4. Ensuring timely access and safe care in hospitals

Key messages
• By international standards, Australia's public and private hospitals provide high quality care for most people most of the time.
• Our hospitals perform many vital roles. They are an essential part of the 'care continuum' of services. They are one of the major settings for continuing education of the present and future generations of health care professionals. They undertake world-class research that is used to provide better health care treatment and improve outcomes for people.
• We also know that our hospitals are under severe pressure, directly influencing their ability to provide safe, high quality, accessible and timely care to all patients. – Waiting times for planned or 'elective' surgery (such as hip replacements) and critical medical care (such as radiotherapy) are too long for many people who rely on public hospitals. – Public hospital emergency departments are often over-crowded (potentially compromising safety with adverse outcomes including preventable deaths) and 30 per cent of people visiting an emergency department are not seen within what is regarded as clinically safe times. – A significant minority of patients experience problems with the quality or safety of the care provided by public and private hospitals.
• Improvements in other parts of the care continuum of the health system (strengthening primary health care, expanding community-based mental health services, creating a network of sub-acute services and providing better choices and access for older people needing aged care services) are all vital to providing the right care in the right time and the right place for people and simultaneously reducing some of the pressure on hospitals.
• Our hospitals are a precious resource but not unlimited and we should ensure that they are used wisely.
• Looking to the future, there are opportunities to reshape the role of hospitals and improve the delivery of care for people and their families. We lack a systemic approach to embedding innovation and best practice more rapidly in every Australian hospital.
• There is also scope to improve the way in which we integrate and get best use of our mixed system of public and private hospitals.

Our reform directions

4.1 We propose development and adoption of National Access Guarantees for planned procedures and National Access Targets for emergency care; for example:

- a national access target for people requiring an acute mental health intervention (measured in hours);
- a national access guarantee for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and
- a national access guarantee for patients requiring other planned surgery or procedures (measured in months).

These National Access Guarantees should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries.

Under the National Access Targets for emergency access, all hospital emergency departments should meet the triage access targets specified in *Beyond the Blame Game*, as well as additional measures of performance in promptly admitting people from emergency departments where they need it. These National Access Targets operate at the level of individual hospitals.

4.2 A share of the funding potentially available to public hospitals should be linked to meeting (or improving performance towards) the access guarantees and targets, payable as a bonus.

4.3 We propose there be financial incentives to reward good performance in outcomes and timeliness of care. One element of this should be for timely provision of discharge information including details of any follow-up care required.

4.4 We support the use of activity-based funding for both public and private hospitals using casemix classifications (including the cost of capital):

- This approach should be used for inpatient and outpatient treatment.
- Emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding.
- The costs to hospitals with a major emergency load of having to maintain capacity to admit people promptly should be recognised in the funding arrangements.

4.5 We propose that all hospitals review provision of ambulatory services (outpatients) to ensure they are designed around patients needs and, where possible, located in community settings.

4.6 To improve quality, data on quality and safety should be collated, compared and provided back to hospitals, clinical units and clinicians in a timely fashion to expedite quality and quality improvement cycles. Hospitals should also be required to report on their strategies to improve safety and quality of care and actions taken in response to identified safety issues.

4.7 To improve accountability, we propose that public and private hospitals be required to report publicly on performance against a national set of indicators which measure access, efficiency and quality of care provided.

4.8 We propose that public and private hospital episode data is collected nationally using a patient's Medicare card number, to understand better people's use of health services and outcomes across different care settings.

4.9 We suggest that the future planning of hospitals should encourage greater delineation of hospital roles including separation of planned and emergency treatment, and optimise the provision and use of public and private hospital services.

4.10 We propose a nationally led, systemic approach to encouraging, supporting and harnessing clinical leadership within hospitals and broader health settings and across professional disciplines.

For the purpose of this interim report, we focus particularly on those issues with regard to hospital care that have gained most public attention, in particular timely access to care and safety. We also discuss aspects of the wider health system that affect use of hospitals and hospital performance, many of which are dealt with in more detail in other chapters. We will develop these themes more fully in our final report.

4.1 Defining and scoping hospital care

Hospitals provide the most complex and costly care to the sickest people in our community. They are also where most babies are born, and where many people die. They are the source of emergency care when people are suddenly and/or severely ill, and when no other care is available it is often to hospitals that people turn.

It is crucial that we make the best and most efficient use of these vital and expensive services.

Approximately 40 per cent of all health expenditure in Australia in 2006–07, or about $34 billion, was on hospital care. Hospital services represent about 3.5 per cent of Australia's gross domestic product (GDP) and expenditure on hospitals is projected to be the fastest growing element of health expenditure over the next two and a half decades.[1]

In 2006–07 Australia had 1282 public acute and private hospitals – 739 public acute hospitals, and 543 private hospitals. These hospitals range from small country and 'bush nursing' hospitals through to major metropolitan referral hospitals and specialist women's and children's hospitals. Half (265) of the private hospitals were free-standing day hospitals. In 2006–07 there were 53,565 beds in public acute hospitals, and a further 26,758 in private hospitals including 1992 in the private free-standing day hospitals. Over the last ten years the number of patient days in public acute hospitals increased by 10.2 per cent while, in private hospitals, patient days increased by 24.9 per cent.[2]

In 2006–07 public and private hospitals provided 7.6 million episodes of care for people admitted to hospital, 39.9 million outpatient occasions of service and a further 6.7 million emergency department occasions of service. Over time, Australian public hospitals have experienced sustained growth in outpatient attendances and all hospitals have seen a reduction in the average time that a patient stays in hospital (from 4.1 days in 1997–98 to 3.3 days in 2006–07). Increased provision of same day procedures, investigations and treatments and alternative care models such as hospital-in-the-home have contributed to this average reduction in length of stay. Like other countries in the Western world, hospital admissions have continued to increase since the early 1990s. In the five years to 2006–07 acute hospital separations increased by an average rate of 3.4 per cent each year.[3]

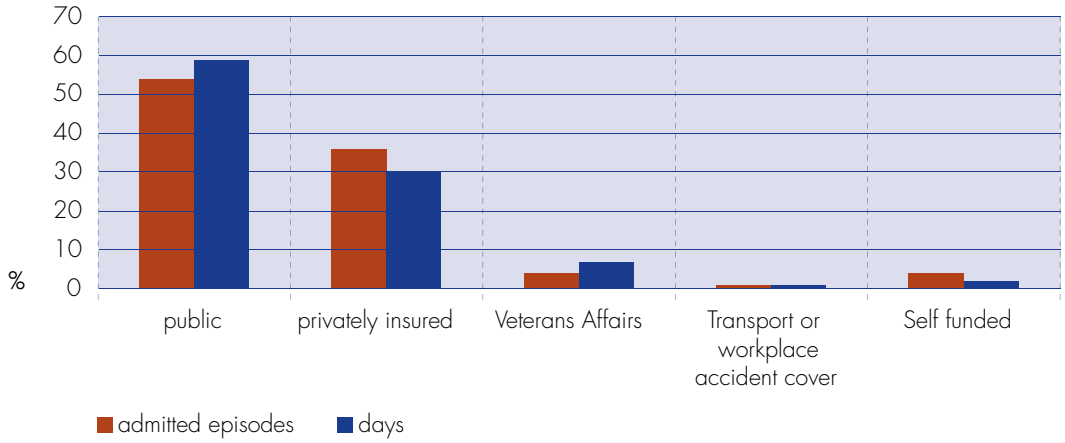
1 J Goss (2008), Projection of Australian health care expenditure by disease, 2003 to 2033, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

2 Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

3 Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

Figure 4.1 shows the proportion of patients and days in hospitals by the source of payment for their care.

Figure 4.1: Most episodes in hospitals are for public patients, followed by the privately insured, then veterans and their families



Source: Australian Institute of Health and Welfare (2008), Australian Hospitals Statistics 2006–07

The full-time equivalent workforce in public hospitals is around a quarter of a million.[4] There are another 47,000 full time equivalent employees working in private hospitals.[5]

In addition to health care, hospitals also play vital roles in clinical education, training and research.

4.2 Building on our strengths

Australia's hospitals provide virtually all of the proven treatments available anywhere else in the world. These range from the most expensive and complex, such as heart, lung or liver transplants, to the relatively simple but essential, such as removal of an inflamed appendix.

Australians also have access to the most complex technologies for diagnosis and treatment though our hospitals, such as Positron Emission Tomography for medical imaging, and linear accelerators for cancer treatment.

Australians are indeed fortunate to have access to such a wide variety of treatments provided by highly competent people, most often at no direct charge to the person treated.

A great strength of our health system is that all Australians eligible to receive a Medicare card can receive public hospital care at no out-of-pocket cost to themselves. Those with private insurance and those entitled to other forms of third party payment such as veterans and people who have suffered workplace or transport accidents can choose to have treatment as a private patient in a public or a private hospital, and by the doctors of their choice. Others, who have the capacity to pay for themselves, also have this choice.

4 Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

5 Australian Bureau of Statistics (2008), Private Health Establishments 2006–07 (Australian Bureau of Statistics: Canberra).

People are often at their most vulnerable when they go to hospital. They may be very unwell, in severe pain or at risk of dying. Many are incapacitated, and many are frail. Most are away from their families and may be completely unprepared for their hospital stay and the disruption it causes to their daily lives. Essential to even the most complex care in hospitals is personal interaction with trusted and compassionate carers. People working in our hospitals include many of the most highly trained professionals in our community.

