

Access block: problems and progress

We need a coordinated approach to address the underlying problems in the health system

THE EFFECTS OF ACCESS BLOCK on acute hospital services are most disturbingly reflected by patients on trolleys queued in emergency department (ED) corridors and ambulances circling hospitals, waiting to deliver acutely ill patients. The Australasian College for Emergency Medicine and the Australian Council on Healthcare Standards (ACHS) have defined access block for emergency patients as the percentage of all patients admitted, transferred or dying in the ED where their total ED time exceeds eight hours.¹ For elective patients, access block is reflected in ballooning elective waiting list numbers and length of time spent waiting.

Access block has been with us since the 1980s, but in recent years, in Australia, it appears to have become both endemic and critical across all our major cities.^{2,3} There is now evidence that access block causes poor patient outcomes and interferes with efficient hospital functioning.^{4,5} In this issue of the Journal (*page 103*) the impact of access block across Australia and potential solutions are outlined.

Causes of access block

The causes for this untoward development are not straightforward, but appear to correlate with major decreases in hospital bed numbers, community residential care facilities, and with changes in workforce and community attitudes.

Bed numbers: In Australia, the total number of acute hospital beds has decreased over the past two decades, with a 15% decrease in public hospital beds occurring from 1995 to 2000.⁶ There have been concomitant decreases in inpatient length of stay, but the number of hospital admissions have also increased.⁷ There are now more day procedures and day admissions. Although some of these replace multi-day stays, others represent new work or multiple admissions replacing a multiday, single admission.⁸

Concurrent with decreasing acute hospital bed numbers, access to residential care beds in the community has decreased, especially beds designated for high-dependency patients.⁹ This has increased demand on acute hospital services as elderly inpatients wait for long term placement or are inappropriately sent back to the community to avoid pressure on an already congested residential care system.

Community-based treatments: Many patients with complex and chronic illnesses are now treated as hospital outpatients or in the community. However, when serious complications occur, patients frequently present to EDs, particularly if access to community healthcare services is not available. This lack of community support increases patient load on the acute care system.

Workforce: No single person can master the high-technology solutions and complicated treatment regimens prevalent in acute care hospitals. At the same time, many elderly or infirm patients need basic nursing care, which at times is considered too mundane for highly trained hospital staff.

Increasingly, the workforce model required in healthcare is team-based, with multidisciplinary input and multiple levels of expertise, even within disciplines.^{10,11} Training programs for doctors, nurses and allied health workers do not yet reflect this need. This imbalance between career aspirations, systemic needs and actual working environments results in dissatisfied workers or insufficient staff with necessary skills. These factors contribute to low morale, which further reduces workforce flexibility.

Social changes: The demise of the extended family and changes in the demographics of marriage and childbearing have led to more elderly people living alone, and with greater feminisation of the workforce fewer people can be carers.^{7,12} Population projections indicate that the number of informal carers in the community (largely middle-aged women) will decline sharply as the baby boomers age and require care themselves. The default solution for many partially dependent people is referral to an acute hospital.

Funding models: Payments to hospitals and healthcare providers are rigid and reward rapid treatment of uncomplicated conditions. In the community setting, payment is for episodes of care rather than continuity of care. Complicated emergencies, time-consuming conditions involving multiple medical specialties, and social issues stretch the time and financial resources required, and are dealt with piecemeal. Patients with complex or multiple problems frequently have no alternative but to attend a public hospital ED.¹¹

Casemix payments in the acute care setting and fee-for-service models of payment in the community setting usually disadvantage patients who require longer stays and supported post-hospital care. Rigid rules around definitions such as "inpatient" versus "outpatient" treatment create financial risk for hospitals introducing innovative treatment strategies. Furthermore, public ED workloads increase as GP consultation rates in older age groups decline, along with a reduction in GP bulk billing and availability after hours.¹³ Increasing indemnity insurance premiums for procedural GPs and private specialists also lead to greater public ED demand.

