

JOINT STATEMENT ON PUBLIC HOSPITALS

This statement is made to inform Tasmanians about the unacceptable condition of their public hospitals and to encourage the state government to address critical problems which it has the financial capacity to improve.

The statement is made by:

Australian Medical Association, Tasmania: Dr Stuart Day, President.

Australian Nursing and Midwifery Federation: Ms Emily Shepherd, Acting Tasmanian Branch Secretary; Mr James Lloyd, President.

Health and Community Services Union, Tasmania: Mr Tim Jacobson, Secretary.

Royal Hobart Hospital Medical Staff Association Dr Frank Nicklason, Chairman.

Royal Australian College of General Practitioners, Tasmania: Mr Matt Rush, Manager; Dr Mariane Catchpole, spokesperson.

Independent Health Policy Analyst: Mr Martyn Goddard.

ON ALMOST ALL measures, Tasmania has the least adequate and worst performing public hospital system in Australia. Although the state government has the clear fiscal capacity to lift the standard of our hospitals at least to the national average level and beyond, it has chosen not to do so. We appeal to the government to reconsider its policy settings, which we daily observe to be causing immense distress and a significant avoidable loss of life.

We make the following observations:

Tasmania has a critical shortage of beds: To reach the national average, taking into account the Commonwealth Grants Commission's calculation of the health service needs of our population, Tasmania needs an extra 200 public hospital beds. We note that this calculation is backed up with extra GST funding of \$251 million in 2016-17 and \$263 million in 2017-18. Despite this extra money, this state has the greatest shortfall in the number of beds of any state or territory in the nation. It is clear that this extra GST money allocated to Tasmania in recognition of our special health needs is not being spent on running our hospitals.

Bed block: This occurs when patients needing specialist care remain in emergency departments for eight hours or longer because no beds are available on the wards. Research conducted for the Australasian College of Emergency Medicine found that this increased the relative risk of death by between 20% and 30%. The researchers calculated that bed block in Australia accounted for at least 1,500 avoidable deaths in one year, 2004. Bed block has since worsened everywhere and official data show that in Tasmania it is occurring at almost twice the national average. This implies, conservatively, that 70 to 80 people die avoidably each year in this state as a direct result of the bed shortage. For the first two months of this year the number of patients who spent more than 24 hours in the Royal Hobart Hospital emergency department was 132 compared to 35 for the same period last year. There have been several days this year when all treatment spaces in the emergency department were occupied by patients needing to be admitted but for whom no beds were available. The percentage of ambulances unable to offload a patient in 30 minutes so far this year is 13% compared to four per cent last year.

Chaotic flu season anticipated: Tasmania's major hospitals, and particularly the Royal Hobart Hospital, routinely operate at or above full capacity. Even in the current "low demand" season, capacity has been exceeded. This is unsustainable and is already leading to many thousands of patients being unable to access care in a reasonable time or at all. The system has no capacity to deal with surges in demand and will not be able to cope even with entirely predictable peaks, such as the winter flu season. Suspending elective surgery, which the government ordered last year, is unlikely to solve the problem in medical wards. It is also exceptionally wasteful, with surgeons and anaesthetists having little or nothing to do for extended periods. It would entirely reverse any gains the government has claimed in treating longer-wait elective surgery patients. The Royal Hobart Hospital, in particular, is facing a winter season in which staff and bed space will be unable to cope with the expected influx of patients: there is no physical room within the current building site. Emergency departments will become even more crowded. Bed block will worsen and, inevitably, there will be a rise in the number of avoidable adverse patient outcomes including deaths.

Mental health: The situation for patients with mental health problems is particularly dire. Ten of 42 acute mental health inpatient beds have been cut by Government over the last few years. The RHH now has only 32 acute inpatient beds, which is seven beds fewer than the national average,

and psychiatric bed occupancy at the RHH is routinely now over 100%. This means that some patients requiring admission are unable to access the safe space and specialist treatment that they require, long waiting times in the ED for others, and premature discharge for many, all of which may lead to serious and sometimes fatal consequences.

Inevitably under these circumstances there are also higher rates of violence and injury, staff sickness, significant difficulties with morale, and serious problems in recruiting and retaining staff at all levels.

The situation is exacerbated by the Government's refusal to erect suicide prevention barriers on the Tasman Bridge. It has been estimated that such barriers would save at least 100 lives over the projected life of the bridge, and both the Royal Australian and New Zealand College of Psychiatrists and the state Coroner's Office support this initiative.

It should also be noted that the Government's accommodation plans for the acutely mentally ill patient in the RHH redevelopment are unsatisfactory, with respect to both the temporary and the long-term units. Both units have insufficient beds, and are too small and have insufficient facilities for both patients and staff. It is contemporary best practice for units to be situated on the ground floor and with access to therapeutic green spaces; both the temporary and long-term units are on the second and third floors, with little access of any kind to the outdoors.