There is much of great value in our hospital system, but there is also room for improvement.

■ There is much of great value in our hospital system, but there is also room for improvement

4.3 Identifying the case for change

The underlying issues affecting the capacity of hospitals to provide timely and safe care are multi-dimensional but can be best understood in two groupings:

- aspects of hospital care or performance which are significantly within-hospital issues such as the capacity to balance emergency department and planned procedure performance, the provision of outpatient care, teaching, research, safety and quality; and
- other elements of health care which affect hospital performance. Many of these are the subject of other chapters in this report, and so the discussion of them here is brief but serves to highlight the opportunities for parallel reform in areas possibly outside hospitals' direct sphere of influence. These include sub-acute care, aged care, community-based care and primary health care services.

4.3.1 Access to care in hospital emergency departments

Across all categories of urgency, only 70 per cent of people presenting to public hospital emergency departments are seen within clinically appropriate times. Worryingly, more than a third of urgent patients are not seen within clinically appropriate times (see Figure 4.2).

Figure 4.2: Many people are not seen as quickly as they should be in emergency departments

Triage (urgency) category	Description	Patients in category (per cent)	Patients seen in benchmark time (per cent)	Patients admitted (per cent)
1	*Resuscitation*	*1*	*99*	*79*
2	*Emergency*	*8*	*78*	*62*
3	*Urgent*	*32*	*65*	*42*
4	*Semi-urgent*	*47*	*66*	*16*
5	*Non-urgent*	*12*	*88*	*5*

Source: Australian Institute of Health and Welfare, Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

The most critical issue for the performance of emergency departments in major public hospitals is 'overcrowding'. Overcrowding refers to the situation where there are more people in an emergency department receiving treatment (not waiting for care) than can properly be looked after by the available staff. Overcrowding should not be confused with people who present needing only low urgency care (discussed further below). People with less urgent needs for care can (and generally do) wait for treatment.

Emergency departments are meant to assess people's need for care and stabilise their condition; determine and provide any immediate treatment required; and then send them on to the most appropriate place to meet any ongoing care needs. This may be at home with assistance from their GP, provided by another health service or admission to hospital for further investigation or treatment. Overcrowding is directly related to a hospital's capacity to admit quickly those people who have been assessed and stabilised in the emergency department and who need admission to a hospital bed for ongoing care. Both mathematical modelling of patient flows[6], and empirical study[7] have found that, in hospitals operating at an inpatient occupancy of 85 per cent or more on any given day[8], some people requiring admission from the emergency department will end up unable to be promptly admitted. This is known as 'access block'.

> *The single most important barrier to the provision of quality care in emergency departments is access block.*[9]

Inability to admit people promptly to hospital from the emergency department results in a situation where there are more patients in the emergency department than can be properly cared for

Inability to admit people promptly to hospital from the emergency department results in a situation where there are more patients in the emergency department than can be properly cared for. This is associated with increased stress on emergency department staff, and sometimes a need to divert ambulances bringing new patients to other hospitals. As we heard from one paramedic:

> *One of the big issues … is the frustration of trying to get patients moved through hospitals.*
>
> *… the system seems to go into a wind-down for weekends where we've got greatest potential of … discharging people and actually moving them out of the hospitals but it seems that Monday to Friday the hospitals work on office hours and, if we could start moving that in conjunction with better facilities in emergency departments and the general practitioner clinics within our emergency departments, we could start to see a better of movement of patients together with proper care and movement throughout the system.*[10]

Major metropolitan public hospitals in Australia commonly experience days when they operate at capacity with high levels of occupancy, occasionally exceeding 100 per cent. This means that more people have been admitted for care than there are available beds – usually achieved by having people on trolleys in the corridors of the hospital.

Occupancy rates in hospitals are a complex function of the numbers of people presenting who require admission – both planned and unplanned – which vary according to the time of the year, the day of the week, and the time of the day as well as to the prevalence of illnesses in the community, and the numbers of people leaving hospital – this also varies by time of day, day of the week, and the availability of follow-up care for those requiring it.

An Australian study has found an association between emergency department overcrowding and increased deaths of people admitted after attending the emergency department.[11] Other authors have also demonstrated a strong association between access block/overcrowding and increased mortality.[12]

We do not see a role for the Commission in prescribing specific bed management practices within hospitals. Other reports, both in Australia and overseas, have investigated bed management and documented strategies to improve bed availability. Very recent examples in Australia

---

6 A Bagust, M Place and J Posnett (1999), 'Dynamics of bed use in accommodating emergency admissions: stochastic simulation model', British Medical Journal (319): 155–158.

7 A Forster, I Stiell, G Wells and colleagues (2003), 'The effect of hospital occupancy on emergency department length of stay and patient disposition', Academic Emergency Medicine 10 (2): 127–133.

8 Calculated as the number of patients in the hospital at midnight plus the number of other patients who occupied an inpatient bed for any portion of the preceding 24 hours.

9 Australasian College of Emergency Medicine (2008), Submission 19 to the National Health and Hospitals Reform Commission.

10 Paramedic (4 June 2008), National Health and Hospitals Reform Commission consultation with frontline health professionals in Sydney.

11 P Sprivulis, J Da Silva, I Jacobs and colleagues (2006), 'The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments', Medical Journal of Australia 184 (5): 208–212.

12 R Forero and K Hillman (2008), 'Access block and overcrowding: a literature review', Prepared for the Australasian College of Emergency Medicine.

include a report by the Victorian Auditor General, Managing Acute Patient Flows, published in December 2008[13], and the Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals.[14] And indeed these challenges are by no means unique to Australian hospitals.[15]

However, we do recognise the need to fund, resource and support through appropriate policies and measurement strategies a sufficient 'base' bed capacity to enable efficient patient flow through emergency departments. As part of addressing this, planning of admitted patient capacity for public hospitals that provide 24-hour 7-day-a-week emergency department care should be based on a target maximum daily occupancy of 85 per cent. In our view there is a need to encourage adoption of proven patient flow-management practices by providing marginal payment incentives for the outcomes of good bed management rather than prescribing particular strategies. These should include incentives for hospitals to ensure that people treated in emergency departments who require admission can be admitted promptly.

4.3.2 Low urgency presentations to hospital emergency departments

It has been argued that the number of semi-urgent and non-urgent presentations to emergency departments is an indication of the failure of general practice to meet the needs of these people, and also that dealing with low urgency patients is a cause of poor performance of hospital emergency departments.[16]

> *The system at the moment forces people to go to emergency departments. If I can't see my GP I go straight to the emergency department.*[17]

On the other hand, it must be noted that almost one in six people categorised as semi-urgent end up being admitted to hospital, as do one in twenty of those in the non-urgent category. Furthermore, a number of people categorised as low urgency have already seen a GP and been referred to hospital for treatment the GP cannot provide. This suggests that not all low urgency presentations to hospital emergency departments could be adequately looked after by a GP.

Perhaps the principal disadvantage of people attending emergency departments for low urgency care is that it fragments their care and ongoing management. Hospitals may provide excellent care while a person is in the emergency department, but they are generally not set up to provide systematic follow-up care or to gain a comprehensive understanding of a person's health and wellbeing over several encounters (although in some cases they may end up doing so).

For reasons of quality of care over time, we believe it would be better for most people presenting to emergency departments who do not require urgent care to obtain their care from a primary health care service with which they have a continuing relationship. In this way the doctors and other health professionals in the service develop a familiarity with the person's health and circumstances, enabling them to provide better treatment and care over time.

> *I'm an Emergency Nurse and I think its very important that we educate the public on the role of the emergency department, what it is there for, what is appropriate and what other services are available as opposed to the emergency department.*[18]

13 Victorian Auditor-General (2008), Managing acute patient flows, at: http://download.audit.vic.gov.au/files/Patient_Flow_Report.pdf

14 P Garling (2008), Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, at: http://www.lawlink.nsw.gov.au/acsinquiry

15 See, for example: D DeLia (2007), Hospital capacity, patient flow, and emergency department use in New Jersey, A Report to the New Jersey Department of Health and Senior Services (The Institute for Health, Health Care Policy and Aging Research, Rutgers University: New Jersey).

16 Booz Allen Hamilton (2007), Key drivers of demand in the emergency department: a hypothesis driven approach to analyse demand and supply (New South Wales Health: Sydney).

17 Consumer (19 June 2008), National Health and Hospitals Reform Commission consultation meeting with community in Brisbane.

18 Nurse (17 June 2008), National Health and Hospitals Reform Commission consultation with frontline health professionals in Cairns.

People go to emergency departments as the best available choice from their point of view

One of the critical challenges to achieving this is that people go to emergency departments as the best available choice from their point of view.