Potential solutions

Systematic management of access block is only just beginning to be discussed at a policy level. The extent of the issue is now such that a more strategic Australia-wide approach is necessary. The experiences described in this issue of the Journal show that hospitals can improve their individual performance with organisational changes. But, despite the impressive changes achieved with the outlined approaches to access block, it is apparent that our healthcare system has serious underlying problems that need to be publicly acknowledged by politicians and appropriately addressed.

Workforce: Historically, the major solution to hospital access issues was to spend money and increase bed numbers

by employing more staff. Recently, in Victoria, money was allocated for increased bed numbers and services, but there were insufficient staff to open more beds (see the Royal Melbourne Hospital report, *page 109*).

Reasons for rigidity in work practice and roles within the healthcare workforce need to be explored, and, where there is no evidence to support limitations in practice, rules should be changed. Universities, clinical colleges and hospitals must work together to train healthcare professionals for the tasks required rather than for roles based on historical models.

Funding: The innovative practices described in the hospital experiences were partly enabled by incentives from federal, State/Territory and hospital initiatives. The funding method can help direct healthcare services toward community needs. For example, funding hospitals for procedures, whether provided on an inpatient or outpatient basis, might allow a hospital to provide those services even when beds are not available.

Casemix payments tend to favour hospitals that provide uncomplicated elective services — perhaps alternative models that encourage healthcare services to look after elderly, complicated, medical patients should be trialled. Funding that allows a hospital to experiment with new clinical pathways and not be financially penalised, such as the National Demonstration Hospitals Project¹⁴ (aimed at improved hospital service efficiency and utilisation) and the Hospital Admission Risk Program¹⁵ (aimed at decreasing hospital bed utilisation), should be encouraged.

The next round of Australian Health Care Agreements should ensure balance in financial incentives between elective and emergency services. There should also be recognition of the need to better remunerate GPs for providing complex care, perhaps involving a trial of a capitated payment or managed competition model.¹⁶

Healthcare delivery systems: The central message conveyed by the experiences described in this issue of the Journal is that changing internal processes can improve access to inpatient resources. Initiatives such as medihotels, placing patients in a transit lounge before discharge, day-of-surgery admission for elective surgery, short-stay wards, and centralised bed control can all save bed-days.

Encouraging clinicians to trial treating patients in different ways and objectively analysing outcomes requires leadership from clinicians and administrators. For high-volume conditions and procedures, there should be standardised treatment pathways to expedite inpatient stay.

Efficient use of beds also requires accurate, transparent data collection with rapid feedback to clinicians. Many hospitals are unable to accurately account for every patient and the purpose of their continued inpatient stay. Similarly, many hospitals do not have an accurate bed census that identifies the variability in the number of beds that are open from shift to shift, nor do all have the ability to accurately count nursing sick leave rates by shift and day of the week.

Residential care: It is important that use of residential care facilities is tightly controlled and residents are allocated to the appropriate level of care. However, the current problem is that patients are unable to access long term residential care facilities and are instead filling acute care

beds. Reform within the subacute and residential/community care sector is necessary to improve efficiencies within the acute care sector and to provide appropriate long term care to patients. Attention to more appropriate locations to care for the small group of long-stay patients is likely to be the most efficient strategy to improve patient flow through the subacute sector.

Service prioritisation: The public must become involved in the debate about which healthcare services are essential. The present rationing method is in essence a lottery — whether your ambulance is allowed to arrive at a certain hospital, or whether your elective surgery is on or off, depends on the capricious availability of beds. The healthcare system cannot provide every service, but basic emergency and elective services could easily be provided within present budgetary constraints. A more transparent and educated debate may allow healthcare providers to work in a more satisfying environment where expectations are matched with necessary resources.

There remains considerable pessimism about the ability of the acute healthcare sector to deliver an effective service in the face of increasing demand and limited resources. There are solutions. However, political leadership and a coordinated national approach are necessary to resolve underlying structural issues surrounding workforce, work practice and funding.

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