NSW Parliamentary Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

Thank you for the opportunity to respond to the NSW Parliamentary Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales.

The Australian Medical Association of NSW ("AMA (NSW)") is a professional association for doctors representing doctors from all specialties and at all stages of their career.

Our submission is based on anecdotal, qualitative, and quantitative evidence and includes input from the AMA (NSW) Hospital Practice Committee, the AMA (NSW) Council of General Practice and our members.

The causes of ambulance ramping and access block are multifaceted and while COVID 19 has impacted access, the pressure on NSW's healthcare system has increased in the last decade as demonstrated in the government's own reporting of performance.

Summary of Recommendations

1. ***An increase in the federal government contribution to funding to 50%, with States and Territories to use the additional 5% 'freed-up' funds on improvement.***

2. ***Removal of the annual growth cap on the federal government's contribution to allow funding to meet increased demand for hospital services.***

3. ***Re-introducing funding for performance improvement, including improvement in elective surgery and emergency department waiting times.***

4. ***Providing additional funding for extra beds and staff to address current capacity issues.***

5. ***Funding out-of-hospital care alternatives to address avoidable admissions and readmissions.***

6. ***Payroll tax exemption to address GP shortage issues.***

Response to the Terms of Reference

(a) the causes of ambulance ramping, access block and emergency department delays;

Ambulance ramping and access block are a consequence of issues related to demand, supply and funding for health care services. These issues existed before the pandemic and have been seriously exacerbated by the pandemic.

Public hospitals were already facing capacity constraints before the pandemic, in terms of both numbers of beds and having the right staff at the right time. This lack of capacity was due to increasing demand from a combination of our aging population and the growing prevalence of chronic disease.

As at 30 June 2021, 17.2% of the NSW population was aged 65 years and over, up from 16.8% the previous year.[1] There is also an increasing prevalence of risk factors for chronic disease, with 46.3% of people in NSW reporting one or more chronic conditions in 2017-18.[2]

The proportion of the NSW population aged 65 years and over made up 50% of admitted bed days in NSW.[3] A measure of how this has impacted public hospital capacity is the ratio of available hospital beds per 1,000 people aged 65 years and over. As seen in Figure 1 below, this ratio has been in a trend of decline for decades.

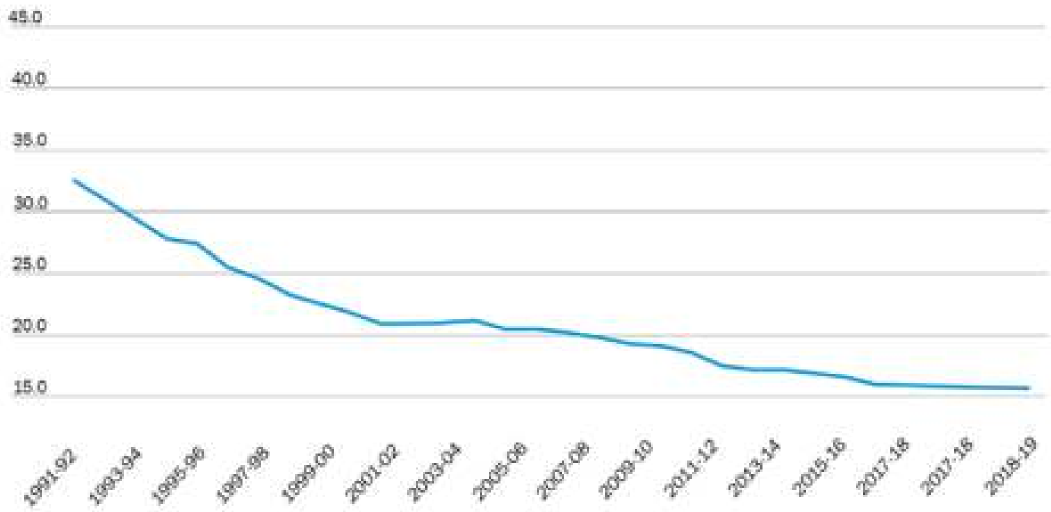

Figure 1: Number of approved/available public hospital beds per 1,000 population aged 65 and over – all States and Territories[4]

These trends above have contributed to access block across public hospitals. As the hospital is a dynamic system dependent on a sustainable rate of patient flow, blockages in one area of the hospital will very quickly impact other areas. Therefore, access block, which impedes the allocation of patients to beds, is associated with emergency department overcrowding and delays and ambulance ramping. These are all indications of a systemic problem within the public hospital system.

