on the things that work.

Planning is needed to allow primary care, led by general practitioners, to cope with the growing demands of chronic disease in the community. Primary care infrastructure grants would better support general practice to manage people outside the hospital setting – people with chronic disease; dementia; those who need palliative care; and the frail aged who deserve to spend their last days in the comfort of their own homes, and not in busy hospital wards. This is rightly where the focus of health reform should be.



In the meantime, very sick Australians will still need hospital care. For many, primary health care reforms will be too late to turn their chronic conditions around. There must be sufficient capacity in the public hospital sector to treat these people, and within clinically appropriate timeframes.

When funding is limited, it must be better targeted, patient-focused, and clinician-led. Whether activity based funding under the NHRA will assist this is yet to be seen.

Public hospitals have traditionally been, and will continue to be, the major provider of medical training. The complete pipeline of medical training needs to be properly funded to ensure we have a medical workforce in sufficient numbers to meet future community need.

Public hospitals provide fantastic care and treatment for their patients. The dedicated and hardworking doctors, nurses, and other health care practitioners who work in them continue to provide Australians with world class health care. The AMA strongly supports our public hospitals, their workforce, and the patients who need their care. We will continue to monitor and report on the capacity of public hospitals to meet the growing demands being placed on them.



Dr Steve Hambleton

President

February 2014

1. NATIONAL PUBLIC HOSPITAL PERFORMANCE

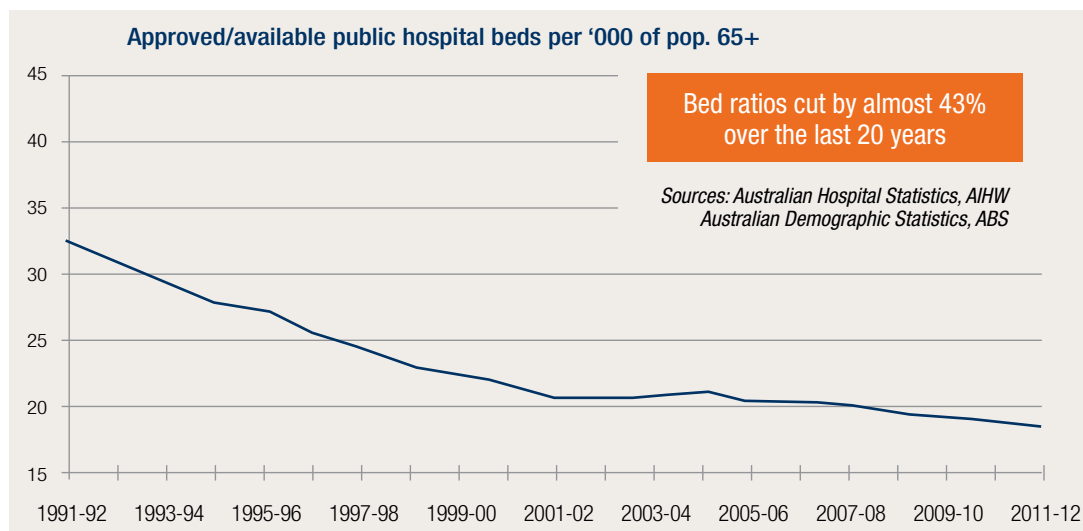
Public hospital capacity

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

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

Graph 1 shows that the number of public hospital beds has been slashed by almost 43 per cent over the past 20 years. In 2011-12, there were only 18.6 hospital beds for every 1000 people older than 65 years of age.

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



While 648 beds were added in 2011-12, the number of public hospital beds per 1000 of the total population remained at 2.6. This ratio has been unchanged since 2009-10. Public hospital capacity is just keeping pace with population growth and is not increasing to meet the growing demand for services.

Without any increase in capacity, our hardworking doctors and nurses have nonetheless managed to achieve some increases in services to patients:

- in-patient care – 5.5 million patient separations in 2011-12 (4.4 per cent increase from the previous year);
- out-patient care – 16.8 million services in 2011-12 (1.1 per cent increase from the previous year); and
- emergency department – 6.7 million presentations in 2012-13 (2.5 per cent increase from the previous year).

Emergency department waiting and treatment times

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

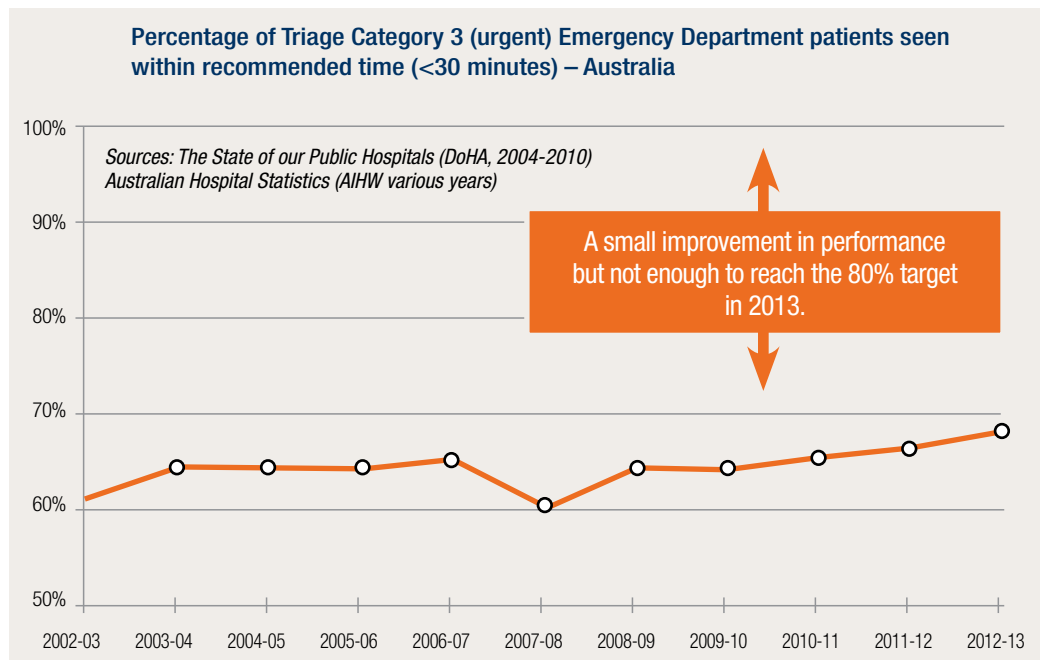
- the percentage of emergency department presentations that are seen within clinically recommended triage times; and
- the percentage of patients leaving the emergency department within four hours.

Patients seen within clinically recommended times

The National Partnership Agreement on Hospital and Health Workforce Reform (February 2009) committed all States and Territories 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 ¹.

That target has not been met. Only 68 per cent of emergency department patients classified as urgent in 2012-13 were seen within the recommended 30 minutes.

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



¹ National Partnership Agreement on Hospital and Health Workforce Reform, 2009, pg 28, clause D11

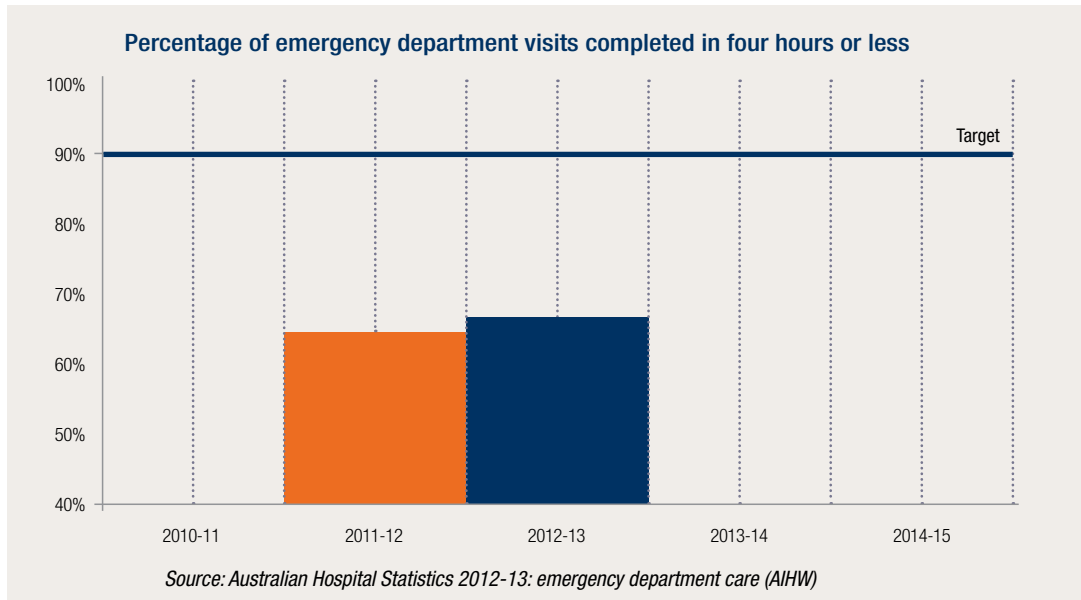
National Emergency Access Target

The National Partnership Agreement on Improving Public Hospital Services (July 2011) introduced the National Emergency Access Target (NEAT).

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 hours². State and Territory governments have committed to progressively achieve this target by the end of 2015, with incremental targets over four years for each State and Territory. Reward payments are available if these targets are met (until June 2016).

In 2012-13, 67 per cent of all emergency department visits were completed in four hours or less, well short of the 90 per cent target to be achieved by the end of 2015.

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



² National Partnership Agreement on Improving Public Hospital Services, 2011, pg 30, clause C1

Elective surgery waiting and treatment times

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

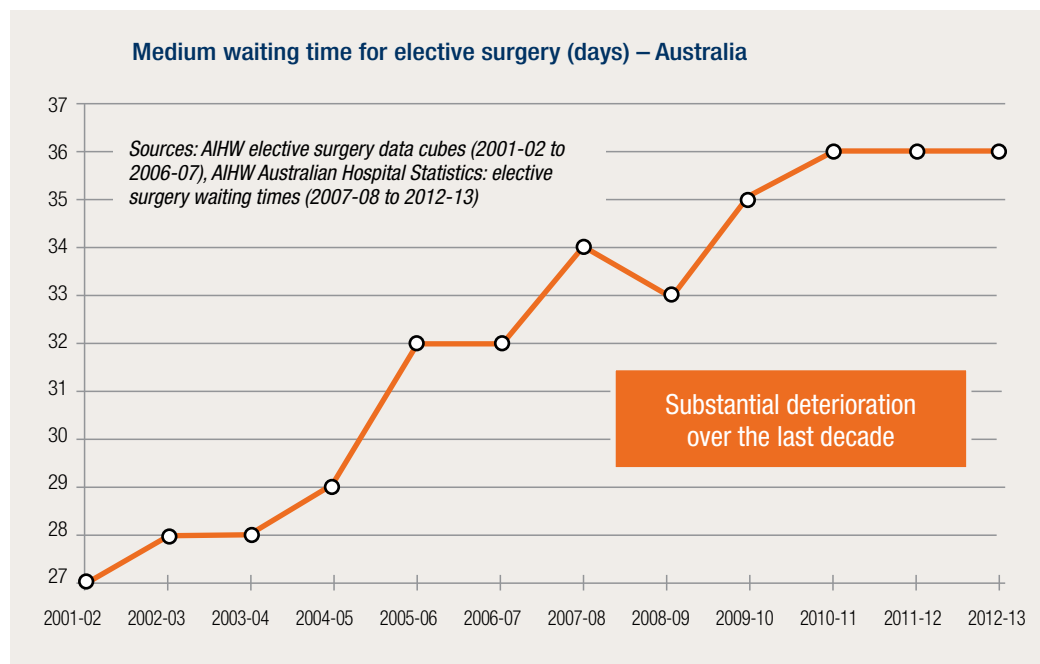
Two performance indicators that measure the performance of public hospitals to provide timely care to patients requiring elective surgery are:

- the median waiting time for elective surgery; and
- the percentage of patients treated within the clinically recommended times.

Median waiting time

Nationally, median waiting times for all elective surgery have increased over the last 10 years. In 2012-13, the national median waiting time remained unchanged at 36 days, meaning no improvement over the last three years.

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



National Elective Surgery Target

The National Partnership Agreement on Improving Public Hospital Services (July 2011) introduced the National Elective Surgery Target (NEST). Under this target, 100 per cent of all urgency category patients waiting for surgery are to be treated within the clinically recommended times. Reward payments are available if incremental targets are met.³

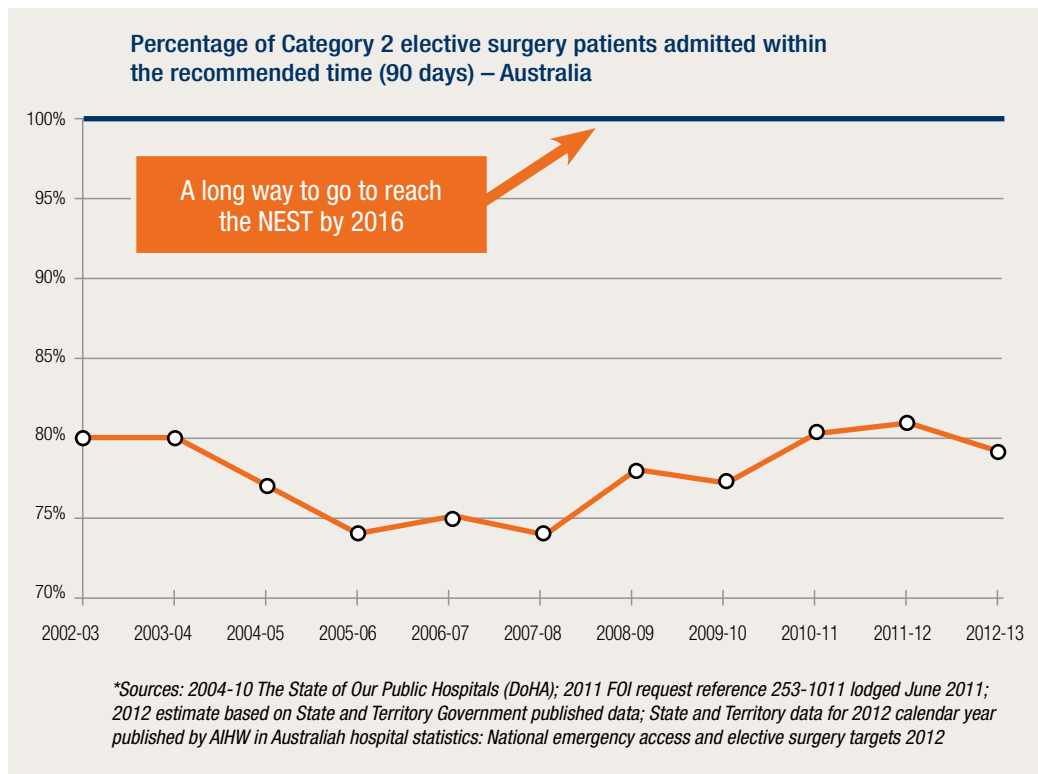
The Australian Institute of Health and Welfare (AIHW) and the Royal Australasian College of Surgeons have proposed new national definitions for elective surgery urgency categories. Category 2 elective surgery is now defined as “procedures that are clinically indicated within 90 days”. This time period was used in the previous definition for category 2 elective surgery.

