Waiting Times for Service in Australia's Public Hospitals—A Most Unsatisfactory State of Affairs

Background

Australia's public hospitals are under enormous pressure as they attempt to meet demands for acute and planned services. These pressures are being generated by a number of simultaneously operative factors, which include,

(1) The aging of the population,

(2) The increasing inadequacy of primary and secondary care services available in the community,

(3) The workforce crisis that is present throughout the country,

(4) The inadequate funding of public hospital services,

(5) A lack of master planning to integrate hospital services (networking) within states and territories, and;

(6) The lack of appropriately cooperative planning between State, Territory and Federal Governments.

Although by OECD standards Australia has a high number of overnight public hospital beds available per capita, we clearly need more to provide an efficient service within the current structure that delivers hospital care in Australia. The irony is that at the moment quality and safety demands insist that we close a number of the available beds to concentrate on offering better services in fewer sites. We simply do not have the workforce to maintain all the services that are nominally on offer at so many public hospitals across the nation.

While the Prime Minister has just announced (April 8, 2006) a most welcome addition in the number of HECS funded places in Australian Universities for the training of doctors and nurses, it will be many years before this injection of capital eases our workforce problems. In the meantime all jurisdictions need to address the importance of immediately proceeding to,

(1) Regard public hospital services, particularly in metropolitan areas, as networked services in which appropriate role delineation for individual hospitals is re-defined with master planning to ensure that those networked hospitals offer safety, quality, and better efficiency.

(2) A transparent conversation with the Australian public to explain the need to limit services at specific sites to make sure that where services

are offered for a particular problem they are as good as possible given the current workforce shortage. Studies particularly in New South Wales have shown that patients are more than willing to travel beyond their local hospital to get quality service in a timely fashion once the imperatives are explained to them.

Waiting Times for Medical Services

While private hospitals in Australia have been funded to significantly increase surgical activity, that sector in general offers very little in the way of elective medical services for the type of patient that is placing pressure on public hospitals. That pressure comes increasingly from older patients with multidisciplinary problems, who required a significantly sized and skilled team to manage their condition effectively. The same comment is relevant for acute medical admissions to Australia's public hospitals. All jurisdictions should be examining the possibility of creating geriatric units of excellence, offering elective and acute services, with acute services offering the early stages of rehabilitation in specifically planned units. These should be remote from principal referral hospitals that are resourced to offer sophisticated medical and surgical services that are currently under utilised because of the pressure to offer secondary aged care services.

Surgical Waiting Times

Much has been written about the most unsatisfactory situation that faces patients waiting for planned surgery in our public hospitals. Two problems predominate. The first is an inadequate total number of overnight beds available any many institutions, which make it impossible to quarantine beds to run an efficient elective program. Night after night hospitals fill up beds, that they had hoped to use on the following day for elective surgery, with patients with acute problems that have presented to the hospital's emergency department. How often do we hear of patients who have taken time off from work, arranged for babysitting, arranged for child minding et cetera, only to be told at the very last minute that their surgery has been cancelled as there is "no room in the inn". It's not an uncommon experience for those dependent on the public hospital system to have this scenario played out two or three times before they actually get their surgery.

However, a second and perhaps an even more important factor, particularly in major tertiary institutions, is a lack of adequate funding for planned surgical services. In metropolitan areas there is no shortage of orthopaedic surgeons willing to operate in the public hospital system on a far more frequent basis than is currently possible. Theatre and recovery time is restricted for budgetary reasons. Often when new and talented young surgeons are appointed to a hospital they can only be given operating time if the existing surgical workforce agrees to share a fixed amount of theatre time with the newcomer.

Around the country, particularly at election time, the boom and bust cycle is played out with a short injection of funds, making it possible to reduce temporarily politically unacceptable waiting lists. It is generally not appreciated by health care systems that people trapped on long waiting lists ultimately involve the system in far more expense than would be the case if they were operated on in a timely fashion. Drug treatments, medical complications, time lost from work and many other factors contribute to the cost ineffectiveness of not having an adequate planned surgical service available for long wait patients.

Initiatives that are being explored around the country to improve the situation include, (1) role delineation for hospitals as mentioned above, with a particular emphasis on having some hospitals not run emergency departments, but taking pride in offering a superbly efficient planned surgical service. In Western Sydney many planned surgical services are focused at Auburn Hospital with patients coming from a very large geographic area to have, for example, their gall bladder surgery at a guaranteed time. This service has achieved a 94 per cent satisfaction rating from patients even though they may have had to travel 30 or more kilometres to attend the hospital offering the service.

Many patients are more than willing to have the first available surgeon provide them with the care that they need, and every effort should be made to balance out the waiting times for individual surgeons. There has been a tendency in systems around the country to use the transference of a patient from one surgeon's waiting list to another to see them slip back to the bottom of that new list, where statistically they become new patients for the system. This is obviously unjust and creates enormous patient frustration.

The introduction of properly staffed "23 hour wards," and a strict adherence to day of admission policies, can further improve our capacity to offer elective surgery in the difficulty circumstances in which we currently find ourselves.

Better Primary Care

Perhaps because of the jurisdictional inefficiencies associated with State, Territory and Federal Governments having different responsibilities for sections of our health system it has been difficult for those struggling in the public hospital system to promote the changes needed to primary care which provide the ultimate methodology for reducing pressure on hospitals. By swinging our health care system around to a wellness model with a major emphasis on prevention and the early diagnosis of potentially chronic problems the demand for surgical services of an elective nature in our public hospital system would significantly decrease.

This would involve the implementation of the" team medicine" approach being used in the United Kingdom, Canada and New Zealand, for example, in which better role delineation among health professionals working in teams increases the chances that doctors would be freed up to do those things that only doctors can do. This includes caring for patients in the community who currently must be sent to hospital, as the primary care physician does not have the resources to look after such individuals at home. Recent studies in Australia and the United Kingdom have demonstrated that with aging populations some 60 to 70 per cent of acute geriatric admissions to public hospitals which so pressurise the system and compromise the careful planning of bed utilisation could have been avoided if there had been an effective community intervention in the three weeks prior to that individual presenting at an emergency department.

New South Wales/ACT issues.

For those of us that have worked in the public health system in New South Wales for many years it has become increasingly obvious that health professionals would welcome political leadership that would see the health care systems of the ACT and New South Wales fused into one entity reporting to two jurisdictions, that is, there would be a united bureaucracy (one set of brains, controlling one set of dollars) that would maximise the efficiency with which New South Wales and the ACT offer their services. The major stumbling block to such an initiative appears to be argument among political leaders about the appropriateness of the funding formula for such a fusion to occur. With health economics so much better understood, this is not a tolerable argument to health professionals and patients looking to see us extract more health from the available dollars and workforce.

As the ACT is looking at problems associated with supplying planned services to people living in the territory who require hospitalisation it would be timely to recognise the breadth of the factors involved in producing the problem and to reinvigorate efforts to form a bilateral partnership that would not only improve the situation for people living in the New South Wales and ACT, but also provide a demonstration to the rest of the country of the only way forward if we are ever to overcome the current State/Federal difficulties.

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