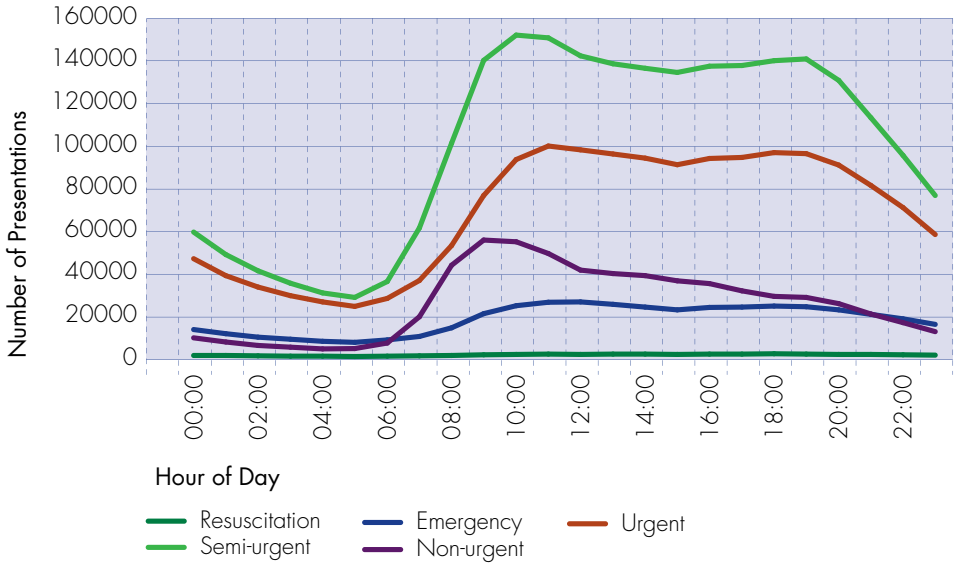
> *Despite differences in the presentation rates, patients in all demographic groups [attending an emergency department for low urgency care] were most likely to identify self-assessed urgency; being able to see the doctor and having diagnostics done in the same place; and self-assessed seriousness or complexity as the reasons for presentation.*[19]

This is partly driven by lack of availability of same-day appointments and extended hours at many general practices, and also the fact that general practices do not provide in one place all the services a person may need. A person attending a GP who requires pathology tests or medical imaging generally has to make additional appointments and/or attend a pathology collection service and/or diagnostic imaging clinic. They generally also require a subsequent follow-up consultation with the GP. Altogether it can take several trips and sometimes several days from initial presentation to final outcome. While waiting times for treatment for low urgency patients in emergency departments can be long, people are reasonably assured of an outcome that day.

We believe the remedy to this is to develop larger, more comprehensive, primary health care services which are able to offer convenient same-day access to 'one stop' care for people who might otherwise present to a hospital emergency department. This requires centres that include not only GPs and other primary health care professionals, but also ready access, preferably on-site or adjacent, to diagnostic services. These centres should be open for extended hours; for example, from 6.00 am to 10.00 pm – the hours during which most low urgency presentations to hospital emergency departments take place (see Figure 4.3).

The development of Comprehensive Primary Health Care Centres is a key focus of Chapter 2 of this report.

Figure 4.3: Most people present to emergency departments during 'daylight' or 'twilight' hours – from 6.00am to 10.00pm



Source: Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

19 P Siminski, A Bezzina, L Lago and K Eagar (2008), 'Primary care presentations at emergency departments: rates and reasons by age and sex', Australian Health Review 32(4).

Some people presenting to GPs actually require hospital care quickly. It is a source of frustration to many GPs that hospital staff cannot preferentially triage people whom GPs refer to a hospital emergency department for good reason. A proportion of people presenting to our proposed Comprehensive Primary Health Care Centres will also be identified as needing hospital care. In order to ensure that such people receive attention within a clinically appropriate time, rather than having to wait twice, hospitals and Comprehensive Primary Health Care Centres should have agreed referral and transfer protocols.

> *I have been here for 39.5 years and one of the best innovations we've had apart from the mobile phone is the patient flow unit which is based at Dubbo Hospital. If we wish to transfer mental patients or psychiatric patients or medical patients we ring through patient flow, they put us onto the admitting officer and then they arrange the transport of the patient in the most appropriate way and this has worked out very well.* [20]

Further work is required to understand the relative cost benefit of treatment in primary health care settings as compared to low urgency attendances at hospital emergency departments. This information will help planning processes to ensure that the 'best' care is provided to low urgency patients and that hospital resources are used wisely and resourcefully.

4.3.3 Access to 'elective' admission

> *Medicare and the public hospital/health system are no longer effective in providing accessible services to all Australians – barriers of co-payments, workforce shortages and waiting lists result in inequitable access, contributing further to unequal outcomes.*[21]

Another challenge for public hospitals is delays in scheduling and repeated cancellations for 'elective' procedures. This aspect of 'timely access to care' receives the greatest public attention. In this context 'elective' means procedures and treatment that in the view of the treating clinician are necessary and for which admission can be delayed for at least 24 hours. The term elective has connotations that the procedures or treatments are optional or a matter of choice. However, most elective procedures are essential; for example, cataract surgery to remedy going blind, and joint replacements to remedy chronic pain and maintain mobility. In some instances 'elective' procedures can be critical to a person's survival; for example, diagnostic procedures to confirm whether someone has cancer.

■ Most elective procedures are essential; for example, cataract surgery to remedy going blind, and joint replacements to remedy chronic pain and maintain mobility

During our consultations we heard that there is wide variation across Australia in the time that people who have been deemed 'ready for care' wait before they are scheduled for surgery in a public hospital. Once scheduled, bookings might be cancelled, even multiple times, because of the precedence given to emergency patients. Lack of prompt access to planned procedures is undoubtedly resulting in a significant burden of disability and pain, and may prejudice people's access to prompt diagnosis of cancer, with possible life threatening effects. Similarly, delays in access to radiotherapy may impact on the potential outcome of cancer treatment.

Notwithstanding the levels of growth in public hospital activity and expenditure in recent years, waiting times for elective treatment were longer in 2006–07 than they were in three of the preceding four years.[22]

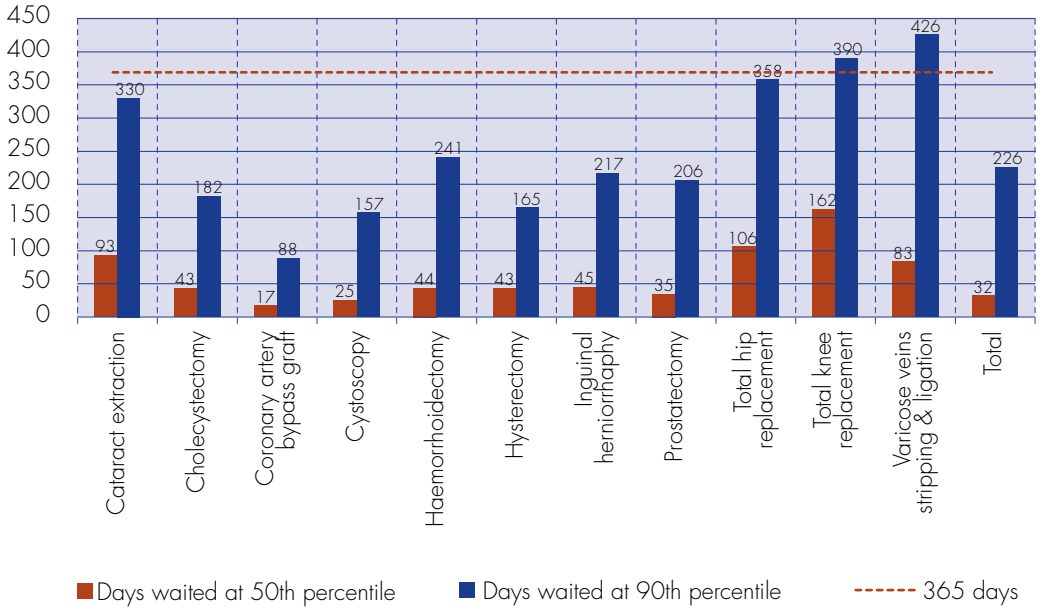
20 General practitioner (3 June 2008), National Health and Hospitals Reform Commission consultation with frontline health professionals in Dubbo.

21 Victorian Primary and Community Health Network (2008), Submission 189 to the National Health and Hospitals Reform Commission.

22 Australian Institute of Health and Welfare (2008), Australian Hospitals Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

Figure 4.4 shows the median waiting time at the 50th and 90th percentiles by type of procedure for a selected basket of procedures. Median waiting time (or the 50th percentile) means that half of all people wait longer than that number of days. Similarly, waiting time at the 90th percentile means that ten per cent of all people wait longer than that number of days. As can be seen from the figure, there are people who wait close to a year or even more for treatment their doctor regards as necessary.

Figure 4.4: For many procedures 5 out of every 10 people treated in a public hospital receive treatment within a month or two, for others 1 in 10 people wait a year or more.



Source: Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

In Australia, the majority of planned surgical and diagnostic procedures are performed in private hospitals. For the fifty-seven per cent of Australians who do not have private insurance they must wait their turn, according to their level of urgency, before they can undergo a planned procedure.

Although a majority of Australians don't have private health insurance, for many procedures public patients constitute a third or less of all patients undergoing that procedure

Although a majority of Australians don't have private health insurance, for many procedures public patients constitute a third or less of all patients undergoing that procedure. Examples include same-day lens procedures (only 26 per cent of procedures performed on public patients in 2006–07) and joint replacements – hip replacement without catastrophic or severe complications (33 per cent public patients) and knee replacement and reattachment (34 per cent of patients treated as public patients). For vein ligation and stripping only 34 per cent were public patients in 2006–07 and, for dental extractions and restorations, only 16 per cent were public patients.[23]

We heard a range of reasons to explain this shifting balance of surgical care provision across public and private sectors. These included surgeons electing to move increasingly or exclusively from the public to the private sector due to dissatisfaction with the public hospital work environment (a view also recently expressed by the Garling inquiry in New South Wales)[24]; views about inefficiency, lack of reliability of theatre availability and frequent and repeated patient

23 Derived from data published in Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

24 P Garling (2008), Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, at: http://www.lawlink.nsw.gov.au/acsinquiry

cancellations; differences in clinical team support, equipment and facilities; perception of better engagement and respect and differences in remuneration.

