Australian Medical Association Limited
ABN 37 008 426 793

42 Macquarie Street, Barton ACT 2600: PO Box 6090, Kingston ACT 2604
Telephone: (02) 6270 5400 Facsimile (02) 6270 5499
Website : http://www.ama.com.au/

Transcript: AMA President, Dr Omar Khorshid, Outlet: ABC Radio National *Life Matters*, Wednesday, 3 November 2021

Subject: Public Hospital performance, elective surgery backlogs, 'hidden waitlists'

HOST: Hilary Harper

HILARY HARPER: Dr Omar Khorshid is the National President of the AMA. He's also an orthopaedic surgeon. Omar, welcome back to *Life Matters*.

OMAR KHORSHID: Morning, Hilary.

HILARY HARPER: Let's have a look, first, at New South Wales. It's just restarted non-urgent elective surgeries at 75 per cent capacity. What is that going to mean for the system, Omar?

OMAR KHORSHID: Well, it's great news, I think, for those patients who are waiting on public hospital waiting lists. And also, of course, for private patients who've also had their surgery suspended for months, as New South Wales has really battled this COVID outbreak. We were very concerned a few weeks ago that, with the opening up, that the numbers of cases in New South Wales would spike, and that would really put enormous pressure on hospitals. But it's been really surprising to see the incredible effectiveness of the vaccines, and the fact that even with the limited opening up that's occurred, we haven't seen that pressure of COVID on the hospitals, meaning they are now able to get back to at least some of their business as usual. But of course, it's going to take many months and possibly longer for them to catch up with that unmet demand from three months of closures.

HILARY HARPER: And it sounds like there was unmet demand before that, too. But you mentioned the private system. Can you tell us about the differential impact on the public and private systems of the shutdowns on elective surgery?

OMAR KHORSHID: So there's actually been a very significant impact on both what New South Wales did, I think it was back in August, was to actually direct 20 of the large hospitals that did have ICUs and were similar to a public hospital in their design, to cease doing that non-elect- sorry, non-emergency or non-urgent elective surgery, and to be ready to respond to COVID demands. And I understand some of their staff were used, but at the end of the day, they had to stop doing what is their main business of private hospitals, which is that non-urgent elective surgery. And similarly, in the public system, where of course, the entire hospitals were focussed on battling COVID, there was just no capacity to do that non-urgent elective surgery. So in New South Wales, it's really just stopped for everybody, which I guess is equitable. It meant that private patients didn't get preferential access to elective surgery, but it means that the size of the impact on the community is really quite large, remembering that around - certainly my speciality of orthopaedics - around 65 per cent of elective surgery actually happened in the private sector. The number of people who have- will be added to those waiting lists is extraordinary. And of course, we're going to see as GPs get back to their normal work, as we saw last year following the short shutdown that we had in our first wave

of COVID, we're going to see demand for medical services really spike at a time when we don't have the workforce, we're still potentially battling moderate COVID outbreaks. And that's why we're really pointing the finger at the state of our hospital system, and particularly the public system, but also the private system and wanting to have a conversation about what we can do to better manage the system going forwards.

HILARY HARPER: Yeah, lots of hospitals have been talking about having staff shortages because people are on furlough. They might have had an exposure. They might have caught COVID. And I noticed, too, reports today that some hospitals- the report was about Queensland. I think there were eight per cent of hospital workers not vaccinated in the Central Queensland Health Service. Is- would that have an impact to- on bed numbers and wait times, if you get that backlog of people still waiting to get their vaccination?

OMAR KHORSHID: Absolutely. If we have a large number of healthcare workers who aren't allowed to work, that's of course just going to exacerbate the already very serious shortages that we have. At the end of the day, Australia has, for many, many years, been extremely reliant on overseas trained health care workers to bolster our system. Doctors, nurses, physios, everybody. Rural and urban, private and public. Our system is extremely reliant on overseas trained health professionals, and for the last couple of years, it's been really difficult to get into Australia, even with exemptions. It's just not an attractive place to come to when you know the borders are basically shut. And it is going to have a- that will also have a lasting impact on our health care system's ability to really flex up, now that we're coming out of the pandemic, but still facing all the rest of the health care demand that we know is out there.

