

Why Public Hospitals Are Overcrowded: Ten Points for Policymakers



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Jeremy Sammut

Papers in Health and Ageing (8)

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Why Public Hospitals Are Overcrowded: Ten Points for Policy Makers

Jeremy Sammut

Executive Summary

Beside the perennial and serious problem of ever-lengthening waiting lists for elective surgery, major public hospitals are unable to provide timely emergency treatment and unplanned admission to a hospital bed for significant numbers of acutely ill patients.

The technical cause of the hospital crisis and the nationwide shortage of acute inpatient beds is 25 years of cuts to public hospital beds, while the systemic cause is the misallocation of resources away from frontline, bed-based hospital care and the corresponding growth in the size, cost and complexity of the state government bureaucracies that mismanage the public hospital system.

Health bureaucrats and select public sector interest groups routinely claim that greater public spending on prevention and on alternative models of care will solve the crisis. These politically convenient myths and misconceptions have convinced bed-phobic state and federal governments that opening more beds is unnecessary.

This paper states the case for structural reform to ensure the Australian hospital system is equipped to cope with the pressures created by an ageing population. Policymakers should keep the following 10 points in mind:

1. **Public hospitals do not have enough beds to provide a safe standard of care for acutely ill patients who require unplanned emergency admission:** Public hospitals are overcrowded and unable to admit and treat patients in a timely fashion because the total number of acute public hospital beds in Australia has been cut by one-third to a level far below the OECD average since Medicare was established in 1984. Taking population growth into account, the real fall in bed numbers is even larger—a 60% fall from 4.8 public acute beds per 1,000 population in 1983 to around 2.5 per 1,000 population today.
2. **Overcrowding or emergency ‘access block’ is caused by genuine demand for emergency admission by patients (particularly elderly patients) who can be treated only in hospitals:** Overcrowding occurs when hospitals operate beyond a safe level of 85% bed occupancy and more patients require unplanned admission than there are staffed ward beds available. When emergency doctors and nurses are forced to care for the overflow of patients queued up on trolleys in emergency department corridors, waiting times for new patients inevitably blow out. Overcrowding is strongly associated with the increasing number of frail elderly patients with an acute medical problem who require admission to a hospital bed in an ageing Australia.
3. **Bureaucratically-run public hospitals are not under-funded:** The real problem is that current funding and administrative arrangements permit vast sums of taxpayer dollars to be wasted paying for bureaucrats rather than for beds. Recurrent expenditure on public hospitals has increased by 64% in real terms (adjusted for inflation) over the last decade. Between 2001 and 2005, the number of hospital administrators in Australia increased by 69%. This is an example of the ‘close a bed, open an office’ syndrome: bed numbers have been slashed while the size and cost of the state area health service bureaucracies have increased.
4. **Government denials avoid the real causes of the hospital crisis:** State governments accept the policy advice of self-interested bureaucrats and wrongly blame the hospital crisis on gaps in other parts of the health system. Governments have also caved in to select public sector interest groups and endorsed a range of ‘solutions’ that involve additional spending on so-called alternatives to hospital care such as boosting primary care services.
5. **Hospital overcrowding is NOT caused by GP-style patients swamping emergency departments:** Patients who could be treated in community-based settings or general practice clinics, and therefore do not require admission to a hospital bed, do not cause access block. Also, unrefuted studies have demonstrated that patients who present at emergency departments and are classified semi-urgent ATS 4 and non-urgent ATS 5 under

the Australasian Triage Schedule (ATS) are not 'proxy primary care patients.' These patients are admitted to hospitals at 20 and 10 times the rate respectively than are patients from general practice.

- 6. Bed numbers are NOT 'less important':** In recent decades, growth in day surgeries and falling lengths of stay have enabled hospitals to treat more patients, especially procedural patients, with fewer beds. Hospital planners therefore claim bed cuts have not gone too far and bed numbers are 'less important.' The assumption that continued efficiencies will make up for the falling supply of beds is an example of flawed central planning. This is erroneous in the context of an ageing population and increasing admissions by acutely ill elderly patients who require bed-based, multi-day staying medical and nursing care.
- 7. Rather than end the blame game, the Rudd government is blaming the wrong problems:** The Rudd government is pursuing a primary care centred reform agenda that has failed to fix the hospital crisis in countries such as New Zealand. This agenda entails spending billions of dollars on a national network of GP Super Clinics offering all-hours general practice services for GP-style patients and enhanced primary care services for elderly chronic disease patients. Unfortunately, it will not take the pressure off public hospitals as promised but will waste money by duplicating existing state and federally funded programs that are already caring for the elderly.
- 8. Acutely-ill elderly patients are not chronic disease patients:** The premise of the Rudd government's reform agenda is that elderly chronic disease patients would receive better care in a GP clinic. But the evidence that primary care can substitute for beds is anecdotal and weak at best. Rather than evidence-based policy, this is the preferred policy agenda of community health and other select public sector provider groups that want greater funding poured into their health silos.
- 9. Better prevention is the problem, not the solution:** The Rudd government's wrong-headed approach is predicated on the idea the hospital crisis has been precipitated by too much focus on hospitals and not enough on prevention. In reality, the problems in public hospitals are partly attributable to the success of better prevention, which is enabling increasing numbers of people to live to older ages and deferring illness to later stages of life. Effective deferment of illness means that 'very old' patients will inevitably get acutely ill and require admission to hospitals. *This age group will be the hospital patients of the twenty-first century.*
- 10. Structural reform of hospitals for an ageing Australia:** To equip the hospital system to cope with an ageing population and provide quality care to all age groups, the tried and failed methods of running and ruining public hospitals must be abandoned; policymakers must decentralise the administration of public hospitals and introduce flexible and responsive voucher-based methods of funding the bed-based hospital care that will be needed to care for rising numbers of older and sicker patients in coming decades.

‘It’s turned into chaos in hospital emergency departments. You have cubicles that have three people on trolleys in it that are designed for one. It just keeps happening and it’s not going to get any better until the Government realises that it’s not about models of care, it’s about...more beds.’

— *Doug Travis, Australian Medical Association Victorian President*¹

‘What could be more indicative of a health system in crisis than a patient being rushed to hospital by ambulance with a life-threatening condition not being able to get into emergency because it is full?’

— *Professor George Jelinek*²

‘There is constant gridlock. We keep hearing and seeing a greater use of the hospital and ambulance services, but there’s nowhere for these people to go because there’s no beds. It means ambulances are literally spilling onto the streets.’

— *Steve McGhie, Victorian Ambulance Employees Association Secretary*³

‘The real challenge for public hospitals at present is to effectively manage and discharge frail elderly patients, and those with cognitive impairment, thus keeping beds free to reduce access block.’

— *Bryan G Walpole*⁴

‘It is a modern tragedy for an ageing population that the healthiest part of NSW health services is the bureaucracy, which appears to thrive at all administrative levels and looks like continuing to do so.’

— *Paul Sullivan*⁵

‘I have prayed to St Jude, the patron saint of lost causes, for more hospital beds.’

— *Daniel M Fatovich*⁶

‘It is usually far easier to focus on the simplicity of the problems rather than the complexity of solutions...’

— *Hon. Nicola Roxon MP, Minister for Health and Ageing*⁷

Introduction

A horrible set of numbers

Australia's public hospital system is in crisis:

- In 2007, more than one-third of emergency patients requiring admission to a public hospital waited longer than eight hours for a bed.⁸
- One in three emergency patients—two million people a year—wait longer than clinically recommended for assessment and treatment.⁹
- Fewer than two-thirds of emergency patients classified as urgent are seen within the recommended time of 30 minutes—a smaller proportion of patients compared to a decade ago.¹⁰
- The Australasian College of Emergency Medicine's Snapshot reveals the problems are getting worse. Forty-one percent of emergency patients requiring unplanned admission wait for a bed, and 81% of these patients wait longer than eight hours—one-third more than in 2004.¹¹

Twenty-five years of nationwide cuts to the number of acute public hospital beds in Australia means our public hospitals are dangerously overcrowded. In the context of rising demand for admission from an ageing population, the vast majority of urban public hospitals are unable to operate at a safe level of 85% bed occupancy.¹² The Australian Medical Association's 2008 *Public Hospital Report Card* received national media coverage when released last November. The report card detailed new academic research linking overcrowding with 1,500 avoidable deaths per year—more than the national road toll. Not even national headlines that screamed '1,500 die waiting for bed'¹³ generated an appropriate policy response.

Australian and overseas studies overwhelmingly show that the single-most important cause of public hospital overcrowding, from a technical perspective, is the national shortage of acute hospital beds.¹⁴ In the age of spin and media management, however, only a 'brave' health minister would admit that *public hospitals don't have enough beds to provide a safe standard of emergency care for acutely ill patients who require unplanned admission to a hospital and cannot be treated elsewhere in the health system*. Rather than admit the truth about the scale of the crisis in our 'free and universal' hospital system, governments prefer to blame extraneous factors such as GP shortages.

The Australasian College of Emergency Medicine (ACEM) has waged a long campaign to draw attention to the scale of the crisis. In the wake of the Council of Australian Governments (COAG) signing off on the five-year Australian Health Care Agreement (AHCA) in November 2008, attempts to lobby and shame governments into resourcing public hospitals with sufficient number of staffed beds have reached a dead end.

Under the new AHCA, the Commonwealth delivered the states a big boost in hospital funding—\$22.4 billion over five years—as part of the Rudd government's much-publicised but as yet largely still-born hospital reform agenda.¹⁵ In return, the states signed up to a national hospital performance reporting system and agreed to report to COAG on the performance of public hospitals against a range of benchmarks such as waiting times and rates of service. This reporting system is meant to measure what counts, publish what is measured, and reward the best performing hospital systems with additional incentive payments. The idea is to encourage the states to run public hospitals as efficiently as possible and improve the responsiveness of government policy.

Although touted as a new era in accountability and transparency, most of the 'new' benchmarks already exist. For more than a decade, every measure of public hospital performance has consistently deteriorated, but governments have failed to open and staff sufficient additional beds.

Not even national headlines that screamed '1,500 die waiting for bed' generated an appropriate policy response.

COAG opted not to performance measure bed capacity or bed occupancy,¹⁶ which means states were not required to report the statistics that really counted and would have drawn public attention to the extent of the crisis.¹⁷ Instead of holding the states accountable, COAG followed the advice of the federal government’s hand-picked advisory body, the National Health and Hospitals Reform Commission, which drew up the reporting framework and inexplicably ruled out an accountability target for acute beds on the spurious grounds that establishing a bed target ‘may drive inappropriate investment.’¹⁸

The hospital crisis

Access block

Hospital overcrowding or access block occurs when emergency departments contain more acutely-ill patients who require admission to a hospital bed than there are free staffed ward beds available in public hospitals that are near or at full capacity. The technical definition of access block is that emergency patients are forced to wait longer than eight hours for admission to an inpatient

bed. Because major urban public hospitals regularly operate at above 100% bed occupancy to maximise elective patients and shorten politically sensitive elective waiting times, hospitals frequently have no spare ward beds to cope with unplanned admissions. As a result, sleep and privacy deprived patients, the majority of whom are frail and elderly, are forced to queue for hours, sometimes days, on trolleys in overcrowded emergency department corridors (and even in storage cupboards).

Surveys show that caring for access block patients constitutes more than 40% of the emergency staff workload in major public hospitals,¹⁹ resulting in prolonged delays and extended waiting times before new patients are assessed and treated. Emergency departments are unable to function efficiently and safely deliver the acute care they are meant to provide.

When corridors and treatment cubicles are full and it is physically impossible for emergency departments to accept more patients, ambulances are ramped outside or circle the hospital. Hospitals are forced to close, and ambulances containing urgently ill people are sent to other hospitals kilometres away.

So endemic has access block become in Australia’s major urban public hospitals that emergency staff refer to the situation as ‘the new normal.’ Access block leads to higher emergency costs and compromised patient safety, and is ‘increasingly affecting the ability of medical and nursing staff to treat critically ill patients in a timely manner.’²⁰ Overcrowding causes unnecessary suffering and is associated with longer stays and poorer clinical outcomes for admitted patients, including higher morbidity and mortality rates.²¹ Because the cancellation of elective surgery is the standard crisis response, bed shortages also contribute to blow outs in elective waiting times.

Overcrowding also imposes a heavy toll on the overworked, stressed, and burnt out emergency staff upon whose professionalism and dedication the health and welfare of every Australian could one day depend.

85% occupancy

The groundbreaking 1999 study by Bagust et al. found that increased risks to emergency patients—incidence of access block, admission beyond a clinically safe time frame, longer length of stay, and higher mortality—were discernable once average occupancy exceeded the safe level of 85%.²² Once bed occupancy rates regularly exceed 90%, lack of spare bed capacity means public hospitals can expect regular bed shortages and overcrowding. Once occupancy exceeds 95%, emergency departments will almost always operate in crisis mode. They will not have the spare bed capacity to cope with surges in demand for admission without unacceptable delays.²³

Average occupancy in Australian public hospitals is 90–95%.²⁴ Studies conducted in Australia, the United States, and Canada (where the problem has been studied in the greatest detail) have all identified lack of available beds as the primary cause of emergency department overcrowding. These studies all point to the same solution²⁵—hospitals need an adequate supply of acute beds

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per 1,000 head of population and the nurses to staff. Hospitals need to operate at 85% bed occupancy so that sufficient unoccupied staffed beds are available for emergency patients to be transferred to wards without undue delay and new patients can be seen.²⁶

Root cause

The technical cause of hospital crisis is 25 years of excessive cuts to public hospital bed numbers. The systemic cause of the critical nationwide shortage of acute beds is the misallocation of resources away from frontline hospital beds and services, and the corresponding growth in the size and complexity of state health bureaucracies.

In the 1980s and early 1990s, local hospital boards were abolished and area health services were established to administer public hospitals on a regional basis. The area health bureaucracies are responsible for allocating state and Commonwealth funding to public hospitals; for planning hospital services, including bed numbers; and for overseeing the rationing of 'free' public hospital treatment. They have unacceptably low percentages of staff directly involved in patient care (perhaps as low as one in five employees²⁷), have developed top-heavy and complex corporate structures, and are notorious for being overstaffed by 'countless people who have ... spent their working lives attending endless meetings, staring at computer screens, and doing precious little else.'²⁸ Along with the state health departments, the area health services have a vested interest in denying resources to hospitals and holding down bed numbers to sustain and expand the size of the bureaucracy.

Area health services have also assumed responsibility for the Community Health Services established by the Whitlam Commonwealth government in the 1970s. This has considerably increased the bureaucratic cost and complexity of the area health system. Community Health Services duplicate Medicare-funded fee-for-service general practice and primary care services and other Commonwealth-funded community-based health programs. They are also notorious for administrative excesses, over-staffing, and creating work-avoidance havens for salaried public sector employees. Community Health Services encompass a range of public health programs (such as drug counselling). They also provide some potentially valuable but often difficult-to-access services such as hospitals in the home schemes.