> *A specialist in private practice can earn $20,000 MBS fee of 100% for a session of 10 cataract operations (equivalent to a morning's work). In the public system they would receive only $4000. This is a massive discrepancy. Are we underpaying or over remunerating? Do we need to move to a system of shared private and public practice responsibilities?*[25]

Similarly, it has been suggested that private hospitals may have also contributed to this trend by responding to market opportunity, commercial preferences for surgical activity, having a lesser role in complex medical care and teaching and seldom providing emergency services. More timely access to surgery is a strong aspect of perceived customer value of private health insurance and this may also influence private hospital activity.

Access to elective procedures is inequitable because of the differential access people have to private hospitals based on their capacity to afford private health insurance or to self-fund. The least advantaged, relying on access to public hospitals, are most likely to experience long waits for elective procedures. We heard that in public hospitals:

- The least advantaged, relying on access to public hospitals, are most likely to experience long waits for elective procedures

> *The workforce doesn't have the physical capacity to do it – if an orthopaedic surgeon decides to drop one day of work and one surgery list a week as they get older, how does the hospital fix the resulting increase in the waiting list?*[26]

Increasingly states are resorting to contracting for some procedures for public patients to be performed in private hospitals. We support this as an approach which leads to improved access to timely treatment for people relying on treatment as a public patient, to meet our proposed National Access Guarantees.

> *Shortage of workforce in some specialist surgical areas means that patients for some categories of elective surgery may experience delays. SA Health has identified specific categories of elective surgery including orthopaedics, plastics and urology where there is a relatively high risk of not meeting State targets. SA Health is working with private providers to undertake elective surgery on behalf of the public sector. A panel of private providers has been established and contracts are in place. These arrangements have enabled a positive relationship to be built with the private sector and provide additional capacity to public sector patients. Such partnerships with the private sector provide potential for the future for the public sector to look at alternative strategies for managing future demand.*[27]

In the UK the National Health Service has developed a long term and comprehensive strategy for reducing waiting times for treatment (see Figure 4.5). Like the example given above they have recently added another 'string to the bow' by procuring elective treatments from the independent sector estimated to be worth $US980 million annually (15 per cent of NHS elective procedures).

25 Participant (24 June 2008), National Health and Hospitals Reform Commission consultation meeting with government agencies in Melbourne.

26 Participant (27 June 2008), National Health and Hospitals Reform Commission consultation with government agencies in Shepparton.

27 SA Health (2008), Submission 458 to the National Health and Hospitals Reform Commission.

Figure 4.5: From more than 18 months to no more than 18 weeks – shortening elective surgery waits in the English National Health Service (NHS)

Since 1997, the English NHS has had three distinct policy phases to reduce waiting times. Between 1997 and 2000, strategies focused on reducing the total number of patients waiting while ensuring that no one waited longer than eighteen months. This was principally achieved through extra investment and sharing of best practices in waiting list management through the National Patient Action Team and Modernisation Agency.

Between 2000 and 2005, the focus moved to the maximum waiting times experienced by patients. The government set general targets (for outpatient appointments and inpatient treatment) and specific targets (for cancer). Extra (non-dedicated) funding was provided, and hospitals' performance was directly managed against published targets. The government introduced targeted initiatives to reduce waiting in orthopaedics and ophthalmology and tightened the performance management framework by introducing independent inspection and a public performance (star) rating system. The aggressive deployment of a robust performance management system alongside targets and increased funding appears to explain England's relative success in reducing waiting times.

During 2005–2008, the focus is to be on tackling the combined wait along the care pathway to achieve a maximum eighteen week wait for referral to treatment. A quasi-market is being introduced through guaranteed choices for patients, with patients able to choose providers with short waiting times at the point of referral using an information technology (IT) platform. New financial incentives are being introduced through the use of hospital activity payments based on an English version of DRGs. The government is also buying additional private-sector capacity. A program of procuring 200,000 elective treatments (worth $784 million) from the independent sector largely 'went live' in 2005. Other procurements include $392 million annually for diagnostic services and a second wave of elective procurements of $980 million annually. It has been estimated that, by 2008, around 15 per cent of NHS elective procedures will be carried out by the independent sector. In addition, budgets are being introduced for primary care physicians so that they bear some of the financial consequences of decisions to refer to a specialist.

Source: Excerpt from Willcox, M Seddon, S Dunn and colleagues (2007), "Measuring and reducing waiting times: a cross-national comparison of strategies – setting targets and national/state commitment are important to reduce surgical waiting times", Health Affairs 26 (4): 1078-1087. NB figures are in US Dollars.

Access times can be improved by measuring performance and having payment incentives for hospitals to achieve benchmarks including in relation to timely access to care

■ We believe that access times can be improved by measuring performance and having payment incentives for hospitals to achieve benchmarks, including in relation to timely access to care. It is also vital in the long term to foster a constructive and productive balance and range of services across the public and private sectors. This will be further explored in our final report.

4.3.4 Outpatient services in public hospitals

While receiving less high profile attention, another important element of services provided by hospitals is outpatient services. In this report, outpatient services refers to specialist medical, nursing and allied health care, provided to people free of charge as non-admitted patients of a public hospital.

There were reportedly 39.9 million occasions of service provided in public hospital outpatient clinics in 2006–07.[28] These data are indicative at best, as definitions vary widely between hospitals and states and territories including whether services provided away from a hospital campus are counted.

Outpatient clinics generally entail a consultation with a medical specialist and often involve investigations to aid diagnosis and management. Services from other health professionals, such as nurses, physiotherapists, dieticians, and speech therapists, may also be an essential component of a patient's outpatient care plan. Chemotherapy, radiation therapy, rehabilitation and a range of other procedures are now commonly provided on an outpatient basis. Outpatient clinics are also

28 Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

a vital source of continuing care for people with particular chronic conditions and follow-up care for patients discharged from an acute care episode. They are an important gateway to inpatient treatment, including for planned procedures and an important setting for clinical education.

However, many of the medical services provided in public hospital outpatient clinics are also provided by specialists privately, including consultations, diagnostic imaging and pathology. As a result there are strong financial incentives for states and public hospitals facing budgetary constraints to shift the provision of non-admitted medical care to medical specialists in private practice, as these attract an MBS rebate paid by the Commonwealth, reducing the call on public hospital budgets and state funding.

Consultations with privately practising specialists in their rooms frequently entail out-of-pocket costs, whereas hospital outpatient clinics must be provided free of charge. The same may also be true of privately-provided diagnostic services.

Importantly, private medical services generally do not provide multidisciplinary, team-based care that is available in many hospital outpatient clinics. Furthermore, the logistics of accessing private medical services can be a problem for people. Attending a hospital outpatient clinic for some services while obtaining diagnostic services from a private provider in another location can require people to engage in significant to'ing and fro'ing, requiring more time, more travel and more cost than if the services were provided in one place. This can result in poorer co-ordination of care for the patient and a higher likelihood of communication lapses between providers of care.

We note that, despite the attention cost-shifting of non-admitted patients has attracted, very little has been done to determine the impact on outcomes of care. Cost-shifting of this kind is too often about which government pays, rather than what is best in terms of providing 'good' care. In the end it is the same tax payers funding outpatient clinics as it is funding Medicare rebates for privately-provided medical services.

There is logic in the same government which funds specialist medical care also funding specialist outpatient care. Funding policy could be used to encourage multidisciplinary specialist care in community settings and promote focus on quality, efficiency and responsiveness to people's needs. For example, there are still hospital outpatient clinics which are operated on the basis of block bookings – patients have to sit and wait, often for hours.

There is logic in the same government which funds specialist medical care also funding specialist outpatient care

> *Parents at one hospital mentioned long waiting times of up to 6 hours each week when they attended for their child's oncology treatments. They discussed this with a staff member and suggested that pagers could be made available to parents so they could take their child to the park or go to the cafeteria or collect medications etc while they waited. The parent pager system was introduced and vastly improved parent and staff satisfaction.*[29]

4.3.5 Restoring people to better health after hospital

Sub-acute care is a vital element of the patient journey, often providing the connection between acute care in hospitals and care in the community and in people's homes. It can help to improve functioning and independent daily living, reduce or slow further decline in health status, reduce unnecessary visits to hospitals, reduce the amount of time people spend in acute hospitals, and prevent premature admission for older people to residential aged care facilities. Sub-acute services are used by people of all ages.

Availability of sub-acute services is highly variable and is not adequately provided in most states, with consequent poorer outcomes (e.g. due to lack of appropriate cardiac rehabilitation) and greater use of less appropriate care (e.g. longer stays in hospital, more repeat admissions and greater use of long-term care at home or in residential care). This is expanded upon further in Chapter 5 but it is a vitally important part of our strategy to ensure that hospital resources are used wisely and people receive the best care in the most appropriate environment at the right time.

