Legislative Council Inquiry into the Tasmanian Public Hospital System

Evidence prepared by the

Australian Medical Association

Tasmania

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AMA

RECOMMENDATIONS

1. Sufficient resourcing of the Tasmanian public hospital system to provide for an average bed occupancy of 85%.
2. The development of evidence-based funding programs for acute hospital patient care.
3. The creation of a *Statewide Medical Services Planning Committee* with the authority to develop, implement and monitor clinical services in our public hospitals, including the acquisition of major capital equipment for the State's public hospitals. This committee would advise the Minister directly.
4. Decision making, planning and implementation should be completely transparent and accountable at State and local hospital levels.
5. The development of reporting systems to clearly identify the value to patient care of incremental health expenditure annually.
6. The implementation of efficient and effective Human Resources systems.
7. Greater devolution of management functions from DHHS central administration in Davey Street to each of the three major public hospitals.
8. The development of realistic accrual based budgets.
9. Introduction of capital replacement budgets to automatically provide for replacement of plant, infrastructure and equipment.
10. Introduction of best practice clinical software for patient care, clinical communication, audits, and morbidity and mortality data and research, which is responsive to the needs of doctors and nurses caring for patients.
11. Funding for and training of all graduates of the University of Tasmania Medical School.

QUESTIONS

In the course of preparing this submission, the AMA found much useful information readily available from the public record. Having said this, some essential details were not accessible and in view of this the AMA requests that the Committee ask the Minister for Health or her representatives the following questions:

1. What are the FTE staffing numbers and case-mix separations for each of the three hospitals over a five year period?

2. What is the annual cost of providing emergency services and elective services that would meet the recommendations of the Australian Institute of Health and Welfare for categories 1, 2 and 3? [DHHS would need an accurate number of cases by mix and would need to multiply each case by the appropriate unit cost of treatment.]

3. What is the projected change in acute hospital service demand each year for the next five, ten and fifteen years?

4. What strategies have been implemented to meet the demand in Q3?

5. What is the appropriate Health Inflation Index to apply for each of these projections in Q3?

6. What are the costs by case-mix per separation by diagnostic category and what has been the trend(s) over the last five years?

7. What are the DHHS' overheads in its central office? [detailed breakdown]

8. How many patients scheduled for elective surgery are cancelled annually and what is the trend over the last five years?

9. What were the reasons for cancellations of elective surgery? [detailed analysis]

10. Of the recent reduction in waiting list numbers, what proportion were day cases?

11. Of the total number of theatre sessions available, what proportion is actually utilised?

12. What is the relationship of the total theatre sessional capacity to those theatres opened with currently available staff?

13. What is the number of ambulance "*treatment not transport*" (TNT) episodes for the most recent year and what has been the trend over the last five years? What is the proportion of TNT to total ambulance emergency episodes of service over the same period?

14. How can DHHS claim that “GP-style” patients ‘clog-up’ Emergency Departments when it does not define a GP patient? What are the data that DHHS use to back its claim? [detailed analysis]

15. Given the perennial difficulty in enumerating and defining staff employed by DHHS, AMA requests:

    a. FTE staffing numbers cross-classified by

        i. staffing category (doctor, nurse, allied health, clerical and administration, domestic and other)

        ii. work location (hospitals, ambulance service, disability services, community health, central office and other).

    b. Time series analysis of these data be provided for each of the five years to June, 2008 in order to identify trends.

16. What numbers of private patients and eligible veterans were treated in Tasmanian government hospitals last year (actual number and percentage of total) and what has been the trend over the last five years?

17. In relation to the acknowledged problem of long stay nursing home and rehabilitation patients awaiting placement in acute hospital beds and thereby limiting emergency and elective admissions – does not DHHS have a perverse financial incentive to maximize the numbers of these patients in its hospitals?

18. What is the ratio of bureaucrats to desktop and server computers in their direct use, and what is the corresponding ratio for medical officers?

19. What electronic off-site access do Visiting Medical Officers (VMOs) have to relevant clinical hospital databases?

20. What plan does the DHHS/State Government have to ensure that sufficient quality pre and post registration training positions are available for the increasing numbers of students graduating from the University of Tasmania Medical School in the next five years?

INTRODUCTION

The Australian Medical Association Tasmania (AMA) congratulates the Tasmanian Legislative Council in establishing a broad ranging inquiry into the operations of Acute Health Services, Department of Health and Human Services (DHHS).

The AMA was disturbed to note an Australian Institute of Health and Welfare (AIHW) report[1] revealed which Tasmania spent fourth most per capita on public hospital patients in the Commonwealth but performed last or second last on the major criteria of

- waiting lists.
- waiting times.
- percentages of patients treated by category.

The State Government was to be commended for spending at the median level of Australian States. However, a more recent report[2] reveals that Tasmania is now *second last* in public hospital expenditure.

Tasmanian patients do not necessarily get best value for the money spent on the State hospital system and have poorer access to hospital and medical services than other Australians. There is clearly a need for better planning with more medical input and less bureaucracy. Every dollar spent on unnecessary bureaucracy is a dollar that is not available for patient care. In other words, *more beds not desks*.

Statewide Medical Services Planning Committee

In the view of the AMA, DHHS has failed to take full advantage of the medical profession's willingness to fully participate in planning for clinical services.

Members of the Committee should be aware that there was no attempt at overall planning on a statewide level until the AMA recommended to the current Minister for Health that a Clinical Services Plan be developed. Despite this recommendation being accepted two years ago, all we have seen to date is an abundance of projects and newsletters but no substantive strategic view for implementation of reforms.

The AMA's view is that DHHS and the Government must work with clinicians to serve the needs of our patients. Unfortunately, our members see a system that operates in isolation from patient care rather than supporting clinical staff in providing that care. AMA believes that DHHS's current systems are process rather than patient orientated.

Discussions with senior clinicians indicate that DHHS has not adequately consulted with the medical profession in developing and implementing policy. The usual result is a proliferation of committees and project officers leading to development of policies which slavishly follow other jurisdictions and which are not based on best evidence. It is important that any such committees and/or working groups need to be relevant, well-constituted, targeted and accountable.