The state takeover of the Community Health Services has drawn resources away from public hospitals to pay for non-hospital services and additional bureaucracy. Annual expenditure on community health is approaching \$4 billion a year, but the community health services are largely unaccountable for their service delivery and funding received. The absence of national performance data means there is no way of knowing what the public is getting for the billions of taxpayer dollars spent on community health.²⁹ As we shall see, the community health sector exerts substantial, misleading and detrimental political influence over the policy debate concerning the hospital crisis due to its coherence as a public sector lobby group.³⁰

Funding and administrative waste

Commentators repeatedly claim that public hospitals are in crisis because of underfunding by the Howard government. The accompanying assumption is that massive funding boosts will fix the crisis.³¹ Total annual government spending on health is \$65 billion. Over the last decade, real expenditure (adjusted for inflation) on public hospitals (funded overwhelmingly by Commonwealth and state taxes) increased from \$17 billion in 1996 to \$27 billion in 2006–07. Activity (measured by the number of patients treated) has only increased by 28%.³²

The problem is not lack of money but that not enough of the money gets through to the frontlines to pay for patient care.

The problem is not lack of money but that not enough of the money gets through to the frontlines to pay for patient care. The size of the hospital bureaucracy is different in each state and is difficult to calculate accurately. Inadequate financial and other data make it impossible to measure the administrative cost of public hospitals.³³ Estimates of the enormous bureaucratic overheads therefore vary. (But legion tales told by hands-on clinical staff about the army of clerks warehoused in the bureaucracy who 'don't do any work' is telling.) Informed estimates suggest

The systemic problems that plague public hospitals across the country are an open secret among health and hospital insiders but have received only fragmentary analysis.

that ‘three-sevenths of the current NSW Health salaries go to bureaucrats and only four-sevenths go to nurses, doctors, paramedics, ambulance personnel, non-clinical hospital employees.’³⁴ Ken Baxter, former head of the NSW and Victorian Departments of Premier and Cabinet, estimated that between 20% and 40% of state health department employees occupy ‘administrative’ or ‘other’ roles.³⁵ Anthony Morris QC, former head of the commission of inquiry into the Dr Death

scandal at Bundaberg Base Hospital, estimated that just 20% of Queensland Health’s 64,000 strong workforce is a doctor and nurse ‘who actually deals with patient care.’³⁶

This is the root cause of why public hospitals are overcrowded. Because hospital funding is not tied to the treatment of patients, taxpayer dollars are being diverted and wasted on bureaucrats rather than beds. Over the last decade, public hospital funding increased by 64% in real terms. Between 1996 and 2006, the number of acute public hospital beds fell by 18% per 1,000.³⁷ Between 2001 and 2005, the number of hospital bureaucrats rose by 69%.³⁸ This is an example of the internationally documented ‘closing beds to open desks’ syndrome³⁹ whereby growth in funding correlates with growth in bureaucracy and reductions in bed numbers.⁴⁰

Systemic dysfunction

Defective funding and administrative arrangements have also created a range of additional systemic dysfunctions in our government-owned and -operated public hospital system. These problems include:

- **Progressive centralisation of control over local hospitals by remote and unwieldy state government bureaucracies and ‘command and control’ micro-management of hospitals by area health services.** The wide disconnects created between the bureaucrats with final authority for hospitals and the staff responsible for delivering frontline services have, in effect, left no one in charge of running hospitals on a day-to-day level.
- **Lack of local accountability and the disempowerment of both clinicians and the community.** The abolition of local hospital boards has led to the breakdown of the relationship between budget enforcing/target monitoring managers on one hand and resource and responsibility deprived clinical staff on the other. The relationship between management and frontline staff is marred by a lack of mutual respect and trust, perpetual infighting, bullying of staff, and plummeting morale.
- **Diversion of staff time and effort into useless paper work.** Complying with centralised accountability requirements has led to more wasteful layers of bureaucracy and the channelling of further resources into administrative positions at the expense of delivering consumer-oriented, patient-centred care. Gaming and fraud have also been encouraged—with evidence of hospital data being manipulated to appear to reach politically mandated performance benchmarks.
- **Distortion of policy and funding outcomes based on special pleading and political influence rather than clinical need and patient demand.** Bed numbers have been cut to fund the expansion of elective services. Policy making has also been captured by heavily unionised bureaucracies and select public sector interest groups that (a) exert strong influence over governments keen to further the interests of political allies, and (b) result in taxpayer dollars being thrown at reforms that fail to address either the technical or systemic causes of the crisis.

Aspects of this litany of dysfunction were detailed in last year’s Garling Commission report on the NSW public hospital system. Victoria was recently rocked by scandals involving the widespread falsification of elective waiting time and unplanned admission data by hospital staff to meet performance targets mandated by remote network managers.⁴¹ The systemic problems that plague public hospitals across the country are an open secret among health and hospital insiders but have received only fragmentary analysis.

The systemic problems in public hospitals are experienced by all bureaucratically run, centrally planned government agencies that receive block funding from taxpayers and cannot go bankrupt regardless of how poorly they perform. These problems stem from the fact that normal market incentives that apply in private enterprises do not apply to public hospitals. As monopolistic providers of publicly funded hospital care, public hospitals are shielded from competition. They have no real incentive to improve efficiency, increase productivity, allocate resources efficiently, and respond to the needs of patients. Rather than seek to maximise service delivery at the lowest possible cost, public hospitals instead focus on enforcing budget limits and reducing frontline services—by closing beds or shutting down entire hospitals or by restricting elective surgeries. Service delivery is also crowded out by a growing bureaucracy. Costs rise and productivity plummets despite an increasing demand for services. It is the ‘customers’ of the public hospital system who ultimately suffer and endure longer queues for essential hospital care.⁴²

Policy challenges

The challenge for policymakers is to rise above the white noise of the highly politicised debate surrounding the hospital crisis. Few policy issues are subject to as many confusing claims as hospitals. These claims and counter claims must be untangled and rigorously scrutinised to accurately assess and understand the problems. A range of flawed arguments are employed, all too successfully, to deny and avoid the truth that hospital overcrowding is caused by excessive bed cuts and bed shortages. One of the aims of this paper is to provide an independent examination of the evidence.⁴³

These arguments fall into three basic categories. The first is the routine and untrue claim that bed numbers in Australia are ‘internationally comparable.’ The second is that bed cuts have not gone too far because hospital bed numbers in Australia are less important owing to falling length of stay and rising day surgeries. The third argument, which is based on highly flawed and outdated central planning assumptions, is that more beds are unnecessary and alternative models of primary care and chronic disease care can substitute for beds.

The challenge for policymakers is to rise above the white noise of the highly politicised debate surrounding the hospital crisis.

These policy ideas obscure the real problems and are not evidenced-based. They represent the policy outcomes preferred by heavily unionised, politically cosseted, and influential health bureaucrats and select public sector provider groups. The community health sector and nursing unions, supported by public health lobbyists and academics, have captured the policymaking process in the public health system. Policymakers defer to the advice of bureaucrats and interest groups claiming experience and expertise in public hospitals, even if they have little genuine knowledge or interest in the real problems.

It is therefore important that policymakers be wary of the self-interested policy advice that health bureaucrats provide to governments. Bureaucracies have expanded by drawing resources away from frontline hospital care and have a vested interest in the status quo, which is why they protest loudly about beds being ‘less important’ and promote policies that involve new funding for so-called solutions that fall well short of extra staffed beds. These policies will only waste further resources while protecting the bureaucracy’s share of the public purse and control over hospital planning and funding.

Policymakers should be equally wary of provider groups seeking greater government funding for their health silos. Because policy and funding decisions are a highly politicised process in the public system, the most coherent, vocal and politically active health lobby groups pursue their own agendas under the rubric of solving the hospital crisis. The community health sector has been remarkably successful in promoting its preferred policy agenda and in convincing governments that greater public spending on prevention, primary care, and chronic disease care will alleviate the pressure on hospitals.

The Labor state governments have been in power for most of the last decade and are complicit in the process. Unwilling to stare down the vested interests of political allies or overcome the institutional obstacles to opening more beds, they have instead caved in to special interests.

The interests of emergency doctors and nurses and their patients have lost out to the interests of more influential groups within the public health system. Bed-phobic governments, state and federal alike, tailor their health policy to suit these groups. As a result, politically convenient myths and misconceptions concerning the alleged causes and cures for the hospital crisis are conventional policy wisdom. This includes perhaps the biggest myth of the policy debate: the erroneous idea that the state-run public hospitals are swamped by GP-style patients and are overcrowded due to a national shortage of Commonwealth-funded Medicare bulk-billed general practice services.

The case for structural reform

The most important challenge confronting policymakers is to address the hospital crisis in terms of structural reform, just as they should in all policy areas that involve inefficient and costly provision of government services. Less politically challenging policy options that fall short of structural reform, and instead tinker with clinical or governance structures at state and federal levels, will not solve the crisis.

The argument of this paper is that a voucher system which ties hospital funding to clinical need and patient demand, in combination with decentralised administration by local hospital boards, will allow demand for hospital services to dictate the supply of hospital services according

to the health needs of the community. These reforms will eliminate waste on excessive bureaucracy, promote efficiency and productivity and, most importantly, enable money to follow patients to the frontlines to open staffed hospital beds and provide bed-based care for Australia's ageing population.

There is more than the normal public policy reasons for eliminating the systemic dysfunctions that cloud the future of our high cost and low productivity public hospital system. Important as financial considerations are, the most important issue is the quality of care that hospitals will be able to provide for all Australians.

Ultimately, the ability of the Australian hospital system to cope with the impact of an ageing population depends on whether policymakers have the courage to undertake structural reform and introduce flexible and responsive voucher-based methods of funding bed-based hospital care.

Important as financial considerations are, the most important issue is the quality of care that hospitals will be able to provide for all Australians.

It's all about beds, beds, and lack of beds

The key statistic is the number of *acute* hospital beds per 1,000 population. This is the figure used to determine and allocate the optimum number of beds in a geographic region. In Australia in the 1960s, 1970s and early 1980s, hospital beds averaged between 6 and 6.5 per 1,000. In 1983, there were 6.2 beds per 1,000. By 1990, the number of beds had fallen to 4.8 per 1,000. Since 2000, bed numbers have plateaued at around 4 beds per 1,000. In 1983, there were 94,000 beds in total, with 74,000 beds in public hospitals. In 2007–08, Australia had 84,235 beds. Private hospital beds had increased to 27,768. Public hospital beds have been cut by one-third in the last 25 years.

Between 1995 and 2006 alone, total bed numbers fell by 3.2% and by 11% per 1,000 population. The fall was entirely due to an 18% reduction in public beds.⁴⁴ The dramatic reduction in public hospital beds is not due to population increasing and bed numbers holding steady. The reduction in bed numbers is bigger than it seems taking population growth into account—a 60% fall from 4.8 public acute beds per 1,000 in 1983 to around 2.5 per 1,000 today. The number of public acute beds troughed at 49,004 in 2001–02, and has since increased to 54,137 in 2007–08. This represents an increase of just 0.04 beds per 1,000 from 2.51 beds to 2.55.

Why were beds cut?

Since the mid-1980s, government policy in all states has been to cut bed numbers. Entire wards that once were filled with beds, patients and nurses have been closed down and padlocked up. Wards have also been converted into offices for area health and hospital administration—the 'close a ward, open an office' syndrome.

The factors that led to bed cuts include:

- **Technological advances and changes in clinical practice.** Innovations such as less invasive key-hole surgery and growing numbers of day surgeries achieved dramatic falls in length of stay in the last 20 years—from an average stay of seven days in the mid-1980s to fewer than four by the end of the 1990s. Bed cuts were initiated and initially justified by falling length of stays.
- **Rapid development of an array of specialist procedures.** The increasing cost of more sophisticated hospital care and procedural equipment encouraged health departments to cut bed numbers (cannibalise existing ‘old fashioned’ services) to control costs and fund other services.
- **The rise and rise of day surgery.** Together with the steady decline in the percentage of the population with private health insurance, the rising number of procedures that could be provided on a day-alone basis created a nightmare scenario for budget-conscious governments. The costs associated with every hospital admission are concentrated in the first day or days of treatment. Reductions in length of stay therefore yielded a relatively small saving. Had bed numbers remained stable, the capacity to treat more patients for more conditions in a shorter time would have led to a cost explosion.
- **Fundamental distrust of doctors by budget-enforcing managers.** Managers feared that if beds were plentiful, doctors would abuse the situation and bankrupt the health system by employing loose admission and discharge practices. The alternative path to efficiency—managers actually managing and monitoring and enforcing admission and length of stay standards—has been eschewed in favour of cutting bed numbers to the bone.

The shift from hospital-based to university-based nurse training and the withdrawal of trainee nurses from the wards in the 1980s also made cuts in bed numbers possible and desirable. These cuts helped obscure the now gaping nurse shortage, which has been caused by increasing numbers of tertiary educated nurses moving out of bed-based nursing to out of nursing altogether or into positions in community health services and the health bureaucracy. The shortage of hands-on nurses prepared to work in hospital wards complicates the task of opening new beds. The heavily unionised and politically powerful nursing profession opposes more beds and prefers investing in prevention and community-based care to avoid forcing nurses back into the wards to do the jobs many university trained nurses no longer wish to do.⁴⁵ The federal government’s Super Clinics policy will exacerbate the nurse shortage and the difficulty of opening more beds by establishing more attractive jobs for nurses outside the wards.

The overarching factor was the Hawke government’s decision to create Medicare (Australia’s universal taxpayer-funded health care system) in 1984. Medicare entitles all Australians to receive bulk-billed general practice consultations on demand, heavily subsidised pharmaceutical medications according to need, and ‘free’ public hospital care at point of access—inviting unlimited demand. Capping hospital budgets and restricting the supply of service is the surest way for government to control the cost of expensive hospital care. Cutting bed numbers (along with tightly controlling global hospital budgets) is the point in the system where real cost controls can be imposed.

The quest to contain the high cost of a ‘free’ health system explains why governments are bed-phobic and determined to hold down bed numbers despite rising demand and chronic emergency access block. Each additional public bed represents a huge potential cost, especially on the elective side of demand for hospital care. Bed cuts enabled ‘free’ public hospital care to be rationed and made lengthy waiting lists for elective surgery the norm.

The quest to contain the high cost of a ‘free’ health system explains why governments are bed-phobic and determined to hold down bed numbers despite rising demand and chronic emergency access block.