29 C Crock (2008), Submission 236 to the National Health and Hospitals Reform Commission.

4.3.6 Long-stay older patients

Another area which receives constant media attention, and which teeters at the interface of Commonwealth and state and territory responsibilities, is that of older people who experience prolonged stays in hospital while awaiting residential care.

The best available data on this issue comes from a census of all patients 65 or over in public hospitals on midnight of 17 April 2002.[30]

That survey obtained detailed data on 16,104 patients aged 65 or over in 99 per cent of public hospitals and found that:

- for one in five older people (19.3 per cent), another form of care was deemed by a health professional as more clinically appropriate;
- for three-quarters of these patients (which represents one in seven older patients overall), the person was in hospital waiting to access the recommended form of care;
- two-thirds of these patients (or one in eleven patients overall) were waiting to access residential aged care with very few patients waiting to access community-based care. This equates to about 1521 older persons occupying about 3 per cent of public hospital beds.

The reform directions put forward in Chapter 6 will significantly improve the responsiveness of aged care providers to meeting the needs of older people awaiting a residential care placement while in hospital.

Aged care assessment services have been established to advise on what is the most appropriate accommodation or mix of home support services for older people, whether their need emerges in hospital or at home. Earlier assessment by these services or a geriatrician can facilitate discharge planning. Better sub-acute services may reduce the demand on residential care facilities and open up other options for the older person.

The pattern of older people's use of hospitals (due to inability to access a nursing home place that meets their needs) may change significantly with the further development of transition care. In the last two years, 2228 transition care places have been allocated, with 1963 of these operational as at 30 June 2008.[31] In the 2008–09 Budget, the Commonwealth Government committed further funds to establish a total of 4000 transition care places by mid-2012. This may substantially alter the dynamics between hospital discharge and entry to residential care for those people needing the latter.

4.3.7 Transfers from residential aged care to hospitals and back again

An area in need of further improvement is the apparent difficulties encountered by older people already in residential care when they become unwell and need assistance from a doctor or health professional. Problems here are threefold:

- Some people are sent to hospital for want of care that could, and arguably should, be provided in the residential facility either by the staff of the aged care home or by visiting primary health care professionals (including GPs) if they were better able to be accessed by residents.
- Some people who should be sent for care in a hospital are not transferred when they should be (again this can be the result of shortcomings in care by the aged care facility

30 The full report of the survey and analysis at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-minconf.htm/$FILE/pr2report.pdf

31 Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

but can also be the result of inadequate access to primary health care resulting in late identification of treatable conditions).

- There is evidence that some older people from residential care suffer adverse outcomes as a collateral result of hospital treatment which may have been avoided if treatment could have been provided 'in place'.[32]

Pressures on hospital beds, and a perception that residential aged care facilities are fully staffed around the clock, leads to hospitals discharging patients back to the residential facility inappropriately:

> *My mother was discharged from hospital at 3am and sent back to her nursing home in a taxi before checking with me that this is okay.*[33]

Part of the answer may lie in closer working relationships between hospitals and residential facilities with clinical staff working across the boundaries. More fundamentally, there needs to be better access to primary health care and end of life care for residents of aged care homes. Approaches to achieving both of these improvements are proposed in the reform directions in Chapters 6 and 7.

4.3.8 Continuity of care

Continuity of care between hospitals and non-hospital settings is often poor.

■ Continuity of care between hospitals and non-hospital settings is often poor

A person's usual GP, where they have one, is frequently unaware that a person has been in hospital, let alone informed of what has occurred in clinical terms during the episode or what follow-up care should be provided.

Community nursing services may not be informed, or may be informed too late to plan support in the home for a patient recently discharged. We were given the classic example of a person discharged on Friday afternoon to avoid staying over the weekend, who then has to fend for themselves over the weekend, because of limited GP availability on the weekend. Advice to the local district nursing service about the patient's discharge arrived too late to organise weekend attendance by a community nurse.

As we heard from a general practitioner:

> *Poor communication between hospitals and primary care staff in the community is a major problem in our healthcare system. General practitioners identify communication from hospitals to them as appalling. This has major implications for ongoing patient care. Involving families fully in their own healthcare will go a long way towards improving this communication.*[34]

This message was reiterated by a community pharmacist:

> *I'm a pharmacist and I'd love to see better communication coming out of public hospitals so people being discharged [have] a discharge summary.*
>
> *So that their GP knows what's changed while they've been in hospital and what they're supposed to be taking now. And so that we can then run with it rather than waiting for weeks.*[35]

32 T McDonald (2007), For their sake: Can we improve the quality and safety of resident transfers from acute hospitals to residential aged care? Report for the Aged Care Association Australia.

33 Consumer (19 June 2008), National Health and Hospitals Reform Commission consultation with community in Brisbane.

34 C Crock (2008), Submission 236 to the National Health and Hospitals Reform Commission.

35 Pharmacist (9 July 2008), National Health and Hospitals Reform Commission consultation with frontline health professionals in Adelaide.

Discharge summaries should be more than a summary of what happened in hospital – they should be a comprehensive care plan to guide the future health care management of the patient. Discharge summaries should contain information that is relevant to all other health providers who will participate in the ongoing care of the discharged patient.

> *South Australian GPs surveyed in 2000, placed little value on the clinical synopsis and in-patient treatment but wanted information on discharge medication (and particularly new or altered medication), future hospital outpatient or specialist appointments, referrals to external agencies and any specific ongoing management they were expected to provide. They saw the summary as a referral for future management rather than a history of past management.*[36]

There are many explanations given as to why discharge summaries are not consistently provided for all patients, by all hospitals and in a timely fashion. The lack of compatible communication technologies is frequently cited. We believe it is high time that this simple issue was addressed in a system wide fashion.

4.3.9 Multi-purpose services for small towns

In rural and remote areas small community hospitals can suffer from low occupancy and difficulty attracting staff. They are also frequently significant providers of long-term (de facto residential) care for older people. Yet local hospitals were not built to be suitable places for older people to live.

There are often also opportunities in smaller communities to bring together in one setting primary health care, community care services, hospital care and aged care.

The most successful response to this has been to redevelop small local hospitals as 'multi-purpose' services which provide a mix of hospital and aged care, and often a base for primary health and community care as well. In this model the Commonwealth provides recurrent aged care funding and the facility can also be redeveloped to provide a better, more homelike environment for frail older people to live. Nevertheless such redevelopments can often strike significant resistance from local communities when it is perceived as a downgrading of the local hospital.

In Chapter 9 we propose that the model of multi-purpose services be extended to towns of up to 12,000 people.

4.3.10 Support for teaching

What distinguishes health professional education from other disciplines is the need to integrate clinical experience during the course. But the increasing pressure of immediate service needs means increasing pressure on training places to provide this clinical experience, short-term priorities thus crowding out what is essential for the long term.

Provision of adequate numbers of training places across medical, nursing and allied health professions needs to be explicitly planned, supported and funded in hospitals and ambulatory settings

■ Provision of adequate numbers of training places across medical, nursing and allied health professions needs to be explicitly planned, supported and funded in hospitals and ambulatory settings.

> *Universities and technical and further education institutes (TAFEs) rely on public hospitals providing opportunities for clinical teaching of students undertaking pre-vocational and vocational training, and also for joint programs of health and medical research.*
>
> *… Public hospitals are increasingly under severe financial pressure, and any activities which are not 'core' to their 'business' and part of a funding agreement are liable to careful scrutiny.*

36 Clinical Information Project (2004), Phase 1 Report PART C Stream 3: National Hospital Discharge Summary, at: http://cip.healthbase.info/phase1/report/cipp1pc.pdf

A worrying trend is that for some public hospitals, teaching and research are now seen as somewhat discretionary.

… Greater transparency is required in the funding arrangements supporting clinical training for both undergraduate and postgraduate students. Key to realising a streamlined clinical training system is the need to determine who is responsible for providing the training and then how it should be funded.[37]

Exposure of trainees to an appropriate mix of cases, admitted and non-admitted, to attain competency needs to be ensured and provided across settings. This means trainees need to undertake placements wherever care is provided, including in doctors' rooms and private hospitals as well as in public hospital wards and outpatient clinics. This requires formal recognition and support for training in all relevant treatment settings.

In support of this we believe a single national body in the form of a health workforce agency – as discussed in Chapter 14 on workforce – needs to be given the authority and responsibility to determine the numbers of course places to be made available and to fund the requisite clinical placements within the health sector across all health professions.

As outlined below, we also propose that activity-based funding should be used to pay for provision of training in hospitals. Such an approach would provide the means for the proposed national health workforce agency to ensure that the required numbers of clinical placements are offered.

4.3.11 Safety and quality, clinical governance and leadership

Admission to hospital is not without risk. According to one Australian study of 14,000 patients in 28 public hospitals in two states, 0.79 per cent of hospital admissions (about one in 126) were associated with an adverse event which resulted in death.[38]

In our first report, *Beyond the Blame Game*, we identified 'promoting improved safety and quality of health care' as one of our critical challenges. Almost every state has experienced a hospital or medical safety crisis in the last five years. This suggests that safety and quality issues are not caused by idiosyncratic behaviours in individual states or hospitals but rather are the result of common issues such as credentialing of doctors, handover of care between different shifts of nurses, patient identification and systematic monitoring.

As identified in Chapter 15 of this report, strong and sustained national leadership in this area is necessary. The lead national body, the Australian Commission on Safety and Quality in Health Care, has been established as a time-limited body, with no statutory base.