Added to this problem is a fragmented relationship between federal and state governments in funding public hospital care. Under the current funding formula:

a. The federal government contributes 45 per cent of the cost of public hospital services each year, while the States and Territories fund the remaining 55 per cent;

[1] Australian Bureau of Statistics, *National, state and territory population, December 2021* (Catalogue No 3101.0, 28 June 2022).
[2] Australian Bureau of Statistics, *Chronic conditions, 2017-18 financial year* (Catalogue No 4364.0.55.001, 12 December 2018).
[3] Australian Institute of Health and Welfare, *Admitted patient care 2020–21. Chapter 3: Who used admitted patient services?,* Table S3.2.
[4] AMA Research and Reform Unit, 'Public hospitals: Cycle of crisis' (Research Paper, Australian Medical Association, October 2021) 12.

b. The amount that the federal government pays in public hospital funding is adjusted retrospectively based on actual hospital services provided in the previous year but is limited by a cap on annual funding growth at 6.5 per cent on the previous year (inclusive of health inflation).

Therefore, if the actual total cost of hospital activity exceeds 6.5 per cent growth on the previous year, the cost risk and budget pressure is shifted onto States and Territories. States and Territories must then limit hospital services volume to keep within the Commonwealth funding cap (which comes at the expense of meeting hospital demand for services) or find more state revenue to pay for increased hospital activity.

While the federal government increased its funding growth above the national cap in 2019-20, as a COVID-19-related measure, this additional funding appears to have been more related to assisting with the difficulties surrounding COVID-19 than with boosting hospital activity and capacity, as actual activity in hospitals declined in 2019–20 from 2018–19 levels.[5]

Further, on the primary care front, general practices have been under threat by:

a. A declining number of general practitioners, particularly in rural and remote NSW.[6] While 80% of Australians have a usual GP[7], only 13.8% of medical students are considering general practice as their preferred specialty.[8]

b. Recent payroll tax decisions which have the potential to threaten the financial viability of medical practices across NSW. Payroll tax will exacerbate challenges to primary care access if some practices are forced to close their doors. AMA (NSW) has been lobbying for a payroll tax exemption for medical practices.[9]

The barriers to access to primary care contributes to hospital demand pressures as patients who would otherwise attend their general practitioner for non-critical care are left with no option but to attend the emergency department for medical attention.

COVID-19 exposed the cracks in this already fractured system by heightening workforce shortages in public hospitals and general practices as available staff were lost to sick leave or mandatory isolation, COVID-management activities or the closure of international and state borders.

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[5] Australian Institute of Health and Welfare, 'Impact of COVID-19 on hospital activity in 2019–20 and 2020–21', *Hospital activity* (Web Page) <https://www.aihw.gov.au/reports-data/myhospitals/themes/hospital-activity>.

[6] NSW Health, Submission No 630 to Portfolio Committee No. 2 – Health, Parliament of New South Wales, *Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW* (January 2021) 4.

[7] Michael Wright et al, 'How common is multiple general practice attendance in Australia?' (2018) 47(5) *Australian Journal of General Practice* 289, 290.

[8] Medical Deans Australia and New Zealand, *Medical School Outcomes Database National Data Report 2022* (Report, July 2022) 30.

[9] 'Payroll tax – who pays the price?', Australian Medical Association (NSW) (Web Page) <https://www.amansw.com.au/payroll_tax/>.

Although there is no publicly available national data on healthcare worker infections, research showed the infection rate of health workers was 2.7 times higher than community infection.[10]

These increased demand pressures cannot be adequately met by a workforce suffering ongoing shortages and the effects have played out through increased reports of ambulance ramping and emergency department delays.

(b) the effects that ambulance ramping and access block has on the ability and capacity of emergency departments to perform their function;

A key measure of a public hospital emergency department's performance is the 'transfer of care': the time period from when an ambulance arrives at hospital to the offloading of the patient from the ambulance stretcher. In NSW, transfer of care should occur within 30 minutes for at least 90% of patients.