In 2012-13, category 2 patients represented 39 per cent of elective surgery admissions nationally.

While work on new elective surgery categories was taking place, the AIHW reported the percentage of elective surgery patients admitted within clinically recommended times for the NEST targets for the 2012 calendar year⁴. Unlike the NEAT data, the AIHW has not reported NEST data for the full 2012-13 financial year, citing an apparent lack of comparability of clinical urgency categories among jurisdictions⁵.

The reported data for 2012 indicates a national percentage of 79 per cent for elective surgery category 2 patients who were admitted within the clinically recommended time. Graph 5 presents performance over the 11 years to 2012-13, with performance in the last few years extrapolated using data from various sources.

Graph 5: Percentage of Category 2 elective surgery patients admitted within the recommended time



3 National Partnership Agreement on Improving Public Hospital Services, 2011, pg 20

4 Australian Institute of Health and Welfare, *Australian Hospital Statistics: National emergency access and elective surgery targets 2012* pp 11-13

5 *ibid*, pg 10



The hidden waiting list

Elective surgery waiting list data hide the actual times that 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 actually seeing a specialist for assessment is not counted. It is only after patients have seen the specialist that they are added to the official waiting list. This means that the publicly available elective surgery waiting list data actually understate the real time people wait for surgery. Some people wait longer for assessment by a specialist than they do for surgery.

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

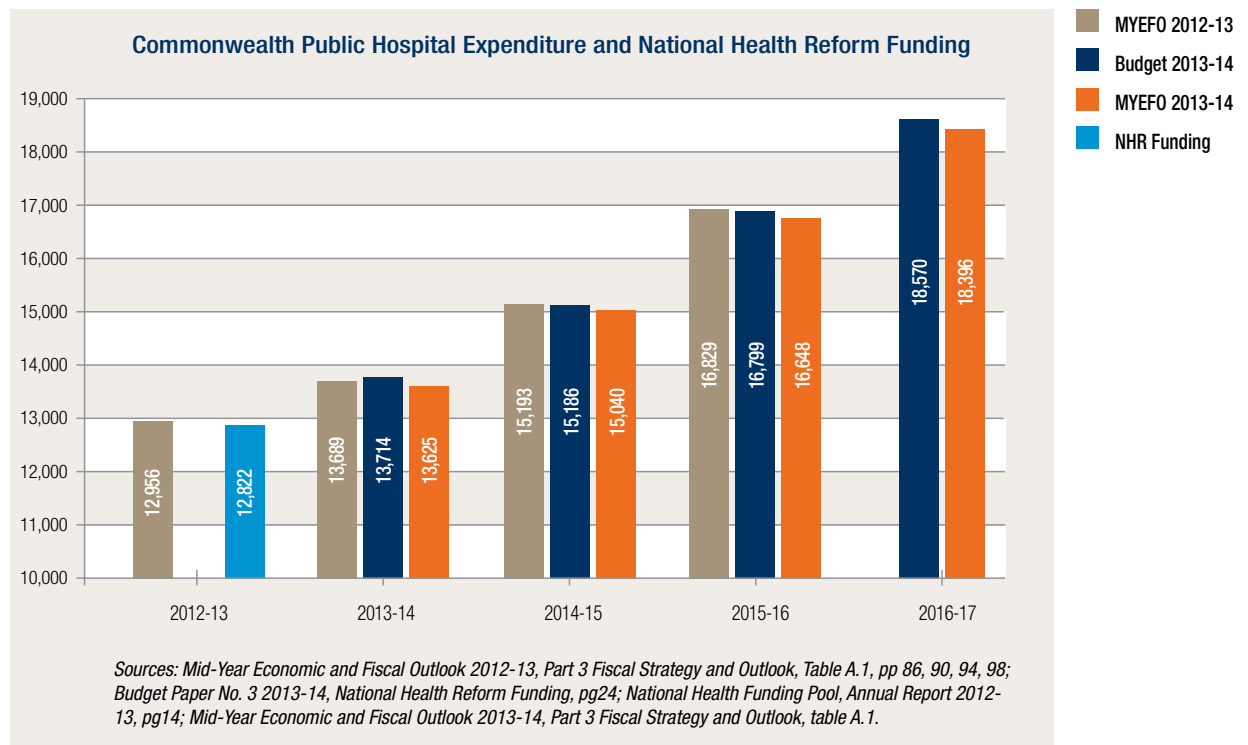
Commonwealth funding

The National Health Reform Agreement signed in August 2011 provided a Commonwealth guarantee that “no State will be worse off in the short or long term, because they will continue to receive at least the amount of funding they would have received under the former National Healthcare SPP...”⁶.

In the Mid-Year Economic and Fiscal Outlook (MYEFO) 2012-13, the Commonwealth effectively reset the National Healthcare SPP funding for 2012-13 and thereafter as a result of revisions to the national population statistics and the measures of growth in health costs.⁷

Graph 6 shows the Commonwealth projection of funding at the November 2012 MYEFO, the revised 2013-14 Budget figures, the December 2013 MYEFO, and Commonwealth funding to the National Health Funding Pool for 2012-13. This graph seeks to track Commonwealth expenditure on public hospital services, over time, to monitor the Commonwealth’s funding commitment under the Agreement.

Graph 6: Public Hospital Expenditure and National Health Reform Funding



The projected Commonwealth funding shown in these Budget documents for hospital services, under the heading *National Health Reform* is not on track to honour the commitment to the State and Territory governments.

6 National Health Reform Agreement, 2011, clause 15.a, pg 9
 7 Mid-Year Economic and Fiscal Outlook 2012-13, pg 75

2 STATE-BY-STATE PUBLIC HOSPITAL PERFORMANCE

This section includes performance information for each State and Territory using available data sources. Summary of performance is shown in Table 1:

Table 1: State and Territory Performance - Summary

State/Territory	Improvement in Emergency Department waiting time - urgent (category 3) 2012-13	Met National Emergency Access Target (NEAT) 2012+	Improvement in Elective Surgery waiting time 2012-13	Met National Elective Surgery Target (NEST)+* 2012	Commonwealth funding for 2012-13 equal to or greater than MYEFO 2012-13
NSW	✓	✗	✗	✓	✗
Victoria	✗	✗	✗	✗	✗
Queensland	✓	✗	✗	✗	✗
Western Australia	✗	✓	✗	✗	✗
South Australia	✗	✗	✗	✗	✓
Tasmania	✓	✗	✗	✗	✗
ACT	✗	✗	✓	✓	✓
NT	✓	✗	✗	✓	✗

+ Targets are set on a calendar year basis; performance as reported by COAG Reform Council

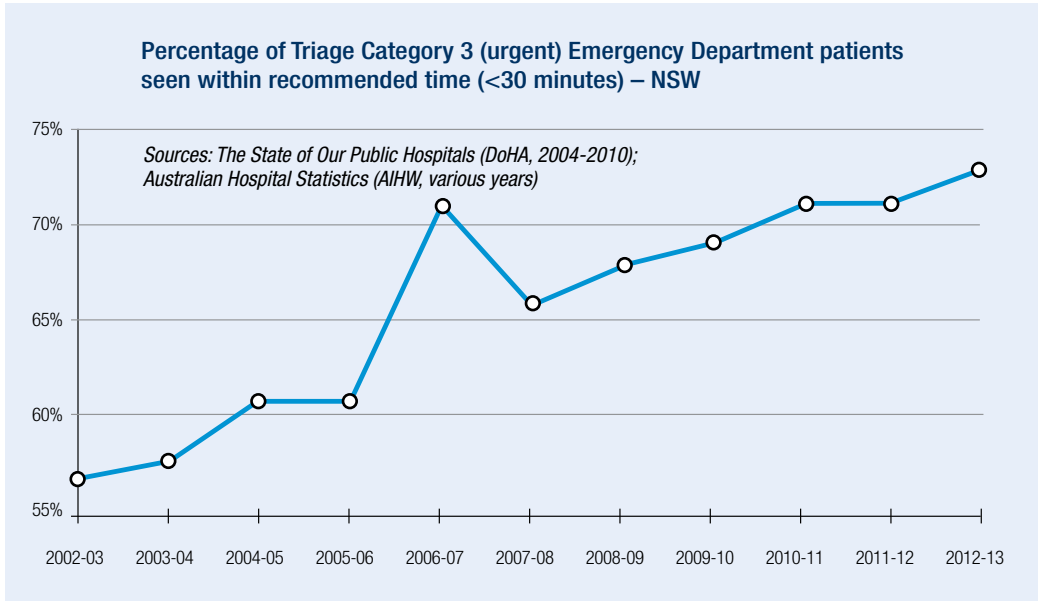
*Treating patients within clinically recommended time – Category 2 (within 90 days)

No State or Territory met the target set for 2012-13 under the National Partnership Agreement on Hospital and Health Workforce Reform for 80 per cent of emergency department Category 3 urgent patients being seen within clinically recommended triage times.

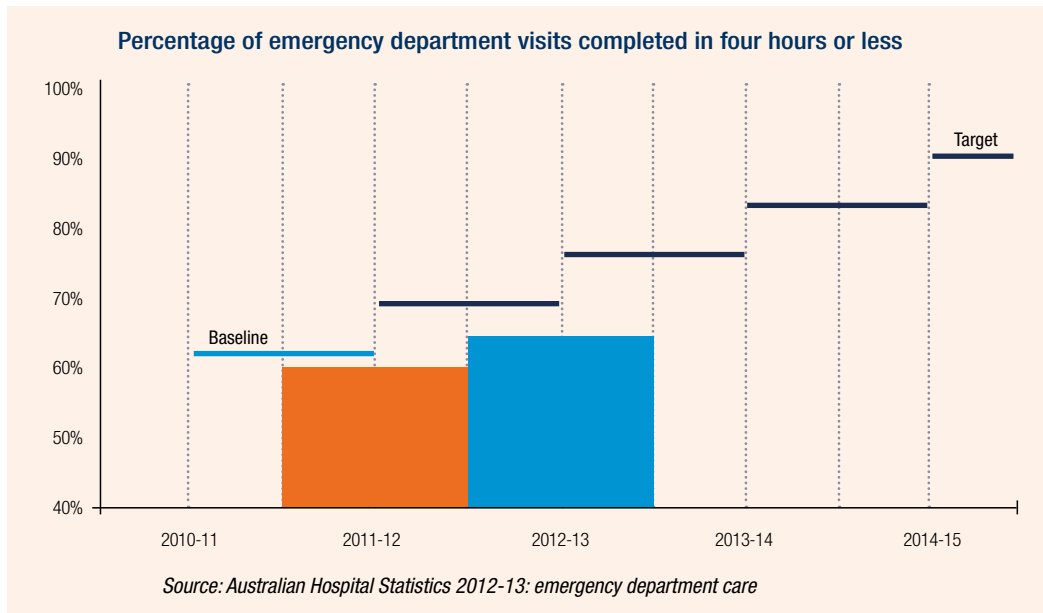
NEW SOUTH WALES

Emergency Departments

Waiting times

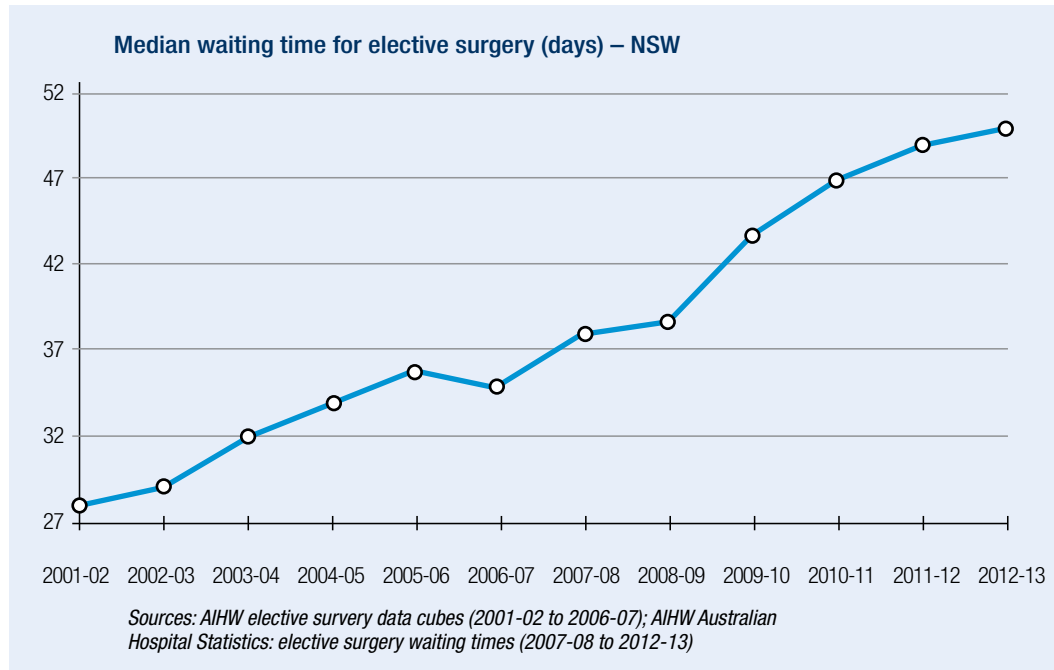


National Emergency Access Target (NEAT)