■ The Australian Commission on Safety and Quality in Health Care has been established as a time-limited body, with no statutory base

Leadership in promoting improvements in safety is not something that is purely the preserve of clinicians, it also needs to involve managers and patients.

My proposition is that no-one really runs these public hospitals in the sense that we understand how a normal organisation should function. There is a major disconnect between corporate governance and clinical governance. They very largely operate in parallel or at best in overlap. Clinical issues and risks are not given the same – or greater – attention as corporate or financial risks.

Clinical communities need to recognise that they must play a much broader role in reforming and modernising hospitals. Senior managers must recognise that they cannot translate policy intentions into changed clinical practices. They must encourage clinicians to take on a much wider agenda including governance and work practices.

Let me give two examples of this bottom-up approach. The first is clinical senates which have been established in many states. They make recommendations for clinical change which reflect general clinical concerns. The senates use their networks to achieve organisational reform. The

37 Universities Australia (2008), Submission 461 to the National Health and Hospitals Reform Commission.

38 R Wilson, W Runciman, R Gibberd and colleagues (1995), 'The quality in Australian health care study', Medical Journal of Australia (163): 458–471.

second is the Greater Metropolitan Task Force in Sydney that addresses major problems in clinical gaps, duplication and safety in Sydney hospitals. These are two examples of clinicians accepting their responsibility for reform that are integrated with organisational objectives, but these examples of clinical involvement are usually about networking between hospitals rather than within hospitals.[39]

We propose in Chapter 15 that a permanent national body should be established and charged with leading and coordinating safety and quality in Australian health care settings. This national body should take a leadership role to help embed a culture of continuous reflection and improvement and strengthen clinical governance, including nationally consistent complaints arrangements. It should also lead the development of nationally consistent indicators to be used for monitoring quality and safety by hospitals and other providers and support providers in responding to any potential issues identified (see Figure 4.6).

Figure 4.6: Public reporting of hospital performance in Queensland

One of the outcomes of Queensland's Bundaberg Hospital scandal and the associated public inquiries was a revitalisation of quality management processes and a new emphasis on transparency in the health system. The Health Services Act 1991 (Qld) was changed in 2005 to require publication of an annual public hospital performance report. A shake-up in clinical governance also occurred, with the introduction of new quality management processes that included more robust and consistent reporting of clinical incidents and sentinel events as well as a monitoring system using statistical process control charts for 30 clinical indicators. The statistical process control approach emphasises the dynamic nature of performance against particular outcome measures and flags significant variations from the state mean. Public and private hospitals are given feedback on their performance against the indicators on a monthly basis. Depending on the extent to which a hospital's indicators deviate from the state average, there are requirements for reporting at various levels of the bureaucratic hierarchy, using a standardised approach to reporting findings that emphasises systematic reasons for variation.

What is critical in the new approach is not that an indicator is flagged for further investigation, but that robust investigation takes place. Investigation reports for indicators flagged at twice the state average rate (for non-mortality indicators, such as complications of care) or 75 per cent above the state average rate (for mortality indicators) are reviewed externally to the hospital to assess the adequacy of the hospital's internal investigation. A rating is given for the 'strength' of actions and the comprehensibility of the report for public presentation.

This dynamic and quality improvement approach to quality management was first used as the basis for the mandated public reporting in 2008. Although quantitative performance data for each of the 30 indicators for each relevant hospital are published as a separate table on the Internet, the main printed public report (also available on the Internet) focuses on whether the indicator performance of any individual hospital was significantly different from the state average and, more importantly, the actions that the identified hospital is taking in response to flagged variations from the average. A similar approach is taken with regard to reporting on clinical incidents and sentinel events.

Source: Excerpt fom S J Duckett, J Collins, M Kamp and K Walker (2008), "An improvement focus in public reporting: the Queensland approach", Medical Journal of Australia 189 (11/12): 616-617.

4.3.12 Patient experience

Quality of care is enhanced if the voices of consumers are listened to as part of routine feedback and continuous quality improvement processes. We proposed measurement of the consumer experience in our first report. Implementation of this requires the development of a nationally agreed consumer survey, to apply to public and private facilities. This should include use of Computer Assisted Telephone Interviewing (CATI) instruments to survey people about their experiences of health care.

39 J Menadue (2008), 'Another design problem in health: no-one runs hospitals', Presentation to the Royal Australasian College of Medical Administrators and the Australasian Faculty of Public Health Medicine New South Wales, University of New South Wales.

What is critical, of course, is not just the measurement of the experience, but that action is taken as a result of consumer feedback.

Consumer experience questionnaires should be supplemented by asking consumers about the outcomes of care they receive. Consumers seek health care to relieve pain, improve functioning and so on. The health sector describes the treatment as surgery or medical interventions, but from a consumer perspective the outcomes are measured in terms of whether they feel better, whether they experience less pain, whether they can regain their independence, and so on.

An important way of evaluating health care is to ask patients themselves to what extent their expectations have been met in terms of improvement in their condition. Standardised 'patient-related outcome measures' questionnaires have now been developed (see Figure 4.7). These include both generic questionnaires covering a range of conditions as well as condition-specific questionnaires.

An important way of evaluating health care is to ask patients themselves to what extent their expectations have been met in terms of improvement in their condition

Figure 4.7: Measuring patient experience internationally

Instruments to measure patients' experience were developed by researchers at Harvard Medical School with funds from the Picker/Commonwealth Program for Patient-Centred Care, a program established in 1987 under the auspices of the Commonwealth Fund of New York. The aim was to explore patients' needs and concerns as patients themselves define them. . The Harvard team designed a patient feedback program derived from qualitative research designed to find out what patients value about the experience of receiving health care and what they considered unacceptable. They conducted focus groups with patients and their family members, reviewed the literature and consulted with health care professionals to determine key priorities. This research program resulted in the development of survey instruments designed to elicit reports from patients about concrete aspects of their experience. Outcomes of these surveys were reported early by Cleary et al. [Cleary, P. et al. (1991), 'Patients evaluate their hospital care: a national survey', Health Affairs 10(4):254–67].

This approach to measuring patients' experience has since been adopted for use in the Consumer Assessment of Healthcare Providers and Systems surveys in the USA, the WHO responsiveness surveys and the national NHS patient survey program in England. The Commonwealth Fund international health policy surveys of a range of countries, including Australia, also ask questions about people's experiences of the health system.

Source: M Draper and S Hill (2008), Submission 500 to the National Health and Hospitals Reform Commission.

Measurement of the patient experience should become a routine part of health service evaluation and is further discussed in Chapter 15. National standards for monitoring consumer complaints and feedback, including presentation of data, should also be developed.

4.4 Creating a better future

4.4.1 National Access Guarantees and Targets

We have proposed an array of reform directions throughout this report which will ease the pressure on hospitals and reduce waiting times for patients requiring hospital care. Nonetheless, our consultations in Australia and research about what works in other countries suggest to us that access times can be improved by measuring performance and having payment incentives for hospitals to achieve benchmarks in relation to timely access to care.

Reform direction 4.1

We propose development and adoption of National Access Guarantees for planned procedures and National Access Targets for emergency care; for example:

- a national access target for people requiring an acute mental health intervention (measured in hours);
- a national access guarantee for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and
- a national access guarantee for patients requiring other planned surgery or procedures (measured in months).

These National Access Guarantees should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries.

Under the National Access Targets for emergency access, all hospital emergency departments should meet the triage access targets specified in Beyond the Blame Game, as well as additional measures of performance in promptly admitting people from emergency departments where they need it. These National Access Targets operate at the level of individual hospitals.

We also propose that there be performance payments for avoiding occupancy crises, by rewarding those hospitals which avoid the consequences – namely:

- emergency department overcrowding;
- undue waiting periods for emergency treatment (using the benchmarks proposed in our first report, *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*);
- undue waiting periods for admission from emergency department for care by other clinical staff elsewhere in the hospital; and
- hospital bypass where ambulances are redirected away from busy hospitals.

All of these are measurable, with data on them being routinely captured in most hospitals. These data should be used as the basis of performance measures at the level of hospitals.

All hospitals at risk of not meeting the National Access Guarantees and/or Targets should be assisted to develop and publish a performance improvement plan which identifies the critical blockages to achievement and specific strategies to address them.

Reform direction 4.2

A share of the funding potentially available to public hospitals should be linked to meeting (or improving performance towards) the access guarantees and targets, payable as a bonus.

4.4.2 Timely provision of information on discharge

To improve the provision of information when people are discharged from hospital we propose that hospitals receive an incentive payment. The payment should be tied to the quality and timeliness of the information provided on a person's hospital care and any follow-up care required, where the person has consented to that information being provided to their nominated GP or other primary health care provider and/or the clinical staff of their aged care provider for those receiving aged care.

We suggest that, in order to receive the incentive payment, a hospital would have to achieve a rating of satisfactory or better for quality and timeliness of information from at least 80 per cent of primary health care practitioners, aged care facilities and other relevant recipients of discharge information within their vicinity.

We propose that, at a date to be set, discharge information should also be available in electronic form, according to a national standard for such information, to every person who wants it.

The financial incentive for all hospitals to provide discharge information in a standard electronic form should be that activity-based payments will not be made or will be discounted for any hospital that is unable to do so.

Reform direction 4.3

We propose there be financial incentives for timely provision of discharge information including details of any follow-up care required.

