AMA

PUBLIC HOSPITAL REPORT CARD 2008

An AMA analysis of Australia's public hospital system

INTRODUCTION/CONTENTS

The Australian public hospital system is a crucial component of our health system in that it potentially underpins hospital care access for all Australians when needed. More than half the Australian population depends on the public hospital system, yet the hospitals have been given insufficient resources (funds, workforce, or infrastructure) to meet their needs.

The situation would be considerably worse were it not for the fact that nearly half of the Australian population do not exercise their right to use public hospitals. The significant rate of private health insurance uptake in Australia means that more than 50% of all elective surgery occurs in the private sector. The public and the private sectors are integral to a viable health system that serves Australians and their futures are inextricably linked.

The 2008 public hospital report card is issued as COAG ponders the next Australian Health Care Agreement. It is to be hoped this report card brings COAG's attention to the key issues which remain around funding and beds. It is a report card on the performance of the Commonwealth and the State and Territory Governments. Government policy that threatens to decrease the current private health insurance participation rate will create greater demand on the public hospital system. This must be kept in mind when reviewing this report card which reflects the occupancy and pressure on the hospitals working in the current public/private environment.

The lack of resources in the public hospital system threatens the quality and the safety of the system. It creates pressure on staff and reduces morale. Doctors have left the public hospital system because they feel compromised in their ability to deliver best care to patients. Where public hospital appointments were once held in esteem for their contribution of care to the community, the teaching and research involvement, and the quality of care, they are now not attracting and retaining doctors. Nurses similarly have suffered and left public hospitals as places of employment. The degradation of the public hospital system is not acceptable and cannot be justified given the responsibility of Commonwealth and State/Territory Governments in the delivery of health care and the comfortable condition of their budgets (boosted by resources boom revenues).

Annual publications on hospital activities and performance are released by both the Australian Institute of Health and Welfare and the Commonwealth Department of Health and Ageing. This AMA public hospital report card provides an independent analysis of relevant hospital issues, including:

- capacity
- performance
- access and equity
- productivity
- funding

These key issues best reflect hospital performance and are intended to be comparable over time and across States/Territories and on a national level.

The AMA has also identified areas where there is room for real action and improvement across all States and Territories.

An opportunity exists for governments to set appropriate goals and achieve real progress through the development of the next Australian Health Care Agreements. We must aim to achieve safe hospital occupancy at 85%. Core to this is an increase in public hospital beds estimated at 3750 beds across the country requiring an investment of an extra 3 billion dollars with appropriate indexation of the Australian Health Care Agreements at 8-9% per annum in order to sustain hospital function.

Much has been made of the "blame game". The AMA believes that adequate funding and acceptance of responsibility is what is required, regardless of which level of government is involved. This AMA public hospital report card aims to assist policymakers and the public with a relevant and useful contribution to the debate.

Dr Rosanna Capolingua
Federal President
Australian Medical Association

SUMMARY/RECOMMENDATIONS

The AMA calls on all levels of government to take immediate action to repair the public hospital system.

CAPACITY

CURRENT ISSUES Public hospital capacity has been slashed by 67% over the past 20 years. Cuts to hospital bed numbers have been too deep and the risk of systematic breakdown is high.

Many hospitals run at well over 85% safe occupancy levels and are pushed to 95% or more.

RECOMMENDATIONS The Australian public hospital system needs more beds. By State and Territory AMA calculations, some 3750 more beds are required. This must be underpinned with investment in workforce and infrastructure to address unmet needs.

PERFORMANCE

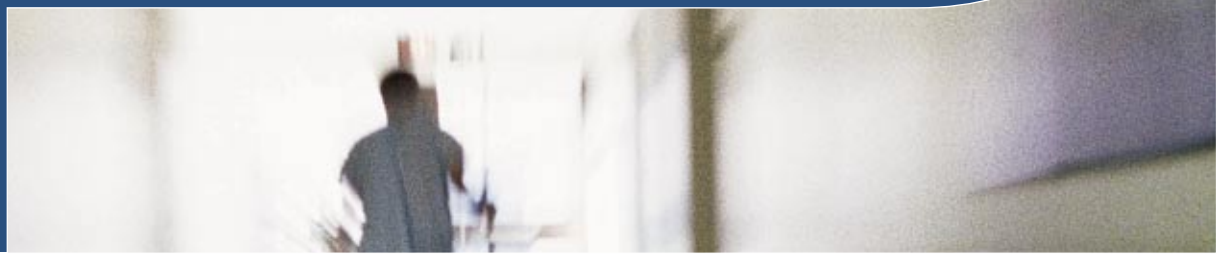
CURRENT ISSUES There has been no improvement in access for urgent emergency department patients. Only 65% are currently seen within recommended times. In many tertiary hospitals, these numbers are lower. The target should be 80% in the short term.

There is no compelling evidence that the decline in hospital performance is due to a rise in inappropriate patient presentations. Access block is occurring because insufficient resources have been made available to meet the genuine demand.

Lack of bed availability causes access block.

RECOMMENDATIONS All Australian governments should commit to more appropriate resourcing of public hospital emergency departments and an increase in public hospital bed numbers so that patients are seen within the recommended times in a high proportion of cases. A target of 80% is achievable in the short term and we should aim for 100% in the longer term.

The Australian Health Care Agreements must include a contract from all governments to measure and reduce the percentage of patients needing admission who are unable to get a bed within 8 hours.



ACCESS AND EQUITY

CURRENT ISSUES There has been some improvement in the proportion of Australians being admitted for elective surgery within medically recommended times. Overall 84% were admitted within recommended times in 2006-07 compared to 81% in 2005-06. For Category 2 (admission within 90 days) 75% are admitted within recommended times compared to 74% the previous year.

Long waits for access to care impair quality of life, reduce workforce productivity, and reduce the contributions that Australians, including older citizens, can make to the community.