The effects of ambulance ramping and access block on emergency department performance are clearly reflected in this measure of transfer of care. In 2018, the percentage of patients transferred from the ambulance to the emergency department within 30 minutes was 92.1%.[11] Each year thereafter has seen a decline in this percentage with emergency departments falling below target to 88.8% in 2019,[12] to 84.8% in 2020,[13] and to a recent record low of just 72.5% in 2022.[14]

As for treatment in the emergency department, data for the quarter immediately preceding the onset of the pandemic showed that for the total 776,593 emergency department attendances, 72.6% of patients had their treatment start within clinically recommended timeframes (which, similarly, was worse than the same quarter in the previous year).[15] Data for the most recent April to June 2022 quarter shows that for the total 793,987 emergency department attendances, only 62.8% of patients had their treatment start on time.[16]

Of more concern, in the most recent April to June 2022 quarter, almost one in 10 patients (76,117 patients) left the emergency department without, or before completing, treatment – an increase of 67.6% when compared against the same quarter in 2019.[17]

While the pandemic has certainly contributed to this fall in performance, it is apparent that these figures had been on the decline prior to the pandemic. This is a further indication that the pandemic was the signal of a much deeper problem facing the health care sector, and not the problem itself.

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[10] Ashley Lindsay Quigley et al, 'Estimating the burden of COVID-19 on the Australian healthcare workers and health system during the first six months of the pandemic' (2021) 114 *International Journal of Nursing Studies* 103811: 1-11, 4.

[11] Bureau of Health Information, *Healthcare Quarterly, Activity and performance – Emergency department, ambulance, admitted patients and elective surgery, January to March 2019* (Report, June 2019) 16.

[12] Ibid.

[13] Bureau of Health Information, *Healthcare Quarterly, Activity and performance, Emergency department, ambulance, admitted patients, seclusion and restraint, and elective surgery, January to March 2020* (Report, June 2020) 17.

[14] Bureau of Health Information, *Healthcare Quarterly, April to June 2022* (Report, September 2022) 4.

[15] Bureau of Health Information, *Healthcare Quarterly, Activity and performance, Emergency department, ambulance, admitted patients, seclusion and restraint, and elective surgery* (Report, March 2020) 2.

[16] Bureau of Health Information (n 14).

[17] Bureau of Health Information (n 14) 4.

(c) the impact that access to GPs and primary health care services has on emergency department presentations and delays;

The barriers to accessing primary health care including general practice, as mentioned above, have contributed to an increase in lower urgency presentations to emergency departments and, in turn, overcrowding and delays.

This impact can be understood by reference to the number of non-urgent presentations to the emergency department which, in NSW, increased by 9.8% in the period 2018/19 to 2019/20,[18] and by another 12% in the period 2019/20 to 2020/21.[19]

Pre-pandemic, an Australian Bureau of Statistics' Patient Experience Survey conducted for the period 2018-19 revealed that 16.8% of respondents aged 15 and over who visited the emergency department thought their care could have been provided by a GP, with 1 in 5 (21%) reporting that the main reason for attending emergency department was because a GP was not available when required.[20]

Notwithstanding the above, caution should be exercised in attributing access blocks and emergency department delays to an increase in lower urgency patients. Firstly, non-urgent presentations do not typically require beds or admission and so their contribution to access blocks should not be over-estimated.[21] Further, focus on this issue alone ignores the deeper systemic causes of access blocks and emergency department delays.

Regional, rural and remote NSW

It is well recognised that people in regional areas are disproportionately impacted by access to health services, including primary care and GP services, compared to those living in metropolitan areas. These access issues relate to both availability and affordability of primary care services.