Staff shortages: Staff numbers in all our major public hospitals have been critically inadequate for some years and are consistently becoming worse. The rate of increase in the numbers of doctors, nurses, allied health professionals and other staff has fallen far behind patient numbers. This has had major effects not only on staff but also on patients. National statistics show Tasmania's public hospital system has the capacity to treat fewer people a lower proportion of population than any other in the nation, even though Tasmanians need more care than others, not less. This means the chance of any patient other than the most critically ill being admitted to a public hospital in Tasmania are the worst in Australia. Under the present government, the rate of increase in admissions has fallen to its lowest level in many years. Over the government's first two years in power, the increase in weighted separations – the measure of admitted patient services, weighted for cost and complexity – was 1.3% at the RHH compared with 11.2% in the previous two-year period. At the Launceston General Hospital, the figure fell from 12.9% to 3.2%.

Safety implications of staff shortages: Staff who are forced by shortages and funding restrictions to take care of many more patients than is clinically appropriate cannot perform at the level of safety, quality and efficiency that the community expects and deserves. A doctor, nurse or paramedic working unduly long and stressful hours, often with repeated double shifts, has compromised cognitive, response and judgment functions. Problems are much more likely to occur and do occur, every day, in our hospitals. For patients, this means a significantly higher risk of complications and, for some, death.

Ambulance ramping: Ramping is caused by such severe overcrowding in emergency departments that staff cannot attend new patients brought in by ambulance. The situation is particularly grave at the Royal Hobart Hospital, where ramping effectively takes several ambulances out of the system for hours at a time. On occasion, this accounts for every ambulance in Hobart, leaving the city to be serviced by country crews who are often volunteers and who wish to serve their own communities.

Paramedic staff shortages: Staff shortages have become increasingly serious, requiring paramedics routinely to work extended shifts, often without a meal break. When shortages in Hobart have to be filled by rural volunteer crews, city crews find themselves sent shortly after to the country to fill that gap. The entire ambulance service is under constant and unprecedented pressure in trying to maintain adequate response times and professional standards. Sick leave is increasing as staff burn out with overwork. Fatigue and the long term effects of constant case exposure and work overload

can have a serious effect on the health and welfare of our Paramedic and Ambulance Communications workforce.

Overtime, agency nurses and locum doctors: The rigid application of staff ceilings has led to massive and unnecessary expenditure on overtime and expensive temporary replacements. A more rational approach would use that money to employ more (and much cheaper) permanent staff which would not only benefit patients but lead to consistent quality care delivery and retention of locally trained nursing and medical graduates in Tasmania. There is often limited capacity to ensure the suitability of temporary staff, and little time for them to become familiar with new methods and protocols.

General practice: General practitioners see one of their central tasks as keeping people out of hospital wherever possible: care under a GP is as much as ten times cheaper than care for the same patient in a hospital. But when patients need hospital treatment, it should be available within a reasonable time: if it is not, they must be managed by their GPs. So general practice must try, as best it can, to fill the void left by inadequate hospital services. This comes at a time when practices are already under immense stress as a result of Commonwealth policies, such as the continuing freeze on Medicare rebates, and under financial pressure as a result to charge high fees to patients. Although GPs try to ensure this is not a barrier to treatment, and can cost as little as one-tenth the amount of hospital treatment, it has an obvious effect on both the doctor-patient relationship and the capacity of patients to access appropriate health care. Many patients in general practice must wait for many months or years to obtain the specialist surgical or medical care they need; others are unlikely ever to receive that treatment. Waiting times for specialist clinics have blown out to an extraordinary and dangerous degree: these are the “hidden waiting lists” that the government had promised to remedy. At the Royal Hobart Hospital it takes, for Category 1 patients – the most urgent level – two years and eight months to get their first consultation with a gastroenterologist or liver specialist. Category 1 patients must wait for 15 months to see a neurosurgeon, nine months to see a kidney physician, two years and three months for a spinal assessment and five months to see a vascular surgeon.

Communication between hospitals and GPs is inconsistent, slow and extremely variable between services to the extent that GPs have started not to trust that the system will provide them with the information that they need to continue the care in a timely and efficient manner. Outdated hospital systems and work overload for hospital doctors contributes to the inadequate performance in this area. It is essential for a GP – a patient’s principal point of contact with the health system – to know what treatment has been undertaken so that when the patient goes back to the GP, an appropriate program of care can continue. This can be extraordinarily difficult and further time pressure is put on practices simply to find out what has happened to their patients in hospital.

Allied health professionals experience the same levels of overwork, frustration and pressure as their colleagues in other areas. Recent cuts to allied health staff numbers have had a serious impact on the provision of clinics to rural communities and the provision of preventative services to the community. This will ultimately lead to higher numbers of presentations to the acute health system and further overburden our public hospitals. A high-quality allied health staffing plan is essential to recruit, train and maintain all staff and especially senior staff. There are only three training schools for allied health professionals in Tasmania and no casual pool exists. Of the 23 professions in this area, Tasmania provides training for only four (social work, psychology, medical science and pharmacy). Therefore, announcements by the Minister that allied health staff are to be hired outside of a staffing plan are highly problematic.