RECOMMENDATIONS All Australian governments should commit to an objective that at least 90% of elective surgery patients are seen within recommended times.

To achieve this objective, governments need to address comprehensively the resource limitations that currently result in poor access to elective surgery.

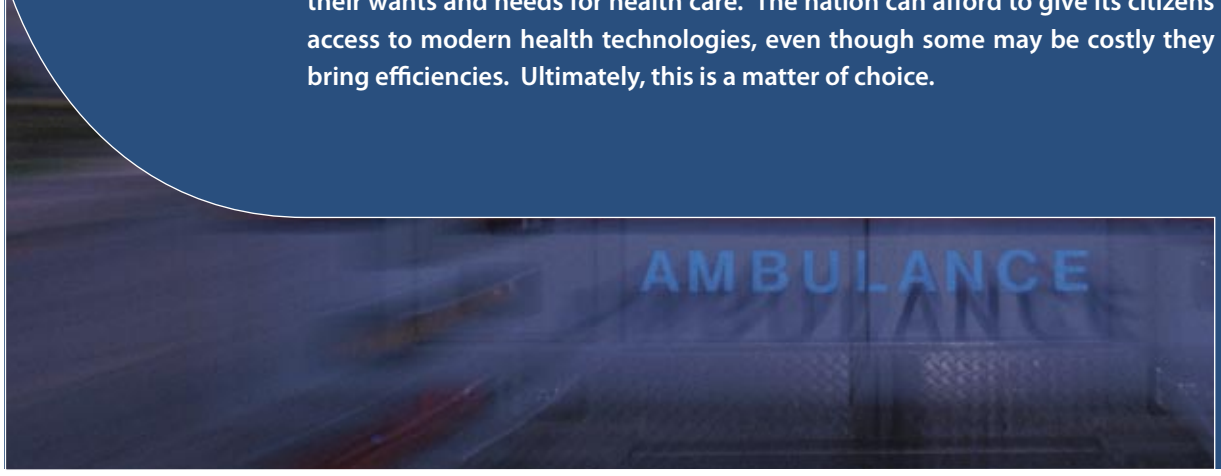
Such an objective should form one of the key performance benchmarks identified in the Australian Health Care Agreements.

PRODUCTIVITY

CURRENT ISSUES Over the past 20 years, the average length of stay in public hospitals has fallen overall (in large part, reflecting the rise of same-day separations due to advances in medical care and technology). In the past few years, this reduction has slowed significantly and in-hospital episodes are becoming more intense and costly.

RECOMMENDATIONS Governments need to understand it is not an option to continue to slash public hospital expenditure in the hope that services can continue at the same or higher levels and at the same or higher quality through productivity improvements.

Governments need to listen more carefully to what Australians are saying about their wants and needs for health care. The nation can afford to give its citizens access to modern health technologies, even though some may be costly they bring efficiencies. Ultimately, this is a matter of choice.



FUNDING

CURRENT ISSUES **This Government has promised an end to the blame game. The average contributions of governments to public hospitals since the 1980s has been close to 50% each but in recent years, the Commonwealth government effort has reduced with the Commonwealth share falling to under 40% on the most recent estimate.**

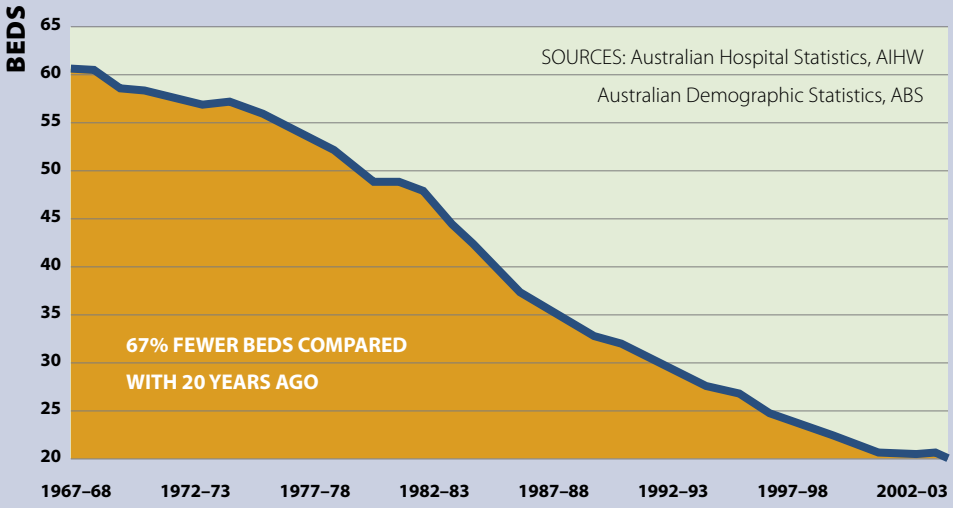
RECOMMENDATIONS **Commonwealth and State/Territory Governments need to remodel the AHCA arrangements so that joint responsibilities are clear and beyond dispute. The Commonwealth Government needs to pull its weight with funding contributions that are more appropriate to the needs of the people.**

An initial injection of $3 billion with no offsetting reductions in state funding goes close to re-establishing the 50-50 contribution coupled with more realistic indexation to keep pace with population growth, ageing and cost increases.

1. CAPACITY

Hospital capacity is measured by relating the number of available beds to the size of the population. The capacity of Australia's public hospitals has been slashed by 67% over the past 20 years (graph 1.1).

We have an increase in longevity and an increasing aged population in Australia. Older people have more hospital episodes with longer admissions than younger people.. The population aged 65 and over is a useful proxy measure for the hospital-using population. Graph 1.1 measures hospital capacity as the number of approved public hospital beds per thousand of population aged 65 years and over.