Firstly, as to the actual availability of general practice appointments in regional NSW, a study in 2017 showed that 80% of people who had recently attended an emergency department cited the lack of GP availability when needed as the major reason for attending.[22] Further, the probability of seeing a GP on the same day in north-eastern New South Wales was less than 50% (47.5%) for any GP and only 30.2% for a female GP.[23]

Regarding cost, only one in five practices (21%) offered bulk billing which was considered a major barrier for people needing to access primary care.[24]

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[18] Australian Institute of Health and Welfare, *Emergency department care 2020-21 data,* Table 2.2.
[19] Ibid.
[20] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of Findings, 2018-19 financial year* (Catalogue No 4839.0, 12 November 2019).
[21] Australian College for Emergency Medicine, ''Lower urgency' ED presentations can't be blamed for crowding' (Media Release, 3 July 2020) <https://acem.org.au/News/July-2020/%e2%80%98Lower-urgency%e2%80%99-ED-presentations-can%e2%80%99t-be-blamed-f>.
[22] Joanne Bradbury et al, 'Actual availability of appointments at general practices in regional NSW' (2017) 46(5) *Australian Family Physician* 321, 324.
[23] Ibid 323.
[24] Ibid.

We note the peak time of non-urgent presentations at emergency departments in regional NSW was between 9:00am and 12:00pm; within the usual operating hours for general practices.[25]

Mental health services

While mental health presentations account for only around 3.5% of emergency department presentations, 90% of mental health-related presentations were completed within 13 hours and 57 minutes, which is longer than the same measure for all emergency department presentations.[26]

Further, while there were fewer mental health episodes of care recorded in the last quarter,[27] mental health average length of stays increased by 4 days from 18.7 days in April-June 2019 to 22.7 in April-June 2022.[28] The total bed days taken up by mental health patients increased by 10% from 2019 levels to a total of 199,295 days.[29]

As reflected in these statistics, this patient population disproportionately experiences delays and access block compared with patients presenting with other emergency conditions. Anecdotal evidence has suggested this is attributable to an inadequate level of mental health support available, both in the community and in emergency departments. This is a particular problem in regional, rural, and remote areas which have demonstrated significantly higher percentages of presentations waiting for inpatient beds and experiencing mental health access block.[30]

AMA (NSW) Member, GP:

> *We regularly have patients scheduled under the mental health act spend 12-36 hours in an ED because there is no transport available. This generally requires additional security staff to monitor them and if restrained they require 1:1 nursing. In smaller towns these 'extra hands' are not always readily available so means already burnt out staff are working overtime or means there is less staff available on the floor.*

(d) the impact that availability and access to aged care and disability services has on emergency department presentations and delays;

Public hospital data currently available does not appear to capture the numbers or proportions of:

1. Patients from aged care or with disabilities presenting to emergency departments for care;
2. Admitted patients waiting for an aged care or disability placement.

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[25] 'Use of emergency departments for lower urgency care: 2015–16 to 2018–19', *Australian Institute of Health and Welfare* (Web Report, 2 July 2020) <https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19/contents/lower-urgency-care/summary>.
[26] 'Mental health services in Australia', *Australian Institute of Health and Welfare* (Web Report, 26 August 2022) <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services>.
[27] Bureau of Health Information (n 14) 16.
[28] Bureau of Health Information (n 14) 28.
[29] Ibid.
[30] Australian College for Emergency Medicine, *Mental Health Access Block* (Report, February 2018) 9.

However, recent reports indicate that these numbers have risen to concerning levels and are contributing to emergency department delays and bed block.

With respect to the first point, what the research has shown is that patients who are over 65 or suffer a disability are more likely to present to an emergency department with non-urgent conditions, and to attribute that visit to not being able to access a GP.[31] Further, some patients with disability reported to use an emergency department as their point of contact with the health system because of a lack of communication or understanding about what services are available to them.[32]

Further inquiry should be directed into how this care can be better delivered through aged care programs, the NDIS and primary care (all of which are federally funded), and not through reliance upon NSW public hospitals. This should involve addressing barriers to care that not only relate to cost but to coordination of care and accessibility of services (particularly communication accessibility).

We have also received reports of increased presentations by patients brought in from residential aged care facilities because of uncertainty by those facilities as to their appropriate management, even where there are advanced care directives as to their management in a medical emergency. There must be better consultation regarding those who should not be sent to hospital between aged care staff and paramedics, and this should include access to clear and identifiable information regarding advance care directives for aged care residents.