4.4.3 Paying for what's actually provided, with incentives for efficiency and better outcomes.

Hospitals are our most costly and complex health care organisations. Problems of quality or timely access to hospital care can cause the greatest public concern. In the end this requires consideration of how much is done in hospitals, and how much it costs or should cost. When people's lives and quality of life are at stake we tend to want to be sure that as much as should be done is being done. When billions of dollars are being spent, we want to be sure that the best possible use is being made of the funds. Together these imperatives raise questions such as whether our hospitals are as efficient as they could be. Could they do more with current levels of funding, or does it require more money to do more? How much more? The answers to these questions must come from a much better understanding of the relationship between what hospitals do and the levels of funding provided.

Understanding the relationship between funding and services provided is vital to improving access and to ensuring as many services as possible are provided with the available funds. That is why we propose the use of activity-based funding for all hospital services (discussed further in Chapter 13).

Activity-based funding requires an understanding of how much of what kinds of services will be provided, and what the efficient cost of providing them is. It rewards the efficient and puts the inefficient under pressure to improve. This is a critically important attribute for funding the most expensive services in our health system, and indeed those services for which expenditure is projected to grow fastest. If we are going to spend more, we should be certain that we will get more for it.

■ If we are going to spend more, we should be certain that we will get more for it

Activity-based funding provides a powerful incentive for hospitals to perform as efficiently as possible, maximising services provided for the available funds. This is a critical feature when people are waiting too long for care. Other advantages are that:

- It is person centred, in that the funding is tied to the treatment of people, not simply the funding of an organisation or the size and characteristics of a population.
- It is information rich – generating useful data on what services are provided to whom and at what cost across many different types of hospitals and services, enabling better understanding of the provision of hospital services.
- It is transparent, making clear on what basis funding is provided, with less opportunity for funding based upon influence or special pleading.

- It also increases hospital autonomy to deliver care within a clear funding and accountability framework – it separates and clarifies the role of the funder to determine, and be accountable for, the overall level of services to be provided and the level of funding to deliver those services, while requiring (and empowering) hospitals to deliver those services in the best possible way.

Because activity-based funding defines and specifies service outputs, it is also a remedy to cost-shifting. When a hospital receives a level of funding irrespective of the numbers and kinds of services it provides, there is an incentive to manage within budget by reducing service delivery and shifting provision to other providers, as this has no direct or immediate impact on its funding. Conversely a hospital can also find itself picking up the provision of services not adequately provided elsewhere, without any corresponding increase in its funding. Under activity-based funding with payment proportional to services provided, hospitals that provide fewer services by shifting provision to other providers will get less funding, while those that take on more should get more funding.

A further key strength of activity-based funding is that it can be used to pay for important hospital outputs other than treatment services. A critically important function of many hospitals is teaching health professionals. Under funding approaches that use general grants where funding is not tied to what is done, the pressure to provide services can result in resources being diverted from other important activities such as teaching. Activity-based funding can be used to define and pay for teaching. In particular, hospitals can be paid specifically for the number and kinds of clinical training placements they provide, and/or the number of completed months of training delivered, or even the numbers and kinds of students completing a recognised course.

A final strength of activity-based payment is that it can be used in conjunction with scientific evidence and economic evaluation to determine what should, and what should not, be paid for. If a particular treatment has no proven efficacy, or is less cost effective than an alternative, it is possible not to pay for that treatment under activity-based funding.[40] A crucial component of activity-based funding should be systematic use of evidence to inform what treatments qualify for payment, including hospital treatments.

Some may suggest that funding should be based on outcomes rather than activity. In principle they are right, but in practice it cannot be used as the primary basis of funding. It is technically very difficult to use outcomes to determine the base funding for a hospital, as it requires a capacity to measure outcomes reliably, to identify what part of those patient outcomes the hospital is responsible for, and to work out the precise cost of producing those outcomes efficiently.

For these reasons paying for outcomes or performance is best done as incentive payments at the margin, where outcomes, or at least the processes that reliably lead to good outcomes, can be identified and measured and are clearly attributable to the hospital. The amounts paid based upon outcomes may be only a small fraction of the cost of providing hospital services, but often such marginal payments can be quite influential in rewarding good practices and service delivery.

Overall, we believe hospital funding should be predominantly activity based, using nationally standard approaches, augmented by some use of payment for performance.

40 S Nicholson, M Pauly, A YA Wu and colleagues (2008), 'Getting Real Performance Out of Pay-for-Performance', The Milbank Quarterly 86 (3): 435–457.

Reform direction 4.4
We support the use of activity-based funding for both public and private hospitals using casemix classifications (including the cost of capital).
• This approach should be used for inpatient and outpatient treatment.
• Emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding.
• The costs to hospitals with a major emergency load of having to maintain capacity to admit people promptly should be recognised in the funding arrangements.

Activity-based funding for public hospitals should recognise the role of those who work in hospitals in determining how best to organise and deliver the various elements of an episode of care. In support of this we believe activity-based funding for public hospital care should be for whole episodes of care classified using casemix classifications – in particular Australian Refined Diagnosis Related Groups (AR-DRGs) for acute, admitted patient care; and classifications such as the Victorian Ambulatory Care System (VACS) for outpatients, and the Casemix Rehabilitation and Funding Tree (CRAFT) or Sub-acute, Non-acute and Palliative care (SNAP) classifications for sub-acute care and rehabilitation.

Emergency departments cannot be funded purely on an activity basis, as they are required to be available even when activity is low. Accordingly we propose that emergency departments be funded using a mix of a fixed grant for availability and a variable component related to activity, using a casemix classification. Similarly, hospitals with a major emergency load need to have stand-by bed capacity and on-call staff, irrespective of whether any person requires admission or the specific skills present on a given day. These costs, similar to the availability costs of emergency departments, need to be recognised in funding.

4.4.4 Improving outpatient care

To remove the incentive to shift costs, we suggest there is merit in having the same government fund specialist medical care provided privately in the community and specialist outpatient care provided in public hospitals. This will enable a much clearer focus on the relative health benefits of each care option and allow greater innovation in location and setting of specialist care. This reform direction is explained in more detail in Chapter 12.

This would create the opportunity for the development of policies and funding for outpatient clinics that is not driven primarily by cost shifting between governments, but rather has regard to achieving outcomes for people needing the kind of care provided by outpatient clinics. It will also enable a sensible appraisal of the best combination of outpatient clinics and private medical services for achieving health service outcomes. And with the Commonwealth also responsible for policies and funding for primary health care, it should enable the development of more integrated approaches to the provision of both primary and secondary care.

Many ambulatory services provided by hospitals do not require the expensive overheads inherent in inpatient provision. Over the last few decades, services which previously required inpatient care have been decentralised to community settings (renal dialysis and some outpatient services being examples). Decentralising these services can reduce travel time of those attending and, because they are of smaller scale, can provide a less institutionalised, more person-centred service.

Reform direction 4.5

We propose that all hospitals review provision of ambulatory services (outpatients) to ensure they are designed around patients' needs and, where possible, located in community settings.

4.4.5 Reporting on quality

> *A system that cannot openly scrutinise its processes, decisions and outcomes is unable to learn from what works and what does not and is therefore compromised in its capacity to implement improvements. For there to be open scrutiny, there must be reporting, and that reporting must be in a format that is understood and accessible. Only then can the system, services and individuals be held accountable. Accountability and transparency are essential parts of safety and quality.*[41]

As noted in Chapter 15, the Australian Healthcare and Hospitals Association has strongly advocated a nationally mandated 'balanced scorecard' of key performance indicators for the health of the entire nation. They emphasise the importance of timely feedback to the place of service delivery as well as to higher levels within the system – national, state/territory, area region.[42]

Reform direction 4.6

To improve quality, data on quality and safety should be collated, compared and provided back to hospitals, clinical units and clinicians in a timely fashion to expedite quality and quality improvement cycles. Hospitals should also be required to report on their strategies to improve safety and quality of care and actions taken in response to identified safety issues.

Women's Hospitals Australasia[43] and Children's Hospitals Australasia[44] also advocate for the national collection and analysis of key performance indicators to allow speciality hospitals in each state to compare results on patient outcomes and care processes. They note that peer pressure has been shown to be one of the most effective levers in changing practice and improving outcomes. This type of peer group benchmarking also encourages sharing of knowledge and best practice and reduces duplication of effort.

Reform direction 4.7

To improve accountability, we propose that public and private hospitals be required to report publicly on performance against a national set of indicators which measure access, efficiency and quality of care provided.

These performance measures should be based upon indicators developed by the Australian Commission on Safety and Quality in Health Care and should include nationally standard methods of surveying people on their experience as patients (see Reform direction 15.6).

41 Australian Council on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission.

42 Australian Healthcare and Hospitals Association (2008), National Data and Benchmarking.

43 Women's Hospitals Australasia (2008), Submission 436 to the National Health and Hospitals Reform Commission.

44 Children's Hospitals Australasia (2008), Submission 435 to the National Health and Hospitals Reform Commission.

4.4.6 Improving information for service design

One of the challenges to understanding the outcomes of health care in Australia and the relationship between hospital care, primary health care and aged care is that there is no linkage between hospital 'episode' data and care provided elsewhere. One solution to this, nationally, would be for public and private hospital episode data (inpatient for public and private, emergency department and outpatient for public hospitals) to be collected nationally with the patient's Medicare card number wherever available. These data could be provided direct to Medicare Australia, which has a 33-year track record of handling health information on Australians without incident.