Graph 1.1: Available public hospital beds

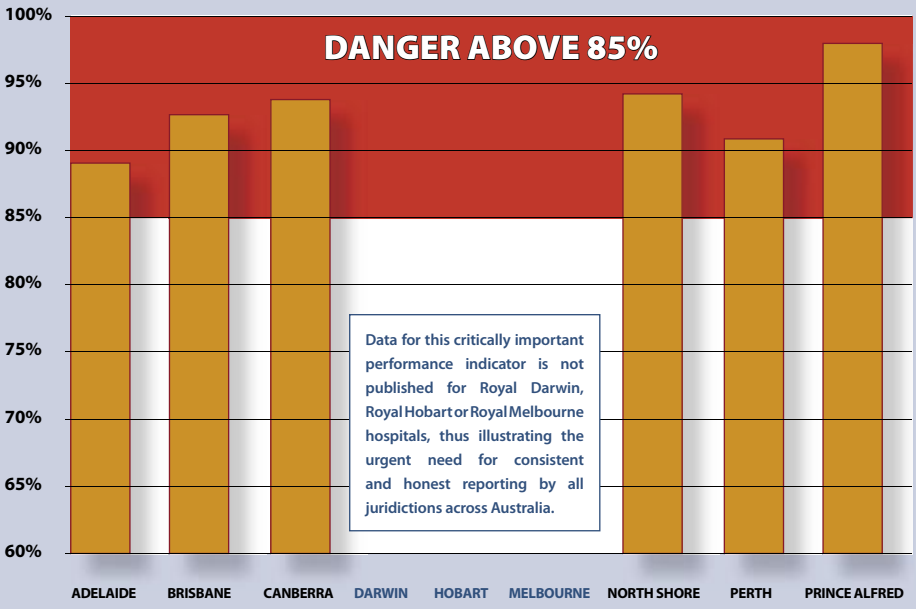
WHY IS THIS IMPORTANT?

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

However, the cuts in bed numbers have been too deep. While advances in health technology may continue to generate efficiency gains, there will be an offsetting increase in needs reflecting the complexity of caring for an older population. Governments cannot keep cutting public hospital capacity without further adversely impacting on, and reducing access to, hospital care.

The shortage of beds manifests itself in a dangerously high bed occupancy rate. The Australasian College for Emergency Medicine has shown that an occupancy rate of more than 85% (on average over the year) risks systematic breakdowns, extended periods of 'code red', and puts patient safety at risk of higher mortality and disability rates. In fact, hospital overcrowding has been described as the most serious reversible cause of reduced patient safety in our hospitals.

Teaching hospitals commonly operate on a bed occupancy rate of 95% (graph 1.2). Some jurisdictions set a target bed occupancy rate of over 90%. These rates are too high. They risk systemic failure and compromise patient safety. The 85% rule should apply in every hospital.



Graph 1.2: Bed occupancy rate, the Royal hospitals

WHAT NEEDS TO BE DONE?

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

Workforce shortages continue to bedevil the public hospital system. Overseas trained doctors have helped avert even greater problems. However, Australia is just one of many countries to have failed to train enough health professionals for the needs of their population. Worldwide competition for health professionals is increasing.

Australia has invested in increasing the number of medical student places and we look forward to doubling the number of medical graduates by 2012. In the intervening years we have increased medical graduate output. Interns, prevocational doctors and doctors in specialty training are the back-bone of patient care and service delivery in our public hospitals. Commonwealth and State and Territory Governments have the opportunity and responsibility to provide positions for this growing number of doctors who are desperately needed in our public hospital sector. The Commonwealth Government should use the Health Care Agreements to require States and Territories to report on key workforce performance indicators such as increased Intern positions and increased specialty training places in public hospitals.

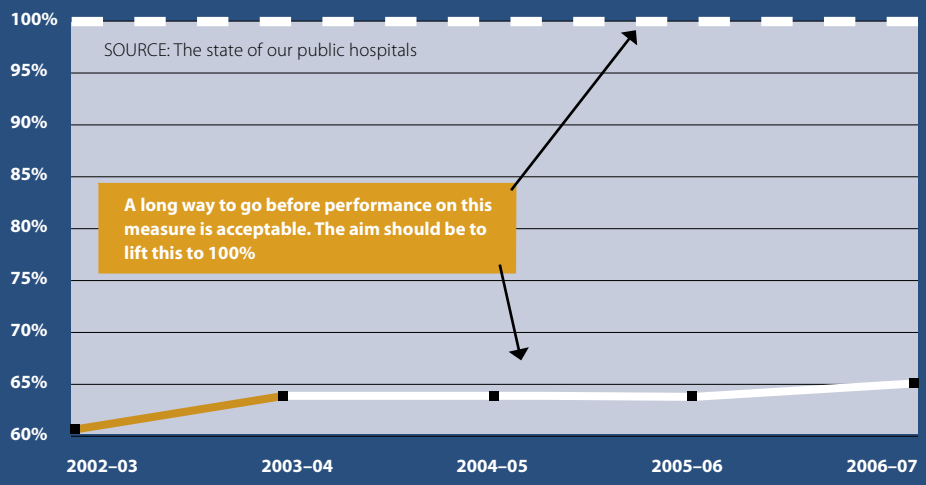
At the same time, public hospital infrastructure has been allowed to decay in many areas. Equipment, facilities and environment need updating, modernising and brought up to standard. Health infrastructure underpins safety and efficiency and is essential to produce the quality outcomes and meet the expectations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

The Australian public hospital system needs more beds. By State and Territory AMA calculations, some 3750 more beds are required. This must be underpinned with investment in workforce and infrastructure to address unmet needs.

