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ACEM Submission to the National Health Reform Agreement Addendum 2020-2025 Mid-term Review

1. Introduction

The Australasian College of Emergency Medicine (ACEM) welcomes this opportunity to contribute to the review of the National Health Reform Agreement (NHRA) Addendum 2020 -2025. ACEM understands that the agreement is an important vehicle for ensuring that our health funding, planning and governance is fit for purpose.

ACEM is concerned with the lack of capacity and capability within the hospital, and in the primary care, aged care and disability interface sectors, to respond effectively to the current and future health needs of our population. The declining access and increasing wait times in Emergency Departments (EDs), despite EDs working harder and better than ever, is a symptom of our health system being under pressure.

ACEMs broad recommendations are that the next NHRA:

- Adopts the ACEM proposed Hospital Access Targets.
- Focuses on patient flow in, through and out of hospital.
- Prioritises innovative and transformative funding models which support access to quality healthcare outside of hospitals.

2. Background

2.1 About ACEM

ACEM is a not-for-profit organisation responsible for training emergency physicians and advancement of professional standards in emergency medicine in Australia and New Zealand.

The practice of emergency medicine is concerned with the prevention, diagnosis, and management of acute and urgent aspects of illness and injury among patients of all ages, who present to EDs with a spectrum of undifferentiated physical and behavioural disorders. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to EDs.

2.2 Experience of the NHRA

EDs have experienced significant scrutiny under the NHRA. The Australian Health Performance Framework (AHPF) uses ED waiting times as a key measure of hospital and health system access. In part this focus is appropriate. It recognises that EDs are one of the few parts of the healthcare system where people can always seek care, at all hours of the day and night, without cost, and are therefore particularly vulnerable to gaps or issues in other parts of the system.

The AHPF measures suggest declining performance of EDs, but we know that they now have more people entering and moving through them than ever before. There is insufficient recognition that deteriorating ED length of stay times are predominantly a symptom of systemic failure in health care. A key role for EDs is referral to definitive care, for example referral to surgical ward in preparation for an operation. When other services do not have sufficient capacity to accept that referral, patients wait longer in the ED.

What we see is a health system that does not have the capacity, and in some cases, the capability to provide the access to the health care that our population needs. Our inaugural *State of Emergency report (2022)* shows that the stressors on the ED are a result of higher numbers of people requiring acute health care and with complex health needs, and a system trying to do more with less.

This stress shows up in long waiting times in the ED, and particularly long waiting times for those who need to be admitted to hospital. The impacts of this are significant, with ED clinicians spending up to 40% of their time providing care to those who are waiting for an inpatient bed rather than responding to new cases, and subsequent harm to patients and to the healthcare workers who treat them.[1]

Efforts to address this have focussed on demand management and diversion, such as through virtual ED or other telehealth models. However, while these may reduce the number of people physically attending the ED and can be valuable in supporting care in place, they do nothing to reduce the most significant issue which is to increase the access and availability of inpatient hospital bed capacity.

ACEM is also aware that issues with the interface between the hospital, primary care, aged care and disability sectors contribute to the issues experienced by patients. When these sectors are unable to provide a bed or appropriate care when a patient is ready to be discharged but remains in hospital, it reduces overall hospital bed capacity, compromises patient flow, and delays patient treatment. Similarly, when they are unable to provide timely or earlier care, or it is inaccessible, this leads to more demand for ED care. Funding arrangements are not sufficient to support the relationships, communication and practice within hospitals and other sectors that are required to make this interface work.

From an ED perspective we also see funding arrangements within a constrained resource environment contribute to unhelpful resource competitiveness within the hospital. The most obvious is the trade-off that happens between providing more elective (planned) surgery and the funding that comes with this, and allowing adequate bed capacity to support patient flow from the ED. Similarly, we see delays in patient transfers within the hospital, as in-patient units negotiate for tests or other interventions to occur in the ED rather than use (limited) ward resources to coordinate this.

ACEM's interest in the NHRA is in its ability to drive and support change within the broader health system, ensure sustainable service delivery and support responsiveness to both current and future demands. While ACEM welcomes the long-term reforms around prevention and a more effective and efficient health system, it believes that the NHRA must focus on ensuring that our EDs and hospitals have the capacity to respond to acute and chronic needs today and provide a seamless and integrated patient journey.

2.3 ACEM's investment in improved health outcomes and the NHRA

ACEM has undertaken a significant amount of work to better understand what issues impact on the performance of EDs and has built a body of knowledge focussed on new ways of doing business. This work informs our submission.