Increasing bed numbers defeats the rationale for reducing bed numbers, which is why governments prefer to latch on to flawed solutions that don't involve opening more beds.

Supporters of Medicare, including bureaucrats, academics and politicians, are understandably reluctant to draw attention to the shortage of hospital beds and the extent to which government is failing to provide 'free' hospital care as promised. They do not want to admit that the hospital crisis is the long-term result of a deliberate strategy to cut beds, ration services, and control frontline costs.

Area health 'planners'

One of the reasons why area health services were established was to implement bed cuts without politically embarrassing confrontations between state governments and (abolished) local hospital boards.⁴⁶ The official rationale for regionalised hospital bureaucracies was that an administration at arm's length from local interest and political considerations was essential to create an integrated hospital system. The thinking was that only impartial bureaucrats—as opposed to local boards-cum-pressure groups dominated by empire-building clinicians—could judiciously cut bed numbers, close hospitals, and make wise capital funding decisions in relation to new, high-tech and expensive medical technologies to avoid over-servicing and prevent duplication and waste.

The area health services are supposed to operate as planning agencies responsible for identifying strategic needs and coordinating service provision. The idea that these large and costly bureaucracies are skilled at efficiently allocating resources is belied by the reality of public hospital overcrowding.

Initially, falling length of stays, increasing numbers of day surgeries, and the delayed impact of population ageing (see below) masked the effect of justifiable bed cuts without reducing levels of service. The efficiency gains offset increase separations and demand for admission, and allowed hospitals to treat increased numbers of patients with fewer beds.⁴⁷ Cutting bed numbers appeared to simultaneously improve services and lower costs.

Though reasonable at first, these assumptions have unravelled since overcrowding first became a major problem in the late-1990s. Admissions are currently growing by over 4% a year. This is twice as fast as population growth, and attributable to the severity of illness experienced by an ageing population.

Despite the billions of taxpayer dollars poured into the public hospital system each year, public acute bed resources are only two-thirds of the OECD average and well below international par in every state.

Due to excessive bed cuts, instead of rationing care based on relative need, the queue for 'free' hospital treatment now starts in and outside of emergency departments in the form of unacceptable delays in emergency assessment and admission, especially of frail elderly, acutely ill patients. Service delivery and the needs of frontline staff and the most vulnerable patients come last. Calls for significantly more beds have fallen on deaf ears inside the health bureaucracies, which find it easier and cheaper to ignore the human suffering caused by bed cuts rather than address the challenging and costly path of opening new beds.

Formulas for disaster

Health bureaucrats and hospital planners routinely claim that Australia has an adequate and internationally comparable number of hospital beds in line with the OECD average. (This is the meta-myth of the policy debate concerning the hospital crisis.) The Garling Report took the NSW Health Department at its word and dismissed the issue of bed numbers in a single sentence. The report claimed NSW hospitals were world class because the number of beds per 1,000 population was close to the top four or five OECD countries.⁴⁸

The OECD average is four beds per 1,000 population. Official bed numbers tabulated by the Australian Institute of Health and Welfare appear to show that Australia has an equivalent number of beds—3.9 beds per 1,000.⁴⁹

This is misleading. Despite the billions of taxpayer dollars poured into the public hospital system each year, public acute bed resources are only two-thirds of the OECD average and well below international par in every state. (See Table on page 9)

Of the total number of beds, 2.6 per 1,000 are public hospital beds (including psychiatric beds). Private hospitals contribute 1.3 beds—33% of the national total. Including private beds in the national count hides the lack of bed capacity in the public hospital system. It also ignores the artificial barriers that prevent efficient use of private hospital beds and prevent public health funding following patients to private hospitals. The majority of patients who present at public hospital emergency departments cannot be admitted to private beds. These beds are either occupied for privately funded elective surgery or are located in private hospitals that are not equipped to deal with emergency cases. Due to rapid growth in day surgeries, many private beds are often under-utilised (used mostly for procedural patients during the day) or are unoccupied (mostly overnight). But in relation to public hospital overcrowding, the vast majority of private hospital beds do not make up for the shortage of public acute beds. Outside of specific contractual arrangements, most private beds cannot be used to provide care for publicly funded elective patients.

Public Acute Beds per 1,000 population* 2007–08—by State or Territory

State or Territory	Public Acute Beds per 1,000 population	Available Beds per 1,000 population—Major Cities
New South Wales	2.7	2.7
Victoria	2.4	2.4
Queensland	2.4	2.3
South Australia	3.0	2.8
Western Australia	2.4	2.6
Tasmania	2.4	n.a.
Australian Capital Territory	2.5	2.6
Northern Territory	2.8	n.a.
Australia	2.5	2.5

Source: AIHW, *Australian Hospital Statistics 2007–08*.⁵⁰ * Excluding psychiatric beds.

A generous estimate is that around 0.2 beds per thousand in private hospitals may at any one time be occupied by acute cases. (That is, patients admitted through private emergency departments or patients with private insurance transferred from public hospitals.) Only 10% of all admissions identified as emergency admissions occurred in private hospitals in 2005–06. At best, this means that on average there are just 2.7 acute beds per 1,000 in Australia, which ranks at the bottom end of the OECD spectrum.⁵¹

To appear to bring bed numbers up to the OECD average, bed planners count private bed numbers and allocate public beds accordingly. Public hospital funding is generally allocated on a regional basis based on population. But as the *Sydney Morning Herald* reported in October 2007, the NSW Health Department employs a secret ‘redistribution formula.’ Regions with high levels of private health insurance and private hospital beds receive less public hospital funding and fewer public hospital beds.⁵² This is a formula for disaster.

Overcrowding is especially critical where private bed numbers are the highest, for example, on the North Shore of Sydney. In September 2007, the hospital crisis attracted national attention. Jana Horska miscarried in the emergency department toilets at Royal North Shore Hospital. Under intense media pressure, the NSW government hastily convened an inquiry into the Third World standard of public hospital care. The inquiry made no finding on the crucial issue—the unavailability of acute care hospital beds.⁵³ The issue was ignored despite the fact:

the sole reason that Ms Horska miscarried in the toilets was because the hospital was full to capacity and no bed was available ... At the time ... there were

46 patients in the ED, with all beds occupied, and 16 admitted patients waiting to go to the ward.⁵⁴

Are bed numbers 'less important'?

Public hospital bed planning is, to say the least, an imprecise science because of the problems of imperfect knowledge that plague all exercises in top-down central planning. Estimating the required number of beds (establishing bed norms) must take into account a range of variable and often difficult-to-calculate factors such as the demographic and disease patterns that influence patient demand and characteristics. The former is easier to gauge. The latter is much more difficult to calculate in the absence of comprehensive epidemiological data.

Bed planning therefore tends to be based on limited knowledge rather than evidence or outcomes. Bed numbers are often deemed adequate by relying on unquestioned assumptions about usage and the adequacy of alternative models of care. These assumptions invariably reflect preferred policy outcomes and systemic dysfunctions—such as the need to ration hospital services and funnel resources into paying for useless bureaucracy.⁵⁵ Regardless of the reality that in recent years, 'the actual trend has been towards higher demand for inpatient beds,'⁵⁶ the orthodox position among planners is still that total bed numbers, together with the concept of available beds, is increasingly 'less important.'⁵⁷ The flawed and outdated assumption remains that bed cuts have not been excessive because demand for hospital beds will continue to fall and the hospital of the future will be procedurally focused. Further reductions in average length of stay will be generated by technical innovations, rising numbers of same-day only admissions, and by less and less need for overnight and multi-stay admissions. The resulting efficiencies will make up for rising demand and allow hospitals to treat more patients with fewer and fewer beds.

Are more beds needed?

Case-mix

Whether hospital beds are less important depends on case-mix, which refers to the range of patients cared for, the proportion of procedures or surgery undertaken, and the overall nature of the care and treatment provided.

Hospitals with a higher proportion of procedural and same-day patients benefit more from rising day surgeries and falling length of stays than do hospitals with a higher proportion of non-procedural and multi-day-staying patients. In 2006–07, average length of stay was 2.5 days in Australian private hospitals compared to 3.6 days in public acute hospitals. Private hospitals had a higher proportion of same-day procedural separations (66.9%) compared to public hospitals (54.2%).

In 2006–07, one-fourth of public hospital separations involved no procedure at all compared to just 7% in private hospitals. This reflected the fact that 73% of public acute separations were associated with medical (that is non-surgical) Diagnosis Related Group (DRG) categories compared to just 38% of private hospital separations. By contrast, surgical DRGs accounted for 20% of public separations compared to 41% of private separations. Since 2002, medical DRGs have been growing at double the rate of surgical DRGs in public hospitals.⁵⁸ According to the June 2009 *State of Public Hospital* report, 67% of patients admitted to public hospitals receive acute medical care compared to just 18% requiring surgery.⁵⁹

Same-day overcrowding

In isolation, the figures that show rising same-day admissions and falling length of stays do not consider total demand against total bed capacity. Nor do they consider the critical relationship between rising demand, reduced bed numbers, increased bed occupancy rates, and hospital overcrowding.

More day surgeries can take the pressure off hospitals if growth in same-day admissions substitutes inpatient admissions for patients who once had to stay overnight. Yet a substantial proportion of the growth in day surgery has been and continues to be generated by new technology

stimulating new demand for elective procedures. As a result, day surgery takes up beds rather than replacing and reducing multi-stay demand.⁶⁰

Same-day separations in Australian public hospitals have increased steadily since 1996. Overnight and multi-day separations (which fell only slightly in the late 1990s) have increased by 12% since 2002, in line with increasing demand for hospital care associated with an ageing population. Average length of stay with same-day separations excluded is 6.2 days in public hospitals. This has remained relatively stable over the last decade, falling by less than 5%, a result that is also attributable to the impact of population ageing.

The idea that rising day surgeries make up for rising demand also overlooks the fact that public hospitals need free beds around the clock for unplanned emergency admissions. Because of beds being occupied by a procedural day patient, many emergency patients are forced to wait longer than eight hours for a ward bed. Increasing numbers of same-day separations thereby contribute to hospital overcrowding.

This problem has been intensified by rising demand for day surgery and ever-increasing political pressure plus financial incentives to cut long and politically sensitive elective waiting times. Hospital managers have been encouraged to both cut bed numbers and run hospitals at maximum efficiency, or at least at maximum capacity, to maximise elective surgery. Running hospitals at full throttle has proceeded to the point that major Australian public hospitals routinely operate above 100% occupancy. Endemic access block is the inevitable outcome in hospitals with zero spare bed capacity.

If bed numbers were less important and if cuts to hospital bed numbers were an efficiency dividend reflecting surplus capacity and reduced need and usage, then there should be no hospital overcrowding. In fact, falling lengths of stay have not offset bed cuts nor made up for rising demand. Demand for bed-based hospital care—measured by hospital occupancy rates and endemic emergency access block—has clearly outstripped the supply of acute beds.

The idea that rising day surgeries make up for rising demand also overlooks the fact that public hospitals need free beds around the clock for unplanned emergency admissions.

Delayed demand*

Some analysts still claim hospital bed numbers are less important despite demographic change. They maintain that the ageing of the population has not been associated with an increase in the proportion of hospital beds used by older patients and that the demand for hospital beds has decreased because the elderly population is healthier. The veracity of this claim relies on a trick in the hospital usage statistics. When carefully examined, these statistics demonstrate why bed cuts have gone too far and more beds are needed.

In the 1990s, demand for hospital beds remained static in the over-65 demographic. Bed usage by those aged 65–74 fell by 6%. The proportion of bed days in this age-group declined from 18% to 16%. One-off falls in demand among healthier people aged 65–74, together with reduced lengths of stay for elderly procedural patients, helped to temporarily mask the effects of bed cuts. But between 1993 and 2001, the population aged over 75 increased by 36%. Hospital separations in this demographic increased by 89%. Bed utilisation—or number of days in hospital—rose by 23%. Growth in separations in the 75 plus age group accounted for the entire growth in separation of people aged over 65, with multi-day separations increasing by 42%.⁶¹

These figures strongly suggest that demand for hospital care from people aged over 65 has been delayed or deferred for 10 years or so until people reach 75 and beyond. (See Appendix A) The ‘deferred illness’ and ‘delayed demand’ for hospital care started appearing in public hospitals in the late-1990s, contributing to the emergence of serious overcrowding as increasing numbers of ‘very old’ patients require care in emergency departments.

* I acknowledge my debt to Dr Paul Cunningham who drew my attention to the concepts of ‘deferred illness,’ ‘delayed demand,’ and the ‘success of prevention’ and their significance for the future of hospitals and the health system.

Not enough prevention?

Public health and community health lobbyists claim the problems in hospitals are due to government policy focusing too much on hospitals rather than prevention.⁶² Even hard-headed commentators have been seduced by the wellness model of health care to promote health, reduce health costs and—in the words of the federal health minister—‘keep people well and out of hospital.’⁶³

Average life spans have increased dramatically in the last 40 years due to better prevention. Healthier lifestyles and more effective medications have resulted in significant falls in rates of heart attacks and strokes.⁶⁴ People who once would have entered hospitals and died while in their 50s and 60s now live longer and eventually become users of emergency departments and consumers of acute public hospital beds when they are older and sicker. These frail and ‘very old’

Even hard-headed commentators have been seduced by the wellness model of health care to promote health, reduce health costs and—in the words of the federal health minister—‘keep people well and out of hospital.’

patients aged 75 years and over suffer from chronic conditions in association with other co-morbidities and experience multi-system failures that are complex and time-consuming to diagnose and treat. They are ‘frequent flyers’ in emergency departments and often require unplanned admission to inpatient beds.⁶⁵

Struggling public hospitals are already bearing the brunt of the inexorable ageing of the population. Between 2004 and 2007, the number of patients presenting at emergency departments with medical problems requiring unplanned admission increased by 15%.⁶⁶ Total public acute beds per 1,000 now number roughly the same as in 1996. Public hospital activity—measured by total patient days—has increased by over 10% in a decade. Putting this another way, while bed numbers increased by less than 0.02% since 1997, between 1998–99 and 2007, public hospital admissions increased

faster than population growth by nearly 16%, and there has been a ‘strong upward trend nationally since 2000–01.’ The rise in admissions is ‘mainly accounted for by an increase in acute medical care admissions,’ which increased by 23% since 1998, and by 7% alone since 2004–05.⁶⁷

The growth in admissions reflects the increase in demand among ‘very old’ patients. In the last five years, separations in public hospitals by patients aged 75–84 and 85 and over have increased by 25%.⁶⁸ Patients in these age groups accounted for 20% of separations in 2007–08.⁶⁹ Patients aged 75 and over accounted for 14% of separations in 1996–97. A decade ago, the 85 plus demographic was not even separately distinguished in the statistics.⁷⁰

Prevention is the ‘problem’ not the solution

The reality is that better prevention, combined with improved medical treatment of elderly patients with complex conditions, is enabling increasing numbers of Australians to live to older and sicker ages. The illnesses these patients experience, and their need for hospital treatment, is being deferred to later stages of life—adding to the pressure on overcrowded public hospitals. In an ageing Australia, an increasing proportion of the population will be aged over 75. Increasing numbers of ‘very old’ patients are inevitably going to fall acutely ill and require admission to hospital. This patient group will be *the hospital patients of the twenty-first century*.