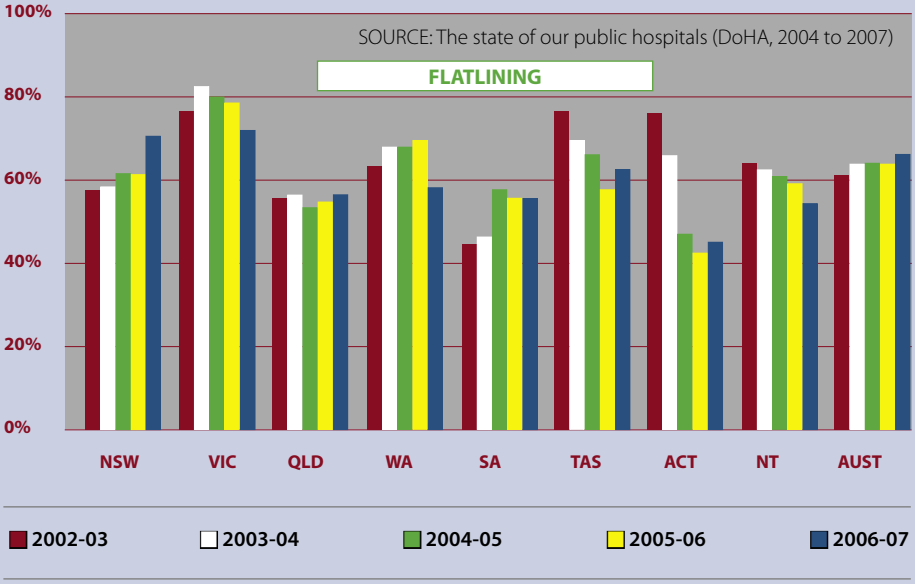
2. PERFORMANCE

The hospital system's ability to cope with emergency and urgent cases is a critical measure of performance and any decline in recommended emergency admission rates is unacceptable.

Despite minor recent improvement, less than two-thirds of emergency department patients classified as urgent are currently seen within the recommended 30 minutes. (graphs 2.1 and 2.2).



Graph 2.1: Urgent ED patients seen within recommended time, national



Graph 2.2: Urgent ED patients seen within recommended time, State/Territory

In September 2008, the Road Trauma and Emergency Medicine Unit at the Australian National University carried out an Access Block Prevalence Survey on behalf of the Australasian College for Emergency Medicine. The Unit surveyed 83 Australian public hospitals in all States and Territories. Similar surveys were carried out in 2004 and 2007.

Of the 2,226 patients being treated in Emergency Departments at the time of the survey, 897 (40%) were awaiting admission to a ward. 690 patients had been waiting for more than 8 hours. Access block is defined and measured by patients waiting more than 8 hours. This represents 31% of all patients being treated and 77% of all patients waiting for admission to a ward. In commenting on the data the survey leader noted that:

"This survey has documented continued dysfunction in Australian EDs. In terms of ED staff workload, around 40% represents provision of care to patients who have been unable to access appropriate inpatient beds, depleting the ability of ED staff to provide for their core business. In terms of physical space there is inadequate surge capacity for a multi-casualty incident."

WHY IS THIS IMPORTANT?

Due to the peaks and troughs in the demand for health care, everyone realizes that it is not possible for public hospitals to achieve short waiting times 24 hours a day, 365 days a year. There will always be busy times. That said, hospital performance indicators are falling too far short of what is a minimal standard on too many occasions.

Triage categories 1 (resuscitation, patient needs to be seen immediately), 2 (emergency, patient needs to be seen within 10 minutes), and 3 (urgent) together represent 41% of emergency department presentations.

The proportion of these highest triage category presentations — that is, patients who have the highest need to be there — has changed little in the past few years. There is no compelling evidence that the decline in hospital performance is due to a rise in inappropriate patient presentations. Data from the College of Emergency Physicians show that some 10–20% of ED presentations are cases that can be dealt with in General Practice, and these presentations consume only 1–3% of Emergency Department resources. Public hospitals have well developed protocols to divert patients to GP services when that is appropriate.

Access block is occurring because insufficient resources have been made available to meet genuine demand. Inability for patients to be admitted to hospital beds means that they continue to reside in Emergency Departments occupying beds and resources. This puts pressure on Emergency Departments being able to deal with new urgent presentations. An increase in hospital beds allowing for timely admission is essential.

WHAT NEEDS TO BE DONE?

All Australian governments must commit to better resourcing of public hospital emergency departments and an increase in inpatient beds so that patients are seen within the recommended times in a higher proportion of cases. A target of 80% is achievable in the short term (up from 70%) and 100% should be the objective in the medium term.

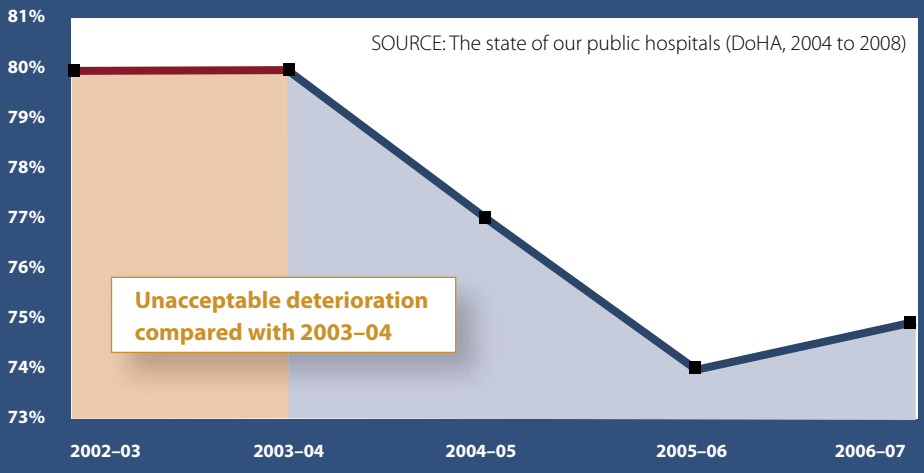
The Government cost and blame-shifting culture must change by governments both Commonwealth and State and Territory, accepting responsibility for public hospital health services for their constituents and providing appropriate funding. Governments need to commit to acceptable targets in contractual form (in the Australian Health Care Agreements) to measure and reduce the percentage of patients needing admission who are unable to get a bed within eight hours. Australian governments have to be jointly and individually accountable for outcomes against this critical measure of public hospital performance.