This includes:

- The report *Access block: A review of potential solutions* *(2022)*[2] which unpacks the issue of long waiting times in emergency departments and using best available evidence to offer some solutions. It identifies two key areas of interlinked action – to improve patient flow within the hospital and to increase capacity within the health system. The latter significantly supporting the former, including to reduce competition and gatekeeping of resources which results when resources are limited.

- Our inaugural annual report *State of Emergency (2022)*[3] which presents the numbers behind the current healthcare crisis. It shows that there have never been more people requiring acute health care, people have never had such complex health needs and the health system has never been more strained. It is a problem everywhere, but it is worse in rural, regional and remote areas.
- A significant body of work exploring the experience of people with mental health issues and/or behavioural conditions within the ED and best practice responses. It includes the report *"Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments".* This work has highlighted the lack of alternative options for this group of people, the trauma, stigma and discrimination that occurs because of this, and subsequent negative impacts on wait time and patient care.[4]

3. Health Systems Performance

3.1 Decline in access, sustainability, equity and safety

The NHRA has a strong focus on efficiency, and from an ED perspective there were early gains in reducing waiting times and systemic changes in care delivery to improve patient journeys. However, the gains have not been sustained with EDs now seeing more people, with more complex needs, in an environment with less capacity. Since 2016 -17 ED presentations have increased by 14% (exceeding population growth of 5%) while hospital admissions increased by 3% and available inpatient beds decreased by 4%.[3]

EDs are providing health care to those who are unable to access it elsewhere. They respond to a higher number of presentations of people with psychiatric or behavioral disturbances, older people and are Aboriginal and/or Torres Strait Islander people than would be expected based on population.[3] It highlights the lack of equity regarding access to both primary and specialist health care, and the reliance on EDs to respond to system gaps.

The decline in access and sustainability is adversely impacting on hospital safety, performance and efficiency. In the EDs this is most evident through what is called "access block" where patients are unable to move from the ED within eight (8) hours due to a lack of availability of an inpatient bed. In 2020-21, it took almost 13 hours for most (90%) patients in the ED who required a hospital admission to be admitted. In some jurisdictions it was longer. ACEM recommends that quality care demands that this be a maximum of eight (8) hours.[3]

The impacts include:

- That 40% of ED staff time is now spent caring for patients who are waiting for an inpatient bed, rather than looking after new emergency patients.[5]
- A 10% increase in mortality for new patients presenting to EDs when more than 10% of current patients waiting for inpatient admission are experiencing access block.[6]
- Clinical errors and delayed time critical care and increased morbidity due to waits longer than eight hours.[7]
- Longer hospital stays from delayed transfer of admitted patients from the ED.[7]

Although access block can be measured in and reported from EDs, access block is not primarily an ED problem – it is a health system problem with two main proximal drivers.

- Sufficient inpatient beds so that hospitals can run at around 85% - 90% capacity so that there is always room for new urgent care cases.[3] A recent Australian time series analysis, which included the "natural experiment" that was COVID in which hospitals increased bed capacity and where there was reduced ED presentations, confirmed that the main determinants of access block and ED overcrowding are reductions in hospital occupancy and elective (planned) surgery, and not volume of presentations or ambulance presentations.[8]

- Lack of integration across the ED and inpatient service interface, and inpatient services and other clinical services within the hospital.[3] This is a complex area which considers hospital systems and workforce roles and responsibilities. For example, how the decision-making authority of medical and nursing staff at different levels of seniority impacts on relationships and communications between the ED and inpatient teams.

3.2 Not measuring the right thing

ACEM remains supportive of time-based targets and recognises that they have been and can be useful tools to drive systemic changes in care delivery and improve patient journeys. However, unrealistic time-based targets, and the excess pressure that results in trying to meet a single point measurement, increases the risk of unintended consequences.[9]

ACEM considers that there are several issues with the AHPF, and particularly with its capacity to measure and report on practice which assists Government and hospital administrators to identify access and quality issues.

The existing time-based measures are becoming increasingly meaningless. They are:

- not based on current best practice.
- are not sustainable in the current resource environment and contribute to a stressful work environment.

ACEM is also cognisant that time-based measures are leading to business practices which improve the data but not practice. For example, recording any intervention as a treatment regardless of its relationship to the presenting issue, or moving a patient to another part of the hospital such as a short stay unit regardless of when actual inpatient care commences. They also incentivise practices which focus on those patients who have the best chance of meeting time-based targets at the expense of those who have “missed” the four-hour mark.

ACEM advocates for a more nuanced set of time-based targets at the hospital level (called Hospital Access Targets (HAT)) which focus on patient flow, recognize the different types of patients that attend the ED and move away from a single point in time measurement.