Much attention has been focused recently on access to hospital beds which have been limited or blocked by admitted patients awaiting placement in an aged care or NDIS-funded facility. The Australian Institute of Health and Welfare (AIHW) estimates that people waiting in hospital for a place in a nursing home occupied 7.2 patient days for every 1,000 patient days in hospital in 2018-19 for major cities, or 222,000 patient days.[33]

Further, research into NDIA decision-making revealed that many participants who have requested funding for specialist disability accommodation (SDA) are experiencing long processing periods, with the average participant waiting 196 days for the NDIA to fully consider their request.[34] Public hospitals cannot afford to keep operating with this current level of exit block given the downstream effect it has on emergency departments. More needs to be done to improve the arrangements around transitions out of hospital care in order to free up beds in public hospitals.

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[31] Debbie Faulkner and Julia Law, 'The 'unnecessary' use of emergency departments by older people: findings from hospital data, hospital staff and older people' (2015) 39(5) *Australian Health Review* 545.

[32] 'Access to health services by Australians with disability', *Australian Institute of Health and Welfare* (Web Report, 3 December 2017) <https://www.aihw.gov.au/reports/disability/access-health-services-disability/contents/content>.

[33] Australian Institute of Health and Welfare, *Admitted patient care 2020–21. Chapter 4: Why did people receive care?,* Table 4.14.

[34] Public Interest Advocacy Centre, *Housing Delayed and Denied: NDIA Decision-Making on Specialist Disability Accommodation Funding April 2022* (Report, April 2022) 30.

(e) **how ambulance ramping and access block impacts on patients, paramedics, emergency department and other hospital staff;**

Patients

When both sides of the emergency department are choked up and resources in the emergency department are subsequently overcome, patients are left receiving care from paramedics either in the ambulance or by emergency staff in hospital corridors. The obvious risk to these patients is that care they receive is inappropriate, inadequate, or absent altogether. Unfortunately, this risk has materialised in numerous cases and has resulted in poor health outcomes.

There is moderately strong evidence from Australia and internationally that delays in patients being admitted to the hospital following presentation to the emergency department are associated with an increased number of deaths.[35] There is also international evidence that patients who experience these same delays have worse outcomes than those admitted promptly.[36]

Anecdotally, patients are waiting very long periods for ambulance retrieval, with patients having to arrange for alternative transport which commonly involves family members driving them to the emergency department. The wait does not end on arrival to the emergency department, as patients wait hours for basic management. Once patients are eventually attended to, the investigation and/or treatment they receive is suboptimal and, in some cases, patients are discharged early with their symptoms unaddressed.

AMA (NSW) Member, GP:

> "*A couple of anecdotes from my recent work in Sydney's inner west… I had a patient at Balmain hospital who we X-ray-Ed and found had a complex, comminuted humerus fracture. We have him morphine and sent across to RPA. He waited 18 hours in a chair with no pain relief beyond Panadol.*
>
> *I had a mum with a young child who had a respiratory illness, and we were work-shopping what to do if the child deteriorated over night. This child had recently had a terrible mid-of-the-night respiratory deterioration and when mum had called for an ambulance it took several hours to arrive (she lives in inner Sydney). This time she decided that she would not call for help but would throw the child in the car and drive hell for leather because she doesn't trust that help will come when she needs it*."

AMA (NSW) Member, GP:

> *GP have to follow up patients that may have had prolonged wait times in emergency - suboptimal care, work up and treatment or unsafe discharge or unreported /missed pathology on radiology…*
> *In some cases unsafe discharges presumed due to bed pressures resulting in inappropriate early discharge…*

[35] Arshia Javidan et al, 'The International Federation for Emergency Medicine report on emergency department crowding and access block: A brief summary' (2021) 38(3) *Emergency Medicine Journal*, 245.
[36] Grant Innes et al, 'Emergency overcrowding and access block: A smaller problem than we think' (2019) 21(2) *Canadian Journal of Emergency Medicine* 177.

The effects on patients as described above been well publicised through numerous 'horror stories', causing patients to grow resistant to attending the emergency department as they do not want to wait all night to be seen.

In regional, rural, and remote areas, unavailability of ambulances due to ramping has meant that urgent inter-hospital transport needs are unable to be met in a timely manner. Inter-hospital transfers are already considered an independent risk factor for mortality as transferred inpatients are recognised to carry a greater service burden and risk of death compared to other inpatients.[37] Delays in transfers for these patients adds another complicating factor to their care and, further, creates bed block and further delays to care for other admitted patients who cannot access a bed.