The AMA strongly supports the creation of a *Statewide Medical Services Planning Committee (SMSPC):* a simpler, more cost effective approach for acute health services planning in Tasmania.

The AMA believes that more could be achieved in planning by arranging for representatives of medical craft groups from around the State to develop policy for local and statewide implementation of clinical services in those disciplines.

Goals and priorities would be clearly identified as a result and refinement of those objectives would then be fully developed with DHHS officers in consultation with a nominated representative of each respective clinical planning group. A *Statewide Medical Services Planning Committee*, comprising representative clinicians from each group, the Secretary of DHHS, the Deputy Secretary for Acute Health Services and hospital CEOs would then consider recommendations put forward from each planning group.

At a meeting in Launceston on 4 April, 2008 with the Secretary of the Department, Mr David Roberts, Dr Scott Parkes (Chairman of the LGH Medical Staff Association), and Dr Michael Aizen, it was recommended to Mr Roberts that DHHS set up an SMSPC. To date there has been no response.

Expanding on the lack of consultation theme, it is the repeated experience of the AMA that proposed health-related legislation has not been referred to the Association in a timely fashion for review and input prior to being tabled in Parliament.

Human Resources

From the perspective of our members DHHS human resources management is dysfunctional, centralized and inflexible with multiple layers of bureaucracy which effectively impede the timely employment of essential clinical staff.

AMA members who work in the public hospital system as Salaried or Visiting Medical Officers have expressed and continue to express concern that DHHS bureaucracy is slow to respond and frequently obstructive when approached to correct staffing and also equipment deficiencies.

The Richardson and Wellington reports both identified difficulties with HR management centralized at head office in Davey Street, Hobart. Decisions that ought properly be made at a local level are currently processed through multiple managers and committees. There is a requirement for clinical staff to sacrifice time more properly spent on patient care to prepare overly complex submissions when requesting additional or even replacement staff. Clearly the process requires an overhaul and there should be scope for staffing and equipment requirements to be administered and funded at a local level.

State hospital underfunding

Members of the Committee should ask DHHS for a breakdown of staff numbers and patient separations for each of the three State hospitals with five year trend data.

Tasmania's major hospitals have been significantly underfunded for many years. Staffing accounts for approximately 70% of recurrent expenditure but budgeting for each hospital is not based on *projected case-mix separations.* Indeed, there may be no correlation between staffing levels and productivity.

Funding to hospitals has been historically based with subsequent increases set well below the Health Inflation Index.[3] There would appear to be no real understanding by DHHS of the resources required to provide high standard and timely care, particularly for Category 2 and 3 patients on the waiting lists around the State.

The *Australian Institute of Health and Welfare* (AIHW) recommends treatment in our hospitals by category.

- Category 1 is the most urgent with treatment recommended within 30 days from placement on the waiting list.
- Category 2 patients are those who should be admitted within 90 days.
- Category 3 patients should be admitted within 12 months.[4]

AMA notes the failure of the DHHS and this State government to calculate the cost of providing treatment according to AIHW criteria.

Also the Royal Hobart Hospital (RHH) and the Launceston General Hospital (LGH) provide services referred by other regions but DHHS cannot identify these cases and therefore these hospitals are not appropriately funded.

This ongoing funding anomaly is largely the result of a combination of

- Historical bases
- Political expediency
- Cash budgeting

An alternative is a*ccrual* budgeting which is used in many businesses and organisations. This recognises anticipated equipment and infrastructure repair and replacement costs. This is not currently the case in Tasmanian hospitals although a model of this system is planned to run in parallel with the cash budget in Launceston this year.

Until this was proposed very recently, there was no accounting for depreciation and writing off of assets and there were no funds earmarked specifically for replacement of plant and equipment once these had reached the end of their serviceable lives. Under the current system, when equipment wears out or becomes obsolete, clinical staff are frequently required to put patient care to one side in order to prepare long winded submissions for replacement. The money then has to be found from departmental budgets not adequately funded for this purpose. Clearly adequate financial resources need to be available for recurrent funding of obsolete or worn-out equipment.

Information technology

It is impossible to conceive of or expect our bureaucrats to use hand written notes as their principal means of communication. Yet this is exactly how DHHS expects clinical staff to communicate with each other within hospitals and with community-based medical practitioners. Patients' well being and safety are put at risk every day because of this.

AMA Tasmania considers it essential that modern Information Technology systems be made available to clinicians to improve internal and external flows of clinical information.

Given the new era of relatively short patients stays in hospital and the limited supplies of medication given to patients on discharge, it is essential for GPs to receive timely, high-quality and legible discharge summaries immediately their patients are discharged. Hospital IT systems should also support user-friendly prescribing and clinical decision-support software to optimize patient safety, research, and morbidity and mortality data collection.

Although information system programmers are located in each of the three acute hospitals, CEOs have no administrative control over them and clinicians cannot utilize their skills in developing user friendly software and systems.

In addition, it is apparent to teaching general practices in the community that students in their fifth year of medical school have never seen a 'computer screen' of clinical software which is now commonplace in Australian general practice. This is a sad indictment of the lack of 'hi-tech' teaching in our State's medical school, and naturally would give a low expectation on the availability and use of clinical IT tools when students graduate to become interns in our hospitals.

Intern positions

In response to a nationwide shortage of doctors resulting from very poor planning on the part of the Commonwealth about a decade ago, the previous Federal Government made funds available to Australian Universities to greatly increase intakes into medical schools around the country.

In 2 or 3 years time, the numbers graduating will vastly outstrip the ability of State hospitals around Australia to provide the essential first year post graduation hospital training positions (internship) which enable these graduates to be registered as medical practitioners. These medical graduates will then not be able work as doctors in any capacity, a huge disappointment for them after 5 or 6 years of intense study and an absolute waste of talent and the significant resources expended by the nation in training such essential personnel.