Hospitals are facing an unprecedented tsunami of (delayed) demand for unplanned admission and bed-based medical and nursing care from ‘very old’ patients. The problem is not that there has been too much focus on hospitals and not enough on prevention. The problem is that overcrowded public hospitals do not having enough beds to properly care for older and sicker patients who require hospital care *due to the success of prevention*.

The myth of GP-style patients

If we are to address the bottlenecks that form in our emergency departments, we cannot afford to think there is a simple solution ... that beds are the solution ... I believe that the solution is far more complex than that—that it is a product of a health system which has focused too exclusively on acute care.

—*The Hon. Nicola Roxon MP, Minister for Health and Ageing, Speech to the Australasian College for Emergency Medicine, Access Block Solutions Summit, 12 September 2008.*

State Labor governments blame the hospital crisis on the idea that public hospitals are swamped by GP-style patients⁷¹ and the (Howard) federal government's alleged failure to provide sufficient Commonwealth-funded general practice services, particularly after-hours care.⁷²

In reality, the conventional policy wisdom that hospital overcrowding is caused by patients seeking primary care at emergency departments is a myth. So is the 'fact' that public hospitals are swamped by patients classified ATS 4 semi-urgent and ATS 5 non-urgent under the Australasian Triage Scale who in the words of federal Health Minister, Nicola Roxon, are a 'proxy of primary care patients.'⁷³

The Minister has also stated that 'a significant issue when we talk about blocks' is elderly so-called chronic disease patients: emergency staff are forced to spend time with too many elderly patients suffering complex illness who are classified ATS 4 and ATS 5, who could be seen and have their conditions better managed in primary care settings.⁷⁴

The reasoning is that rising numbers of high-risk, frail and elderly patients with complex, chronic illnesses are being admitted to hospitals because of gaps in the primary care system. Inadequate management of their multiple conditions at home or in the community is failing to prevent the onset of acute illness and the need for hospitalisation. The policy implication—endorsed at the highest levels inside the health bureaucracies—is that 'more beds' are not only (allegedly) unaffordable but also unnecessary and will lock in inappropriate and unsustainable traditional modes of hospital-based services. Alternative or new models of community-based care—hospitals at home and coordinated care schemes—can be substituted for beds for the growing group of 'very old' patients who allegedly would be better treated outside hospitals rather than in a hospital bed.⁷⁵

These claims are highly problematic. There is no stand-alone data showing how many true primary care patients are treated in emergency departments. The claim that elderly chronic disease patients who could be treated by GPs are using emergency departments to access primary care for ongoing conditions is based on anecdotal reports.⁷⁶

Despite the lack of evidence, these claims have created much confusion about the causes and cures of the hospital crisis.⁷⁷ John Menadue, an experienced ex-Commonwealth bureaucrat and prominent advocate for boosting primary care and community health, claims that '*unplanned admissions* pouring in through emergency departments ... is caused by a major problem in another part of the "system"—the collapse of practice at night, weekends, in outer suburban and rural areas.'⁷⁸ Bulk-billing after-hours GP clinics near or co-located with public hospitals, or primary care or medical assessment units, are therefore recommended to solve the hospital crisis. The claim is that GP clinics will ease overcrowding and reduce so-called unnecessary emergency presentations by GP-style ATS 4 and ATS 5 and elderly chronic disease patients who allegedly do not require specialist assessment in an emergency department.⁷⁹

These policy prescriptions require closest scrutiny. They are refuted by the evidence readily available in the Australian and international literature on access block. When an expert panel was convened to examine overcrowding in Canadian public hospitals, access to primary care services was the first cause eliminated. This was because the 'types of ED patients leading to overcrowding

The problem is that overcrowded public hospitals do not have enough beds to properly care for older and sicker patients who require hospital care due to the success of prevention.

are those who would be referred to the ED even if alternate sources of primary care are available (e.g. those with chest pain).⁸⁰

A number of studies have also revealed that GP-style (or low acuity) patients, who have a cold or a headache or sore toe, are cheaply and quickly treated once they are seen by emergency staff or diverted to appropriate services as per established protocols. Low acuity patients have been found to constitute between 10 and 15% of emergency presentations. These patients also account for only a fraction, 2 to 3%, of the emergency workload, and for less than 10% of emergency costs. Because GP-style patients are few and far between—around 10 patients per day and no more than one per hour—the provision of costly alternative GP services is estimated to reduce total emergency presentations and costs by no more than 2%.⁸¹ Where co-locating extended hours and bulk-billing GP clinics have been trialled, the effect at best has been ‘an average reduction in attendances of one patient every two hours while the clinics are open.’⁸²

Overcrowding is caused by a genuine demand for emergency admission by patients who cannot be treated anywhere other than in a hospital.

It stands to reason that streaming GP patients away from emergency to alternative primary care services does not alleviate overcrowding. ‘Vertical’ patients—who can sit or stand in a waiting room, who are not so sick they need to lie down, and who attend emergency departments though they could be seen by a GP—do not cause overcrowding by definition. This is because a GP-style patient (contra John Menadue) is never an unplanned admission. It is ‘horizontal’ patients—those who are so sick they need to lie down in a treatment cubicle, on trolleys in corridors, or in ambulances queued up or circling outside, and who need to be admitted to a hospital bed—who cause (or rather contribute to) overcrowding.

It is impossible to treat ‘horizontal’ patients in a GP clinic. There are no alternative care settings for patients who need to be admitted and are acutely ill and require the specialised assessment, equipment, and facilities that are only available in acute hospitals.⁸³ In other words, overcrowding is caused by a genuine demand for emergency admission by patients who cannot be treated anywhere other than in a hospital.

ATS 4 and ATS 5 patients are not proxy primary care patients

Yet according to the federal health minister, public hospitals are overcrowded because over 40% of emergency presentations are by proxy primary care patients in triage categories ATS 4 and ATS 5.⁸⁴ The basis for this claim is a flawed study of the key drivers of emergency demand in NSW hospitals, which was prepared for NSW Health in collaboration with other state health departments. The report found that the root cause of overcrowding was that ATS 4 and ATS 5 primary care type patients consistently made up 44% of emergency presentations. Highly inaccurate criteria were used to identify proxy GP patients who could ‘potentially be treated in a primary care environment.’⁸⁵

By contrast, the leading and unrefuted Australian study used far more robust and accurate criteria to identify true GP patients and accurately measure so-called demand transfer from primary care:

- ATS 4 or ATS 5; AND self-referred; AND
- Did not arrive by ambulance; AND
- Presented between 0800 and 2400; AND
- Treatment time (time seen by doctor to time ready for discharge) less than 60 minutes; AND
- Subsequently discharged from the emergency department.

This study by the NSW Faculty of the Australasian College for Emergency Medicine forensically analysed the patient data generated by the NSW Health Emergency Department Information System (EDIS).⁸⁶ Just 10% of presentations were identified as potential GP-style patients.⁸⁷

Most ATS 4 and ATS 5 patients were also found to have been referred to emergency departments by general practitioners. And most of these patients presented during business hours when GPs were available. Hospitals that were not located near after-hours GP clinics were also found to have similar numbers of ATS 4 and ATS 5 patients as hospitals located near such clinics. Most importantly, the complexities of these patients and the workload they generate were accurately assessed. The study found ATS 4 and ATS 5 patients consumed up to four and two times more clinician time respectively than the average GP encounter.

ATS 4 and ATS 5 patients were also found to be admitted at a rate of up to 20% and 10% respectively compared with an admission rate of just 1% in general practice. What the admission rate data demonstrates is that ATS categories rank emergency patients in order of urgency. Urgency is not the same thing as the severity and complexity of illnesses. A lower ATS 4 and ATS 5 rank means it may be safe for patients to wait an hour or two while more urgent cases are attended to. But it does not mean, and was never intended to mean, that less urgent patients could be seen by a GP. It does not mean that only ATS 1, 2, and 3 patients who need treatment within 30 minutes should be seen in emergency departments.

Nor does it mean that 'if it is all right for you to wait for an hour or more to be seen in an emergency department then you probably didn't need to be seen by an emergency specialist.'⁸⁸ The condition of many ATS 4 and ATS 5 patients may be serious. A frail, elderly, and acutely-ill patient (a so-called chronic disease patient)—who is suffering an underlying condition that is difficult and time-consuming to diagnose and treat, who needs to be assessed by experienced and highly trained emergency specialists, and who needs to be admitted—would be coded ATS 4 and could never be treated in a GP clinic. For example:

A person who comes in as triage category four who has a slight temperature and is 80 years old and then ends up in the ICU because of what seemed like an insignificant illness is actually quite seriously ill and dies two days later ... Anyone who's been a director of an emergency department knows that [this] group of people are the ones [at] the greatest risk for misdiagnosis, and although they are a low triage category does not mean they don't have serious problems that require an expert to review them.⁸⁹

The leading and unrefuted Australian study used far more robust and accurate criteria to identify true GP patients and accurately measure so-called demand transfer from primary care.

The Rudd Plan

Despite promising to deliver so-called comprehensive national health and hospital reform, the Rudd government has adopted the same politically motivated and bed-phobic approach as its state counterparts. The centrepiece of the Rudd government's plan to take pressure off public hospitals is a national network of GP Super Clinics. These Super Clinics are designed to provide all-hours GP services for GP-style patients and coordinated primary care for elderly chronic disease patients.

As I have argued elsewhere, the government's Super Clinic policy is predicated on the misguided idea that the problems in hospitals are because of the hospital-centric health system focusing too much on hospitals and not enough on primary care and prevention of lifestyle-related chronic diseases.⁹⁰ Rather than ending the 'blame game' between the states and the Commonwealth, the government is blaming the wrong problems and ignoring the evidence and everyday realities in public hospital emergency departments.

Rather than a modern take on health care for the twenty-first century, Super Clinics are a failed Whitlam government experiment of the 1970s. Based on the Poly-Clinic or Community Health Centre model, they represent the policy dream of ideologues in the public health sector and academia who dream of salaried and socialised rather than fee-for-service general practice services.⁹¹ The Rudd government is taking the health reform agenda down the same failed path as in New Zealand. The comprehensive primary care reforms implemented by the Clark Labour government are singled out as the model for Australia to follow.⁹² Never mentioned is that public

hospitals in New Zealand (which stopped publishing information about bed numbers in 2000) suffer the same if not more serious problems than their Australian counterparts—the unacceptable clogging up of emergency departments due to the lack of beds.⁹³

The government’s Super Clinic policy is predicated on the misguided idea that the problems in hospitals are because of the hospital-centric health system focusing too much on hospitals and not enough on primary care and prevention of lifestyle-related chronic diseases.

The Rudd Plan is based on the alleged benefits of coordinated care. Otherwise called ‘managed care’ or ‘disease management,’ coordinated care involves a GP or a practice nurse monitoring the condition and managing the care of the chronically ill and elderly patients. The proponents of coordinated care say that ensuring patients receive all available care from a wide variety of allied health providers will prevent conditions from deteriorating to the point these patients require urgent, unplanned, and potentially avoidable admission into hospitals.⁹⁴

The Rudd government’s hand-picked National Health and Hospitals Reform Commission (NHHRC) has endorsed the idea that Super Clinics will take the pressure off overburdened public hospitals based on the highly questionable assumption that ‘many acute beds are occupied by people who could be better cared for in community settings.’⁹⁵ The 2008 COAG communiqué reinforced

the Rudd government’s wrong-headed commitment to create a ‘less hospital-focused’ health system that concentrates more on prevention and primary care.⁹⁶ The NHHRC interim report on the future of the health system (the Bennett report) goes further and recommends a complete federal takeover of primary care services from the states. The Bennett report also recommends the upscaling of Super Clinics into Mega-Clinics that offer an even wider range of Medicare-funded primary care health services.⁹⁷

Why beds, rather than the alternatives, matter

- The ageing of the population is a key driver on overall ED demand ...
- The numbers of elderly patients going to ED is on a wave—if we don’t solve this problem we’ll be in gridlock ...
- We are seeing more complex patients, often with multi-system failures.
- We are keeping people alive longer and treating more complex conditions.⁹⁸

The evidence that alternative community-based models of care can substitute for hospital beds and hospital care, especially for elderly patients, and will alleviate the pressure on emergency departments is ‘weak at best.’⁹⁹ Some studies indicate that schemes designed as substitutes in practice ended up complementing hospital care. They have resulted in increased hospital activity in the context of rising overall demand and bed cuts.¹⁰⁰

Survey articles suggest ‘good evidence’ that coordinated care of chronic disease patients reduces risk of emergency admission.¹⁰¹ But this conclusion is primarily based on one early 1980s trial in the United States, which found that coordinating the primary care of patients aged over 65 resulted in a static hospital admission rate.¹⁰² On this slender evidentiary basis rests the grand claim that large numbers of ‘horizontal’ older and sicker patients can be more appropriately treated in the alternative community-based settings.¹⁰³

The results of the second round of the Australian Coordinated Care Trial suggest we should be sceptical about the effectiveness of alternative models of care in reducing hospital usage by ‘very old’ patients. One of the coordinated care programs studied as a part of the trial, which was conducted in the northern suburbs of Melbourne, targeted the key demographic—elderly chronically ill patients aged 75 and over. Coordinating the care of a trial group of patients appears to have produced no significant reduction in hospital use compared to a control group who continued to receive their usual level of care from their GP. Overall inpatient cost trends for intervention and control groups did not differ significantly once hospital admission data were adjusted for the much larger number of patients in the control group admitted for kidney dialysis

compared to the intervention group. Intervention patients also had significantly higher hospital usage early in the trial. In fact, except for a three-month period, between nine and 12 months, during the 15-month trial, intervention patients had significantly higher use of inpatient hospital services at the beginning, the end, and throughout the trial on average than the control group.¹⁰⁴ (See Appendix B)

One of the well-demonstrated effects of coordinated care is to uncover unmet needs and bring forward demand for hospital services. This is no bad thing and hardly an argument against coordinated care. But it does mean that rather than take the pressure off hospitals, coordinated care may well add to the pressure.¹⁰⁵

Other studies hint at other explanations for this outcome. Studies that have examined the use of emergency departments by elderly patients have, as expected, established that the elderly are frequent users of emergency departments. But they also found that very few visits were avoidable since the vast majority were for high-intensity reasons. In other words, very few patients were found who could be diverted to allegedly more appropriate primary care.¹⁰⁶

Meeting rather than preventing hospital demand

On top of the high quality Commonwealth-funded general practice services, a multiplicity of federal and state programs already exist to care for older patients with complex and chronic conditions in the community health sector. Medicare-funded GP Super Clinics will only add to the duplication.¹⁰⁷ Crucially, existing programs appear to be working well. As a result of the community-based care the elderly are already receiving through state government community health services and other federal and state government funded providers, ‘patients are entering high dependency residential aged care facilities later than previously.’ However, residents are entering these facilities sicker than in the past. They are, therefore, more likely to need referrals to hospitals and almost always true emergency cases requiring admission to a ward bed.¹⁰⁸

The problem is not that elderly chronic disease patients are not receiving appropriate primary care but that more effective community-based care is leading to greater demand for hospital care for reasons that ‘seem unavoidable.’¹⁰⁹ This identifies a major flaw in the alternative models of care approach. It simply is not possible to endlessly prevent the need for ‘very old’ patients to be admitted to hospitals.¹¹⁰ As people live to older ages due to more effective prevention, they develop conditions the onset of which are linked to genetic and hereditary factors, which tend to deteriorate with age until the point is reached when inpatient admission becomes inevitable.¹¹¹ Put another way, it means ‘morbidity of chronic illness occurring later in life will still mean the patient requires hospital care, though at a later stage in life.’¹¹²

A new situation is developing in hospitals. Older patients are no longer being admitted solely for ‘end of life’ care. Instead, they are frequent and repeat visitors.