HILARY HARPER: We're speaking with Dr Omar Khorshid, AMA national president, practising orthopaedic surgeon. And as you're hearing about the demand on the health care system, we'd like to hear from you too, about whether you've had elective surgery postponed or suspended indefinitely and whether you've managed to land back on that waiting list eventually, afterwards. Head to the ABC Radio National Facebook page and tell us what's what with your situation. Or, the text number, you can text me straight away, is 041 822 6576. Omar, there were some surgeons critical of the surgery shutdowns that we've seen, particularly in New South Wales and Victoria. They're saying that people with quite irksome conditions that were classified as non-urgent were having to take a backward step in order to treat the COVID patients that were coming through. What's the AMA's stance on that idea that that might not have been the best option?

OMAR KHORSHID: Look, it's really difficult to make these decisions. And we are in a way, a little bit split on this because we absolutely have seen the pressure on our public hospitals in particular. Those frontline healthcare workers have been under enormous strain. And as the pandemic peaked in both Sydney and Melbourne, it was really all hands on deck in order to try and give those frontline health care workers a bit of a break or when they get furloughed due to exposures. And you just have to flex to focusing on your sickest patients. That's at the core of our medical ethics. But at the same time, we have to remember that this so-called elective surgery is still critically important surgery for the lives of those people on the waiting list.

And if you're living with severe pain, like the people requiring joint replacements in my own specialty, that's Category 3 surgery. That's called non-urgent, and you can wait up to a year without breaching any of the targets that we set for elective surgery in the public sector.

That's living with severe pain that impacts your quality of life, your ability to do your daily activities, your ability to work or exercise. So it's not- just because it's elective, it doesn't mean that it doesn't need to be done and it isn't reasonably urgent and critically important for that person's life. So, it was very frustrating for many doctors who saw their, in particular, their private hospitals being a bit empty and not really being used that much for COVID, particularly in New South Wales, but also not being utilised for those patients who really needed that surgery. That's been very frustrating. And of course, many of our surgeons also only work in the private sector, so they're literally twiddling their thumbs while they wait for the pandemic to pass. And I think that's extremely frustrating. We've understood that feeling that they've been expressing.

HILARY HARPER: And the categorisation might be confusing for people too. As you said, urgent elective surgeries were still happening. Perhaps we could talk a bit about the difference between urgent and non-urgent in this classification system, and the different levels of urgency that you might see.

OMAR KHORSHID: Yeah, so the categorisation has actually been found wanting during the pandemic. A little bit like our whole health system has been found wanting, in that we had no spare capacity. Our categorisation system, which is 1, 2 and 3. 1 is generally that urgent surgery must be done within 30 days. That's cancer surgery, or surgery that, if it is delayed, may result in an emergency admission. So the really most urgent surgery that is generally life-saving or life-changing. But Category 2 surgery is still very serious conditions. That's a target of 90 days. And that's conditions like aneurysms, or the most extreme end of the spectrum of musculoskeletal complaints, areas where, if you delay the surgery, the patient's going to deteriorate and could actually face much more serious health consequences. Now, that is actually quite a large amount of patients, and what most of the Government's decided during the pandemic was to split Category 2 into urgent Category 2 and less urgent Category 2. But the line between the 2 was always a bit of a mystery for clinicians, and it still hasn't really been clearly defined. And then Category 3 surgery is the rest of the procedures. It's the bulk of my own specialty of orthopaedics. But it's still, as I mentioned before, conditions that really are affecting people's lives. And you really wonder whether it's reasonable in the first place that people should wait a year for a joint replacement, for instance. And that's something that I think, following the pandemic, we're going to be taking up in my own specialty because certainly, the impact on our patients, because the bulk of them are Category 3, was greater than the impact on the patients of other types of specialities due to these categorisation rules.