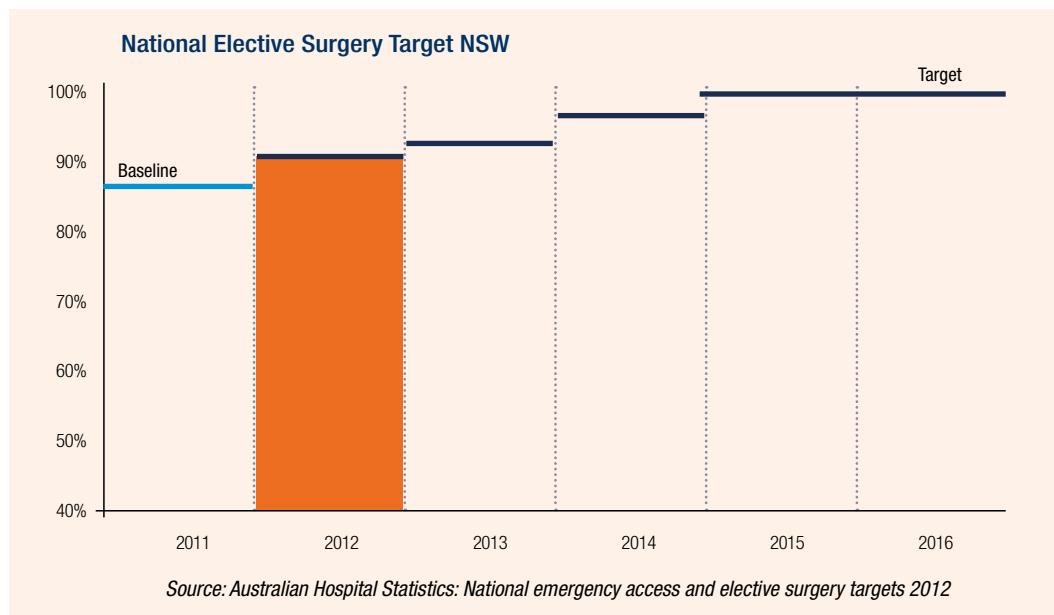


Elective Surgery

Waiting times

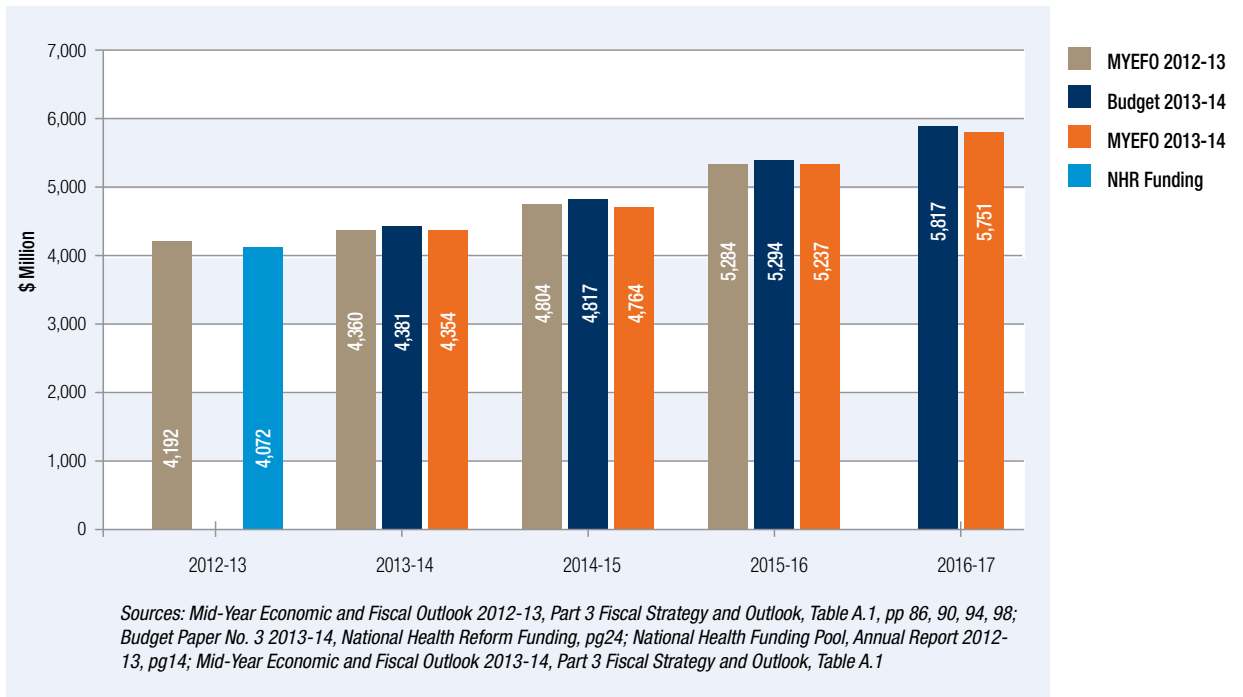


National Elective Surgery Target (NEST)



Commonwealth Funding

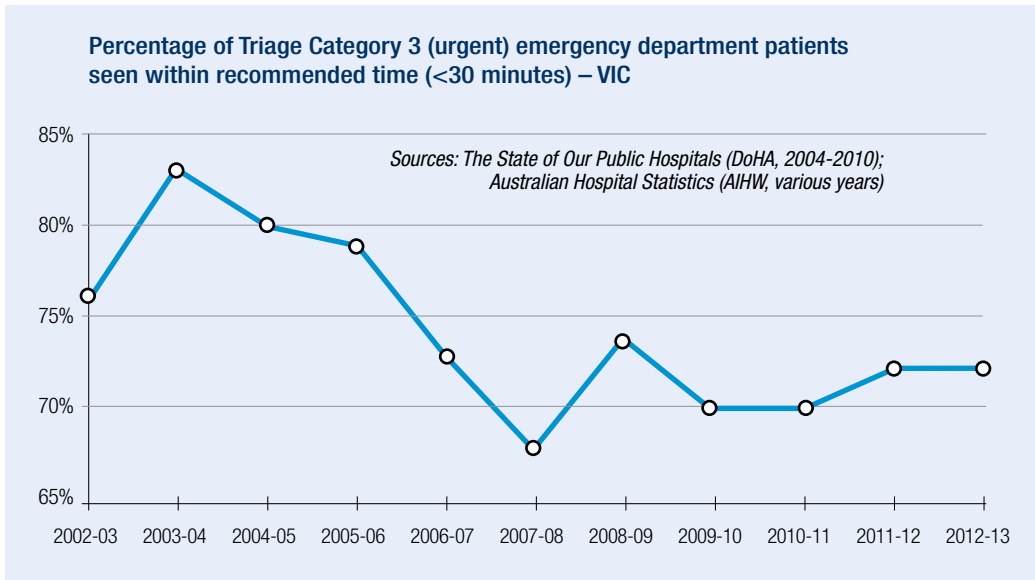
National Health Reform Funding: New South Wales



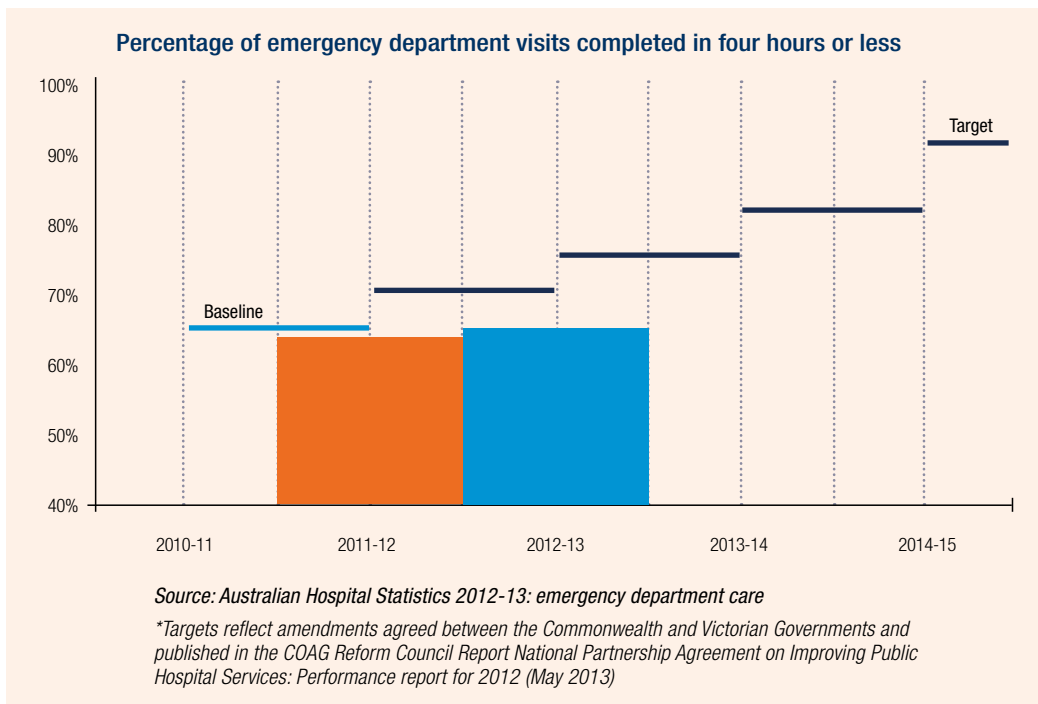
VICTORIA

Emergency Departments

Waiting times

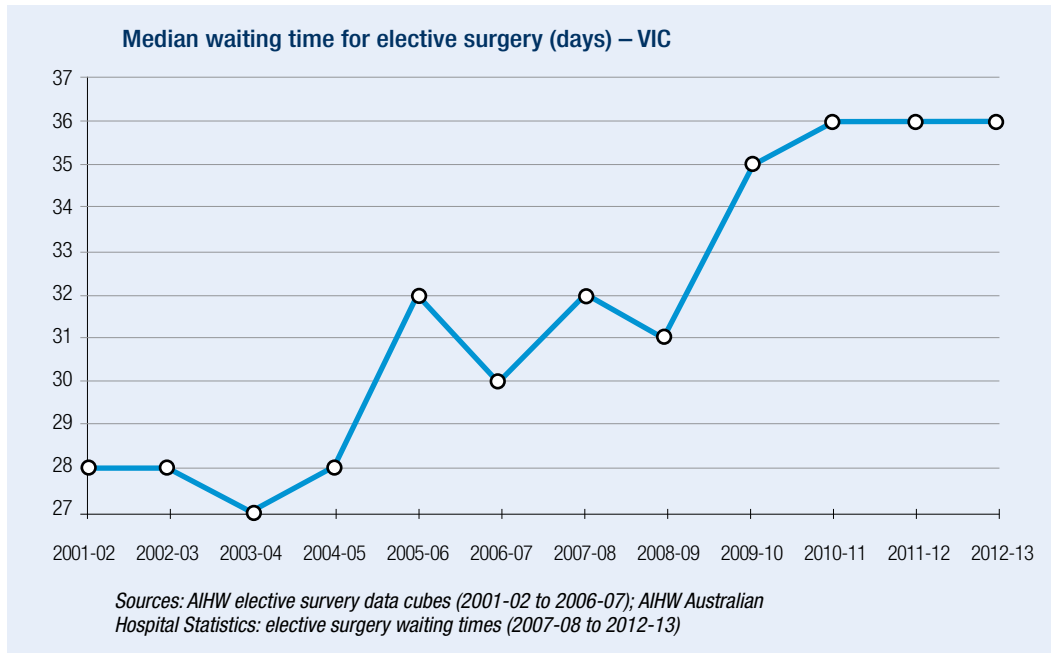


National Emergency Access Target (NEAT)*

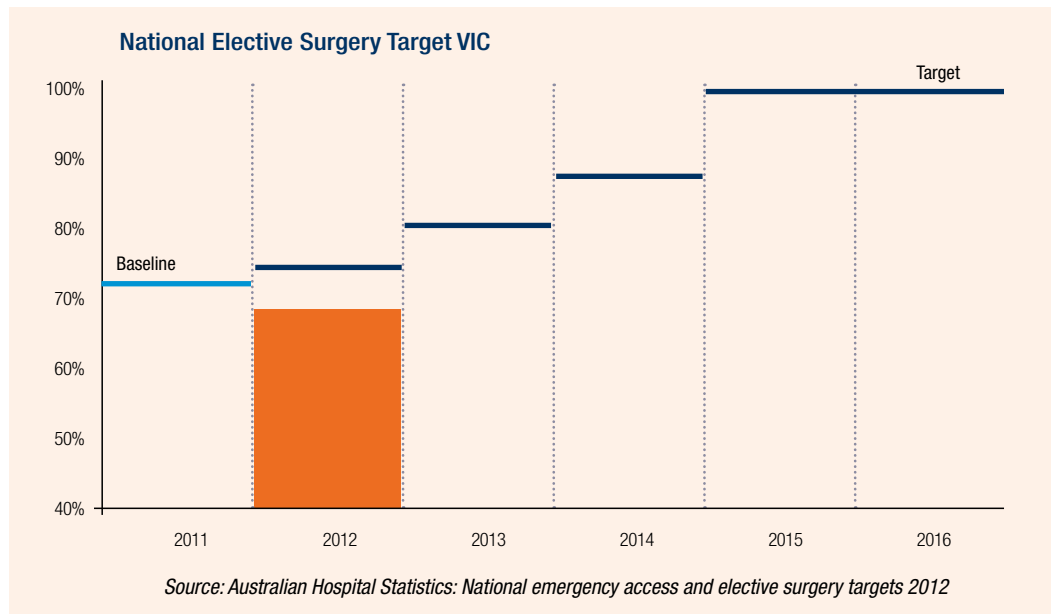


Elective Surgery

Waiting times

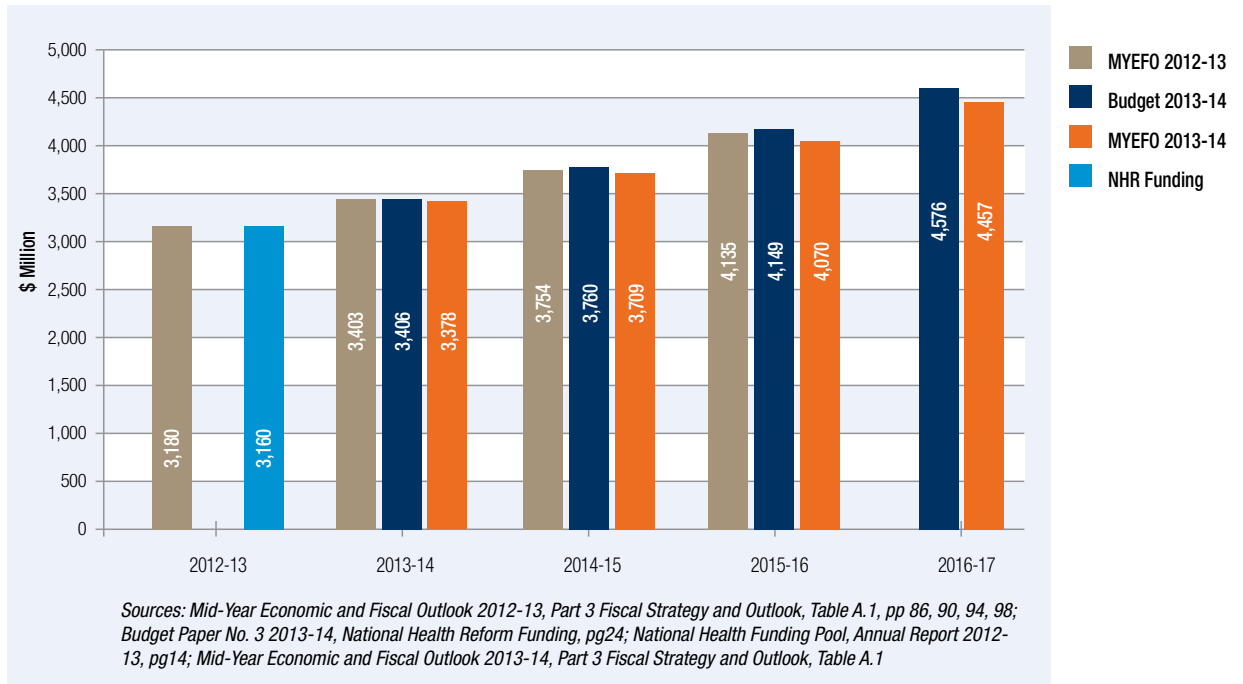


National Elective Surgery Target (NEST)



