

Clinical workload in Tasmanian public hospitals

Data presented at the recent budget estimates hearings show that the numbers of doctors and nurses working in Tasmania's public hospitals have been relatively stable over the past twelve months on a full-time equivalent basis. But because the number of patients increases significantly over any year, the average workload borne by staff has also increased.

For most practical purposes, numbers neither rose nor fell significantly over the period.

Table 1: Full-time equivalent medical officers and nurses, Tasmania, June 2014 to March 2015

	THO South		THO North		THO North-West		TOTAL	
	2014	2015	2014	2015	2014	2015	2014	2015
Salaried doctors	453.58	445.56	219.26	211.38	131.44	*106.13	804.28	763.07
Change		-8.01		-7.87		-16.00		-31.88
Visiting doctors	15.65	14.96	15.43	17.99	8.85	8.36	39.93	41.31
Change		-0.69		+2.56		-0.49		+1.38
Nurses	1 589.47	1 584.96	1 050.06	1 077.37	613.94	626.55	3 253.47	3 288.88
Change		-4.51		+27.32		+12.61		+35.41

*This decline is partly due to a reclassification of locums rather than an overall reduction in clinician numbers in the north-west.

Source: Hansard, House of Assembly, 11 June 2015.

The most satisfactory indicator of overall clinical workload is the number of weighted separations for admitted patient care. This takes into account the complexity of each patient's condition but does not, of course, include outpatients and emergency presentations.

Data on separations is not yet available for the 2014-15 year and will not be released until much later in the year. For the time being, to gain an idea of how demand increases over twelve months we have little option but to look at the most recent 12-month data available to us, which is for 2013-14.

These show a substantial rise in caseload throughout the system, with an average increase over the year of almost 10%.

Table 2: Weighted separations, Tasmania, 2012-13 and 2013-14¹

	THO South		THO North		THO North-West		TOTAL	
	2012-13	2013-14	2012-13	2013-14	2012-13	2013-14	2012-13	2013-14
Number	56 762	59 729	32 827	36 614	19 795	23 460	109 384	119 803
Increase		2 967		3 787		3 665		10 419
Change		+5.21%		+11.54%		+18.51%		+9.52%

Source: DHHS Progress Chart, September 2014.

Data so far available indicate that the increase in clinical caseload over 2014-15 is likely to be relatively similar to that of the year before. By putting figures from these two periods together, we can gain an idea of the likely increase in workload experienced by the average doctor or nurse over a 12-month period, in the absence of any rise in FTE staff numbers.

Because there are so many fewer doctors than nurses, the per-doctor workload has increased by a far greater proportion. However, this does not take into account the higher level of patient contact for nurses.

¹ Data for patient numbers exclude small hospitals but staff numbers include them. This has the effect of making workload figures somewhat lower than they are in reality. In fact, staff work harder than these figures show.

Nevertheless, the increase of almost 20 in the average number of patients for every doctor is remarkable.

Table 3: Changes in workload: Weighted separations per FTE doctor and nurse

<i>Separations per</i>	<i>THO South</i>	<i>THO North</i>	<i>THO North-West</i>	<i>TOTAL</i>
Doctor (2013)	120.97	139.87	141.10	129.57
Doctor (2014)	129.70	159.63	204.91	148.94
Change	+8.73	+19.76	+63.81	+19.37
Nurse (2013)	35.71	31.26	32.24	33.62
Nurse (2014)	37.68	33.98	37.44	36.43
Change	+1.97	+2.72	+5.20	+2.81

Source: DHHS Progress Chart, September 2014.

A steady, though apparently less pronounced, increase in workload can also be seen in the rates of emergency presentations. However, these figures are far less reliable as an indicator of emergency workload than the weighted-separation figures are as an indicator of workload in admitted patient care. The emergency figures do not take account of the complexity of cases; patients with straightforward conditions can usually be treated very quickly and do not add substantially to workload. Complex cases, on the other hand, can require a great deal of attention from emergency doctors and nurses, particularly when beds on specialist wards are unavailable for them.

Table 4: Emergency department presentations, 2012-13 and 2013-14

	<i>THO South</i>		<i>THO North</i>		<i>THO North-West</i>		<i>TOTAL</i>	
	2012-13	2013-14	2012-13	2013-14	2012-13	2013-14	2012-13	2013-14
Number	51 011	54053	42 533	44 989	51 535	49 373	145 079	148 415
Change		+3 042		+2 456		-2 162		+3 336
% change		+6.0%		+5.8%		-4.2%		+2.3%

Source: DHHS Progress Chart, September 2014.

The government appears to be relying on increased productivity from structural reorganisation and clinical redesign to balance increased caseload. This will not work.

On the basis of statistics comparing the cost per weighted separation between Tasmania and jurisdictions such as New South Wales, Victoria and South Australia which have already implemented these efficiency measures, it is reasonable to expect an improvement of 10% to 15% in overall productivity. But this will be achieved only gradually, over the next three or four years. If current trends continue and staff numbers are not significantly increased, the improvements in efficiency will be dwarfed by the inexorable rise in demand. Workloads will continue to increase at perhaps 10% a year and patient safety, inevitably, will suffer.

Eventually, something will have to give. At some point, doctors and nurses in their present numbers will be able to do no more. Either more and more patients will be turned away untreated, or the government will have to reverse track and employ more staff.

At the moment, the first of those options appears to be the most likely.

Martyn Goddard
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