This view is supported by anecdotal reports from experienced emergency staff, who say it is uncommon to find elderly patients whose admission could have been prevented by better primary care.¹¹³ A new situation is developing in hospitals. Older patients are no longer being admitted solely for ‘end of life’ care. Instead, they are frequent and repeat visitors. They fall ill, are admitted, and receive acute medical treatment plus traditional overnight bed-based care. They recover, leave, and come back again when their conditions decline.¹¹⁴ It is complex older and sicker patients who now generate the greatest and most complex emergency workload, consume the bulk of staff attention, and slow the assessment of new patients.¹¹⁵ Various studies show that access block is highly associated with acuity of condition, with patients who arrive by ambulance, and with increases in the age of patients.¹¹⁶ Not surprisingly, older patients are disproportionately represented in emergency presentations. They are admitted at double the rate compared to younger patients, and have more frequent and longer stays in ward beds.¹¹⁷

The policy point is that endlessly trying to provide alternative care to contain rather than meet the need for hospital care generated by elderly patients is a futile strategy. At some point, older and sicker people need to go hospitals to access the acute care—the specialist assessment, modern diagnostic, therapeutic, and procedural equipment, *and* bed-based medical and nursing care—that is only available in a hospital. If this is correct, then greater government spending on

alternatives to hospital care for very old patients is no short- or long-term alternative. The quality of care that an older and sicker population receives will depend on whether Australia has a hospital sector equipped to meet the demand for bed-based care that they will inevitably require. Based on the experience of the last 25 years and the state of the health reform debate, there is good reason to think this will not happen unless public hospitals are rid of the systemic problems that have created the continuing crisis.

Structural reform

All stakeholders recognise that public hospitals must be made more accountable for the taxpayer funding they receive and that hospital performance must improve to justify funding increases.

The tacit but unstated concession that underpins the Rudd government's reform agenda is that due to poor productivity and systemic dysfunctions in the public system, it is a waste of money for governments to throw funding at state-run public hospitals.

The tacit but unstated concession that underpins the Rudd government's reform agenda is that due to poor productivity and systemic dysfunctions in the public system, it is a waste of money for governments to throw funding at state-run public hospitals to inefficiently expand their services.¹¹⁸

The introduction of case-mix funding as the principle and transparent mode of funding public hospitals in Victoria and other states has created a kind of hospital voucher. (Funding for public hospitals in all states and territories except the Australian Capital Territory involves some element of case-mix funding.) Case-mix or activity-based funding forces hospitals to earn income according to the work they do and to find the most cost-effective means of delivering care. By tying money to treatment of patients, case-mix also makes public hospital services more responsive to patient demand.

It drives greater productivity and promotes allocative efficiency because hospitals are required to assess how much of what kind of services they are required to provide. The case-mix system has improved hospital productivity to the extent that the Victorian public hospital system is acknowledged (with some important provisos concerning emergency care and alleged falsification of performance data) as the most efficient and best performed in the country. The lowest cost and most efficient hospitals in the nation are located in those states in which the case-mix system has been established the longest—Victoria and South Australia.¹¹⁹

However, the introduction of case-mix funding is not far-reaching enough reform, because it does not address the dysfunctional mismanagement of public hospitals.

Structural reform is the only cure for the systemic problem in public hospitals. The means by which publicly funded hospital services are provided must be reformed to resemble a normal market as closely as possible, subject to equity requirements that all citizens have access to necessary hospital care irrespective of their capacity to pay out of private income. A three-prong structural reform strategy is required to create a quasi-market for hospital services that will force autonomous service providers to respond appropriately to market signals and efficiently expand the supply of hospital care to meet demand.

The first step is to reform the way hospitals are funded. Equity concerns can be satisfied by taxpayer-funded hospital vouchers issued by Medicare according to clinical needs and the case-mix basis of calculating the efficient cost of emergency and inpatient hospital services (covering the whole episode of care and including cost of capital). Vouchers will also tie funding to patients and address the urgent need to liberalise the demand side of hospital care. They will empower consumers with a wider choice of public and private providers, and all hospitals will have to compete for revenues and make satisfying patient demand their number one priority.

To directly address overcrowding and access block, hospitals providing emergency care will also submit bids twice a year (to adjust for changes in 'winter' and 'summer' demand) for extra 'bed vouchers.' These extra vouchers will pay for the fixed costs of an adequate supply of beds and appropriate levels of staff in specific regions to maintain capacity to admit patients from emergency.¹²⁰ This system will be overseen by a national hospital voucher agency whose role will be to express demand for beds pegged and adjusted according to a demonstrated need for unplanned admission on a hospital-by-hospital basis.

The second step is to liberalise the supply side of hospital care. Transforming public hospitals into the price and quality conscious, customer-oriented service providers they are not at present requires decentralising control of hospitals by re-establishing local hospital boards. Public hospitals run by boards with a mix of medical representation and citizens with commercial and financial expertise will resemble non-profit corporations. They will employ professional administrators and have full financial responsibility for and operational authority over their facilities. Boards will have to calculate their costs and be cost-conscious to earn their vouchers and ensure long-term viability. Genuine accountability for the financial performance of hospitals and the economic realities of voucher-based funding will give boards the incentive to close down loss-making services and to specialise in certain services. Waste and duplication, and the associated political problems that contributed to abolition of local boards in the first place, will be avoided. Empire-building clinicians will no longer be able to use special pleading and lobbying for extra funding to ensure hospitals maintain all specialities.¹²¹

Genuine local autonomy combined with financial responsibility will also encourage integration and regionalisation of hospital services ‘from below’ as hospitals network their services with nearby facilities. This will minimise the problem of hospitals in close proximity to each other and small rural hospitals (outside of a minimum Community Service Obligation) attempting to offer a broad array of health services. It will also remove the political obstacles that impede the rationalisation of hospital services and resolve the problem that area health services were created to fix (by planning regional hospital networks) but have failed to solve. The development of city-country hospital networks will be encouraged. Small rural hospitals will be keen to establish links with major urban hospitals that offer all specialities, while city hospitals will have the incentive to access new patient bases in the bush.

The third step is to end the waste on bureaucracy that reduces productivity and leads to rationing and shortages, and abolish the superfluous area health bureaucracies and downsize the parasitic state health departments. The resources saved will be reallocated to fund vouchers and pay for the hospital services and hospital bed capacity rather than a bloated bureaucracy, which doctors, nurses, and patients can all do without.

Not that radical, but superior

A voucher system is not that radical a proposal. The idea of channelling state and federal hospital funding into vouchers is consistent with the support across the political spectrum for demand-driven reform initiatives in sectors of the economy plagued with inefficient public service delivery.¹²²

These reforms (which could be trialled in a state or in a region to assess results against the status quo) will also remove the artificial barriers that prevent taxpayer funding following patients to private hospitals and allow more care to be delivered in private facilities. Exposing public hospitals to direct competition with more efficient private hospitals that already deliver the same care for lower cost¹²³ would enhance the drive for greater public sector productivity. Privately operated health systems have been shown to deliver more care at a lower cost compared to bureaucratically run systems due to better management and the benefits of competition.¹²⁴ Vouchers would also increase access for patients and enable the efficient utilisation of private hospitals. Greater use of spare bed capacity in private hospitals for procedural patients would help ease the burdens on public hospitals that need to deliver increasing amounts of unplanned acute care.

A voucher system is consistent with the support across the political spectrum for demand-driven reform initiatives in sectors of the economy plagued with inefficient public service delivery.

Vouchers and the abolition of the area health services will allow resources to be reallocated away from wasteful bureaucracy and into frontline patient care. This will not only encourage technical efficiency (the delivery of hospital services for lower cost) but also enhance allocative efficiency. Vouchers—direct funding on a case-by-case basis—in combination with the reestablishment of hospitals boards will enable hospitals to regain their independence and respond appropriately to the health needs of the community. Doing away with the present arrangements of population-based block funding and centralised control will realign organisational and financial incentive structure. Local hospitals will have the freedom and authority to align resources with patient demand and end bed shortages.

Ending the crisis

The most important argument in favour of a voucher system is the perpetual crisis into which public hospitals have spiralled. Despite rising demand, emergency doctors and nurses have been unable to convince health authorities to properly resource hospitals with adequate numbers of beds.

The most important argument in favour of a voucher system is the perpetual crisis into which public hospitals have spiralled.

The problem is that emergency doctors and nurses lack political clout and the ability to lobby effectively for more beds. They are but one small provider group competing for government funding amongst a myriad of competing groups, and the professional interests of procedural specialists, along with community health services and the nurses unions, who are not interested in bed provision, have won out. Special pleading and ‘capture’ of the policy making process at both the bureaucratic and political level means the squeakiest wheels have received the funding and policy grease. The result is that bed numbers have been cut to a level far below the bare minimum and

there is no institutional or political will within the public health system to rebuild the bed base despite the deleterious impact on the standard of patient care.

Unless change occurs, there are real fears that the impossible situation in emergency departments will mean that even fewer graduate doctors will specialise in emergency medicine. There will not be enough emergency specialists to deliver the acute care our ageing population will require.¹²⁵

Funding methods have been found to help direct health care services towards patient needs if the care delivered is appropriately remunerated. Existing funding arrangements (including case-mix funding) are biased towards elective procedures. Procedures are easier to cost and measure. Emergency and acute medical care is more labour and capital intensive, and more costly, complex, time-consuming, and difficult to measure.¹²⁶ Case-mix funding therefore gives hospitals an incentive to operate at maximum capacity to maximise high turnover of simpler elective patients at the expense of the emergency department and rather than manage complex acute patients.¹²⁷ This seems to have occurred in Victoria¹²⁸ where bed occupancy levels are the highest in the nation and access block is perhaps more serious than in hospitals in other jurisdictions.

A transparent and rigorous case-mix voucher system will minimise the procedural bias in existing funding arrangements and remedy the underfunding of non-procedural care. Hospitals will earn vouchers for each occasion of emergency care provided, and each voucher will properly price the case-mix cost of the acute care provided to sicker, more complex patients, including the full capital and labour costs. In addition, hospitals providing emergency care will be free to bid twice a year for extra bed vouchers to pay for the fixed costs of an adequate supply of beds and appropriate levels of staff in specific regions. This will enable hospitals to have emergency and bed capacity on call during periods of low demand, to operate at 85% occupancy, and secure the prompt unplanned admission of patients.¹²⁹ The allocation of beds and the determination of bed numbers will be transformed into an open and accountable process and bypass the vested interests of bed-phobic bureaucracies. Local boards will also be directly responsible for the state of their emergency department, and will have the operational authority and economic incentive to increase staffed bed numbers.

What if it costs too much?

A reasonable objection to a voucher system is that liberating the supply and demand for hospital care may prove enormously expensive, irrespective of the savings made on slashing the bureaucracy. Governments will have to pay for all the demand that is currently unmet due to rationing.

If, after the waste on bureaucracy is eliminated, the cost proves too expensive, then we will have to have a serious discussion about cost sharing and the future of the fiction that is a ‘free’ health system. This is necessary anyway given the unsustainable inter-generational impact on future taxpayers and government budgets of the rising cost of medical technology and paying for the health care of an ageing population.¹³⁰

The overriding point, however, is that we cannot afford to continue with the status quo.

Conclusion: the politics of planning and market-based reform

The systemic problems at the heart of the hospital crisis highlight the high price the community pays for the so-called ‘free’ hospital care that government taxes us heavily to pay for. Far less of the health care we all wish to access to lengthen and improve our lives is provided than is warranted by the billions of taxpayer dollars poured into the public hospital system—a poor return measured by growth in bureaucracy against the ever-spiralling amount expended and ever-lengthening waits for treatment. Every health dollar wasted on excessive bureaucracy is a dollar of health care the community forgoes—literally on a bed forgone for a sick patient to lie in.

It is no revelation that bureaucratically run government agencies fail to efficiently allocate resources and are the least efficient way to provide public services. Compared to other public policy areas, the impact on the delivery of hospital services is especially dire. Nevertheless, far-reaching health reform is difficult to accomplish. The majority of voters remain attracted to the idea of ‘free’ hospital care irrespective of the litany of problems in public hospitals. This has politically quarantined public hospitals—the area with the most serious problems in service delivery—from market-based reforms. The case for taxpayer-funded vouchers is well established in the field of education as a way to improve efficiency, quality and access to publicly funded services.¹³¹ Given the basic shortages and inefficiencies in public hospitals and the effect on the timeliness and safety of the acute care received—or rather not received—the need for hospital vouchers is even more critical.

The need for a voucher system is reinforced by understanding how difficult it is for governments to get it right when they attempt to centrally plan for future demand. The assumptions employed to plan hospital services—by cutting less important beds as demand has increased—have proved flawed and placed public hospitals in a critical condition. The national health reform agenda is dominated by subterranean public sector interest group politics. It is also dominated by new central planning assumptions that assume, based on evidence that is weak at best, that alternative community-based primary care can make up for bed shortages in the long run in an ageing Australia. If top-down approaches are adopted (based on the presumption that governments know what health services are required and can plan the circumstances in which they should be delivered), then politicians will ultimately have to bear the blame for continued shortages in the provision of hospital services. If hospitals remain in crisis, members of parliament can expect to receive a lot of complaints from a lot of angry relatives about poor treatment received by grandparents and great-grandparents forced to wait a long time for admission in public hospital emergency departments.