Commonwealth Funding

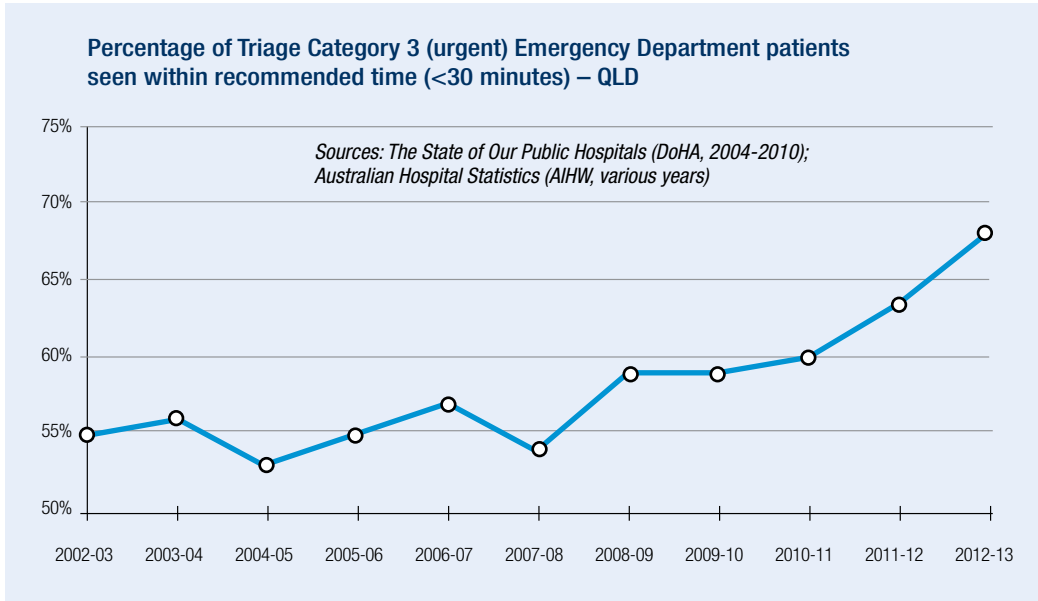
National Health Reform Funding: Victoria



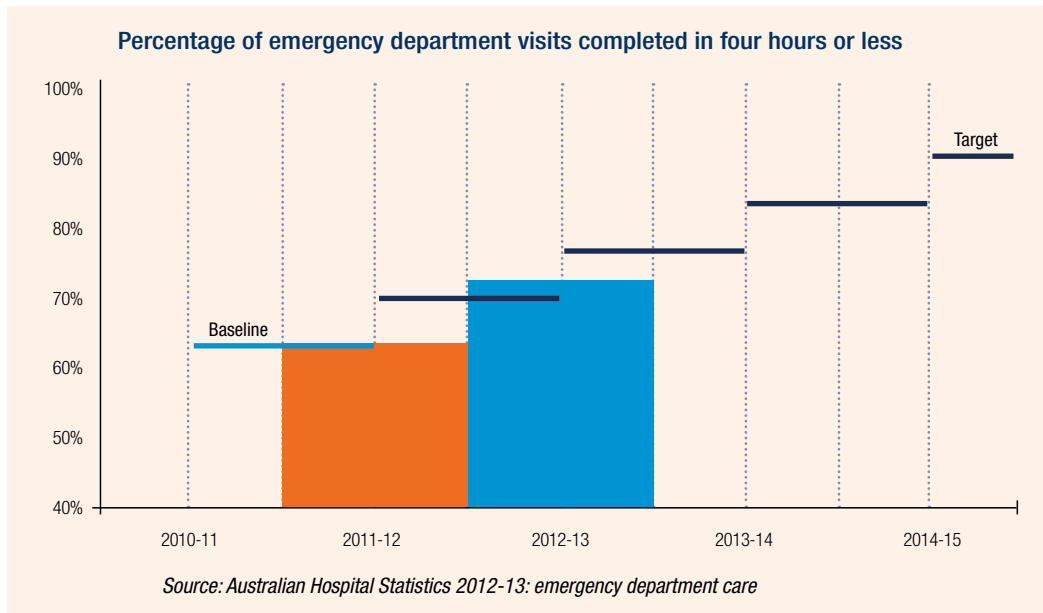
QUEENSLAND

Emergency Departments

Waiting times

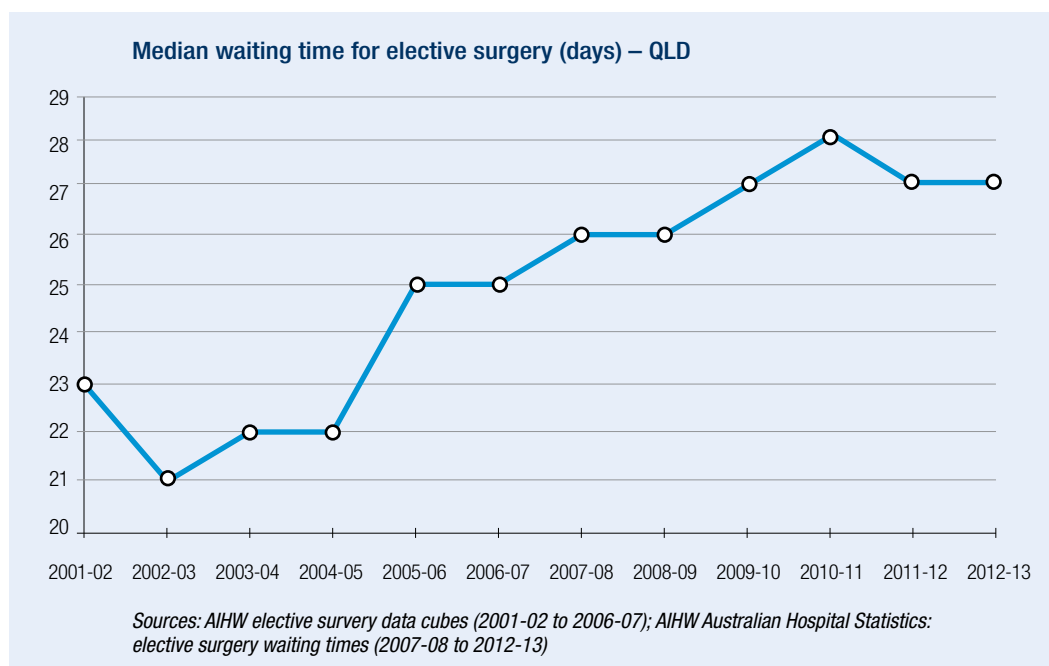


National Emergency Access Target (NEAT)

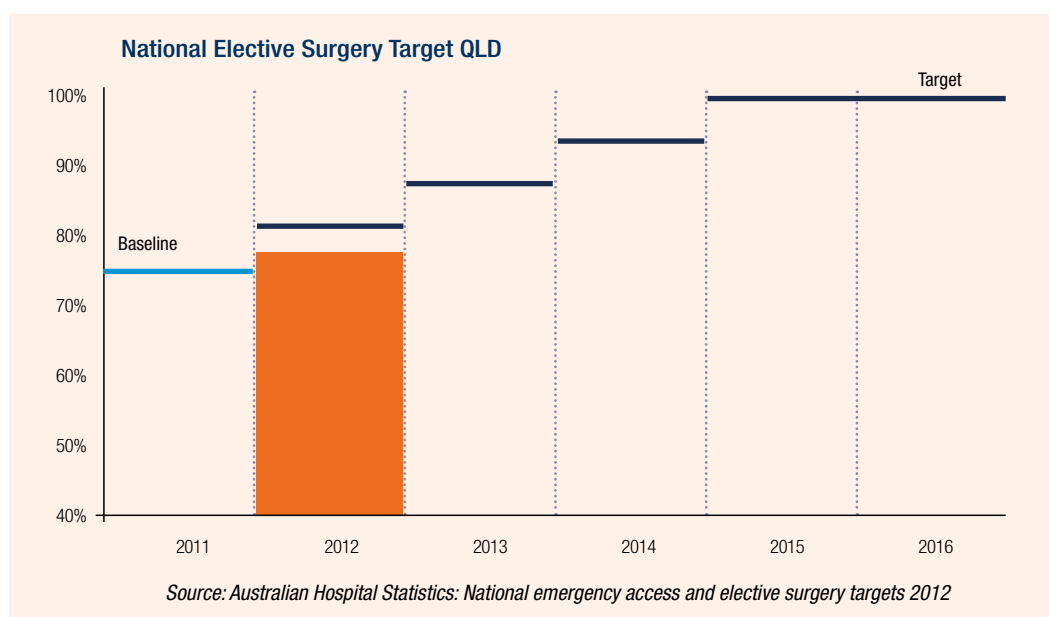


Elective Surgery

Waiting times

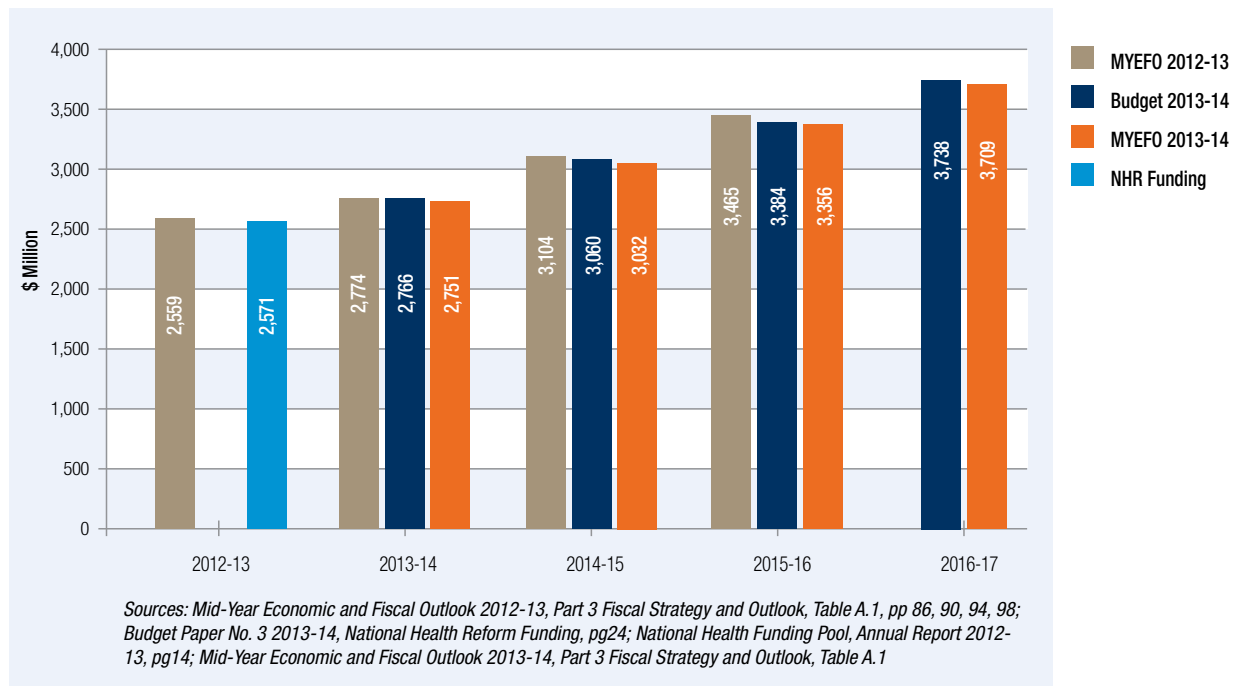


National Elective Surgery Target (NEST)