For example, at the end of 2008, it is anticipated that 83 medical students will complete the final year of their training at the University of Tasmania. There are currently 58 positions available for interns in Tasmanian hospitals in 2009. Fortunately there are sufficient positions available interstate at present to absorb the overflow, however in 3 years there will be 110 students graduating in Tasmania and the interstate positions will all be oversubscribed by the larger numbers graduating in the other States at that time.

At the Council of Australian Governments meeting on 14 July, 2006 the previous Premier of Tasmania (Paul Lennon) accepted additional Australian Government funding to provide pre-registration intern training for every University of Tasmania medical graduate.

The AMA is unable to find any evidence that this critical Intern training commitment has been, or is likely to be, honoured.

ISSUES IN DETAIL

Elective surgery

ADMISSIONS

Public patient admissions per 1,000 weighted population are fewer in Tasmania than any other state or territory at 150 patients per 1,000 population when the national average is 188.[5]

BEDS

Tasmania is equal 5th across jurisdictions for the average available beds per 1,000 weighted population, with 2.5 beds per 1,000 people in public hospitals.[6]

AVERAGE LENGTH OF STAY

Average length of stay for overnight patients is longer in Tasmania than any other state or territory at 7.4 days, when the national average was 6.5 days.[7]

FUNDING

Recurrent public hospital expenditure per person in 2006-07 is second lowest of any jurisdiction in the country at $1,131 per person compared with the national average of $1,213 per person.[8]

ACCREDITATION

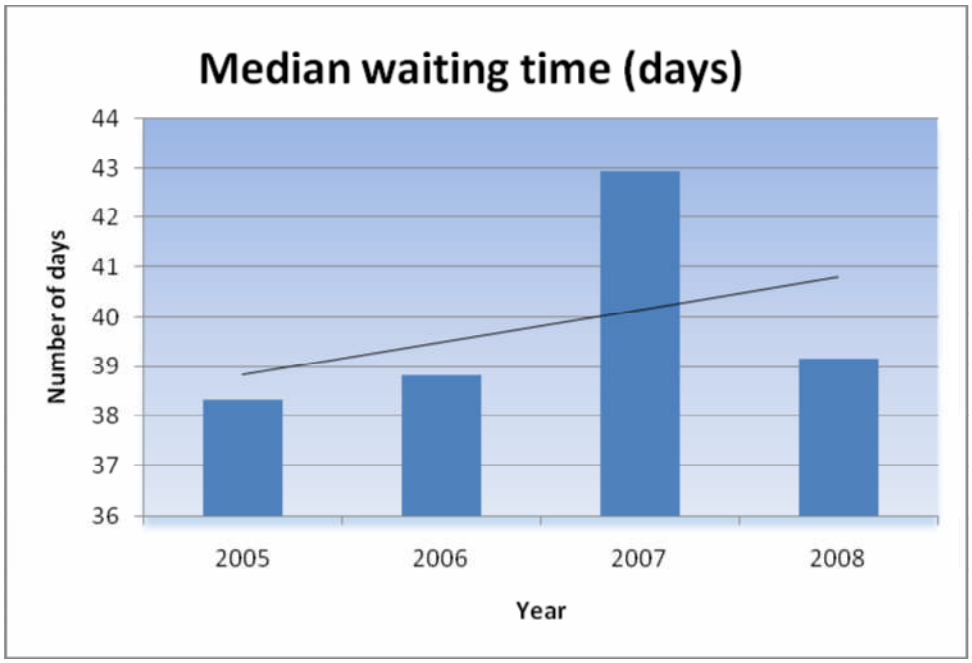
The percentage of public hospitals and public hospital beds accredited in Tasmania is by far and away the lowest across any jurisdiction in the country, with only 19% of public hospitals and 83% of public hospital beds accredited in 2006-07.[9]

ELECTIVE SURGERY WAITING TIMES

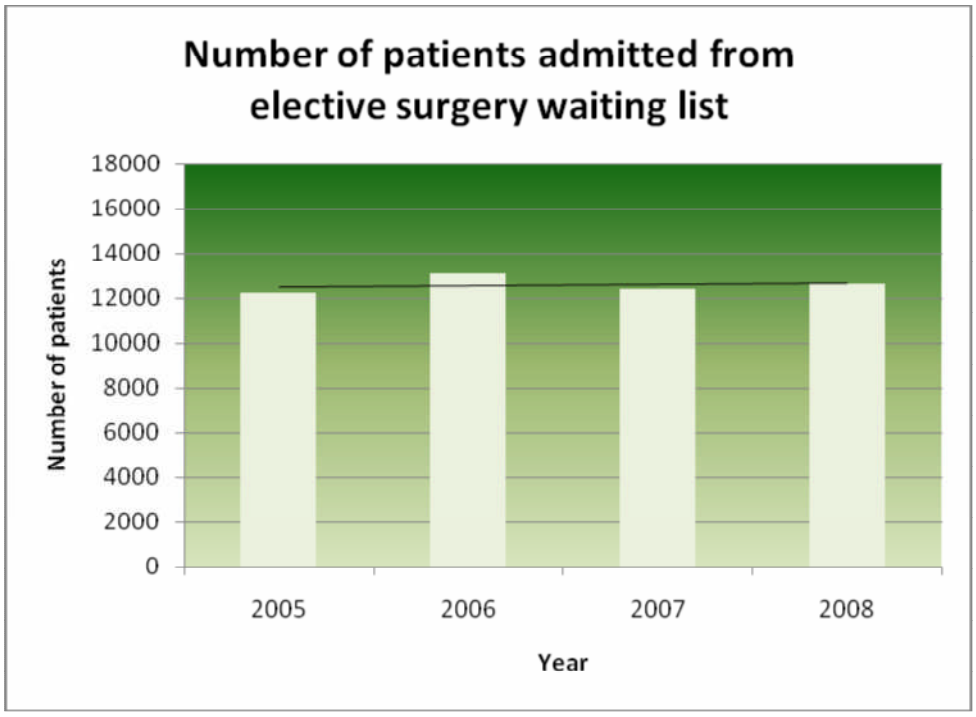
The percentage of admissions for elective surgery seen within the recommended time in Tasmania was 68% overall, lowest in the country.[10]

The percentage of elective surgery patients waiting for more than 365 days is third worst across all states/territories, with 9.2% of elective surgery patients waiting more than one year.[11]

Data from Your *Health and Human Services Progress Chart, 2008,*[12] reveal the following trends. Median waiting times and admissions from the elective surgery waiting lists have shown adverse trends in recent years.