AMA (NSW) Member, Anaesthetist:

> *Patients are being refused transfer to larger metropolitan institutions due to their own bed limitations but this is leaving patients in regional rural and remote locations dislocated from the appropriate medical services and blocking a bed for those with appropriate medical conditions…These patients, by virtue of needing transfer are already the most acute and delaying definitive care in the appropriate location is a clinical risk.*

AMA (NSW) Member, GP:

> *A NSTEMI patient can wait for 12-48 hours before transport (or a bed) is available in the referral hospital. I have had relatives drive an obstructed kidney from Lithgow to Nepean, parents drive their children to Katoomba with bronchiolitis.*

Another major impact of access block to patients is through elective surgery waiting times. Access block has restricted the number of patients that can be admitted for elective surgery which has resulted in an increase in median waiting times for elective surgery since 2016-17.[38]

It is important to note that elective surgery does not solely refer to surgery that is optional or not urgent – this is a common misconception. It simply means that the surgery can be scheduled in advance. Elective surgeries have varying levels of urgency and can sometimes be very time-sensitive (for example, diagnostic procedures that could reveal cancer).

The impact of COVID-19 on elective surgeries in NSW has been significant due to restrictions and suspensions placed on elective surgery in 2020-21 and early 2022. At the end of the April-to-June 2022 quarter, there were 18,748 patients on the waiting list ready for surgery who had waited longer than clinically recommended,[39] compared to only 2,037 at the end of the January-to-March quarter in 2020 (at the time of the first COVID-19 outbreak).[40]

[37] Hassan Assareh and Helen Achat, 'Accuracy of inter-hospital transfer information in Australian hospital administrative databases' (2019) 25(3) *Health Informatics Journal* 960, 961.
[38] Australian Institute of Health and Welfare, *Elective surgery waiting times 2021-21 data tables,* Table 4.2.
[39] Bureau of Health Information (n 14) 22.
[40] Bureau of Health Information, *Healthcare Quarterly, January to March 2022* (Report, June 2022) 25.

Unfortunately, this has led to poorer outcomes for patients on elective surgery waitlists with AIHW data from 2020-21 showing that 3,158 people who were waiting for elective surgery in a public hospital in NSW either died or were unable to be contacted,[41] up from 2,704 the year before.[42]

Paramedics

Not only does ambulance ramping prevent patients from receiving timely care, but it also prevents paramedics from responding to subsequent ambulance callouts while they must wait with the patient. In addition to paramedic resources being stretched thin, the added pressures to respond to life-threatening emergencies, which has been compromised by ramping, has caused paramedic morale to suffer.

AMA (NSW) Member, GP:

> *Some problems felt in primary care due to bed block, ambulance ramping, increased demands on public hospitals… paramedics and ambulance officer mental health presentations in primary care for burn out and poor satisfaction of job.*

Hospital staff

The overwhelming feedback from our member hospital staff is that insufficient resourcing to meet demand pressures is contributing to high levels of doctor burnout.

In 2021, AMA (NSW) conducted a Senior Doctor Pulse Check Survey which was completed by 1,023 senior public hospital doctors across NSW. Key among the findings was that 80% of respondents reported experiencing workplace stress, with the majority citing a lack of resources and excessive workloads as the source of that stress. As to the lack of resources, around two thirds of respondents reported the number of medical staff was inadequate, whilst almost 3 in 4 reported the number of beds to meet demand was in adequate or highly inadequate.

Further, AMA (NSW) was concerned to find that while 87% of respondents indicated they felt valued or highly valued by patients, less than half felt motivated to go above and beyond what was required of them at work.

AMA (NSW) Member:

> "*I work in the South Western Sydney, most of our staff are tired and are no longer willing to go the extra mile to help others. This is a huge change in attitude*."

These responses have been echoed by our doctors-in-training members, many of whom have expressed concern about unsafe working hours due to demand pressures and workforce shortages, particularly in regional and rural areas of NSW.

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[41] Australian Institute of Health and Welfare, *Elective surgery waiting times 2021-21 data tables,* Table 2.2.
[42] Australian Institute of Health and Welfare, *Elective surgery waiting times 2019-20 data tables,* Table 2.2.