HILARY HARPER: Reading up about cataracts too, they're an interesting case, are they? Because if you delay cataract surgery, you can see an increase in falls. And some research out of the School of Ophthalmology in New South Wales found that if you cap the wait time at three months, you could save over 50,000 Falls in a three-year period and save millions of dollars too. Is that kind of flow-on effect born out in your experience, Omar?

OMAR KHORSHID: Well, I think it makes absolute sense, doesn't it? And cataracts, along with joint replacement surgery, are deemed non-urgent, because they're not conditions that generally threaten your life. And therefore, people wait long periods of time. But of course, while they are waiting, their health deteriorates. In the case of the cataracts, of course they may fall. In the case of joint replacements, people become less fit. They gain weight. They are unable to work, which can have a huge impact on their ability to survive, going onto welfare, et cetera. So, the impact of waiting is actually very substantial, and by having a health system

that was more responsive to the needs of the community, it actually will generate a positive economic outcome for Australia and improve the quality of life of our people. But of course, it requires investment and that's something that the AMA has been calling out for last few weeks, is the real lack of investment in the capacity, the size of, in particular, our public health system due to the design of our health system and design of the funding mechanisms. And it means that in every state and territory, we're now facing really serious hospital problems, despite the fact that we're a first world, rich country which is highly attractive for healthcare workers around the world to come to.

HILARY HARPER: One really interesting thing that comes up when you read the reporting around cataract surgeries, and also on our Facebook page at the moment, is people saying, in the private system, no problems. I can get through really quickly. But, you know, and if anyone lets their private health cover lapse, because of financial constraints, they wait ages in the public system. So is that one example where elective surgery really does impact different people differentially depending on whether they've got private health insurance?

OMAR KHORSHID: Absolutely. I mean, the AMA has been calling out for many years, through our public hospital report cards, the fact that people are languishing on surgical waiting list, and the performance, generally speaking, over the last few years, has been deteriorating gradually around most of the country and that's access to the surgery. And of course, that only includes patients who've actually already been put onto a waiting list. But there are many thousands of Australians waiting for an appointment in an outpatient clinic, in a public hospital, particularly in some specialities. And they can wait more than a year for their first appointment, in some cases, several years, before they have any chance of actually being even put on to a waiting list. So that so-called hidden waiting list really exacerbates the size of the problem. And we need to recognise that these people who are waiting, their health is deteriorating whilst they are waiting. And we really need to do better.

HILARY HARPER: Dr Omar Khorshid, the AMA has said that the system is in crisis at the moment. How do we know that? What data do we have available to us?

OMAR KHORSHID: Well, we know it through the- really, the frontline access to services. So, when a system is bursting at the seams, the patients are queuing at the entry point, at the front door. So in terms of emergency sur- emergency care, that is at their front door of the emergency department or in ambulances. And we've seen the ambulance ramping in most states and territories, and worse in my own state of Western Australia, where in August there was a record 6,000 hours of ambulance ramping in one month. That's 6,000 hours of patients sitting in the back of an ambulance without entering the hospital, despite them being sick enough that they thought they needed to call an ambulance. And I think that's- it's horrific to think that you might call an ambulance, drive to a hospital and just be left in the care of the paramedic in the back of the ambulance for hours while waiting to get into the front door.

Similarly, elective surgery is another door to the hospital, and we can see through the data of elective waiting times slipping, gradually that, again, patients are queuing there. And COVID is just going to make these trends that have been happening for many years so much worse, partly because the hospitals have to manage the COVID, but also the efficiency of hospitals as they're trying to continue doing health care in a COVID environment decreases. The PPE requirements, the processes, the testing, the disruption that COVID is causing to our hospitals means they're not going to perform the way they used to. They're not going to be an

elective surgery factory, because COVID disrupts their care. So we can see, looking forward, elective surgery waiting times are blowing out. And ED is really struggling to look after demand. And that's why we're calling for urgent investment in the hospital system to make it bigger, to make it focussed on performance, but also to invest in primary care, to do our absolute best to keep people out of hospital that don't need to be there. Because we know that if we can prevent a deterioration of chronic diseases, if we can better manage people in a, for instance, in an aged care facility, we can save them from needing to go to the hospital, which saves money and keeps that hospital bed available for somebody else who really needs it.