The long term trend is for longer median waiting times for elective surgery.



Admission of patients from the waiting list has barely changed over four years from 12,200 in 2005 to 12,600 in 2008 despite additional funding.

Tasmania continues to languish at the bottom of the ladder.

Theatre Management

The scheduling of theatres is intimately linked to a variety of factors viz. availability of beds for elective admissions, demand for urgent non-scheduled cases, the availability of intensive care beds where appropriate and the availability of theatre staff. Our members often experience the sudden cancellation of their lists because their elective cases were not admitted, because emergency cases have replaced the scheduled ones, because intensive care beds were not available or because theatre staff were not available. When they do have an opportunity to operate, surgeons may also have their lists cut short because hospital administrations will demand completion of lists by a predetermined time.

It is clear that current overall theatre capacity is not enough to reduce waiting lists to and maintain them at acceptable levels.

Possible Reforms

AMA Tasmania suggests the following:

- Budgeting for AIHW throughput targets**.**
- Ensuring that there is a sufficient number of acute beds available in each hospital to run at an average 85% occupancy.
- Providing sufficient capacity to allow for emergency operating theatres around the clock.
- Providing sufficient numbers of intensive care beds to ensure that cancellation of major elective surgery occurs only very rarely.
- Employing sufficient numbers of nurses for adequate staffing of theatres, general and intensive care beds

Emergency Departments

Tasmania is fortunate in having the lowest number of Emergency Department (ED) presentations in the country. With 233 presentations per 1,000 weighted population it is well below the national median of 311.[13] Our waiting times and percentage seen within the recommended time are on par with other jurisdictions but this meant that only 64% were seen within the recommended time despite the relatively low numbers presenting. [14]

Waiting Times – 'ramping'

While waiting times to be seen are well within the norm, the real problems arise in finding inpatient beds for patients who need admission. This, in turn, has an effect on ambulances arriving with additional patients. These new patients must wait in ambulances parked outside the entrance to the ED, a phenomenon colloquially known as "ramping". Ramping is an increasing problem for patients, medical and

nursing staff and ambulance officers alike, often tying up ambulances for hours at a time.

AMA has anecdotal evidence that ambulance officers sometimes decide not to take patients to hospital because of this. This scenario is called "*Treatment not Transport*" (TNT).

Admission to Inpatient Services

As a result of all of the foregoing factors patient care is put at risk. Sick patients are left on trolleys, often sharing single bay treatment areas, lying on waiting benches and sometimes on the floor. Procedures that were previously the preserve of inpatient areas are now commonplace in EDs eg cardioversion, pleural taps etc.

There is evidence from the medical literature that prolonged waiting for inpatient admission in emergency departments increases mortality and morbidity. [15]

Not only is it harmful for patients but ED staff also become very stressed as a result and morale suffers. Stressed and demoralized staff take more sick leave and there is greater staff turnover than other hospital departments.

Our Emergency Departments face considerable pressure of increasing workload from the increasing number and complexity of patients presenting; markedly compounded by unprecedented levels of access block.

Alternative Workforce and Planning Strategies

It is highly desirable that public hospitals should operate at an average of 85% of total capacity. At this level, unplanned admissions can be accommodated without undue delays.

We know from Commonwealth data that was utilized for the *"AMA Public Hospital Report Card 2007"* that by State and Territory our public hospitals are working at unsafe occupancy levels. Public hospitals do not routinely publish bed occupancy data, but we know from our members working in the public hospital system that bed occupancy in the major teaching hospitals in Australia is routinely in the 95-100% range or more. Bed occupancy levels of this degree are unsafe and lead to serious delays in the Emergency Department, treatment in corridors, multiple patients in treatment bays etc.

It has been demonstrated with historical and prospective data that, when bed occupancy rates are reduced towards 85%, this allows patient transfer to the wards, which in turn, frees up EDs so that patients who are waiting can be seen and processed, reducing ED length of stay. [16]

It is only when overall bed occupancy is at the 85% level or lower that EDs are able to function smoothly.

Lack of access to beds for patients awaiting surgery often results in these patients presenting to the ED for emergency management, thus compounding the situation.

Genuine 'GP-type' patients presenting to EDs are about 10% of presentations and consume about 1% of ED resources and are not a cause of admission pressure.[17]

Hospitals do not collect information on what is a 'GP-type' patient.

Diversion of low acuity (i.e. 'GP type') presentations and use of telephone services to decrease ED presentations do not work to reduce access block and ED overcrowding. Also, some researchers have suggested increased co-located after hours GP services to reduce ED presentations, but these have been unsuccessful in Australia.

It must be accepted that increasing the number of hospital beds is a priority if we are to restore bed occupancy to safe and manageable levels given current population growth, increased longevity and the ageing of our population.

In addition, the requirement for public hospitals to maintain a bed occupancy rate of 85% or lower should become a national performance benchmark. This can only be achieved by a 15-20% increase in bed capacity in our public hospitals.

The Australian College of Emergency Medicine has conducted a literature search and has concluded that overcrowding in Emergency Departments can be addressed only by increasing the overall capacity of hospitals.[18]

It is clear to the AMA that there are not enough available beds to meet demand in the public hospital system.

There are many staffing issues in Emergency Departments but the most pressing at present is the lack of specialists. The inability to recruit is putting a very heavy work load on the few remaining specialists and unless there is relief in the near future further resignations appear to be inevitable. This would then have a flow-on effect for those increasingly few who remain. It also has major implications in the ability to recruit and retain registrars and for Emergency Departments to provide all the services that they are expected to.