(f) **the effectiveness of current measures being undertaken by NSW Health to address ambulance ramping, access block and emergency department delays;**

NSW Integrated Care Strategy

AMA (NSW) supports important measures taken by NSW Health to address the fragmented nature of our health system through the NSW Integrated Care Strategy. This strategy has sought to implement models of healthcare that involve a better flow of information between hospitals, specialists, community and primary care healthcare providers. This is particularly aimed at people with chronic and complex conditions who require multi-disciplinary and holistic care.

We note this model of healthcare was trialled in Western Sydney in 2014-17 with 1,510 patients with one or more of four chronic conditions: congestive cardiac failure, coronary artery disease, chronic obstructive pulmonary disease and diabetes. Results from the preliminary analysis showed decreases in hospital admissions, emergency department presentations and hospital costs for the patient cohort.[43]

We also note other Integrated Care initiatives being implemented by NSW Health, including:

a. The Secondary Triage Service, which has been operating since March 2020 to reduce ambulance transfers to EDs for low acuity patients in residential care;

b. The expansion of this service through the Alternative Referrals Pathways project, which is currently underway; and

c. The Emergency Department to Community initiative, which aims to reduce the number of hospitalisations by providing case management and specialist care to patients who, due to complex chronic health and social care needs, have been identified as frequent emergency department presenters.

AMA (NSW) looks forward to the supply of appropriate data from NSW Health which tracks the use and effectiveness of these initiatives over the next year.

(g) **drawing on other Australian and overseas jurisdictions, possible strategies, initiatives and actions that NSW Health should consider to address the impact of ambulance ramping, access block and emergency department delays;**

The causes of ambulance ramping, access block and emergency department delays are complex but appear to be symptoms of a broader problem of managing patient flow into and through the hospital system. These issues cannot be managed by treatment of one or more symptoms; a whole-system response is required.

AMA (NSW) supports and reiterates the solutions for public hospital reform proposed by Federal AMA in its campaign to 'Clear the Hospital Logjam'.[44]

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[43] Western Sydney Local Health District and Western Sydney Primary Health Network, *The new frontier of health care, Western Sydney Integrated Care Demonstrator 2014-17* (Report, 2018).
[44] 'Clear the Hospital Logjam – Solution for public hospital reform', *Australian Medical Association* (Web Page) <https://www.ama.com.au/clear-the-hospital-logjam/solution>.

Central to this reform is an increase in federal government funding for public hospitals, namely:

a. ***An increase in the federal government contribution to funding to 50%, with States and Territories to use the additional 5% 'freed-up' funds on improvement;***

b. ***Removal of the annual growth cap on the federal government's contribution to allow funding to meet increased demand for hospital services.***

At the State level, reform should include:

1. ***Re-introducing funding for performance improvement, including improvement in elective surgery and emergency department waiting times***

Incentivised performance improvement should be reintroduced and monitored with the objective to address the decline in public hospital performance. Monetary and non-monetary incentives have demonstrated to be effective in improving performance in hospitals as it creates a sense of accountability among staff.

A successful case study can be drawn from Leeds Teaching Hospitals NHS Trust in the UK ("the Trust"), which was able to achieve one of the lowest rates of ambulance handover delays in the UK due to its 'whole-system approach' to managing incoming patients. The Trust has worked with the Yorkshire Ambulance Service to build a positive culture which relies upon collaborative working and has a 'zero-tolerance approach' to transfer of care delays. This 'zero-tolerance approach' encourages staff to take ownership of the patient particularly as this performance indicator is recognised by other colleagues throughout the public health organisation.[45]

With staff morale low and rates of burn-out high, providing monetary incentives to staff is an effective way to make them feel valued, work harder and can, in turn, help hospitals work towards meeting their performance targets.

2. ***Providing additional funding for extra beds and staff to address current capacity issues***

The bottom line is that more hospital beds need to be supplied to help ease the emergency bottleneck created by access block. This must be coupled with investments in clinical workforce.

One way to strengthen the medical workforce is through overseas recruitment, particularly as international border restrictions are eased. We suggest NSW Health consider offering incentives (in consultation with the Department of Home Affairs) such as immediate visas to attract skilled migrants.

Further, State and Territory governments should use the 5% of 'freed-up' funds, as proposed above, to invest in evaluation and improvement activities to increase their capacity and efficiency through improved processes. Some of these activities are recommended below.