HILARY HARPER: Omar Khorshid, I mean, whenever we talk about hospital resourcing, it comes down to brass tacks. Do you have a figure that you would like to lay out there for resourcing for our hospitals nationally? Or is it more about the approach that governments take when they're looking at hospital funding?

OMAR KHORSHID: It is all about the approach. What we'd like to see is a change in the health care agreement that underpin the funding of the hospitals, that there is split funding between state and Commonwealth. And of course, the Commonwealth has most of the taxation ability. They've got the deep pockets. And the states actually run the systems, and it's created a blame game over many years that I've been in this game, 20 odd years of working and interacting in public hospitals. Wherever there are interfaces between the state government funded system and a federal government funded system, we get inefficiencies. And of course, the- it's easy to blame the operator of a hospital when it doesn't work, when in fact maybe the problem is the funding mechanism. So we'd like to see it designed differently. We have something called activity based funding, which has really driven hospitals to be efficient, but it hasn't provided an incentive to grow the capacity of hospitals.

And at the end of the day, the states pay more than half of the cost of running the hospital. So they don't really want to pay more, they haven't got the ability in many cases to pay more. And it means we haven't had that growth. So we'd like to see a change that allows growth, but also that rewards good performance. And as I mentioned before, a specific focus on the Commonwealth and what it can do in primary care to protect that hospital system. So yes, it does come down to money, but it's not just a dollar figure. It's about setting the system up to drive the behaviours of the individuals, behaviours of the managers, to really focus on improving the quality of our system and the capacity of our system. Because we know, with ageing population, with better survival rates from cancers, with the ongoing challenges of COVID, the demands on our hospitals are going to be bigger than we've ever seen before, and we've got to do what we can to prepare for that.

HILARY HARPER: Well, and the AMA's annual report card makes some very interesting reading when it comes down to not just elective surgery wait times, but capacity generally. How did the various states compare, Omar, in that analysis? Is anyone doing better or worse than anyone else?

OMAR KHORSHID: So each of the states have their challenges, and we haven't released this year's report card yet. But if we look over the years at the report cards, we've got states, for instance, like Tasmania, which have pretty openly had real struggles with their public hospitals. They don't perform well. The ACT also has a fairly poorly performing hospital sector when it comes to access, and that includes the primary care, where it's just a difficult place to access healthcare for people who are relying on the public system or on bulk billed

Medicare. But each state has its challenges, none of them are immune. My own state of Western Australia, as I said, has a pretty terrible ambulance ramping figures at the moment. Other figures, like four hour waits and so on.

They vary amongst the states, but the trends have been getting worse, and the trend that really worries us the most is around the country, the number of beds per head of population over the age of 65. So they're the people who actually need our public hospitals, people over the age of 65, that's been declining for 27 years in a row. Twenty-seven years of decline. And whilst some of that is okay, because we have improved health care, we've got much more efficient, we've got better treatments, it reaches a breaking point where you simply don't have the capacity. We can't manage the complexity of disease that people are presenting within the community anymore. And our system just has to be able to respond. And it's hard when you just haven't got the physical beds, the doctors or the nurses to look after those patients.

HILARY HARPER: Yeah, it would be a really interesting time to see whether the demands of COVID will change the political appetite around health funding. Dr Omar Khorshid, thanks so much for joining us on *Life Matters* today.

OMAR KHORSHID: No worries. It's been a pleasure, Hilary. Cheers.

HILARY HARPER: Dr Omar Khorshid, AMA president, practising orthopaedic surgeon. And you can read previous years' annual report cards on the AMA's website. They're a little bit of a depressing read, but it's good to have the facts, isn't it?

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CONTACT: 02 6270 5478 0427 209 753 media@ama.com.au

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