The AMA also has concerns regarding plans by government hospitals (eg. LGH Circular to GPs 28/10/08) to increase their employment of GPs in their EDs.

General treatment and/or admission to the public hospital system

Access to Public Hospital Beds

Committee members should also be aware of the existence of a *hospital "pre-waiting" list*.

The following scenario is not uncommon:

A GP sees a patient who requires a hip replacement. Under current practice the Specialist Clinic at the hospital will accept referrals of patients by facsimile message only. The patient is referred. The specialist sees the referral and categorizes the patient for an appointment which may range from one week to, incredibly, twelve months (eg. LGH diabetes clinic). None of these data are available and these patients are not considered to be on a waiting list when clearly they are.

Patients on this pre-waiting list have not been personally assessed by hospital specialists (relying on the referral letter from the GP for prioritisation) and so clearly may be at risk. Further, patients on the pre-waiting list have to continue to be cared for by their GP when quite clearly their GP has made a decision that they require specialist hospital attention and care.

Not surprisingly, there is no data available to comment on the time from appointment to being seen in the Clinic.

Rehabilitation services

Considerable attention has been given recently to rehabilitation services. A report commissioned by DHHS [19] has revealed gross underinvestment in rehabilitation services over the last 20 years resulting in poor recovery from treatment and prolonged inpatient stays. It has been demonstrated that timely, appropriate and coordinated rehabilitation will reduce the post medical and surgical treatment time in hospital. [20]

DHHS must establish a framework for rehabilitation and increase the number of rehabilitation beds in the State by approximately 100 with appropriate attention to their geographic distribution.

Aged care

There will always be a number of frail elderly patients who cannot be returned home or to low level community care. *These frail-elderly patients who require nursing home care can occupy an acute bed for an average of six weeks*. Some patients wait up to ten weeks for nursing home placement. [21]

With an average bed occupancy of three days for acute patients this in effect means that, on average, *up to 15 patients cannot be treated for each nursing home patient awaiting placement.*

AMA Tasmania suggests *that the three major public hospitals assume direct administrative control of the smaller hospitals in their catchment areas.*

Currently Community Health Services are responsible for these services. Not only could transfers be effected smoothly, the larger hospitals would also assume responsibility for medical, nursing and allied health staffing in those smaller hospitals. Consultation with local General Practitioners (GPs) would be of utmost importance.

The challenge for the State is to fund and create transitional and nursing home beds outside the hospital, or to use funds to place these patients in existing nursing homes.

Lack of rehabilitation services is another rate limiting factor in discharging patients. Milne and Eagar concluded that rehabilitation services in Tasmania were well below that of other jurisdictions, were not organized and placed heavy demands on existing acute beds. On average, up to 100 acute care beds in Tasmanian public hospitals are occupied by rehabilitation and other subacute patients. [22]

The authors also noted the following:

- A shortfall of 50 to 60 designated rehabilitation beds
- Medical and allied health staffing levels well short of recommended numbers.
- Lack of ambulatory services limits alternative options for those who require them.
- That shortages of allied health staff and alternative rehabilitation options have a negative impact on health care outcomes and length of stay. [23]

Full-time equivalent staffing

Direct Health Care

AMA research into staffing suggests the following:

1. Tasmanian hospitals have slightly below-average staffing using a crude measure of patient days as the "output" for a ratio calculation. Note that patient days only capture the in-patient workload.

2. Salaried medical officers in Tasmania as a percentage of total staffing are on the average of all States and Territories.

3. Nurses in Tasmania as a percentage of total staffing are slightly above the all states average;

4. Diagnostic & allied health professionals in Tasmania as a percentage of total staffing are below average (9.2% of public hospital staff compared with national average of 14.6%.); therefore

5. All health professionals in Tasmania as a percentage of total staffing are below average (64.3% of the staff cf. 69.3% on average);

6. Clerical and administrative staff in Tasmania as % of total staffing are slightly below average (14.6% cf. 15.7%), and if at the average there would be 50 more of them; and

7. Domestic and other staff in Tasmania as % of total staffing is well above average (19.3% cf. 14.1%), and if at the average there would be 260 fewer of them.

Caveats:

- A major problem with these data is that they only capture the administrative and clerical data for the hospitals themselves. The ideal measure would take account of all the "overhead" staff in health departments and area health authorities as well, at least to the extent that they work on hospital issues.

- There is no way of telling whether the differences in staffing patterns reflect different practices as to what is contracted out and what performed in-house by employed staff.

- AIHW reports that data for two small hospitals in Tasmania were not supplied. Therefore, Tasmanian staff numbers are under-estimates.

- Not all states report in a consistent manner. Not all staff categories are directly comparable state to state.

The analysis leads to the conclusion that an excess of administrative staff **within the hospitals** may not be a relatively larger problem in Tasmania. That does not tell us whether or not there is a problem with the Tasmania health department or not. And it still may be a problem Australia-wide, i.e. being better than, or no worse than, other States does not mean that we are performing well in any absolute sense.

At face value, the number of domestic and other staff appears very high compared with other states and also relative to the workload. That is a standout feature and may be worth probing.

AIHW reports average staffing (FTE terms) of 5,013 in public hospitals in 2006-07.

The Tasmanian Department of Health and Human Services reports 10,843 paid employees as at 30 June 2007 (not year-average), equivalent to 8,992 FTE.

In broad terms, therefore, nearly 3,000 DHHS Tas employees work outside the hospitals.

We were unable to find any data in the annual report as to how many staff are employed in "head office" as opposed to other service delivery units (community health, disability services, child protection, etc).

There are, however, some data on the number of health professionals. Mixing and matching year-average and end-year data, we could infer that health professionals represented 55% of DHHS Tasmania staffing and that there were nearly 1,700 health professionals employed by the Department in settings other than the hospitals, comprising (in round terms) 100 doctors, 760 nurses and 600 allied health professionals.