This paper presumes we are going to need more beds to provide more bed-based medical care for a much larger elderly population. A 50% increase in patients presenting at emergency aged over 85 is predicted over the next five years alone.¹³² Even if alternative models of care and other strategies—including clinical redesign, improved discharge, and transfer initiatives—free up significant numbers of beds, they are expected only to accommodate existing demand and waiting lists. Bed numbers will still need to increase significantly to accommodate demographic change.¹³³ Policymakers must ensure flexible funding and responsive administration arrangements are in place to ensure bed numbers can increase to cope with rising demand.

In the wake of the global financial crisis, there has been a reaction against market-based reform led by the committed enemies of the market. Most Australians, including politicians, are non-ideological. For better but usually worse, the vast majority of politicians see their job as using taxpayer dollars to provide services the community wants. Most Australians, like the people they elect to represent, are empirically minded. They are interested in what works and what doesn’t. The average citizen, and perhaps most policymakers, may consider the systemic problems in public hospitals an abstract issue. Yet in their bones, both politicians and the people know that bureaucracies cannot deliver public services properly, even if they know not how else these services might be provided.

The hospital crisis illustrates this policy impasse. Public hospitals have been mismanaged on an epic scale. Taxpayer dollars have been channelled into useless bureaucracy at the expense of

Every health dollar wasted on excessive bureaucracy is a dollar of health care the community forgoes—literally on a bed forgone for a sick patient to lie in.

patient care. Critics of vouchers have already protested this would ‘unleash’ the market on public hospitals.¹³⁴ And so we should. The genius of markets is that they efficiently allocate resources to enable the most productive and efficient providers to deliver goods and services consumers demand at the lowest cost and highest quality. A voucher-based approach to funding hospitals will mean that if in the future there is greater demand for beds and bed-based care—based on clinical need as diagnosed by doctors—hospitals will be able to adjust to meet it. By dispensing with central planning and improving the responsiveness of the hospital system to patient demand, far-reaching structural reform can improve access in the long run. If the demand is there, hospital vouchers will pay for beds and not for the bureaucracies that have presided over a bed crisis 25 years in the making.

Hospitals provide essential services that the community is going to need more and more in coming decades. So essential are these services that government bureaucracies cannot continue to be allowed to run and ruin hospitals. The policy options are to stick with tried and failed methods or strike out in a new direction. It’s time for structural reform:

- Flexible voucher-based funding arrangements which allow money to follow patients according to clinical need.
- Localised administrative arrangements responsive to patient demand.
- An end to central planning and ‘command and control’ bureaucracy, and the closing down of the area health services to open more beds.

Appendix A: Ageing and hospital beds: Gray et al. vs Mackay and Millard

- ‘Trends in the use of hospital beds by older people in Australia’ by Gray et al. was published by the *Medical Journal of Australia* in 2004. This paper purported to show that hospital bed numbers are less important because the ageing of the population had not been associated with an increase in the proportion of hospital beds used by older patients. Based on an analysis of a decade’s worth of hospital data, the authors argued that despite falling bed capacity, the rising demand for hospital care associated with an ageing population had been offset by increases in day surgery and falls in lengths of stay. As a result, between 1993 and 2002, the Australian population aged 65 and over had increased by 18% compared to total population growth of 10%, but the proportion of hospital bed days used by older patients remained stable at 47%.
- However, the study showed clear evidence that population ageing was associated with large increases in hospital separations by ‘very old’ patients. The proportion of separations of people aged over 65 increased by 28% and was entirely due to separations by patients 75 and over increasing by 89% and rising from 13 to 18% of all admissions. Bed days utilised by patients 75 plus also increased by 23%. The outcome Gray et al. highlighted—rising rates of separations but no change in proportion of beds used for older people—was partly explained by the growth in same-day separations. Just as most of the increase in total separations in the period was due to growth in same-day separations, most of the rising rate of separations in older patient groups was also due to massive growth in same-day separations. While multi-day separations had increased by 20% for the over 65s and by 42% for the over 75s, by contrast, same-day separations increased by 113% for patients aged 65–74 and 260% for the over 75s.
- Equally important were the factors that reduced bed-utilisation rates per 1,000 population, which Gray et al. claimed outweighed rising separation rates. One was the difference between the elderly cohorts in rates of bed utilisation. While the proportion of bed days used by the 75 plus groups increased slightly from 28 to 31%, it fell from 18 to 16% for those aged 65–74 because bed utilisation fell by 6% and multi-day separation rates per 1,000 population fell by 10%. While multi-day separations increased by 4% for the 75 plus group, this was offset by ‘disproportionate reductions in length of stay for multi-day admissions.’ Average length of stay for multi-day separations fell by 11% for patients aged 65–74 and by 17% for patients aged 75 plus. As a result, the rate of multi-day bed use per 1,000 population for older patients declined significantly, by 20% for patients aged 65–74 and 14% for those over 75. This reflected the overall decline in average length of stay by 33% for patients aged 65–74 and 35% for patients over 75.
- Mark Mackay and Peter Millard were quick to point out the flaws in Gray et al.’s analysis and the implications for policymakers. In a letter to the *MJA*, they argued that relying on the proportion of beds used by the elderly masked the real trend in total bed days and separations, and did not address the issue of supply. They argued that this did not mean that demand for hospital beds was not increasing and that there may not be enough beds. They pointed out that despite the large increase in same-day activity, the number of multi-day bed days fell only slightly by 1.4%. They pointed out that although multi-day separations and bed days declined for 65–74-year-olds, separations increased by 41% and bed days increased by 28% for those aged 75 plus. In addition, same-day activity increased significantly for patients aged 65 or more—due to the expanded range of treatments available to this patient group. Even more importantly, hospital use in elderly groups grew faster than population. While the proportion of the population aged 75 plus increased by 1.1%, the proportion of separations by this age group increased by 5.8% and bed days increased by 1.8%. While the proportion of the population aged 65–74 fell by 0.2%, the proportion of same-day activity increased by 1.3%.

- In summary, Mackay and Millard found that there had been little fall in multi-day demand, while demand for multi-day stays grew strongly for those aged 75 plus. This was combined with significant growth in same-day demand, especially for those aged 65–74. Furthermore, not only had total bed numbers fallen, the growth in same-day activity had been achieved by ‘substituting same-day beds for inpatient beds.’ The reduction in the supply of multi-day beds, they surmised, combined with the ageing of the population having increased demand for hospital care, had led to rising incidence of access block. This was identified by pointing to implied bed rates—total bed days divided by total available bed days—which indicated that as bed numbers had fallen and utilisation had increased, implied occupancy had increased from 77% in 1998–99 to 81% in 2001–02.
- This controversy illustrates that the impact of population ageing on demand for hospital care is more complicated than it may seem due to the impact of the delayed demand phenomenon. What is most relevant is the huge growth in multi-stay day admission in the 75 plus age group. Because occupancy rates and the availability of free beds is the best measure of how equipped the public hospital system is to meet the needs of emergency patients, when the Mackay and Millard’s methods are replicated, we find that implied public acute bed occupancy for 2006–07 was above 85%. The implied bed occupancy was 77% in 1996–97 with 2.9 beds, 85% in 2001–02 when bed numbers troughed at 2.51, and 82% in 2004–05 when beds peaked at 2.6 per 1,000. This strongly supports Mackay and Millard’s surmise that reduced supply of beds combined with the ageing of the population and the resulting rising multi-day stay demand accounts for increased incidences of access block.

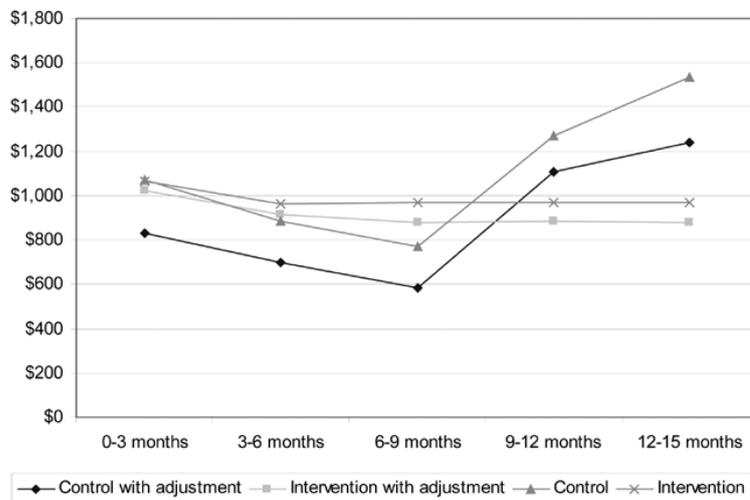
Appendix B: Does coordinating the care of very old chronic disease patients reduce hospital usage?

Table 285 Statistical comparison of inpatient services and costs between control and intervention excluding diseases and disorders of the kidney and urinary tract

Measure	Statistic	Pre-commencement		Trial				
		3-6 months	0-3 months	0-3 months	3-6 months	6-9 months	9-12 months	12-15 months
Adjusted Inpatient Services	Mean Control			0.20	0.16	0.16	0.23	0.22
Adjusted Inpatient Services	Mean Intervention			0.23	0.22	0.21	0.19	0.23
Adjusted Inpatient Services	Difference			0.03	0.06	0.06	-0.04	0.01
Adjusted Inpatient Services	SD Difference			0.03	0.03	0.03	0.03	0.04
Adjusted Inpatient Services	Z			0.99	2.16	2.17	-1.25	0.19
Adjusted Inpatient Services	LCI90%			-0.02	0.01	0.01	-0.09	-0.06
Adjusted Inpatient Services	UCI90%			0.07	0.10	0.10	0.01	0.08
Adjusted Inpatient Services	p			32.20%	3.04%	2.96%	21.02%	84.89%

Measure	Statistic	Pre-commencement		Trial				
		3-6 months	0-3 months	0-3 months	3-6 months	6-9 months	9-12 months	12-15 months
Adjusted Inpatient Costs	Mean Control			830.49	701.00	581.61	1109.66	1239.90
Adjusted Inpatient Costs	Mean Intervention			1022.20	915.22	879.59	883.47	878.72
Adjusted Inpatient Costs	Difference			191.71	214.22	297.98	-226.19	-361.18
Adjusted Inpatient Costs	SD Difference			205.21	188.85	176.60	272.99	375.32
Adjusted Inpatient Costs	Z			0.93	1.13	1.69	-0.83	-0.96
Adjusted Inpatient Costs	LCI90%			-145.82	-96.41	7.49	-675.22	-978.53
Adjusted Inpatient Costs	UCI90%			529.25	524.86	588.46	222.85	256.17
Adjusted Inpatient Costs	p			35.02%	25.66%	9.15%	40.74%	33.59%

Figure 149 Inpatient costs with and without diseases and disorders of the kidney and urinary tract – control and intervention



The key features of Table 285 and Figure 149 are:

- The overall inpatient cost trends for control and intervention participants did not differ significantly when episodes classified as diseases and disorders of the kidney and urinary tract were removed from the analysis.
- Intervention participants had statistically significant higher service utilisation in the initial stages of trial participation; however, this was not the case in the latter stages of trial participation.
- Intervention participants had higher inpatient costs in the early stages of trial commencement; however, as time in the trial progressed, intervention participants had lower costs than control participants. This result was statistically significant in the six to nine-month period.

Endnotes

- 1 Julia Medew and Jill Stark, 'Hospitals creating ghost wards,' *The Age* (19 May 2008).
- 2 'Admitting our hospital system is sick is the first step to recovery,' *The Age* (29 February 2008).
- 3 Julia Medew, 'Stressed hospitals saying no to more ambulances,' *The Age* (28 November 2008).
- 4 'The public hospital of the future,' *Medical Journal of Australia* 180:1 (January 2004), 47.
- 5 Letter to the Editor, *The Sydney Morning Herald* (2 April 2009).
- 6 'Effect of ambulance diversion on patient mortality: how access block can save your life,' *Medical Journal of Australia* 183:11/12 (December 2005), 672–673.
- 7 Speech to the Australasian College for Emergency Medicine, Access Block Solutions Summit, Hilton Hotel Melbourne (12 September 2008).
- 8 Natasha Wallace, 'Casualty crisis: many wait eight hours,' *The Sydney Morning Herald* (2 August 2007).
- 9 Department of Health and Ageing, *State of Our Public Hospitals June 2009 Report* (Canberra: Australian Government, 2009), 7.
- 10 Australian Medical Association, *Public Hospital Report Card 2008: An Analysis of Australia's Public Hospital System* (Canberra: AMA, 2008), 7.
- 11 'Australia's emergency departments continue to decline in function, new "snapshot" reveals,' Australasian College for Emergency Medicine, Media Release (1 August 2007).
- 12 Jamie Walker, 'Minister John Hill's fury at patient death claims,' *The Australian* (26 September 2008).
- 13 Sue Dunlevy, '1500 die waiting for bed,' *The Daily Telegraph* (13 November 2008).
- 14 Michael J Schull, et al. 'Urban emergency department overcrowding: defining the problem and eliminating misconceptions,' *Canadian Journal of Emergency Medicine* 4:2 (March 2002), 76–83.
- 15 The Rudd government's hospital reform agenda was announced with much fanfare in the lead up to the 2007 federal election. The Rudd plan promised to end the blame game over the hospital crisis, massively boost public hospital funding, and improve hospital accountability and performance. Incentive-based funding arrangements were foreshadowed to boost productivity. The states would also be compelled to collect and report nationally consistent financial and other data to compare the performance of hospital systems across the country. Progress, especially with respect to greater financial accountability, has been slow and patchy. The Commonwealth is yet to make any headway at all in requiring the states to collect and report nationally consistent data to allow national comparison of hospital costs. At the November 2008 COAG meeting, the states agreed in principle to move towards a national system of activity based funding of public hospitals ('within five years,' according to the *State of Public Hospitals 2009 Report*). The Commonwealth has set a target of 80% of emergency department presentations to be seen within clinically recommended time. The states have also been offered \$300 million incentive payments for reductions in elective waiting times as part of a National Partnership with the Commonwealth. (See *State of Our Public Hospitals 2009 Report*, 61, 64.) In the absence of bed increases, the states are highly likely to chase the cash for additional surgery and worsen the situation in emergency departments—as has happened in Victoria under a similar incentive-based payment system.
- 16 For details of Australian Health Care Agreement, see Council of Australian Government (COAG) meeting, Canberra (29 November 2008), *Communique*, Appendix A.
- 17 The AMA proposed that a contract be included in the Australian Health Care Agreement committing the states to measure and report the percentage of patients needing admission forced to wait longer than eight hours for a bed, to enforce the 85% occupancy rule, and that funding be linked to increases in inpatient beds. AMA, *Public Hospital Report Card 2008*, 3.
- 18 *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements* (Canberra: NHHRC, April 2008), 46. For example, this report alludes to the problems in public hospital emergency departments but not a single mention is made in the entire report about bed numbers or the only real solution, which is more beds.
- 19 'Australia's Emergency Departments continue to decline in function, new "snapshot" reveals,' as above.
- 20 Clare A Skinner, 'Inside the emergency department,' *Medical Journal of Australia* 187:11/12 (December 2007), 634–635.
- 21 Drew B Richardson, 'The access-block effect: relationship between delay to reaching an inpatient bed and inpatient length of stay,' *Medical Journal of Australia* 177: 9 (November 2002), 492–495; Peter C Sprivilis, et al. 'The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments,' *Medical Journal of Australia* 184:5 (March 2006), 208–212; Drew B Richardson, 'Increase in patient mortality at 10 days associated with emergency department overcrowding,' *Medical Journal of Australia* 184:5 (March 2006), 213–216.
- 22 Adrian Bagust, et al. 'Dynamics of bed use in accommodating emergency admissions: stochastic