3. ACCESS AND EQUITY

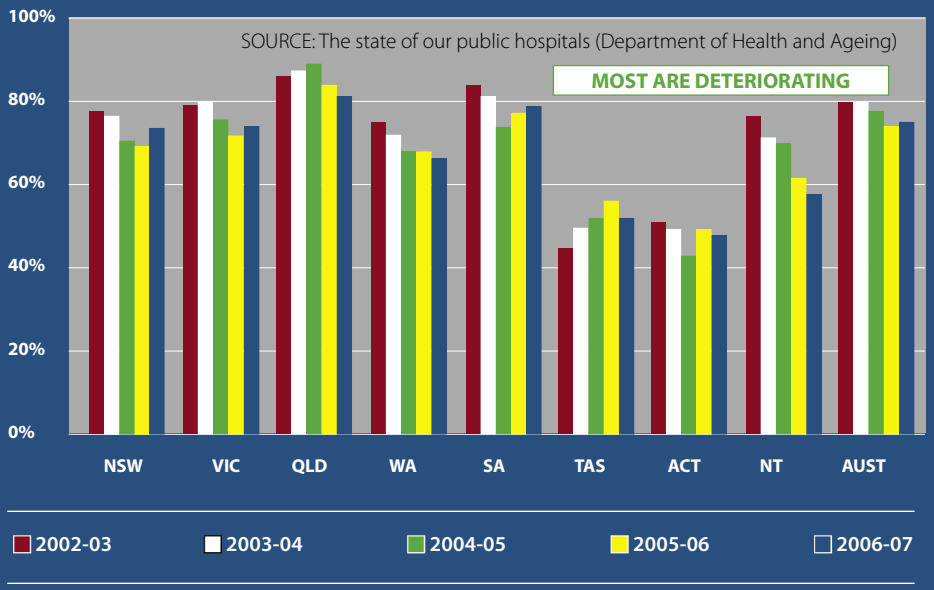
Elective surgery is not about non-essential or cosmetic procedures. It is any form of surgery considered medically necessary but which can be delayed for at least 24 hours.

Governments have dropped the ball on elective surgery evidenced by long waiting lists and treatment provided outside of medically recommended times. They are now scrambling to rectify the situation..

In the past few years, there has been a marked deterioration in access for category 2 elective surgery patients — for whom admission within 90 days is desirable for a condition causing some pain, dysfunction or disability but is unlikely to deteriorate quickly or become an emergency (graphs 3.1 and 3.2). Category 2 patients represent more than one-third of elective surgery admissions nationally.



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



Graph 3.2: Elective patients (category 2) seen within recommended time, State/ Territory

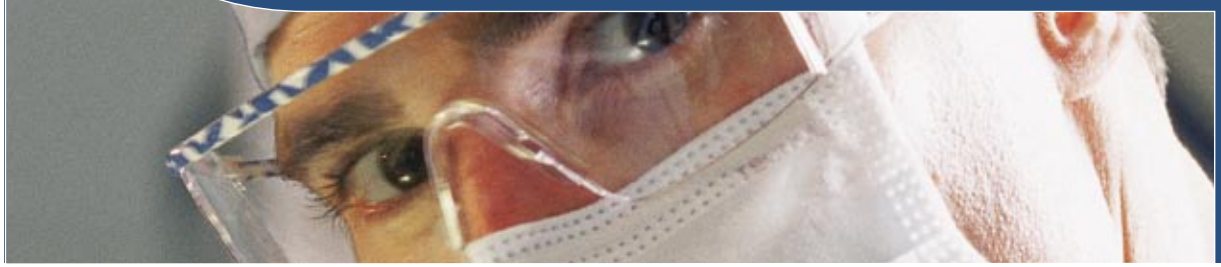
WHY IS THIS IMPORTANT?

When public patients are obliged to wait — for years in some cases — for an indicated procedure, it is no longer possible for governments to claim that access to health care is equitable.

Long waits for access to care results in impairment of quality of life, reduced workforce productivity, and a reduction in the contributions that Australians can make to the community.

WHAT CAN BE DONE?

All Australian governments should agree on and commit to an objective that at least 90% of elective surgery patients are seen within recommended times (up from 84.1%).



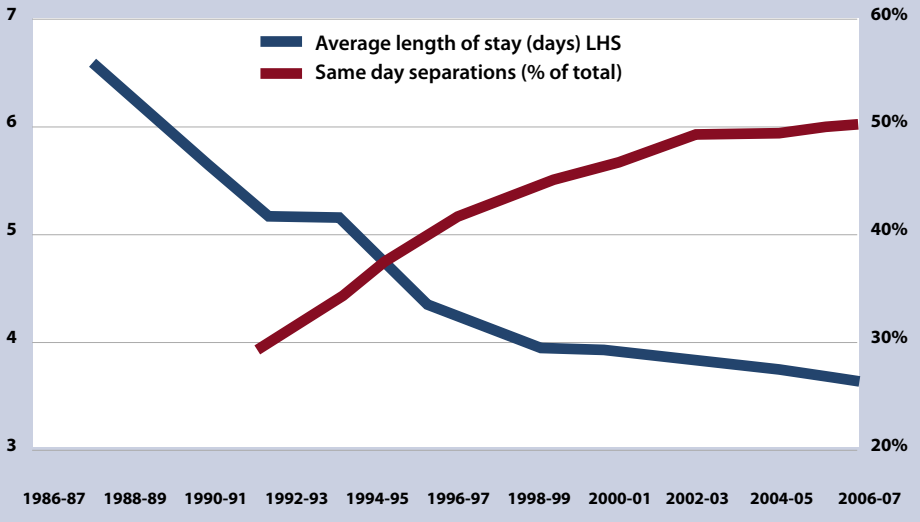
To achieve this objective, governments need to address comprehensively the resource limitations which currently result in poor access to elective surgery — available beds, workforce shortages, funding shortfalls and poor organisation.