Average FTE staff, public acute and psychiatric hospitals, States and Territories, 2006-07

Staffing category	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Salaried medical officers	7,636	6,058	4,965	2,460	2,118	519	423	347	24,526
Registered nurses	na	na	15,077	9,092	6,932	2,008	1,468	1,072	35,649
Enrolled nurses	na	na	2,444	406	1,813	237	291	141	5,332
Student nurses	..	..	10	..	76	..	..	..	86
Total nurses	36,462	26,431	17,531	9,498	8,821	2,245	1,759	1,213	103,960
Other personal care staff	na	na	925	5	733	89	171	15	1,938
Diagnostic and allied health professionals	11,680	12,223	4,464	2,739	1,919	459	455	302	34,241
Administrative and clerical staff	12,334	10,007	5,556	3,988	3,199	733	590	436	36,843
Domestic and other staff	11,477	6,724	7,110	4,237	1,977	968	170	540	33,203
Total staff	**79,589**	**61,443**	**40,551**	**22,927**	**18,767**	**5,013**	**3,568**	**2,853**	**234,711**

Sub-total health professionals	55,778	44,712	26,960	14,697	12,858	3,223	2,637	1,862	162,727
% of total FTE staffing:									
Salaried medical officers	9.6%	9.9%	12.2%	10.7%	11.3%	10.4%	11.9%	12.2%	10.4%
Nurses	45.8%	43.0%	43.2%	41.4%	47.0%	44.8%	49.3%	42.5%	44.3%
Diagnostic & allied health professionals	14.7%	19.9%	11.0%	11.9%	10.2%	**9.2%**	12.8%	10.6%	14.6%
Health professionals	70.1%	72.8%	66.5%	64.1%	68.5%	64.3%	73.9%	65.3%	69.3%
Administrative and clerical staff	15.5%	16.3%	13.7%	17.4%	17.0%	14.6%	16.5%	15.3%	15.7%
Domestic and other staff	14.4%	10.9%	17.5%	18.5%	10.5%	**19.3%**	4.8%	18.9%	14.1%
If Tasmania staffed at all states average, total numbers in categories									
Health professionals						3,476			
Administrative and clerical staff						787			
Domestic and other staff						709			
If Tasmania staffed at all states average, change in numbers in categories									

Health professionals						**+253**			
Administrative and clerical staff						+54			
Domestic and other staff						**-259**			
Number of patient days	6,015,425	4,419,117	2,872,078	1,610,062	1,598,163	406,365	260,346	257,532	17,439,088
Staff members per 1,000 patient days	13.2	13.9	14.1	14.2	11.7	12.3	13.7	11.1	13.5
Domestic & other per 1,000 patient days	1.9	1.5	2.5	2.6	1.2	**2.4**	0.7	2.1	1.9

Source: Australian Hospital Statistics 2006-07, Tables 3.5 (staffing numbers) & 2.4 (patient days).

Administrative Staff who do not deliver Direct Patient Care.

Given the difficulty in enumerating and defining staff employed outside our hospitals, AMA suggests the Committee requests detailed data from DHHS. In particular, FTE staffing numbers cross-classified by staffing category (doctor, nurse, allied health, clerical and administration, domestic and other) and by work location (hospitals, ambulance service, disability services, community health, central office and other). We also request that these data be provided for each of the five years to June, 2008 in order to identify trends.

WORKFORCE PLANNING STRATEGIES

Recruitment and Retention of Health Care Workers

Our members have consistently complained about delays in advertising for positions, even though funding has been approved, and the long appointment process once applications have been received. Notwithstanding that Human Resources and Information Technology personnel are physically within our hospitals, the hospital managers have no administrative control over them.

AMA suggests that DHHS fully devolve staff and positions to the hospitals for the purpose of internal management.

Another major area of concern is the relationship between DHHS and Visiting Medical Officers (VMOs). Repeated failure of timely admissions and cancellation or truncation of theatre lists mean that VMOs' time is not effectively utilised. This has a demoralising effect resulting in these doctors leaving the public system.

Support for New Medical Graduates.

For a number of years AMA Tasmania has alerted the current and previous Health Ministers to the increasing numbers of medical graduates.

We have known and made known to both Ministers since 2005 that there will be 83 medical graduates in 2008, 92 in 2009 and 110 in 2010 – an increase in excess of one-third over 2005.

Ministers and DHHS have been remiss in their response to planning Intern places for these graduates in Tasmanian hospitals. In 2009 there will be only 58 Intern places for the 83 graduating this year. There is no plan for intern places for 2010 and beyond. This lack of planning beggars belief especially when one considers the lack of doctors available to staff our hospitals and the great reliance on recruiting overseas trained doctors*. It is important to understand that Tasmania is party to a national agreement to fund intern places for all local graduates.*

ISSUES THAT IMPACT ON THE PUBLIC HOSPITAL SYSTEM

General Practice

The gridlock in Accident and Emergency Departments along with the almost 100% inpatient occupancy in hospitals in the North and South has caused enormous difficulty for the elderly and the more medically complex patients in the community.

In the past, when these patients suffered an acute unexpected medical event, they relied on the local hospital to assess them, and then investigate and manage these events. This may have included admission to hospital for a period of observation. More recently, the hospital will often not have a bed and, especially in the last five years, a perception has arisen that elderly patients are potential "*bed-blockers*" and so should not be admitted unless nigh unto death. Inappropriate 'discharge' of elderly nursing home residents from the ED back to the nursing home – on the assumption that the nursing home is some kind of step-down acute hospital – is also a problem increasingly being seen by AMA GP members.

AMA members have reported the incidence of ambulances from the Tasmanian Ambulance Service attending patients but not transporting those patients to hospital has steadily increased in recent years.

It has been reported to our members the reasons given to patients by the Ambulance Service vary from "*you will wait for hours to be seen*" to "*they are full and you will be left in a corridor for days*". As a result GPs are being called to see these patients at home and then having to try and make a diagnosis with limited diagnostic services. On other occasions patients will be brought to a GP's surgery after a 'funny turn' or fall through the night and the GP is expected to diagnose the problem several hours after the event.