- simulation model,' *British Medical Journal* 319:155 (July 1999), 158.
- 23 Under such circumstances, for instance, as Professor Drew Richardson of the ANU told the *Sydney Morning Herald*, NSW would be unable to deal with a major incident or multicar accident. Natasha Wallace, 'Casualty crisis: many wait eight hours,' *The Sydney Morning Herald* (2 August 2007).
- 24 AMA, *Public Hospital Report Card 2008*, as above, 6.
- 25 This is not merely a theory. When industrial action, or in one case the Sydney 2000 Olympics, led to the cancellation of elective surgery in Australian public hospitals, the resulting decrease in hospital occupancy markedly reduced access block in the emergency departments that had been chronically blocked. Drew B Richardson, 'Responses to access block in Australia: Australian Capital Territory,' *Medical Journal of Australia* 178:3 (February 2003), 103–104.
- 26 The AMA calculates that the Australian public hospital system is 3,750 beds short, and that to allow hospitals to operate safely at 85% occupancy would require a 6.6% increase in the total number of public acute beds. AMA, *Public Hospital Report Card 2008*, as above, 7.
- 27 Malcolm Colless, 'Lance bloated beast of bureaucracy,' *The Australian* (23 October 2007).
- 28 John Graham, 'Turning back the tide of errors,' *The Australian* (4 October 2007).
- 29 'Statistical information on these services is not as highly developed as that on other services (such as hospitals) and there is no nationally agreed basis for describing the nature of the services or for measuring the amounts of service provided.' Australian Institute of Health and Welfare, *Australia's Health 2008*, Cat. No. AUS 99 (Canberra: AIHW, 2008), 342.
- 30 The way to end the waste and duplication and clean up the structural overlap in the provision of primary care services is to repeat the dose of radical surgery in community health. Governments should end block funding of community health and pay for care delivered by Community Health Services and non-government providers using only case-mix vouchers, with general practitioners, hospital physicians, and other specialists acting as gate-keepers and referring patients to community-based chronic disease and hospitals-in-home programs based on clinical need.
- 31 Graeme J Stewart and John M Dwyer, 'Implementation of the Garling recommendations can offer real hope for rescuing the New South Wales public hospital system,' *Medical Journal of Australia* 190:2 (January 2009), 80–82.
- 32 Australian Institute of Health and Welfare, *Health Expenditure Australia 2006–07*, Health Expenditure Series No. 35 Cat. No. HWE 42 (Canberra: AIHW, 2008), 45–48.
- 33 It is difficult to establish the true scale of these bureaucratic monsters due to the dubious practice of allocating head office and other centralised administrative positions and costs to hospitals.
- 34 Siobhain Ryan and Imre Salusinsky, 'NSW healthcare "a victim of Soviet system",' *The Australian* (29 January 2009).
- 35 Siobhain Ryan, 'More clerks than nurses in health system,' *The Australian* (19 March 2008).
- 36 Submission by Anthony Morris QC, cited in House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on Inquiry into Health Funding* (Canberra: Commonwealth of Australia, 2006), 36.
- 37 AIHW, *Australia's Health 2008*, as above, 346.
- 38 As above, Table 8.21.
- 39 AMA, *Public Hospital Report Card 2008*, as above, 15.
- 40 'Gammon's Law of Bureaucratic Displacement': A note from Dr Max Gammon with some quotes from Milton Freidman, Teleconference Presentation to the Australian Doctors' Fund (25 January 2005).
- 41 Nick McKenzie and Richard Baker, 'Hospital fraud claim goes to police,' *The Age* (16 March 2009); Stephen Rodgers-Wilson, 'A symptom of ill-health,' *The Age* (20 March 2009).
- 42 Wolfgang Kasper, *Radical Surgery: The only cure for NSW Hospitals*, Papers in Health and Ageing (7), CIS Policy Monograph No. 91 (Sydney: CIS, 2008).
- 43 I am neither a medical doctor nor an emergency physician. So the standard thinking that calls for more beds is just another attempt by another 'doctors' lobby group to feather their own nests at the expense of the public purse does not apply in my case.
- 44 AIHW, *Australia's Health 2008*, as above, 346.
- 45 For the nurses policy program and opposition to the 'simplistic option of opening more beds,' see Ged Kearney, 'Nurses perfectly able to do more,' *The Australian* (14 February 2009).
- 46 John Graham, 'Garling misses chance to fix hospitals,' *The Australian* (17 January 2009).
- 47 Stephen J Duckett, 'Australian hospital services: an overview,' *Australian Health Review* 25:1 (2002), 2–18.
- 48 Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals (Garling report), *Final Report* (27 November 2008), 2.
- 49 AIHW, *Australian Hospital Statistics 2007–08*, Health services Series No. 33 Cat. No. HSE 71

- (Canberra: AIHW, 2009), 13.
- 50 As above, Table 2.2, Table 3.3. The other factor is that bed cuts have not been evenly distributed. Major urban hospitals have been targeted for bigger reductions, while under-utilised beds in country hospitals, which have low occupancy rates, have been retained for political reasons. For example, in Western Australia, 1,200 overnight beds are located in country hospitals with an average occupancy of around 50%, compared to average 90% occupancy for beds in metropolitan regions. Ross Fox, *Talking the Pulse: Reform Initiatives for the WA Health System* (Melbourne: Institute of Public Affairs and Mannkal Economic Education Foundation Project Western Australia, 2008), 7.
- 51 Department of Health and Ageing, *State of our Public Hospitals June 2007 Report* (Canberra: Australian Government, 2007), 23. This information and analysis is partly based on an unpublished paper provided the author by Dr Paul Cunningham.
- 52 Kate Benson, Alexandra Smith, and Natasha Wallace, 'A bit rich: Iemma's class wards,' *The Sydney Morning Herald* (28 September 2007); Natasha Wallace, 'Health boss spilled the beans,' *The Sydney Morning Herald* (9 October 2007). Natasha Wallace, 'Minister takes heat on private patients,' *The Sydney Morning Herald* (10 October 2007).
- 53 NSW Department of Health, 'Inquiry into miscarriage at Royal North Shore Hospital,' Media Release (26 October 2007). A select parliamentary committee subsequently investigated the standard of care at the Royal North Shore Hospital. Again the committee ignored the systemic issues and made no finding on the crucial issue—the shortage of hospital beds at RHNSH. Where in the Committee's report, asked Jana Horska's husband, Mark Dreyer, was a recommendation regarding the extra beds and funding required to prevent this from happening again? 'Hospital report just waffle, says husband,' *The Sydney Morning Herald* (21 December 2007).
- 54 Roberto Forero and Ken Hillman, *Access Block and Overcrowding: A Literature Review*, report prepared for the Australasian College of Emergency Medicine (2008), 9.
- 55 Nigel Edwards and Anthony Harrison, 'Planning hospitals with limited evidence: a research and policy problem,' *British Medical Journal* 319:20 (November 1999), 1361–1363.
- 56 Tony J O'Connell, et al. 'Health services under siege: the case for clinical process redesign,' *Medical Journal of Australia* 188:6 (2008), S9–S13, S9.
- 57 AIHW, *Australia's Health 2008*, as above, 346. This is a constant refrain in AIHW publications.
- 58 AIHW, *Australian Hospital Statistics 2006–07*, as above, xv.
- 59 Department of Health and Ageing, *State of our Public Hospitals June 2009 Report*, as above, 18.
- 60 Nigel Edwards and Anthony Harrison, 'Planning hospitals with limited evidence,' as above.
- 61 Len C Gray, et al. 'Trends in use of hospital beds by older people in Australia: 1993–2002,' *Medical Journal of Australia* 181:9 (November 2004), 478–481.
- 62 For the flavour of these arguments and a critical discussion, see Jeremy Sammut, *The False Promise of GP Super Clinics Part 1: Preventive Care*, Papers in Health and Ageing (3) CIS Policy Monograph No. 84 (Sydney: CIS, 2008).
- 63 For example, see Michael Costa, 'Lingering blame a sign of indifferent health,' *The Australian* (5 December 2008).
- 64 As demonstrated by the latest edition of *Australia's Health 2008*. See Mark Metherell, 'Some of the healthiest people on earth,' *The Sydney Morning Herald* (25 June 2008).
- 65 Australian men who live to 65 are now expected to go on to live to at least 83, and women who live to 65 to at least 86. Ashley Midalia, 'Living longer but bill is a wealth hazard,' *The Australian Financial Review* (24 June 2008). Since 1991, 50% of the extra emergency admissions by patients aged over 75 in Britain have been for complex conditions. *Shaping the Future NHS: Long Term Planning for Hospitals and Related Services, Consultation Documents on the Findings of the National Bed Inquiry* (London: Department of Health, 2000), 9.
- 66 Tony Joseph, 'Aiming for goals and kicking behinds,' *The Sydney Morning Herald* (2 August 2007).
- 67 *State of our Public Hospitals June 2007 Report*, as above, 24, 28.
- 68 AIHW, *Australian Hospital Statistics 2006–07*, as above, 177.
- 69 AIHW, *Australian Hospital Statistics 2007–08*, as above, 191.
- 70 AIHW, *Australian Hospital Statistics 1996–97*, as above, 61
- 71 This has also been described as having always in part been a squabble over which tier of government should pay for the GP-style care rather than where GP-style care is best delivered. Australasian College of Emergency Medicine, *Access Block and Overcrowding in Emergency Departments* (Melbourne: ACEM, 2004), 11.
- 72 Due to the national doctor shortage, an increased workload from elderly patients, and the changing character of Australia's ageing and increasingly feminised GP workforce, fewer and fewer general practitioners are willing to provide after-hours care. Originally, the crisis was linked to falling rates of

- bulk-billing. Now that bulk-billing has recovered to average historical levels and the idea that people are seeking 'free' primary health care at hospitals is less credible, the focus has shifted to lack of after-hours care.
- 73 Nicola Roxon, 'Speech to the Australasian College for Emergency Medicine.' ACEM held the Access Block Solutions Summit at the Hilton Hotel in Melbourne on 12 September 2008. Before an audience of doctors, nurses, bureaucrats, politicians, and researchers, the Australian leaders in the field of emergency medicine gave detailed and evidence-based presentations which explained why—due to lack of hospital beds—public hospitals are overcrowded. No state Health Minister attended, but to her credit, the federal Health Minister, Nicola Roxon, agreed to open the summit. During her short address, the Minister again blamed long emergency waiting times on the myth that hospitals are being swamped by GP-style patients. Her minders whisked the Minister away before she could hear that the truth about the real cause of the crisis in public hospitals.
- 74 Nicola Roxon, as above.
- 75 Tony J O'Connell, et al. as above.
- 76 Booz Allen Hamilton Ltd, *Key Drivers of Demand in the Emergency Department: a hypothesis driven approach to analyse supply and demand* (Sydney: NSW Department of Health, 2007), 2, 14.
- 77 For example, the federal government provided an additional \$750 million as part the 2008 COAG agreement for emergency departments that 'are treating an increased number of patients who could otherwise be treated in the primary care sector.' In other words, the denial and avoidance continued. COAG meeting (Canberra, 29 November 2008), *Communique*, Appendix A, 15.
- 78 John Menadue, *Another Design Problem in Health: No One Runs Public Hospitals*, Presentation to the Royal Australasian College of Medical Administrators and Australasian Faculty of Public Health Medicine NSW, University of New South Wales (February 2008), 2, emphasis added.
- 79 TGF International, *Report in the operation and future of the Australian Health Care Agreements and the funding of Public Hospitals* (Melbourne: Australian Centre for Health Research, 2008), 454–456; See recommendations of Garling Commission, particularly concerning Medical Assessment Units, outlined in Natasha Wallace and Alexandra Smith, 'Public hospitals on "brink of collapse",' *The Sydney Morning Herald* (28 November 2008). Medical Assessment Units were established at 17 hospitals in metropolitan Sydney in 2008. In the Garling report, they have inexplicably been linked to the issue of ATS 4 and ATS 5 patients and diverting 'non-emergency' and GP-style patients away from emergency departments. Despite their name, patients are not assessed in the units. Patients first attend emergency and are referred *after they receive specialist assessment* to the medical assessment units. The units, in truth, are short-stay hospital wards. Patients can remain for up to two days before being sent home or admitted to a general ward. They are specially designed to cater for the needs of elderly patients aged 75 and over suffering complex, chronic, acute illness. They have added 235 extra hospital beds across the system. In other words, medical assessment units are hospital wards by another name. They are proof that more beds *are* needed for an ageing population and to relieve the pressure on overcrowded hospital departments. 'Medical Assessment Units provide specialist treatment for elderly patients,' NSW Health, Media Release (9 April 2008); 'Elderly Patients Medical Assessment Units,' *New South Wales Hansard* (9 April 2008).
- 80 Michael J Schull, et al. as above.
- 81 ACEM, *The Relationship Between Emergency Department Overcrowding and Alternative After Hours GP Services* (Melbourne: ACEM, 2004), 2–3; ACEM, *Fact Sheet Re: Urban Emergency Services and ATS 4 and ATS 5 Patients*, as above; ACEM, *Access Block and Overcrowding*, as above, 12–14.
- 82 In another case, referrals from the emergency department to the nearby clinic were found to be fewer than three per day. Other studies have found that establishing nearby clinics did not result in 'a measurable reduction in the absolute number of ED presentations.' Dale W Hanson, et al. 'Bulk Billing GP clinics did not significantly reduce emergency department caseload in Mackay, Queensland,' *Medical Journal of Australia* 180:11 (June 2004), 594–595.
- 83 Martin Hensher, et al. 'Better out than in? Alternatives to acute hospital care,' *British Medical Journal* 319: 7217 (October 1999), 1,127.
- 84 Nicole Roxon, as above.
- 85 The extremely broad and flawed criteria to identify potential GP patients even included patients referred by a GP to the emergency department. The other criteria were:
- patients who were classified as triage categories T4 (semi-urgent: within 60 minutes) or T5 (non-urgent: within 120 minutes) under the Australasian Triage Scale.
 - who did not arrive by emergency vehicle.
 - who were not admitted to the wards.
- The report also failed to specify whether the patients identified were actually GP patients. It also