4. PRODUCTIVITY

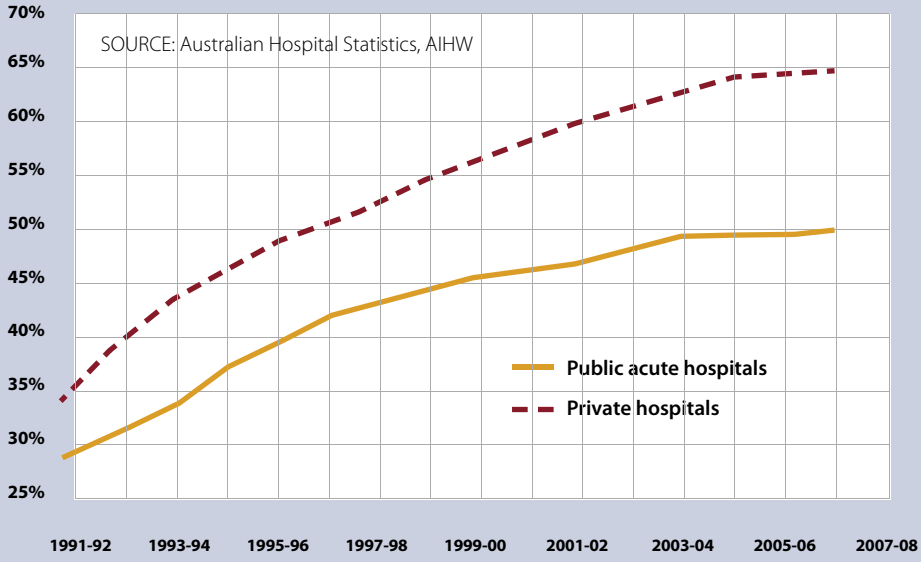
Average length of patient stay and the proportion of same-day separations provide an indication of hospital system productivity. Advances in medical care and technology have progressively lifted the proportion of separations that are same day. Average length of stay has also been reduced for separations that are not same day.

Over the past 20 years, the average length of stay in public hospitals has fallen overall (in large part, reflecting the rise of same-day separations). In the past few years, this reduction has slowed significantly (graph 4.1).

While the proportion of same-day services has grown to 50% of public hospital separations, this growth has been much slower than in the private sector (graph 4.2).



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

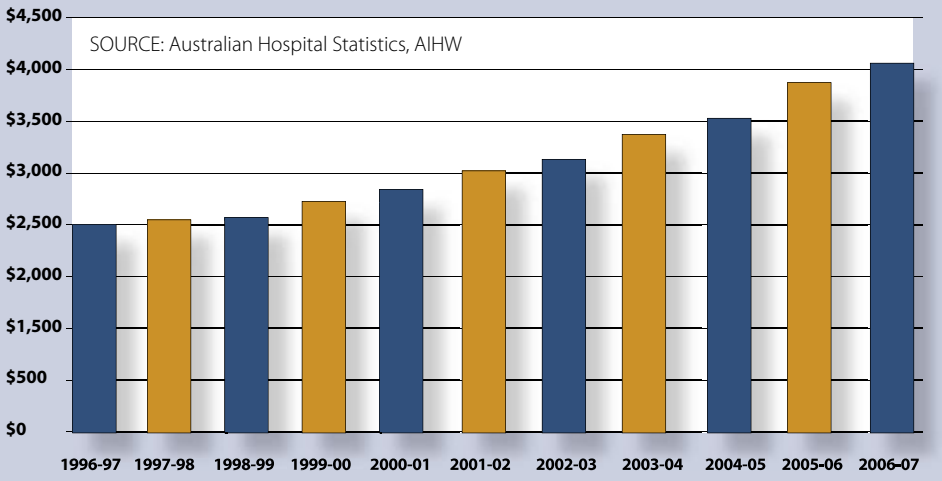


Graph 4.2: Same-day separations, public and private sectors

WHY IS THIS IMPORTANT?

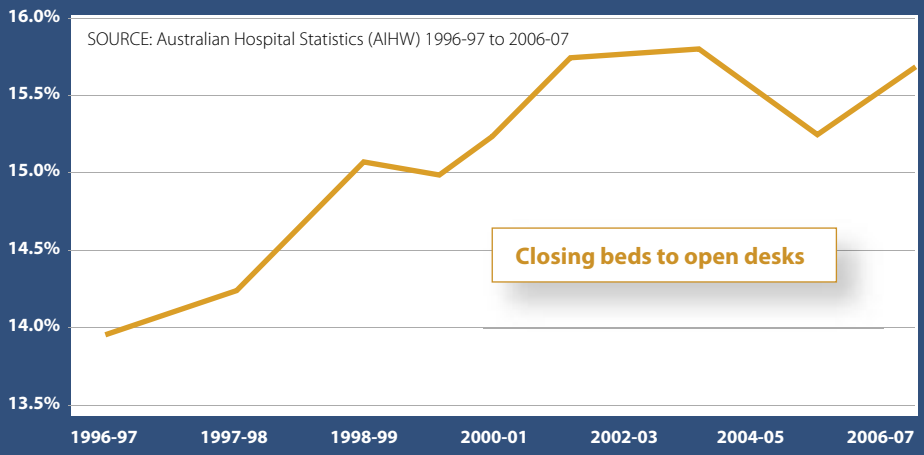
It is imperative that governments at all levels understand that the average length of stay is falling much more slowly than in previous years and that, given the inexorable growth in chronic illness, in-hospital episodes are becoming more intense and costly (see graph 4.3).

As a result, it is not an option to continue slashing the capacity of the system and yet expect to deliver the same quality of care.