These work demands add to the long standing problem of GPs having to provide care for patients on the various hospital waiting lists. This is one of the reasons that the community has difficulty accessing GPs in a timely manner.

Currently GPs are required to do the following hospital-type work:

- Care for patients on waiting lists – no arrangements are made by the hospitals to care for these patients through their out-patient clinics.
- Have a consultation with each patient on the waiting list just prior to their scheduled admission to confirm the operation scheduled months before is still required.
- Provide much of the follow-up following surgery including the removal of sutures and staples and other wound care.
- Assess patients following hospital discharge who have an unexpected problem.

- See all patients within five days of discharge as hospitals have a policy of confiscating patients' medications on admission then only issuing five days medication on discharge.

- Providing results to patients for procedures conducted within the hospital such as colonoscopies and biopsies.

- Provide workers compensation certificates to injured workers being managed by the hospital as the hospital prefers not to be involved in that aspect of care.

The AMA believes that hospital-type patients are swamping General Practice, not the other way around.

In addition all hospitals in the State pressure GPs to write named referrals in certain specialities rather than refer to a Speciality service so that some of the public out-patient work can be cost-shifted to Medicare. On occasions hospitals have refused to provide an appointment to a public patient unless a named referral is provided. This is a clear breach of the Australian Health Care Agreement, often resulting in further delays in patients being seen in the Outpatients Clinic.

The quality of information provided to GPs to continue the management of a patient treated at hospital is regularly poor. Pharmacies are able to generate computer based medication lists and this seems the only IT that has been provided to those directly looking after patients. The majority of communication from medical and allied health workers is hand written and distributed by facsimile making it regularly illegible. This again highlights the fact most of the DHHS computers are located in Davey Street or in the back office section of DHHS and not on the desks or in the hands of clinicians.

In summary,

- GPs are propping-up the hospital system by caring for hospital type patients on a daily basis.

- The contention that 'GP-style' patients are a problem in hospitals is quite erroneous.

- The continued provision of hand written communication to GPs is unacceptable and this major issue must be given more priority by DHHS.

- The solicitation by hospitals of GPs to work in their emergency departments is counterproductive and should be avoided.

Private Hospital System

Australia is fortunate in having parallel public and private systems of hospital care. In other parts of the country we are seeing strong and mutually productive relationships developing.

In Melbourne the Epworth and Cabrini Private Hospitals have become Clinical Schools of The University of Melbourne and Monash University respectively. They employ Registrars and Residents on rotation from the Royal Melbourne and Alfred Hospitals at the same time broadening the scope of their training and accommodating the needs of increasing numbers of medical graduates.

These two hospitals, with guaranteed numbers and quality of staff, operate significant numbers of intensive care beds allowing for major surgical and medical care of privately insured patients who would otherwise have had to seek treatment in public hospitals.

AMA Tasmania sees only limited evidence of this type of public/private collaborative development in Tasmania.

At the initiation of clinicians from the Royal Hobart Hospital there are Medical and Obstetric rotations to Calvary Hospitals in Hobart. We do, however, see significant potential locally.

An important factor adding to pressure in the public system is the shortage of General Physicians, most of whom tend to be salaried employees of our public hospitals and not available to the private sector. Surgeons are reluctant to operate on frail patients without their involvement. Rotation of Consultants and/or Registrars to private hospitals would encourage more privately insured frail patients to undergo treatment in the private sector.

The establishment of Intensive Care beds in private hospitals would also reduce the demand for public hospital beds for the frail privately-insured patients. It would not be beyond the capacity of DHHS to expand rotations of its Intensive Care Unit (ICU) Registrars and Consultants to private hospitals to underpin the quality and viability of those ICUs.

Both of the above examples offer greater opportunities for recruitment and retention of our local medical graduates.

Health Care Agreement Funding and Policies

The most recent agreement between the Commonwealth of Australia and the State of Tasmania began in 2003 and is to expire this year (2008). Its objectives and principles include securing access for the community to public hospital services based on "*clinical need and within a clinically appropriate period*" and "*ensuring equitable access for all eligible persons, regardless of their geographic location*". [6 (b) and (c) (p4)]

It is clear from the information provided that Tasmania is amongst the worst performers in terms of timeliness of treatment.

Furthermore, Tasmania has agreed to provide support for medical training positions. [10 (c) (p5)] Over recent times we have seen significant failure to plan for Intern positions and accredited training positions for Physicians, Obstetricians and Gynaecologists, and Emergency Physicians.

Similarly Tasmania committed itself to reform the interface between hospitals and primary and aged care services, and achieving continuity between primary, community, acute, sub-acute, transition and aged care. [19 (a) and (b) p6] The lack of planning in these areas is the major cause of inefficiencies in the operation of acute hospitals, added morbidity and mortality in our Emergency Departments and suboptimal care of significant numbers of patients awaiting discharge and placement.

The Agreement is silent on efficient disbursement of funds for patient care. AMA Tasmania is concerned that Commonwealth and State monies are increasingly insufficient and not being spent efficiently, to the detriment of patient care.

The Federal Government and the States all have Departments of Health. In all cases, they rank amongst the larger departments in each of the public services. At a State level, a significant part of the 'health bureaucracy' is involved with hospital administration and overseeing public hospitals. The structures of the States' health bureaucracies vary quite considerably. This makes direct and accurate performance comparisons difficult.

It is also clear that there is no relationship between the size of health bureaucracies at Federal and State levels and health outcomes.