ACEM’s Hospital Access Targets

For patients needing to be admitted to hospital or transferred to another hospital:

- ≥60% should have an ED length of stay (EDLOS) no greater than 4 hours;
- ≥80% should have an EDLOS no greater than 6 hours;
- ≥90% should have an EDLOS no greater than 8 hours; and
- 100% should have an EDLOS no greater than 12 hours.

For discharged patients:

- ≥80% should have an EDLOS no greater than 4 hours;
- ≥95% should have an EDLOS no greater than 8 hours; and
- 100% should have an EDLOS no greater than 12 hours.

For patients who need to be admitted to a short stay unit (SSU) for observation:

- ≥60% should have an EDLOS no greater than 4 hours upon SSU admission;
- ≥90% should have an EDLOS no greater than 8 hours upon SSU admission; and
- 100% should have an EDLOS no greater than 12 hours upon SSU admission.

The HAT makes clear that no patient should be in the ED for more than 12 hours. They are evidence based and set clear expectations around standards of care. As part of this adoption of measures, ACEM advocates that mandatory notification to the hospital executive should happen when ED stays longer than 12 hours occur, and mandatory notification to health ministers for any patient with an ED length of stay of more than 24 hours.

ACEM sees that the HAT is a better tool for both hospitals and system managers to assist in collating the data needed to clearly identify where bottlenecks are and the types of patients that are more likely to experience access block. It will allow individual hospitals to examine their unique circumstances, including to inform where additional resourcing, or changed practice is required in areas such as inpatient wards, diagnostics, specialists, and allied care providers.

The Australian Institute of Health and Welfare (AIHW) is already reporting the ED length of stay of patients who are admitted to an inpatient ward from the overall length of stay as part of the AHPF. This is positive as it shows the bottleneck at the point of admission. However, further expansion to clearly separate out patients who are discharged to the community and those who are admitted to a short stay unit would provide better transparency and understanding of hospital access issues and ED performance.

Western Australia has now formally adopted the HAT, the ACT Government has agreed to a trial the HAT across its hospital system and Tasmania's Department of Health has also committed to implementing HAT as part of its 2021-23 Strategic Priorities. ACEM is working with other jurisdictions to also adopt them.

There is a leadership role within the NHRA for a national approach to time-based targets and to ensure that they are used to improve and inform practice.

ACEM recommends that the HAT be adopted in the next National Health Agreement in 2025, as part of a review and reform of the AHPF. However, the HAT should also be part of a broader suite of measures that are system based and identify sector interface issues. At a national level, we would like to see work progressed on the development of hospital, primary care, aged care and disability interface performance indicators and associated data collection and reporting (item F12 and see also discussion below).

4. The service system interface

The NHRA identifies improving various aspects of the service system interface, and the need for this to operate efficiently and seamlessly. ACEM notes the range of activities to improve this interface outlined in the *Long Term Health Reform Road Map* and that this work is underway. We look forward to seeing the outcomes of new indicators and reporting frameworks that are expected this year.

EDs see the failure of the interface with:

- Ongoing issues with transfers to and from aged care and disability services, with a particular concern about delayed discharges and subsequent impact on bed availability and access block. For example, it is not uncommon for residential aged care facilities to transfer older patients with dementia who are exhibiting behaviours of concern to the ED. Once at the hospital it can be difficult to organise the transfer back to the facility.
- EDs responding to a lack of capability within the aged care system (including nursing care and access to timely and appropriate primary care). For example, the lack of access to primary care can lead to a patient's health deteriorating to the point at which a hospital admission becomes necessary. If primary health and nursing care were given the appropriate resourcing, many patients could avoid hospitalisation and its associated risk of iatrogenic harm.
- Lack of support for collaboration and integrated service options outside the hospital sector. This includes cost effective, timely and coordinated access to diagnostic and specialist support to allow for quick diagnosis and/or immediate interventions. Currently the primary care and specialist systems struggle to (and are not set up) to do this well such that the ED is seen as the most efficient and cost-effective way to access care.

The impact of homelessness and/or safe and stable accommodation also continues to be an issue. Aside from an increased likelihood of relying on the ED for health care, more significant issues include that the experience of homelessness increases patient complexity and can make timely and safe discharge difficult.

The NHRA identifies that most of the interface issues, such as providing continuity of care, are a shared responsibility (Schedule F). However, in reality it is experienced as neither party (or no party) having any authority to implement real change.

5. Funding models

ACEM is concerned that current funding models are inhibiting progress at the hospital, aged care, primary care and disability interface, and constrain the ability of the NHRA to focus on funding adequate levels of care which are patient rather than system centered. There is not enough budget for strategy, innovation and transformation and too much reliance on change through KPIs and budget cuts.

The interface issue is compounded through funding models not providing the resources to provide continuity of care and a seamless patient journey, and address the issues caused by the different governance arrangements. To this end, ACEM believes that the funding needs to provide for investment in relationship development, referral networks and patient transfer and transition support.