This would provide a capacity to understand the use of hospitals by people, and also, through the use of the Medicare card number, would capture longitudinal data on people's use of medical benefits, pharmaceutical benefits, public and private hospitals and potentially aged care (residential and community care packages).

This would be enormously useful in understanding the relationship between use of GPs, use of specialists, use of prescription pharmaceuticals, use of hospitals and use of aged care. It would also enable monitoring of indicators such as avoidable admissions and unplanned re-admission to hospital even where this occurs at a hospital other than that which provided initial treatment.

A further benefit is that the program of voluntary Indigenous identification in Medicare Australia's data, that has been running for some years now, would provide powerful longitudinal and comparative data for a large sample of Aboriginal and Torres Strait Islander people – and it would do so without people needing to repeatedly re-identify to each service, each time they present.

Arguably being able to understand people's use of health services across settings and over time is a basic building block to support design of person-centred health care.

■ Being able to understand people's use of health services across settings and over time is a basic building block to support design of person-centred health care

Reform direction 4.8

We propose that public and private hospital episode data is collected nationally using a patient's Medicare card number to understand better people's use of health services and outcomes across different care settings.

These data should be routinely provided to the Australian Institute of Health and Welfare to undertake its work in reporting on Australia's health and health care. In addition, samples of de-identified data linked across all services should be made readily available to researchers to facilitate health services research

4.4.7 Balancing emergency and planned care

In the case for change we discussed separately two problems of timely access to hospital care – in emergency departments and for elective procedures. These are often competing objectives for hospitals, as improving performance on one can come at the expense of performance on the other. A critical issue for public hospitals is the need to balance provision of emergency care and planned admissions.

Maintaining bed occupancy at no more than 85 per cent to ensure ready admission from emergency departments can mean scheduling even fewer planned admissions for elective procedures.

Even following the best practices in managing bed availability, the need to use operating theatres and clinical staff at very short notice for patients admitted through emergency departments can disrupt the provision of scheduled procedures, requiring planned operations to be cancelled and rescheduled.

Patients admitted for emergency treatment are also significant users of other resources essential to the post-operative care of people undergoing planned surgery, such as intensive care, coronary care and high care units. The need to use these for an unplanned admission can also lead to a need to rescheduling of planned procedures, even when operating theatre time is still available.

Cancelling and rescheduling a planned procedure is highly disruptive for people in need of the procedure, who necessarily have to organise their lives around the planned procedure, and then have to reorganise again. In addition, to prevent a cascade of rescheduling, other planned operations cannot simply be rescheduled to give priority to the person who has suffered a cancellation. This means that a person suffering a cancellation may have to wait for some time before their next opportunity to have the planned procedure.

These disruptions can also apply to the clinical staff, who may have their operating theatre session sidelined by the need for a different clinical team to operate on an emergency patient.

This is a problem that in Australia is essentially limited to public hospitals, as very few private hospitals have emergency departments and those that do tend not to deal in the most serious cases such as major trauma. This is one of the reasons why private hospitals are good places to do planned procedures, because most of the caseload of private hospitals is planned admissions. In addition many private hospitals operate at significantly lower levels of occupancy than larger public hospitals, so even where there is a need to admit a patient urgently, it is less likely to disrupt the hospital's capacity to deliver planned care.[45] This is why contracting for the performance of planned public patient treatments in private hospitals can be effective in ensuring timely access to care.

One approach which can be very effective for the delivery of both planned and emergency care in public hospitals is to have specialised planned procedure hospitals or centres. This strategy has been used successfully in other countries and was recommended by many during our consultation.

> *Elective surgical services should be quarantined from acute services to provide more efficient and predictable patient outcomes. Access to surgeons in the hospital with availability to theatres in a very prompt manner is essential for more reliable emergency surgery.*[46]

This separates completely the facilities and staff responsible for providing planned procedures from those providing emergency procedures. Understandably this model is only practicable where there is a sufficient volume of both kinds of cases to make full use of separate facilities and staff.

These can be 'hospitals within hospitals' – in similar fashion to day surgery suites in public and private hospitals. That is, specialised planned procedure units can be established as separate facilities as part of a larger hospital and co-located in the same precinct, an example being The Alfred Centre in Melbourne.[47] But it is also possible to achieve the same effect in cities with many hospitals by designating particular hospitals as being dedicated to planned procedures. This would entail relocating any emergency department capacity to another hospital in reasonable proximity.

Such developments require regional planning and the careful delineation of hospital roles and facilities across multiple sites. Undertaking this is well beyond our scope; however, we do suggest that consideration be given to further planning and development of specialised facilities for planned procedures in Australia's major cities. While investment criteria for public and private services are often different, hospital developments are expensive and it is therefore important that duplication of facilities between the public and the private sector be avoided. This also has implications for planning emergency hospital capacity, as mentioned earlier.

---

45 Based on data in Australian Institute of Health and Welfare (2008), Australian Hospitals Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra), the national average occupancy of public hospitals is 86 per cent while for private hospitals, not including standalone private day hospitals, the figure is 76 per cent.

46 Royal Australian College of Surgeons, Submission 406 to the National Health and Hospitals Reform Commission.

47 At: http://www.baysidehealth.org.au/Department.aspx?ID=284

Reform direction 4.9

We suggest that the future planning of hospitals should encourage greater delineation of hospital roles including separation of planned and emergency treatment, and optimise the provision and use of public and private hospital services.

4.4.8 Clinical leadership and governance

There should be effective systems of clinical governance at all levels of the health system to ensure continuous improvement in the safety and quality of health care. Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement.[48]

A key feature of new national clinical governance arrangements should be development of national clinical standards and approval of nationally endorsed care pathways (see Chapter 15). A national approach must be taken to ensure that the best available evidence is used in patient treatment, wherever a patient is treated and by whichever professional. This means that care paths for common conditions need to be available and followed. Financial incentives will also play a part here through practice improvement payments (the term used in the USA is 'pay for performance'). Nationally developed and agreed clinical standards should be a core feature of new facility accreditation arrangements proposed by the Australian Commission on Safety and Quality in Health Care.

Safety and quality can only be improved if the Australian health care system acknowledges errors and learns from mistakes. We need to promote and encourage a learning culture in health care, through research and reflection.

But things do go wrong in hospitals and patients are harmed. The first step in moving forward is to recognise that accidents happen – they are in fact 'normal'.[49] There is no serious scholar of safety and quality today who doesn't advocate a 'systems approach' to learning from mistakes, slips and errors and this is what most health systems and health facilities attempt to follow.

A systems approach, though, is not about a 'no fault' approach, as sometimes a professional's actions are 'blameworthy'; for example, when working under the influence of drugs or when involved in criminal activities as occurred with Harold Shipman.[50] Nevertheless, what must be pursued is a 'just culture'. A tragedy involving a patient can't and shouldn't be ignored, but a witch-hunt shouldn't be the starting response.

■ A tragedy involving a patient can't and shouldn't be ignored, but a witch-hunt shouldn't be the starting response

Building a quality performance dimension into local service structures and employment agreements will also help concentrate the attention of both health professionals and managers. Indeed there is a growing realisation of the importance of using government funding levers to hasten the reform agenda in safety and quality. We believe that as a starting point financial incentives to reward continuity and quality of care should be adopted. In Chapter 14 we have identified the importance of ensuring a motivated and engaged clinical workforce. We have suggested clinical senates (already existing in SA and WA) as a possible means of achieving that at a state level. The same issue is relevant at the national level: that national policy is formulated with systematic input from clinicians – medical and non-medical.

48 Australian Council on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission.

49 C Perrow (1984), Normal Accidents: Living With High Risk Technologies (Basic Books: New York).

50 J Smith (2002), The Shipman Inquiry, UK. Harold Shipman was a general practitioner in England who diverted narcotics for his own use and to murder his patients. He is estimated to have killed 215 people.

A further method of engagement on specific issues including those identified in this report would be the establishment of clinical networks as is already happening in a number of states and territories.

> *A series of Statewide Clinical Networks are being established to increase the level of clinicians' involvement in the planning of health services, to find ways to better coordinate the delivery of those services, to ensure better health outcomes for all South Australians and to ensure a strong, sustainable health workforce.*
>
> *These networks will link doctors, nurses, allied health professionals, GPs and community representatives to better work together to assist in fully integrating service provision across hospital sites and GP Plus Health Care Services. For example, the Cancer Clinical Network will explore ways in which country people can receive the majority of their cancer care closer to home. This could be receiving chemotherapy at home or visiting their local specialist. The Orthopaedic Clinical Network will work to identify ways to prevent falls among the elderly and ways in which increased access to elective orthopaedic surgery can be achieved.*
>
> *Clinical Networks will also have a key role in improving the performance of our hospitals by improving safety and quality, reducing the length of hospital stays to national benchmarks, reducing emergency department waiting times and working with community-based services to allow patients to be discharged from hospitals where appropriate and receive care at home.*[51]

Reform direction 4.10

We propose a nationally led, systemic approach to encouraging, supporting and harnessing clinical leadership within hospitals and broader health settings and across professional disciplines.

51 South Australian Government (2008), South Australia's Health Care Plan 2007–2016, attachment to Submission 458 to the National health and Hospitals Reform Commission.