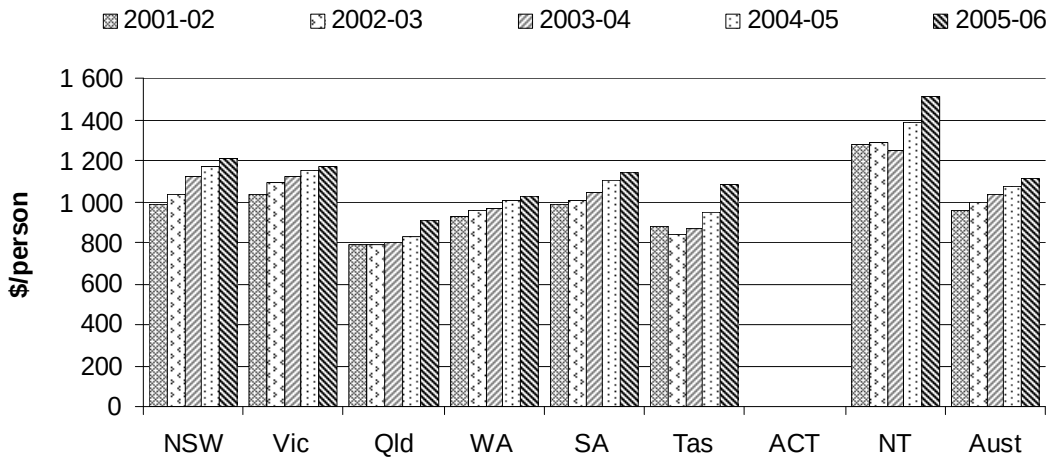
The Australian Council of Health Care Research recommends that the 2008-2013 AHCAs should provide for data to be collected on the costs of and activities undertaken by all bureaucracies administering health services. In addition it recommends that there is agreement upon benchmarks for the extent of these bureaucracies.

One of the key performance criteria recommended is that overhead administration costs have to be lower than a predetermined proportion of total hospital

expenditure.[24] Depending upon the structure of each State's health bureaucracy, this could be done on a whole of State, by Area Health Service, or on an individual hospital basis.

COMPARISON WITH OTHER JURISDICTIONS – selected data

Figure 10.3 **Real recurrent expenditure per person, public hospitals (including psychiatric) (2004-05 dollars)** [a, b, c, d, e, f, g, h]



[a] Expenditure data exclude depreciation and interest payments. [b] Recurrent expenditure on purchase of public hospital services at the State, or area health service level, from privately owned and/or operated hospitals is excluded. [c] Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2007b). [d] NSW expenditure against primary and community care programs is included from 2001-02. From 2003-04, hospital expenditure recorded against special purposes and trust funds is excluded. [e] Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees. [f] WA recurrent expenditure per person increases to $1094 in 2005-06 if the expenditure on public patients at Joondalup and Peel Health Campuses is included. [g] For 2001-02, data for two small Tasmanian hospitals are not included and data for one small hospital are incomplete. For 2002-03, data for one small hospital are not included and data for five other small hospitals are incomplete. For 2003-04, data for five small hospitals are not included. For 2004-05 and 2005-06, data for one hospital are not included. [h] ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

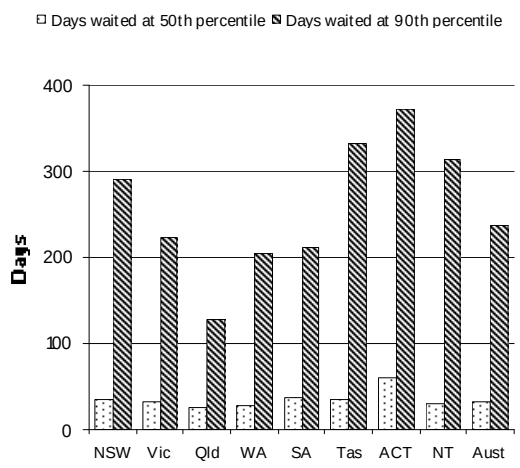
Source: AIHW (2003, 2004, 2005a, 2006a, 2006b, 2007a, 2007b); ABS (unpublished) *Australian Demographic Statistics*; table 10A.3.

http://www.pc.gov.au/gsp/reports/rogs/2008/health

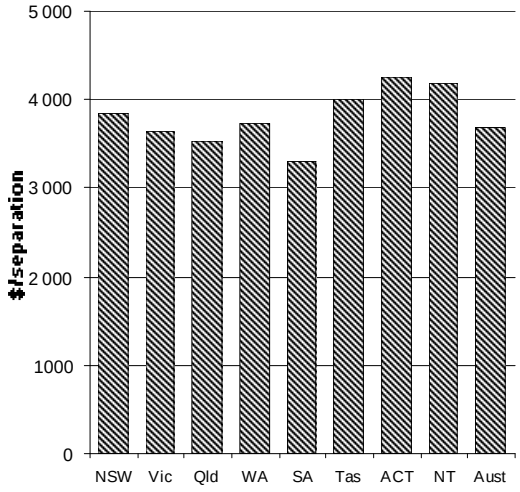
[Note: The Productivity Commission has not updated these data to reflect Tasmania's current lowest expenditure per capita.]

Selection of results

Elective surgery waiting times, public hospitals, 2005-06 ***(p. 10.27)***



Recurrent cost per casemix-adjusted separation, public hospitals, 2005-06 ***(p. 10.54)***



a Data and caveats for these figures are available electronically on the CD-ROM enclosed with the Report and from the website for the Review of Government Service Provision (http://www.pc.gov.au/gsp/reports/rogs/2008). Data may be subject to revision. The most recent data will be available on the Review website.

[Note: Current AIHW data have not been published by the Productivity Commission]

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3. http://www.budget.tas.gov.au/media/pdf/publications/BP2_Volume_1.pdf table 6.2, p 6.8 and table 6.3, p 6.10
4. ***The State of our Public Hospitals Report***, June 2007, Australian Government, Department of Health and Ageing , p 39
5. ***The State of our Public Hospitals Report,*** June 2008, Australian Government, Department of Health and Ageing, p. 26, table 2.2
6. ***ibid*** p. 11, table 1.4
7. ***ibid*** p. 27, table 2.4
8. ***ibid*** p. 19, table 1.9
9. ***ibid*** p. 18, table 1.8
10. ***ibid*** p. 38 table 3.4.
11. ***ibid*** p. 37, table 3.1
12. ***Your Health and Human Services Progress Chart,*** August, 2008, p6
13. ***The State of our Public Hospitals Report*** *op cit* p.44, table 4.1
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