Graph 4.3: Cost per casemix-adjusted separation

In a world of scarce dollars, we need to make sure that money is not wasted needlessly on bureaucracy but is directed to care of patients. The public hospitals employ 250,000 people. Had the administrative and clerical staff been maintained at 14% of the public hospital workforce, there would be 4,000 fewer jobs of that nature and scope to employ an additional 4,000 health workers. We acknowledge that most expenditure on administrative staff is necessary particularly those administrative resources used to support clinical activity, but we need to measure it to avoid the syndrome of closing beds to open desks.



Graph 4.3: Index of bureaucracy

WHAT NEEDS TO BE DONE?

Governments often seek to restrain the growth in costs by delaying access to new health technologies through mechanisms such as the Pharmaceutical Benefits Advisory Committee (PBAC) and the Medical Services Advisory Committee (MSAC). Positon Emission Tomography (PET) is an example. This is a counterproductive strategy. It stymies the productivity gains which have allowed the public hospital system to deliver more for less year after year after year.

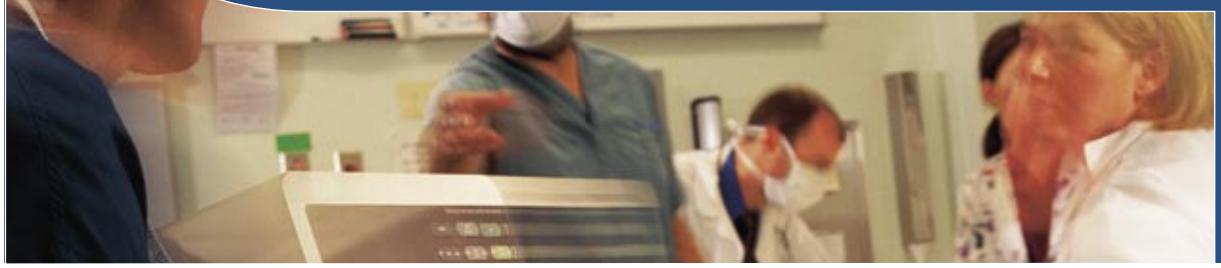
The nation can afford to give its citizens access to modern health technologies. Initial cost outlays often return efficiencies and better clinical outcomes. Ultimately, this is a matter of responsible choice. Communities have a range of wants and needs, of which health care is one. Governments need to listen more carefully to what Australians are saying about their wants and needs for health care.

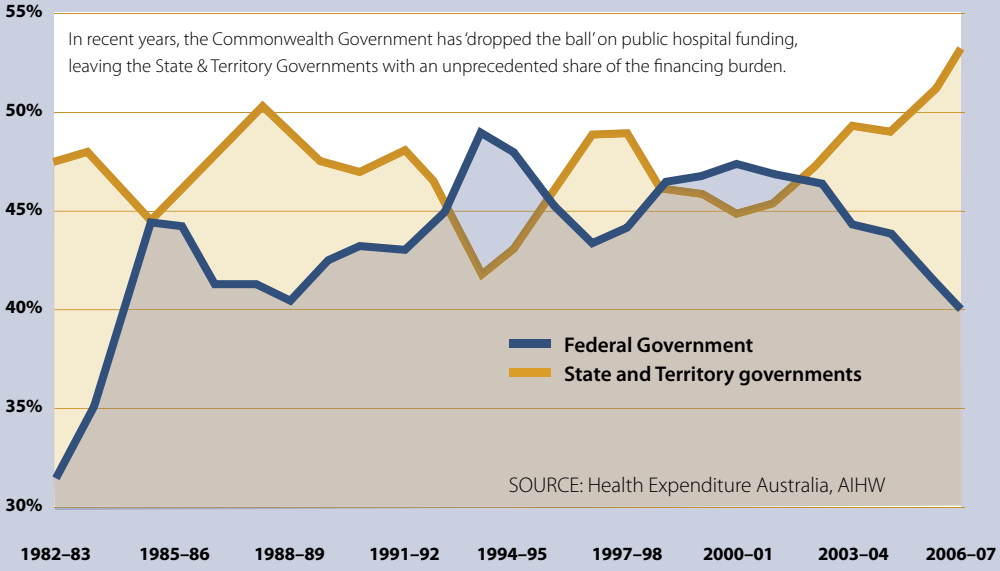
5. FUNDING

The new Federal Government put an extra $717 million into public hospitals in 2007-08 and $228 million in 2008-09. These have been welcome contributions but do not match actual need. In addition it has promised further funding towards elective surgery and $10 billion towards a Health and Hospitals Fund. Recent announcements that $5 billion from this fund is to be rolled out quickly, has the potential to fund emergency department upgrades which is vital in light of under investment in capital in many public hospital emergency departments. This initiative will not relieve access block if there is not an increase in recurrent funding for inpatient beds unless the intent is to turn Emergency Departments into sub acute holding hospitals while patients have short stay or await beds. This would require additional and specific medical staffing to ensure patient safety. The purposes to which this capital funding is used should be co-operatively developed between the two levels of government and not imposed by the Commonwealth.

The Federal Government needs to lift its level of funding significantly in the base year (2009-10). The average contribution of the Commonwealth and State/Territory Governments has historically been close to 50% each (graph 5.1). However, in recent times this has been allowed to erode and the Commonwealth contribution is currently only 39.9%. This means an extra $3 billion in Federal funding is necessary in the first year of the new agreement, with no offsetting reductions in State funding, to re-establish the 50-50 contribution and more realistic indexation to keep pace with population growth, ageing and cost increases.

Government policies which have a negative impact on private health insurance participation in this country will increase need and demand in the public hospital system. There will need to be increased funding to compensate for any fall in private health insurance participation.





Graph 5.1: Government shares in public hospital spending

WHY IS THIS IMPORTANT?