[45] Joseph Plewes, 'What the latest data tell us about ambulance handover delays', *NHS Confederation* (Web article, 24 February 2022) <https://www.nhsconfed.org/articles/what-latest-data-tell-us-about-ambulance-handover-delays?fbclid=IwAR1uGgNx1m--nlGgKtvI9qQu4Q6Y7lNVaafs3Dh0WyOoJb7eCEGIbYAbKeo>.

3. Funding out-of-hospital care alternatives to address avoidable admissions and readmissions

Urgent care centres

AMA (NSW) notes the NSW Government's announcement on 30 August 2022 that it will establish 25 'urgent care centres' (to be matched by the Victorian Government) in an effort to ease demand on busy emergency departments as a result of the pandemic. These services are to be commissioned in partnership with GPs and will offer bulk-billed after hours care for non-critical conditions.

AMA (NSW) has received some reservation about this initiative, including:

- The financial impact on general practices (which are already under threat by staff shortages and payroll tax) should patients use urgent care centres as an alternative means to seek primary care. Urgent care clinics should not replace the care that is best delivered by a GP;

- How these centres will be adequately staffed noting rural and remote areas of NSW are not only facing a GP workforce crisis, but shortages in nurses and other healthcare workers;

- Whether these centres will be effective in easing demand pressures noting that the pressures faced by hospitals are underpinned by much more than lower urgency patients seeking treatment.

While AMA (NSW) and its members support the establishment of urgent care centres as a measure to ease some of the pressures faced by emergency departments, we warn that this initiative should not detract resources or attention away from much-needed public hospital funding over the longer-term, as emphasised under points 1 and 2 above.

Outpatient management

Managing access block is not a matter of targeting the number of emergency department presentations who require admission, but of improving the timely discharge of patients from inpatient beds. Realistically, reducing the number of emergency department presentations who require admission is not something that can be influenced in the short or even medium term.

AMA (NSW) President, Dr Michael Bonning:

> *Many patients exist in the chasm where they are too complex for general practice and too poor for a private specialist and are unable to be seen in public outpatients due to clinic constraints.*

Greater focus should be aimed towards discharge and outpatient programs that ensure ongoing support and management of patients beyond the emergency department, particularly the increasing numbers of elderly and chronically ill patients. Many of these patients face cost barriers in accessing specialist care and are at risk of deterioration and readmission to hospital.

These interventions should include:

- A focus on clinically led discharge programs that function outside of regular hours such as weekends, public holidays as well after hours) and support discharge of patients with appropriate support from family or carers.

- Where possible, outpatient management of presenting issues whereby a patient can be booked in by an emergency department consultant to an appointment in the following days. This is especially important in regional, rural and remote areas with less access to other hospital or private specialist services.

- Outreach from hospital services, such as "hospital in the home" type models, especially for the elderly who are more likely to have mobility issues (and, as a result, call an ambulance for urgent medical attention).

Integrated care and multi-disciplinary chronic disease management

Funding should also be catered to our ageing population and patients with chronic and complex disease. As seen by NSW Health's Integrated Care Initiatives, better outcomes can be achieved in the community through a mixture of primary and specialist care, and thereby reduce the demand on public hospitals by avoiding presentations by patients whose conditions have escalated.

Increases to funding are also recommended for community-based and inpatient mental health and alcohol and other drug services, particularly in rural and regional areas. To address the increasing prevalence of mental health access block, AMA (NSW) also recommends funding is directed to training in emergency departments in acute psychiatric management so that presenting patients can be appropriately supported and managed pending the availability of the hospital psychiatric service.

4. Payroll tax exemption to address GP shortage issues

The success of any out-of-hospital care alternatives as discussed above is dependent on access to primary care through general practice. However, the financial stability of general practice is under threat by recent payroll tax decisions broadening the application of existing payroll tax laws to encompass medical practices operating 'service entities'. If enforced, this could see many general practices hit with punitive financial penalties and interest charges on payroll tax amounts that they did not have to pay in the past.

To ensure the financial viability of general practice, AMA (NSW) reinforces its campaign to the NSW government to exempt medical practices from payroll tax.

Thank you for the opportunity to provide this submission.

Yours sincerely,

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