- begged the report's conclusion by identifying as potential GP patients those who made repeat presentations for the same conditions based on anecdotal reports that these were 'chronic disease' patients who could be treated by GPs and were using emergency departments to access primary care for ongoing conditions.
- 86 ACEM, *The Relationship Between Emergency Department Overcrowding and Alternative After Hours GP Services*, as above.
- 87 This roughly correlates with the actual number of non-urgent presentations. In 2006–07, 12% emergency presentations were ATS 5, and the number has remained fairly stable since 2002. AIHW, *Australian Hospitals Statistics 2006–07*, as above, 94.
- 88 Garling Report, 25, as above.
- 89 Natasha Wallace, 'Patient care option bypasses experts,' *The Sydney Morning Herald* (28 November 2008).
- 90 This paper builds on and should be read in conjunction with the critique of the federal government's GP Super Clinics policy in Jeremy Sammut, *The False Promise of GP Super Clinics Part 1*, as above; and Jeremy Sammut, *The False Promise of GP Super Clinics Part 2: Coordinated Care*, Papers in Health and Ageing (4) CIS Policy Monograph No. 85 (Sydney: CIS, 2008).
- 91 They also believe our health system should be based on the Cuban system. Fiona Armstrong, Chair of the Australian Health Care Reform Alliance has endorsed a primary care-led reform strategy modelled on the Cuban health system. See Fiona Armstrong, 'Will today mark a change towards a fairer health system?' *Crikey* (16 February 2009). To those who want a health system like Cuba's I reply: Move to Cuba and stop trailing red herrings across the real policy debate about how to fix public hospitals.
- 92 See Fiona Armstrong, Chair of the Australian Health Care Reform Alliance, 'The NZ approach to primary health care' *Crikey* (3 June 2008).
- 93 See for example, Brooke Donovan, 'Senior doctors go public on hospital crisis,' *The NZ Herald* (29 February 2008).
- 94 Jeremy Sammut, *The False Promise of GP Super Clinics Part 2*, as above.
- 95 *Beyond the Blame Game*, as above, 15, 21.
- 96 COAG, *Communique*, as above, 15.
- 97 *A Healthier Future for All Australians*, as above, 7.
- 98 Emergency department staff interview quotes, in Booze Allan Hamilton, *Key Drivers of Emergency Demand*, 109–110.
- 99 By the mid-1990s in the United Kingdom, bed reductions and the drive to operate hospitals at above 90% occupancy began to seriously affect the ability of overcrowded NHS hospitals to admit emergency patients without undue delay. (Martin McKee, 'Reducing Hospital Beds: What are the lessons to be learned?' *European Observatory on Health Systems and Policies* 6 (2004), 5) This led to the formation in 1998 of the National Bed Inquiry, which reported in 2000 that acute bed closures had gone too far, that the prevailing view that continued efficiency gains made further bed closer possible was flawed. Given that two thirds of acute beds were used by elderly patients, there may be a need for greater investment in additional bed capacity. The report also speculated that in the absence of bed increases, some of the slack might be taken up by providing the elderly with 'community-based alternatives to hospital care.' (*Shaping the Future NHS*, as above, 12.) But as Allyson Pollack and Matthew Dunnigan were quick to point out in the *British Medical Journal*, papers commissioned by the inquiry itself revealed 'the evidence is weak at best that hospital at home and other early discharge schemes reduce overall hospitalisations and the need for acute hospital beds.' (Allyson M Pollock and Matthew G Dunnigan, 'Beds in the NHS: The National Bed Inquiry exposes contradictions in government policy,' *British Medical Journal* 320:7233 (February 2000), 461–462)
- 100 Martin Hensher, et al. 'Better out than in?' Alternatives to hospitals—such as hospital in the home—complement rather than replace hospital care, because the more intensive the care the elderly receive, the more their utilisation of hospital care increases. McKee, 'Reducing Hospital Beds,' as above, 7. In a similar vein, studies of hospital in the home schemes 'have not looked directly at the effect on the emergency department.' It is 'presumption that decreasing length of stay will decrease bed occupancy and in turn improve emergency care patient flows.' Nor has hospital in the home been found to be a cheaper option over inpatient care, and early discharge schemes can also prove a false efficiency by leading to higher readmission rates. Matthew Cooke, et al. *Reducing Attendances and Waits in Emergency Departments: A systematic review of present innovations*, Report to the National Coordinating Centre for NHS Service Delivery and Organisation R & D (London: NCCSDO, 2004). It might also be the case that sending elderly patients to sub-acute facilities is self-defeating because early discharge leads to higher rates of re-admission as patients come back sicker and quicker.
- 101 'Towards faster treatment: reducing attendance and waits at emergency departments,' A Briefing

- Paper from the UK National Coordinating Centre for NHS Service Delivery and Organization Research and Development. *Longwoods Review* 4:1 (2006), 9. However, the full study was more equivocal about the ‘lack of high quality evidence.’ It concluded ‘Attendance by the elderly, those with chronic disease and those with multiple attendances may be reduced by various interventions. Trials are needed in this area.’ Cooke, et al. *Reducing Attendances*, as above, 95, 187, 192.
- 102 Cooke, et al. *Reducing Attendances*, as above, 89
- 103 For example, the Australian General Practice Network has claimed that coordinating the care of patients reduced hospital admissions by 25% compared to a control group of patients whose care was not coordinated. What this measured was the difference in average rates of growth in hospital use in the trial compared to the pre-trial period. And if you plough through the Commonwealth Department of Health and Ageing report on the trials, you find that when the initial difference in pre-trial rates of hospital use between the two groups was adjusted for, the so-called substitution effect—coordinated care leading to reduced use of hospitals—disappeared. There was no real reduction in hospital use because patients who received coordinated care also received ‘significantly’ more hospital services than did the control group. What this seems to demonstrate is that coordinated care enhances primary care’s traditional roles of timely detection and referral to necessary treatment. See Sammut, *False Promise of GP Super Clinics Part 2*, as above.
- 104 Department of Health and Ageing, *The National Evaluation of the Second Round of Coordinated Care Trials*, Commonwealth Department of Health and Ageing (Canberra: Commonwealth of Australia, 2007), Part 3, 595, 621–622, 627, 630–631.
- 105 For a longer discussion of these issues, see Sammut, *The False Promise of GP Super Clinics Part 2*, as above.
- 106 Fredric D Wolinsky, et al. ‘Emergency department utilisation patterns among older adults,’ *The Journals of Gerontology Series* 63a:2 (2008), 204–209.
- 107 The way to clean up these structural problems is to repeat the dose of radical surgery in community health. End block funding of community health and pay for services from Community Health Services and non-government providers using case-mix vouchers, with general practitioners and hospital physicians and specialists fulfilling a gate-keeping role and referring patients to community-based chronic disease and hospital in the home programs based on clinical need. This issues will be taken up in Jeremy Sammut, *Like The Curate’s Egg: On the Bennett Report* (forthcoming).
- 108 Booz A Hamilton, *Key Drivers of Emergency Demand*, 72, 115. In this report, the full list of Commonwealth and state programs providing community-based care for the elderly and chronic disease suffers, combined with other hospital diversion schemes, covered 21 A-4, 20–41.
- 109 This is consistent with the findings of a 2006 Australian study that found the vast majority (nine out of 10) emergency department presentations by residents of aged-care facilities were appropriate and, in the words of the authors, the vast majority ‘seem unavoidable’ because ‘the therapeutic and/or diagnostic requirements of the patients acute condition preclude the patient being managed outside the ED.’ Though, as the authors pointed out, this wasn’t to say some presentations could not have been avoided if residential aged care facilities had the capacity to provide alternative sub-acute care on-site. ‘However, even with improved skill levels and communication between acute care and residential care facilities, the vast majority of presentations to the ED seem unavoidable.’ Judith C Finn, ‘Interface between residential aged care facilities and a teacher hospital emergency department in Western Australia,’ *Medical Journal of Australia* 184:9 (May 2006), 432–435.
- 110 A sense of the demand for hospital care this creates is gained from the fact that surveys of aged care providers indicate that on average 63% of residents are sent to emergency departments each year. Booz Allan Hamilton, *Key Drivers of Emergency Demand*, as above, 72.
- 111 George Braitburg, ‘Emergency Department Overcrowding: dying to get in?’ *Medical Journal of Australia* 187:11/12 (December 2007), 624–625, 624.
- 112 Statement of Dr Brian Morton, Annexure B to the submission of the Australian Medical Association (NSW) Limited and the Australian Salaried Medical Officers’ Federation (28 March 2008), quoted in the Garling Report, as above, 752.
- 113 Contrary the claim that ‘seventy per cent of the hospital admissions of older Australians who are in very poor condition could be avoided if there was effective community intervention.’ Mike Stekette, ‘Situation is no accident,’ *The Australian* (6 October 2007).
- 114 An out-of-date assumption is that population ageing has a minor impact on demand for hospital care because the demand generated by very old patients is fixed. The idea is that because need for acute care is highly associated with proximity to death, demand is more or less limited to the care of dying patients. Martin McKee, ‘Reducing Hospital Beds,’ as above, 7.
- 115 ACEM, *Access Block and Overcrowding in Emergency Departments*, as above, 8.

- 116 Roberto Forero, et al. 'Access block in NSW Hospitals, 1999–2001: does the definition matter?' *Medical Journal of Australia* 180:2 (January 2004), 67–70.
- 117 Analysis of NSW emergency admission data revealed that patients aged 65 and over accounted for 33, 30 and 25% of ED patients in ATS 1, 2, and 3 categories respectively. Patients aged 75 plus accounted for 22, 18, and 15% of the demand in each of these categories. This analysis also revealed the highest growth in attendances and admissions was among patients aged 75 plus. 'Very old' patients spent longer than other patients in EDs (8.8 hours) and were admitted at higher rates (55%) than any other patient group. Booz Allan Hamilton, *Key Drivers of Emergency Demand*, as above, 11–12.
- 118 Despite the lack of accurate financial data on the cost of public hospital care, analysis by the Productivity Commission reveals a 20–25% productivity gap between least efficient public hospital systems and the relative best practice states, and 35% difference in the average of cost of treating patients between jurisdictions. See Australian Institute of Health Studies, *Revitalising Health Reform—Time to Act*, Discussion Paper (September 2007) 10–11.
- 119 Emily Hurley, et al. *The Australian Health Care System: The Potential for Efficiency Gains—A Review of the Literature*, Background paper prepared for the National Health and Hospitals Reform Commission, June 2009, 25.
- 120 This is similar to the regime recently proposed by the National Health and Hospitals Reform Commission: that hospitals be funded primarily by activity based case-mix payments combined with, for hospitals with major emergency load, fixed grants to maintain bed and staffing capacity. *A Healthier Future for all Australians: Interim Report December 2008* (Canberra: National Health and Hospitals Reform Commission, 2009), 10, 137.
- 121 In other words, the creation of local boards will not just be a means by which doctors will be able to feather their own nests, restore their lost power, and maximise their claims on the public purse, as is feared by some with previous experience of the workings of local hospital boards.
- 122 See David Hetherington, *Market Design in Health and Wellness and Education and Training* (Sydney and Melbourne: Per Capita, 2008).
- 123 An analysis performed by the DVA, comparing the cost differential for equivalent services and treatment, was referred to in evidence before the House of Representatives Committee of Inquiry into Health Funding in 2006. This showed that the department paid 'significantly lower prices in the private sector than in the public sector.' Official Committee Hansard, House of Representatives Standing Committee on Health and Ageing (4 September 2006), HA 11.
- 124 Richard Feachem, et al. 'Getting More for their Dollar: A Comparison of the NHS with California's Kaiser Permanente,' *British Medical Journal* 324:7330 (January 2002).
- 125 Lack of bed resources is exacerbating the critical shortage of emergency doctor as medical graduates prefer not to train in this specialty. NSW hospitals, for instance, train 20 new emergency physicians a year, half the number required to meet future workloads. Natasha Wallace, 'Need for hospital staffing taskforce urgent: college,' *The Sydney Morning Herald* (20 October 2007). Emergency departments across the country now heavily depend on locums and overseas-born trainee doctors working on temporary visas. Lacking the experience to cope with the demands of multi-diagnosis medicine in a high pressure environment, the work of trainees requires close supervision, which further increases the strain on too few experienced staff.
- 126 Forero and Hillman, *Access Block and Overcrowding*, 6–7, 12. Peter A Cameron and Donald A Campbell, Access block: problems and progress, *Medical Journal of Australia* 178:3 (February 2003): 99–100.
- 127 Peter A Cameron, et al., 'Access block can be managed,' *Medical Journal of Australia* 190:7 (April 2009), 364–368.
- 128 Tom Keating attributes the increase in hospital productivity and the rise of access block in the post-case-mix era to this factor: 'Why would you leave a bed vacant for a possible emergency admission when you could fill it with a patient who generated a payment.' Tom Keating, 'Gaming the health system is a rational response to bad policy' *Crikey* (25 June 2009).
- 129 This is a necessary safeguard against 'market failure.' The temptation for hospitals will always be to use spare bed capacity to treat 'cheap and easy' procedural patients at the expense of emergency departments and more complex and costly acute patients. Hence, private hospitals in the United States encounter the same access block problems as do public hospitals in Australia, the United Kingdom, and Canada. 'Bed vouchers' can be thought of as an 'essential service guarantee' to ensure the provision of safe and timely emergency care.
- 130 See Jeremy Sammut, 'The Coming Crisis of Medicare,' *Papers in Health and Ageing* (2), CIS Policy Monograph No. 79, (Sydney: CIS, 2007).

- 131 Jennifer Buckingham, *Families, Freedom, and Education: Why School Choice Makes Sense*, CIS Policy Monograph No. 52 (Sydney: CIS, 2001).
- 132 Garling Report, as above, 55.
- 133 As above, 1,004.
- 134 See NSW Health Minister, John Della Bosca, quoted in Siohbain Ryan and Imre Salusinszky, 'NSW healthcare 'a victim of Soviet system'', *The Australian* (29 January 2009).

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