Electors expect governments to work together to ensure that public hospitals are properly resourced. It is a joint responsibility. The shares of spending count for nought if the total resourcing is insufficient. The Commonwealth and State/Territory Governments also share the responsibility equally when they fail to sustain the public hospital system. The 'blame game' is a failed strategy and a diversion from responsibility and accountability.

WHAT NEEDS TO BE DONE?

The Federal and State/Territory Governments need to bite the bullet and work together — without reserve — to make the public hospital system more responsive to the needs of the population. The funding arrangements need to be remodeled so that joint and individual responsibilities are clear and beyond dispute. There needs to be full accountability by both levels of government.

There must be a clause introduced in the Australian Health Care Agreements that provides for an increased Commonwealth contribution to public hospital funding in direct response to increases in demand due to private health insurance participation falls.

6. STATE BY STATE COMPARISON – PLENTY OF ROOM FOR IMPROVEMENT!

OPENING COMMENTS

In previous years, the Federal Government's State of the Public Hospitals Report has included a brief fact sheet on the performance of each State and Territory public hospital system. This year, this practice has been discontinued and it has been necessary to assemble State specific material from various alternative sources to make comparisons. It is disappointing that the Federal Government has failed to provide this information given its and COAG's commitment to the development and publication of performance benchmark material.

A commitment to open disclosure of performance indicators starts at home and it is regrettable that the publication of these fact sheets has been discontinued. The public has to be able to rely on any performance information published in respect of public hospitals. If critical funding decisions are associated with performance, reliability is all the more essential. According to a report prepared by Ken Baxter of TFG International, public hospital data was "inconsistent, patchy and not readily comparable on a state by state basis" and that some performance figures "are not worth the paper they were written on". The list compiled below is based on the only publicly available data. The AMA advises that this must be taken into consideration when placing reliance on these State comparisons.

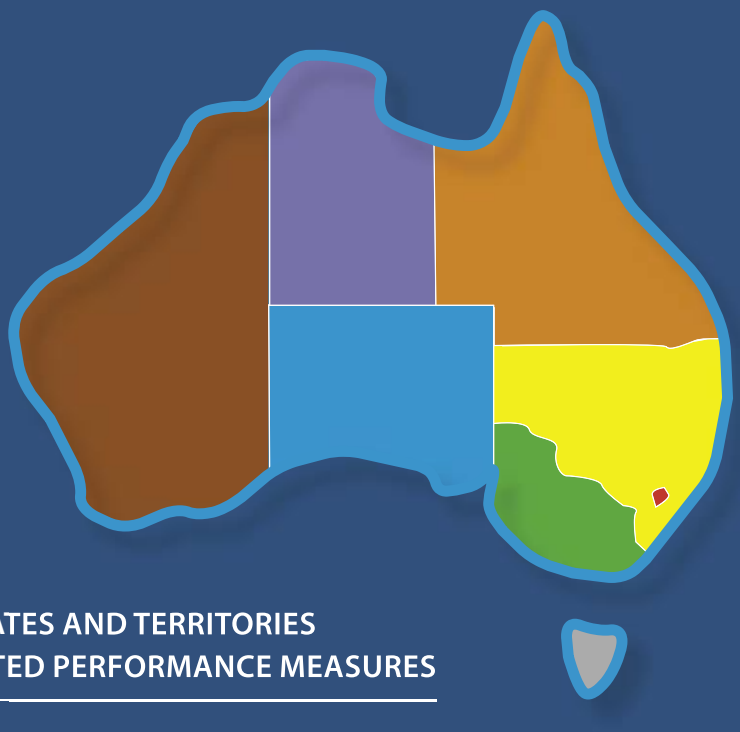
The Government has announced its intention to rationalise Specific Purpose Payments to the States from 90 programs at present down to 6 with possibly only one SPP in relation to healthcare. It has also indicated that the new national agreements will be ongoing rather than fixed term agreements. Given that it is envisaged that the new health care agreement will have an ongoing life instead of a 5 year term, and that it is to be broad-banded with other health programs, establishing a correct base and appropriate indexation is mission critical. Nothing else will work if the initial base is incorrect.

It is worth reflecting on the projected use of performance data in future funding arrangements when problems with the data are evident. The AMA has concerns with the utilization of performance indicators and bench marking if they might generate perverse incentives in public hospital service delivery. The risk is that benchmarks are achieved at the cost of patient care. (eg performance payments based on reduced hospital readmission rates within 28 days of discharge drive hospitals not to readmit patients. This will be a particular problem for the elderly and those in greatest need.)

The AMA has ranked the States and Territories in terms of their performance against seven indicators. While a higher ranking (1st) indicates a better performance than a lower one (8th say), the higher ranking does not indicate satisfactory performance. No State or Territory meets the desirable standards for elective surgery admissions of Emergency Department treatments although clearly some are better than others. The State with the highest public beds per 100,000 weighted population still does not have sufficient beds to provide a safe level of bed occupancy, 85%.

Only those States and Territories which have 100% of public hospital beds accredited (Vic, WA, ACT, NT) have satisfactorily met the accreditation indicator in our view.

Public hospital expenditure per person could reflect inefficiency rather than commitment to the public hospital sector. Public hospital admissions need to be considered in the context of total State and Territory hospital performance. These indicators need to be treated with caution but we include them as we evolve to more discerning indicators.



RANKING OF STATES AND TERRITORIES AGAINST SELECTED PERFORMANCE MEASURES

STATES & TERRITORIES	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Public beds per 1000 weighted population	2	8	5	2	4	5	1	5
Percentage of public hospital beds accredited	7	1	6	5	1	8	1	1
Recurrent public hospital expenditure per person	3	5	8	6	4	7	1	2
Public hospital admissions per 1000 weighted population	7	3	6	5	4	8	1	2
Percentage of elective surgery admissions seen within recommended time	1	2	3	4	5	7	6	7
Category 2 elective surgery admissions seen within recommended time	4	3	1	2	5	7	6	8
ED patients seen within recommended time	1	2	6	5	3	3	7	8

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