Commonwealth Funding

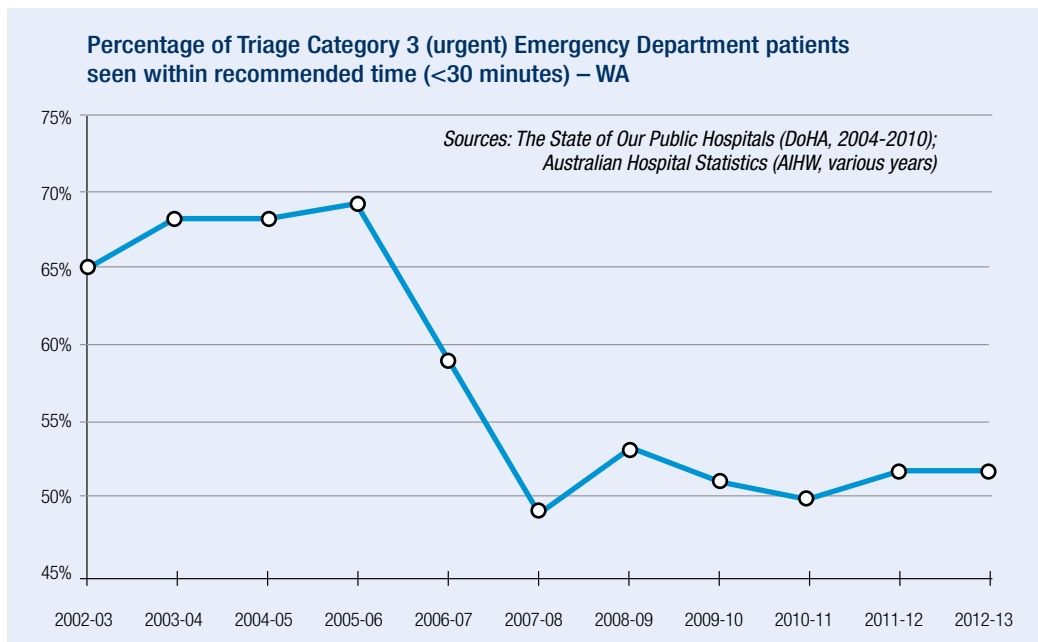
National Health Reform Funding: Queensland



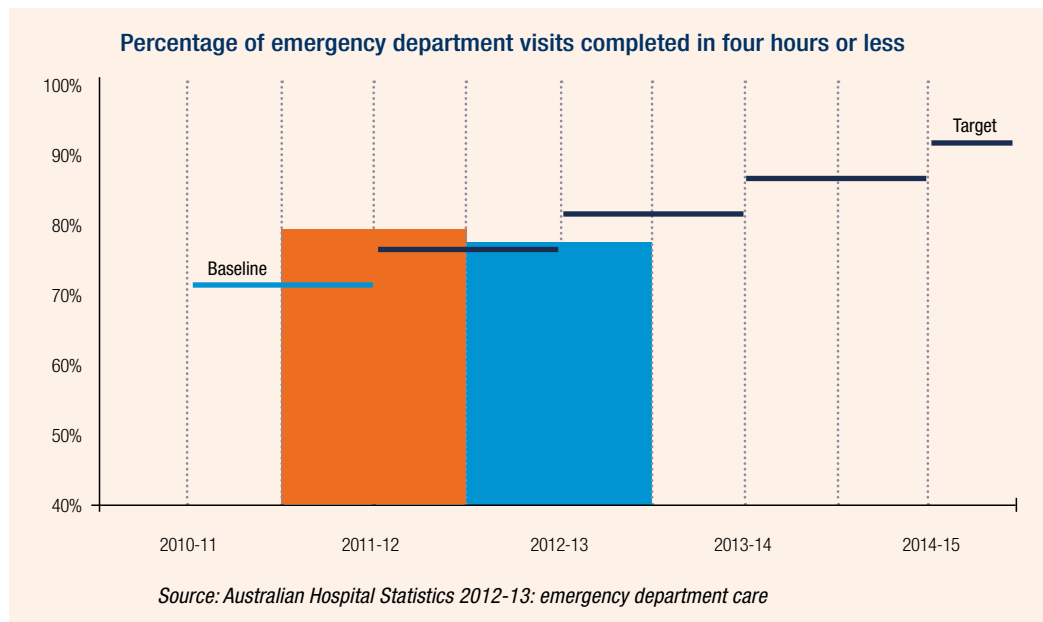
WESTERN AUSTRALIA

Emergency Departments

Waiting times

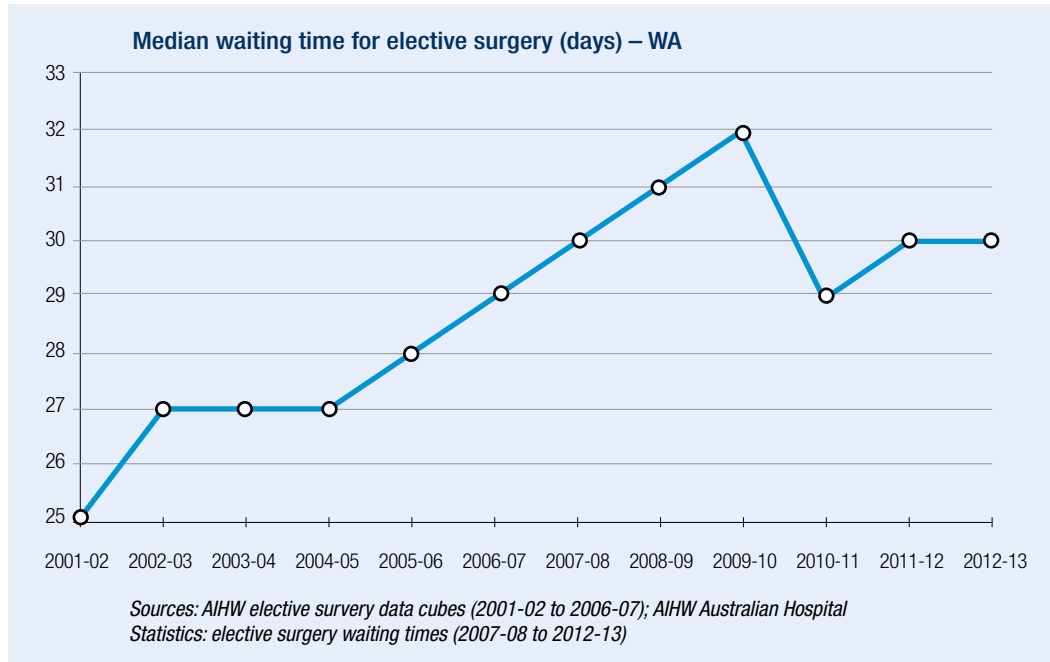


National Emergency Access Target (NEAT)*

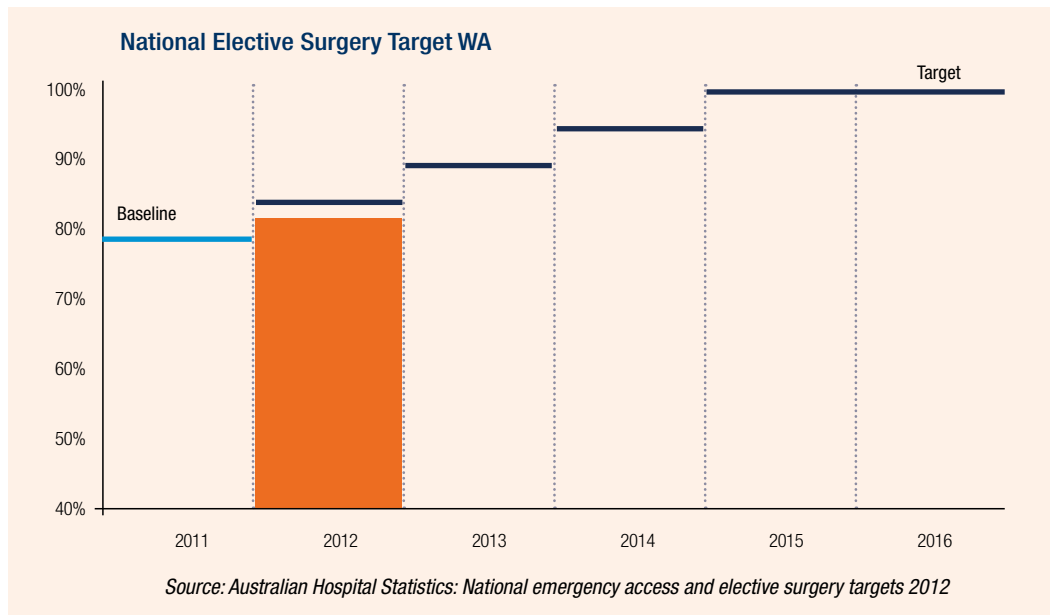


Elective Surgery

Waiting times

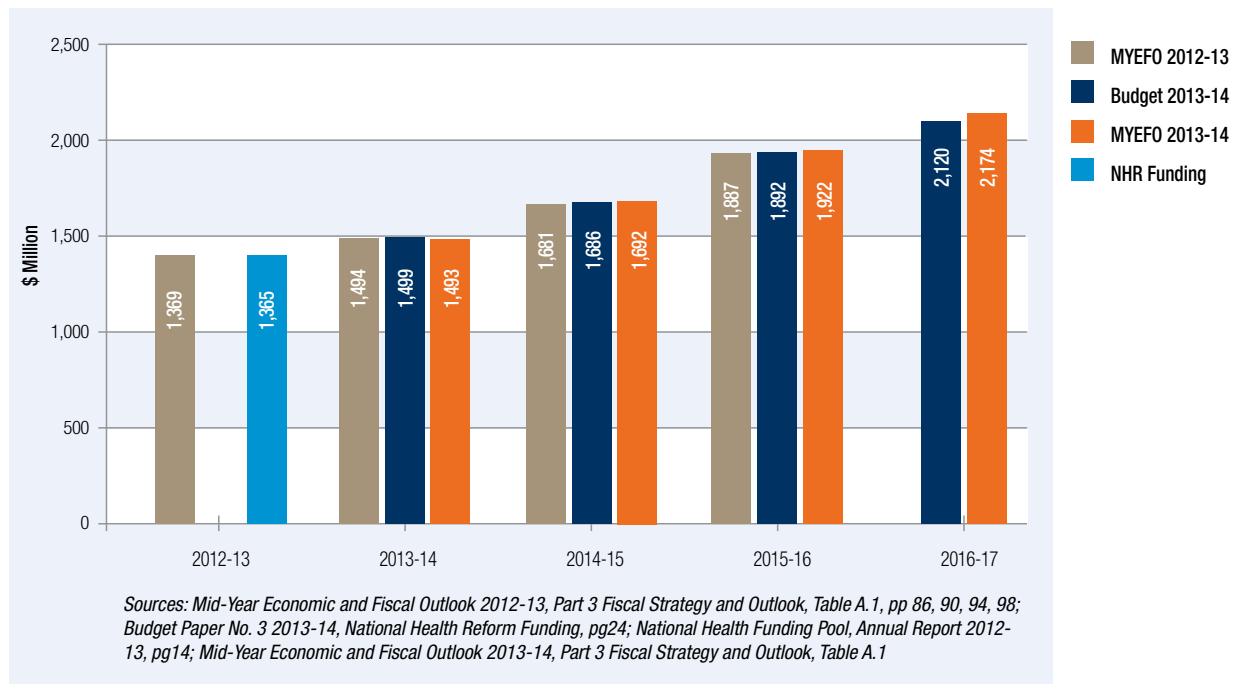


National Elective Surgery Target (NEST)



Commonwealth Funding

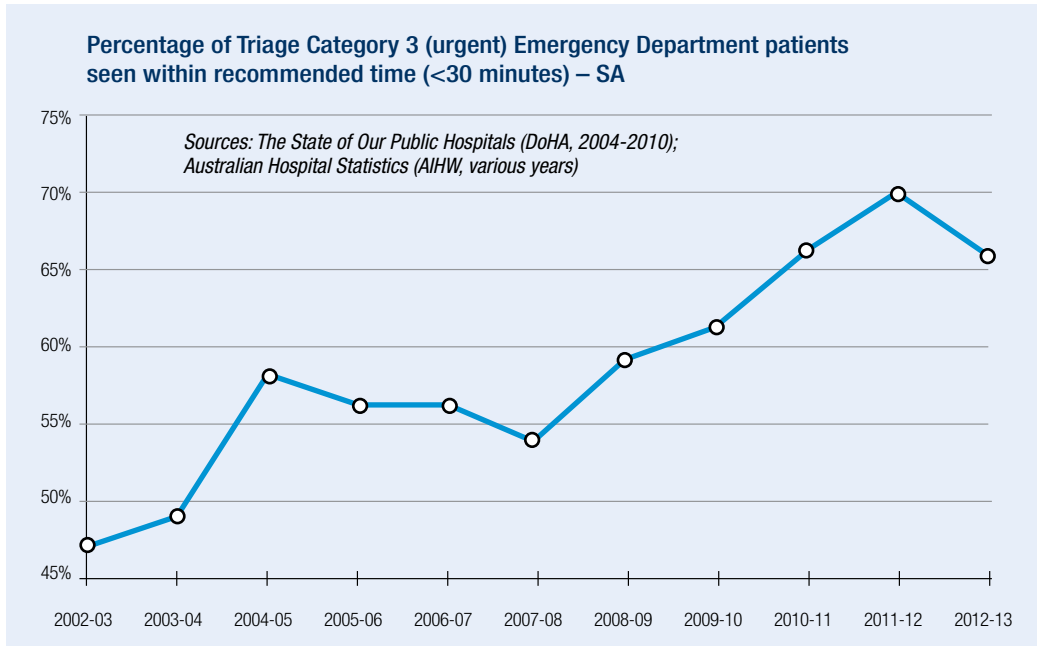
National Health Reform Funding: Western Australia