We also note that there are no price mechanisms that hold the disability or aged sector to account for failure to provide care when required or to provide incentives to provide the right care, in the right place at the right time (Schedule A; 162); and that performance measures associated with the interface between sectors are not yet in place (Schedule F; F12).

6. Long Term Reform Priorities

All the NHRA long term reform priorities are important. However, they are not addressing the significant underlying structural issues within the system, and in any case the investment has been minimal which means changes even at the margins may be unlikely. Of particular concern, is the broader health system's capacity to provide ongoing and sustainable services in the context of population growth and significant growth in the aged population, and its responsiveness to current (immediate) high levels of chronic disease and demand for acute care.

ACEM advocates for a focus in the new agreement on "patient flow" including from how and why a person attends an ED, their journey in and through the ED, and their inpatient admission or discharge journey (from the ED or hospital). It is intrinsically a patient centred approach, that includes resolving the consequences of the differing imperatives of ED staff, inpatient teams, hospital administration and other parts of the health sector.

A focus on patient flow will consider:

- An acknowledgement that from the patient perspective, it should be one health system.
- A commitment to service provision which reflects and changes according to population size and needs, and which can be tailored to local context.
- A recognition that the operational hours of hospital-based services must evolve as more care is required beyond the traditional model of the five-day work week and 'office hours'.
- A measurement framework which is more holistic and combines patient and system outcomes.
- A suite of reforms across hospital management, including workforce and work practices, to ensure responsiveness to demand (see attached document *Access block: A review of potential solutions).*

There also needs to be a focus on the workforce. For example, within the hospital system there needs to incentives and adequate funding, to allow the development of a workforce that includes extended role nursing and allied health practitioners such as nurse consultants, nurse practitioners, clinical nurse specialists, physiotherapists, and psychologists, as well as clerical and administrative support. We believe there are opportunities to explore how a non-medical workforce can support patient flow within the hospital, such as coordinating diagnostic and specialist assistance on the ward, and roles in discharge decision making, planning and coordination. Importantly, these roles also have the potential to identify new systems and processes which are not subject to the power differentials among the medical workforce which can lead to a lack of flexibility and timeliness in decision making. Similarly, with the predicted trebling of people aged over 85 years presenting to Emergency Departments over the next 20 years, we need incentives which will support a workforce of generalists rather than hyper-specialists.

ACEM hopes that the next NHRA will deliver a framework and opportunities for ongoing investment in innovative practice, different ways of doing business and for significant collaboration and integration across sectors and funding jurisdictions. It is important that the framework also includes a commitment to rigorous evaluation and monitoring, so that learnings lead back into practice.

7. Conclusion and Recommendations

ACEM believes that the priority for the NHRA is to increase capacity across the service system, and particularly in primary and tertiary care. EDs need a well-functioning, connected and responsive health system to deliver accessible and quality health care.

ACEM recommends that the NHRA review notes that:

- The NHRA is not delivering a sustainable health system, and an immediate increase in resources is required to support EDs and hospitals to meet current and presenting demand. The immediate focus should be increased bed capacity.
- That improving integration, continuity, and seamlessness at the interface of hospitals, primary care, aged care, mental health and disability requires resources to directly address the work associated with bridging the gaps across different governance and funding arrangements.
- ACEM is supportive of the development of performance measures which hold to account the various sectors at the points of interface, and that the work as outlined in the *Long Term Health Reform Agreement Roadmap to Reform* on the interface should be prioritised.
- ACEM is both willing and able to support any government to implement our recommendations.

ACEM recommends that the new NHRA:

- Adopts the ACEM proposed Hospital Access Targets.
- Includes a focus on patient flow through the system – in, through and out of hospital. This includes:
    - Developing new benchmarks in the AHPF for patient flow in, through and out of the hospital alongside system-based measures.
    - Providing more specific actions, responsibilities and consequences to support action in those areas which are designated as shared commitments, and particularly in relation to resolving the interface issues of hospitals, residential aged care and disability services (Schedules C and F).
- Prioritises innovative and transformative funding models which support access to quality healthcare outside hospitals. This includes:
    - Recognising changing population and disease presentations.

- Addressing workforce and resource requirements to provide continuity of care for patients within and between sectors.
- Recognising virtual care as a potential reform area across all of health, and that a consistent model of care be developed through investigation, trial and evaluation.

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues, or if you have any questions about ACEM or our work, please do not hesitate to contact James Gray, General Manager, Policy and Regional Engagement (james.gray@acem.org.au; +61 427 054 408).

Yours sincerely,

Dr Clare Skinner
President

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