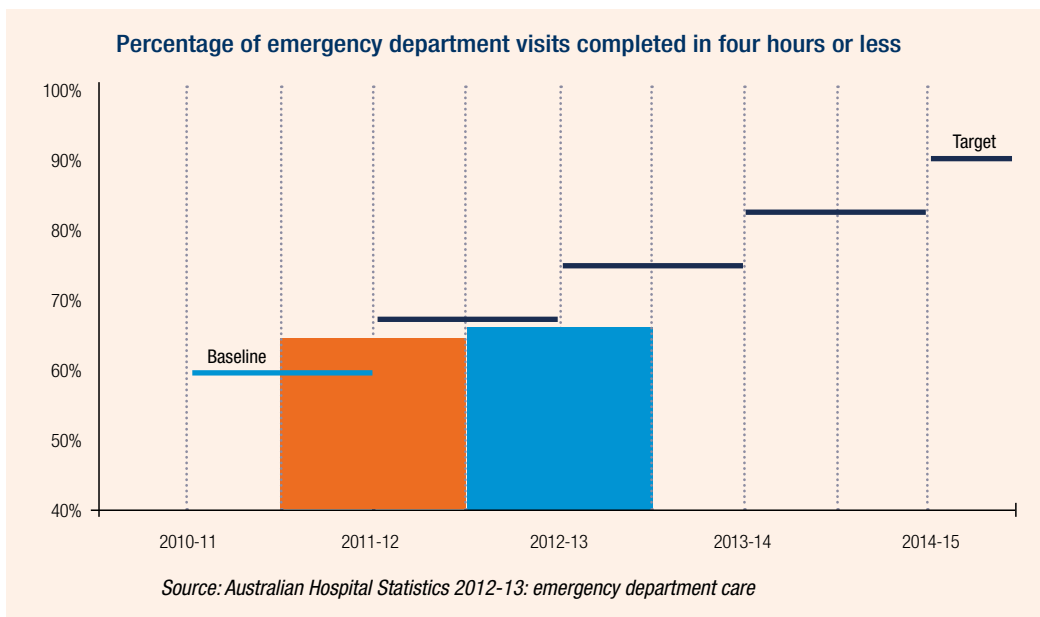
SOUTH AUSTRALIA

Emergency Departments

Waiting times

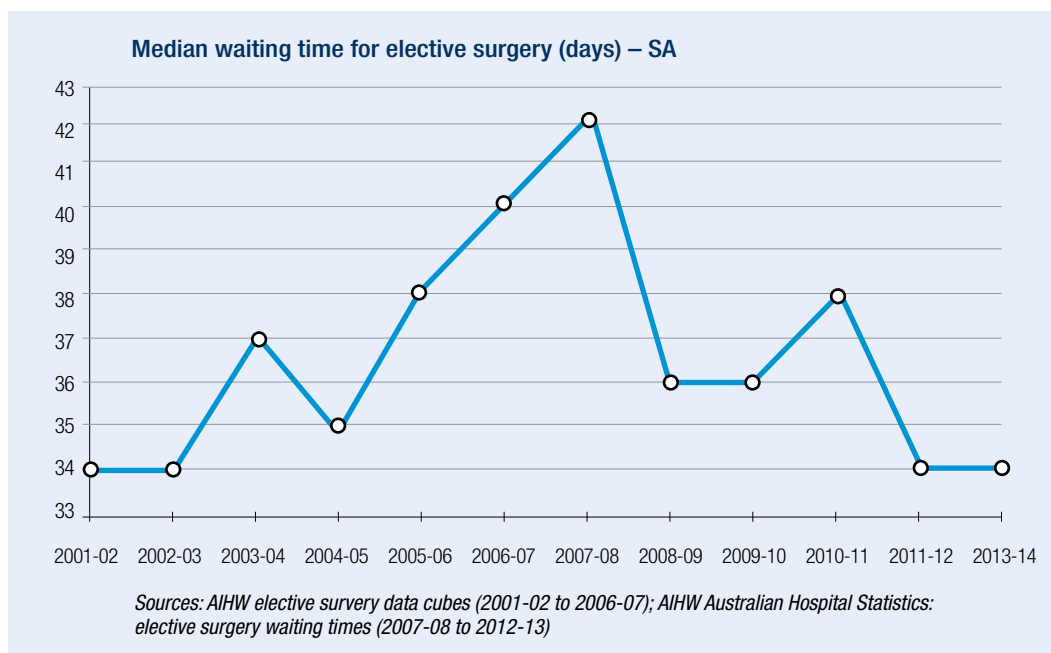


National Emergency Access Target (NEAT)

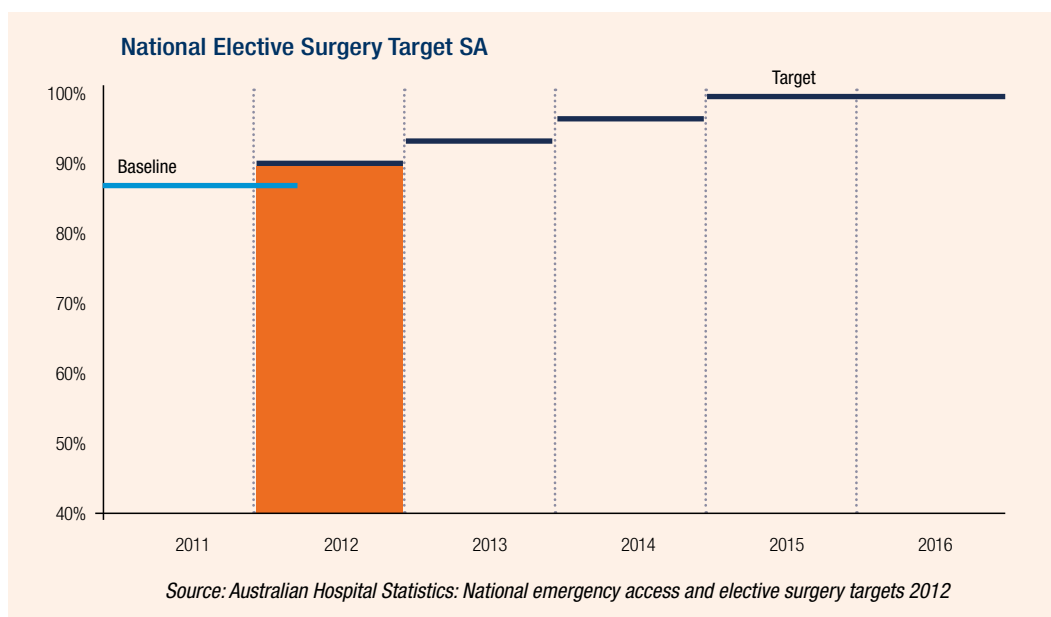


Elective Surgery

Waiting times

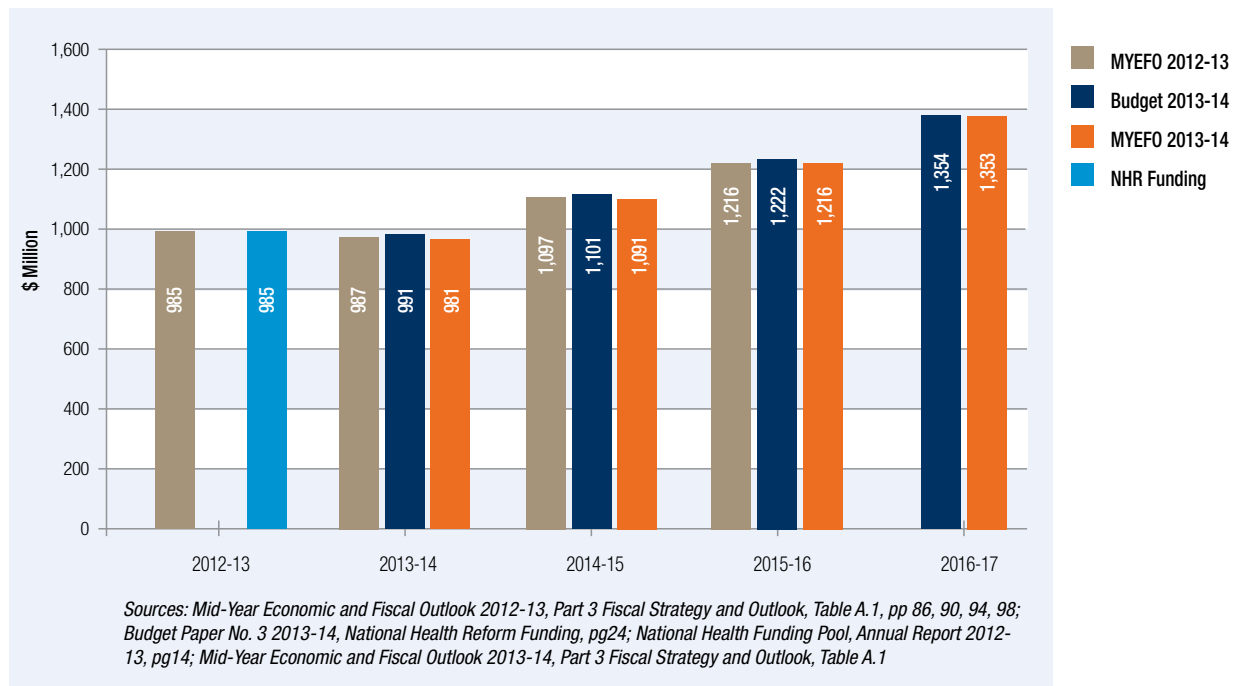


National Elective Surgery Target (NEST)



Commonwealth Funding

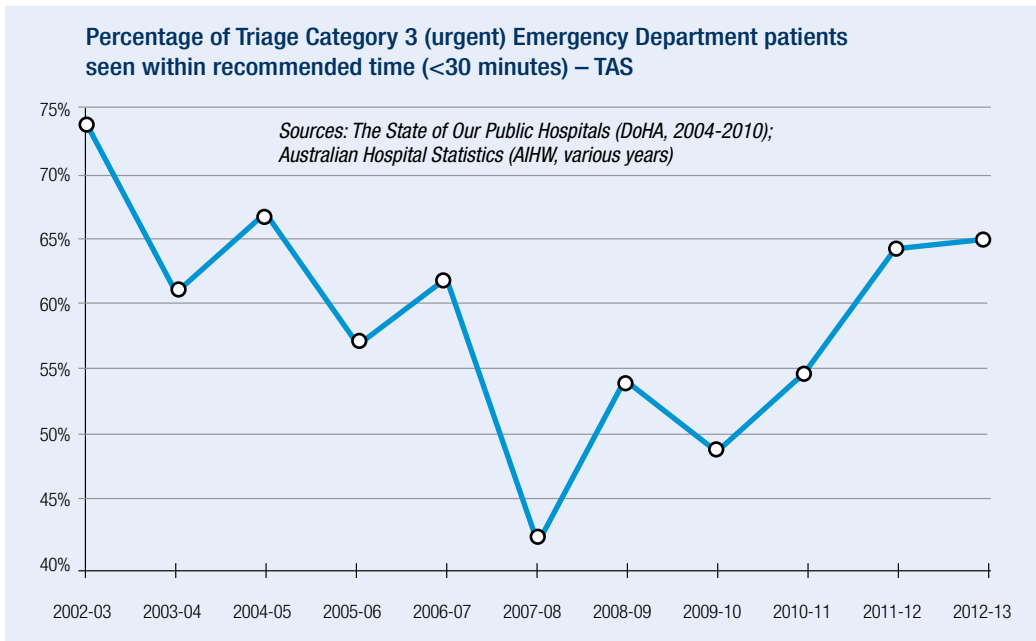
National Health Reform Funding: South Australia



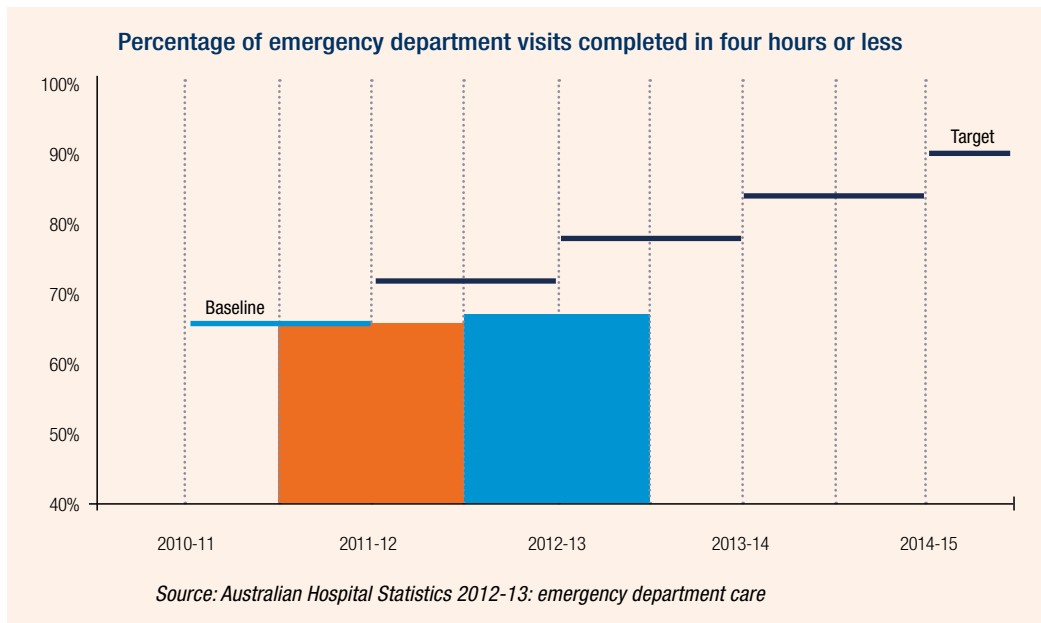
TASMANIA

Emergency Departments

Waiting times

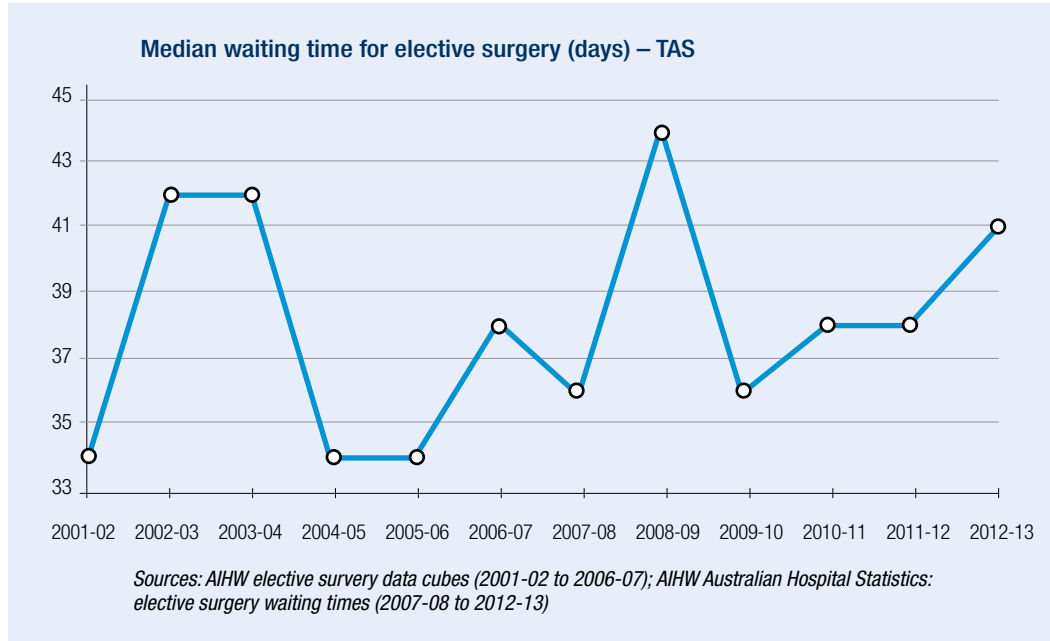


National Emergency Access Target (NEAT)*

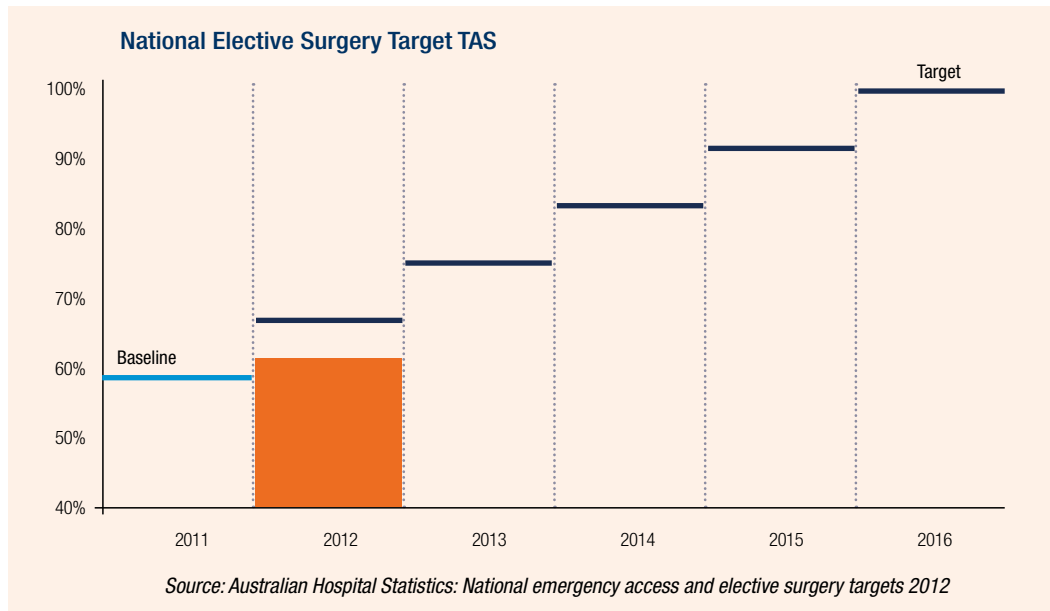


Elective Surgery

Waiting times

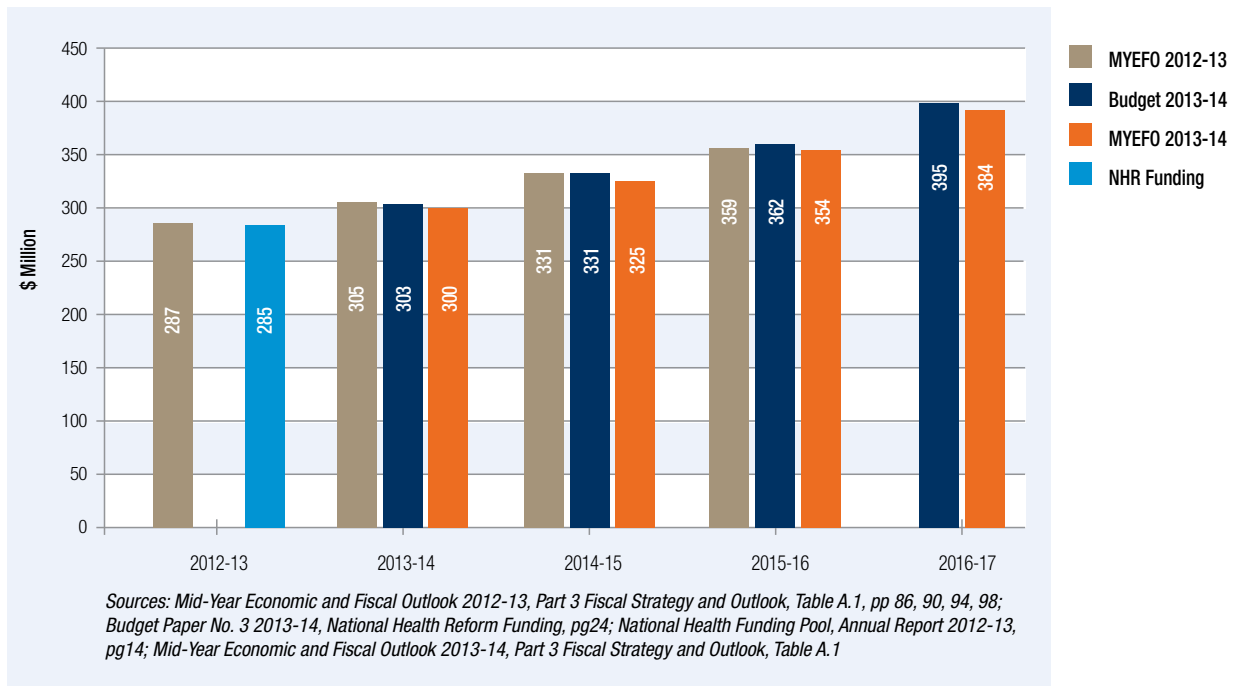


National Elective Surgery Target (NEST)



Commonwealth Funding

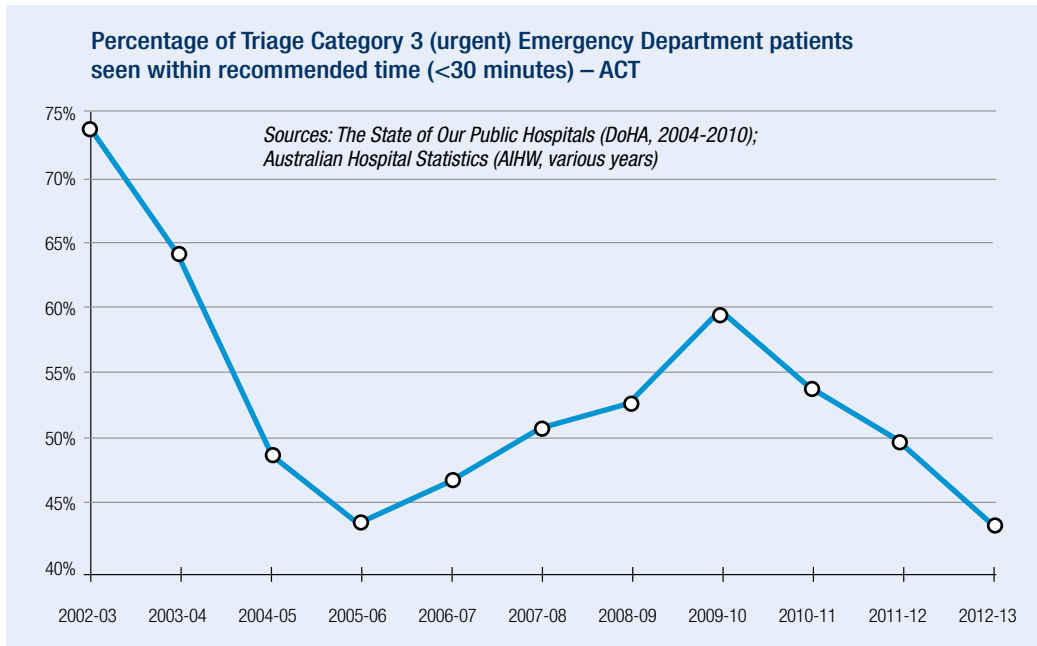
National Health Reform Funding: Tasmania



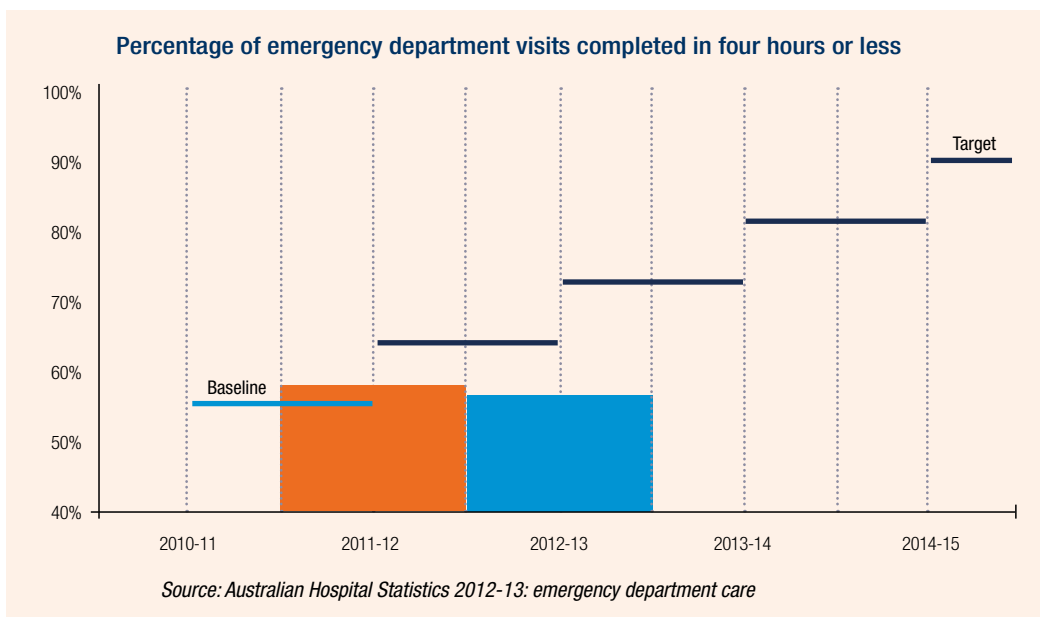
AUSTRALIAN CAPITAL TERRITORY

Emergency Departments

Waiting times

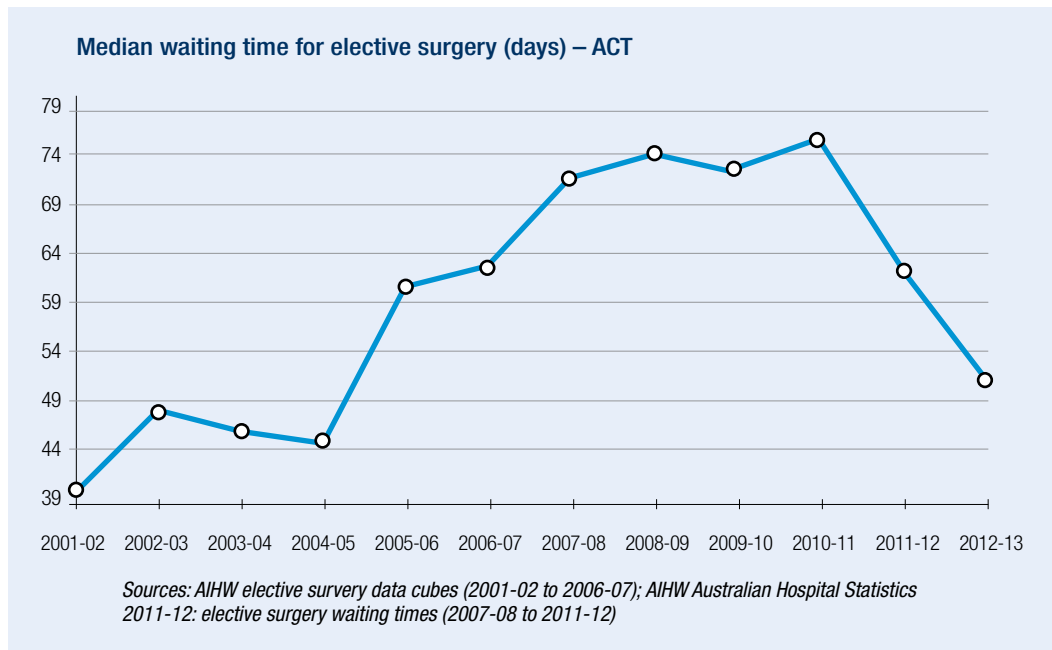


National Emergency Access Target (NEAT)

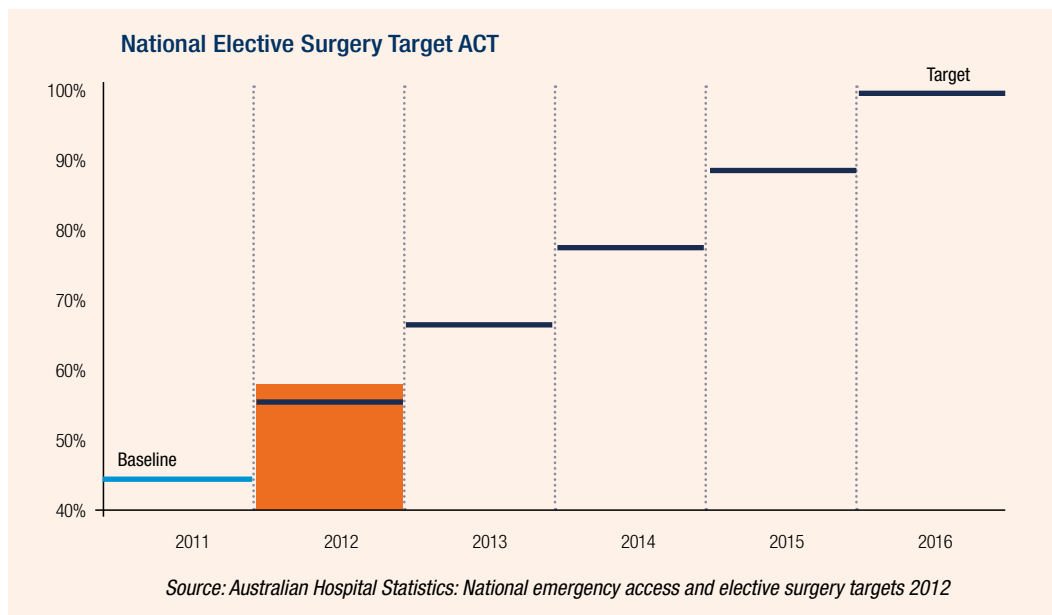


Elective Surgery

Waiting times

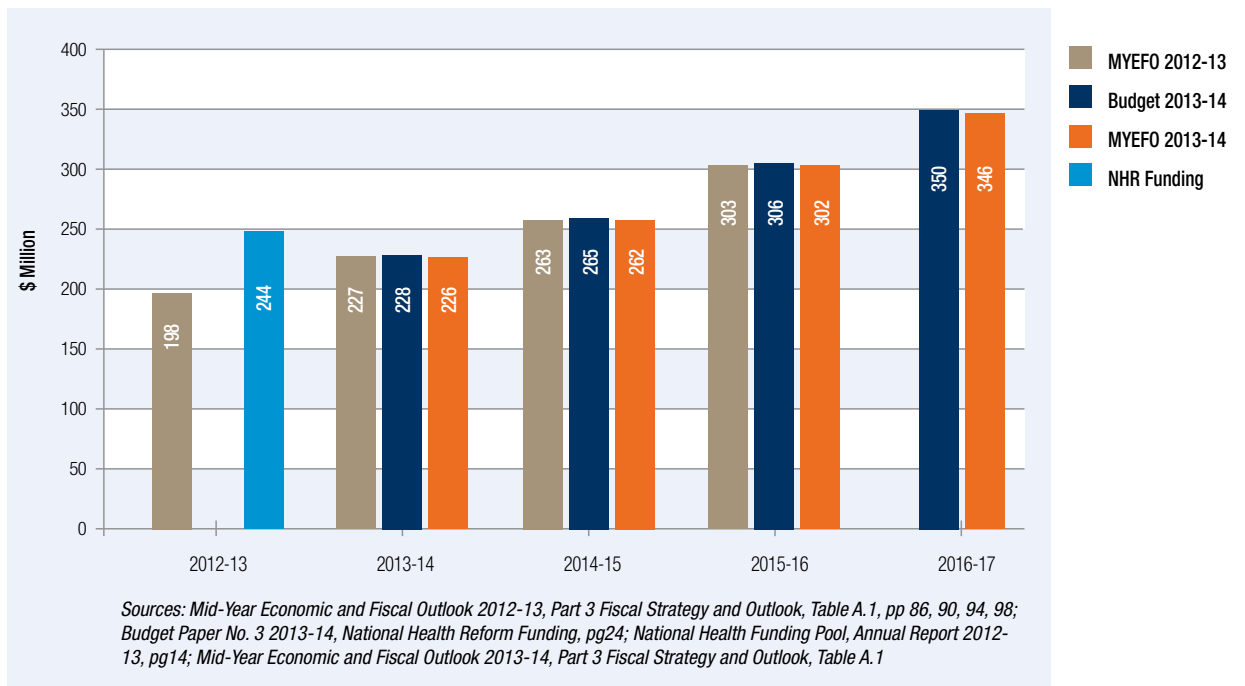


National Elective Surgery Target (NEST)



Commonwealth Funding

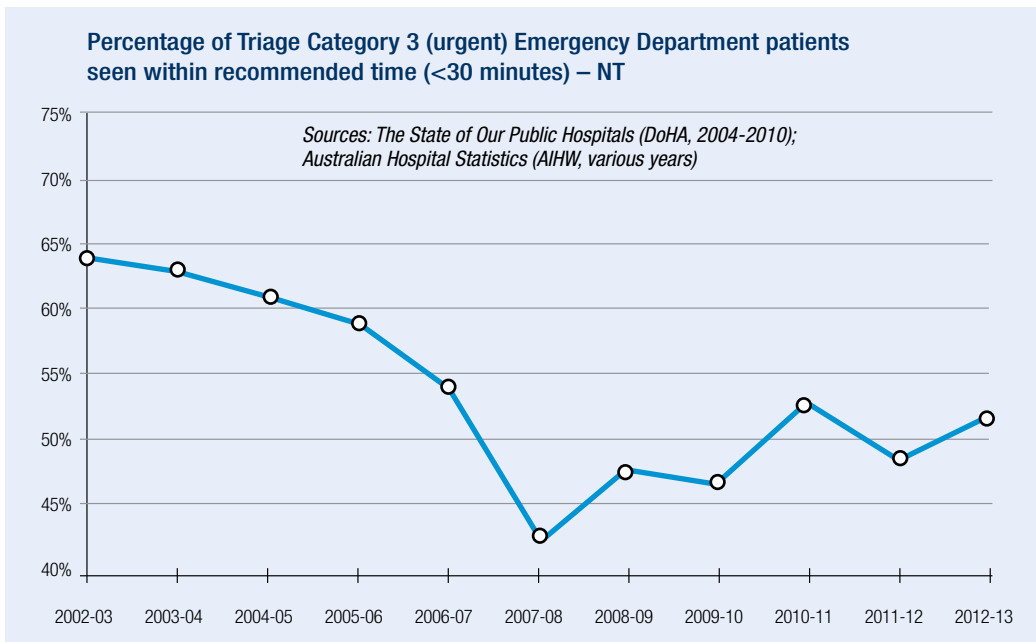
National Health Reform Funding: Australian Capital Territory



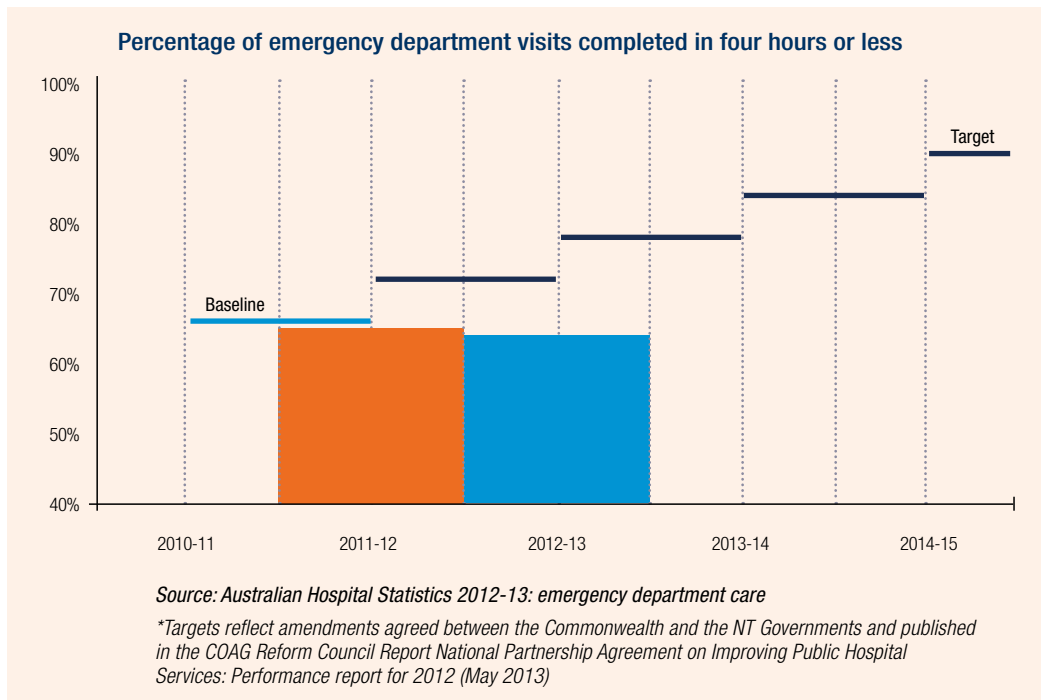
NORTHERN TERRITORY

Emergency Departments

Waiting times

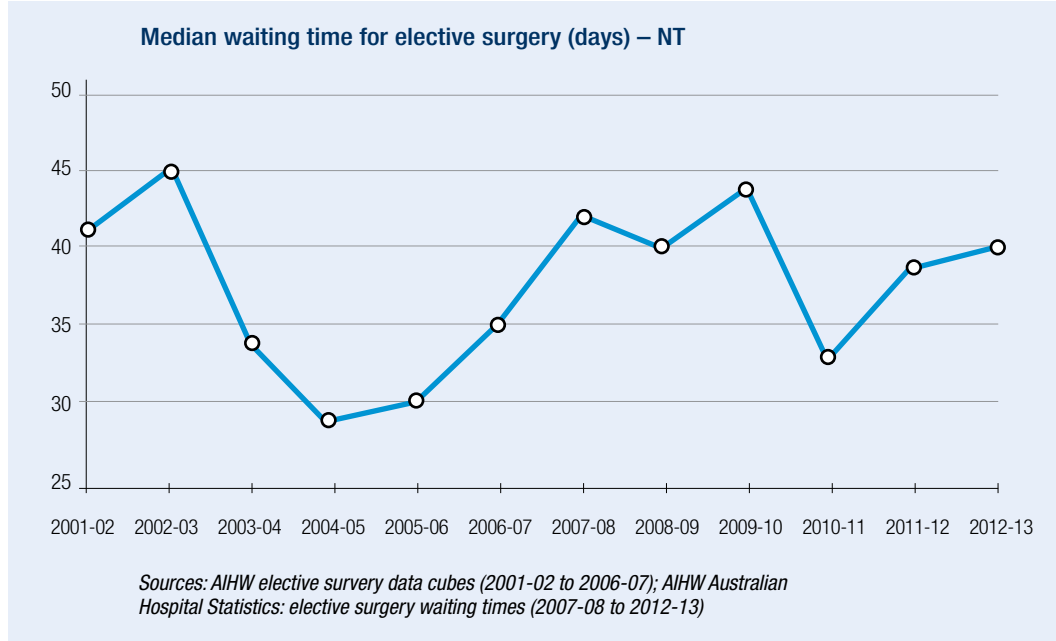


National Emergency Access Target (NEAT)*

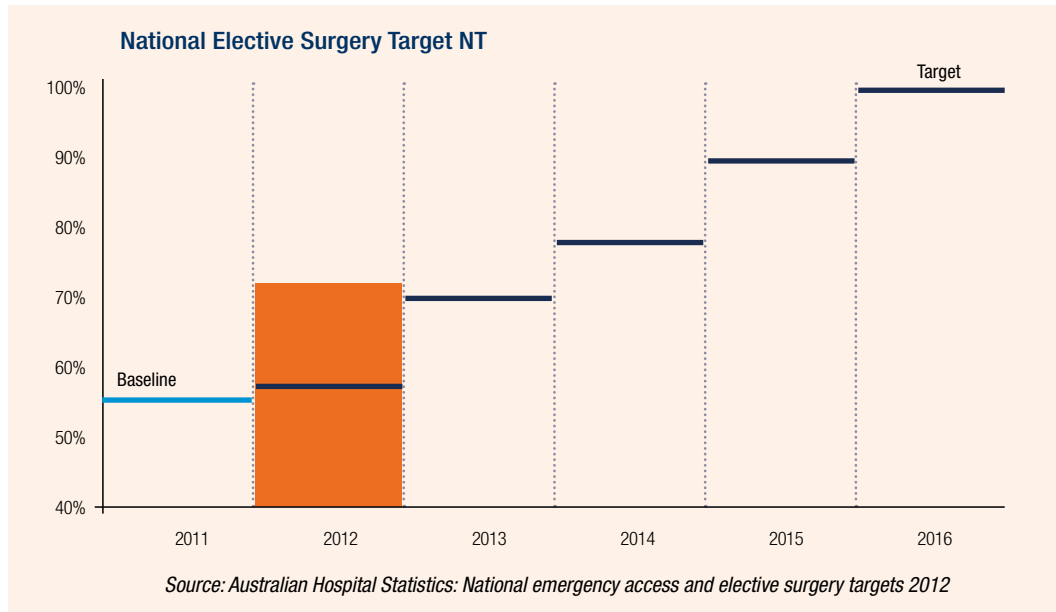


Elective Surgery

Waiting times

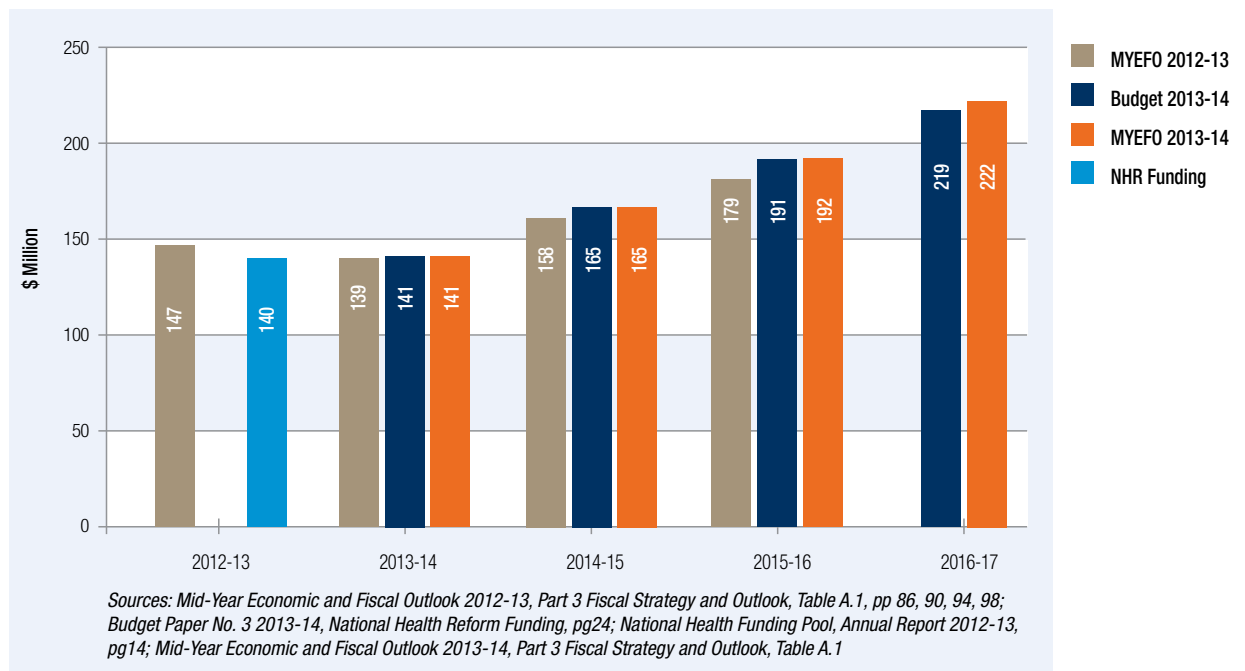


National Elective Surgery Target (NEST)



Commonwealth Funding

National Health Reform Funding: Northern Territory









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