Access block: it's all about available beds

Daniel M Fatovich, Geoff Hughes and Sally M McCarthy

We need more inpatient beds and better management of existing beds

The inability to admit emergency patients to a ward bed in a timely fashion (access block) is a blight on our hospitals and our community. Access block is the most serious issue confronting emergency departments (EDs), as the safety and quality of emergency care are compromised, as is access to emergency care.[1] There is a 20%–30% excess mortality rate every year attributable to access block and ED overcrowding.[2] This equates to at least 80 deaths per million population, a figure that is similar to the road toll.[2]

Australia has been at the forefront of research into this problem, and there is clear evidence that the main cause of access block and ED overcrowding is that there have been major increases in emergency admissions, but almost no increase in the capacity of the system to meet this demand.[2-4]

The number of available public hospital beds in Australia was reduced from 2.65 beds per 1000 population in the 1998–99 financial year to 2.4 in the 2001–02 financial year; since 2005 it has remained steady at 2.6 beds per 1000 population.[2] These bed numbers are below the average for Organisation for Economic Co-operation and Development (OECD) countries of 3.9 acute-care beds per 1000 population.[5]

In the same period, the number of ED attendances annually has increased from 4.1 million to 6.7 million,[6] and case complexity has also increased.[2,3] Furthermore, annual increases in demand for emergency care are expected as a result of population growth and an increase in the burden of disease. This increased demand must be planned for to avoid further unnecessary deaths and suffering.

To tackle this issue, the Australasian College for Emergency Medicine (ACEM) hosted the Access Block Solutions Summit in September 2008. The summit was opened by Nicola Roxon, the federal Minister for Health and Ageing, who, acknowledging the problem of access block, noted: "… the capacity of our hospitals has not kept up with this demand. This is reflected in overflowing emergency departments …".[7] As a result of the summit, two articles highlighting both the problem of access block and potential solutions appear in this issue of the Journal.

Richardson and Mountain (*page 369*) provide a robust outline of the problem.[8] It is worth highlighting that it has been repeatedly proven that general practice patients do not cause access block, ED overcrowding or delays in unloading ambulance patients[8] (ambulance ramping; resulting in delayed ambulance response times). The persistence of this myth is detrimental to finding real solutions.

More sobering are the results of the September 2008 point prevalence survey of national access block, conducted for the ACEM by the Road Trauma and Emergency Medicine Unit of the Australian National University.[9] Caring for patients who are waiting for inpatient beds now represents around 40% of the workload in major hospital EDs, and up to 70% in some.[9] Some patients spend days in EDs waiting for an inpatient bed, in particular, those with mental illnesses who are being admitted involuntarily. The survey confirmed that access block is getting worse, and this development is an indictment of our health system. The problem is nationwide, and no government has been effective in providing sustainable solutions.

Cameron and colleagues (*page 364*) provide a detailed overview of potential solutions.[10] Although these are a pragmatic guide to fixing the problem, it will only be when all stakeholders agree that the problem is systemic and hospital-wide that solutions will be able to be implemented. This requires political will from the Australian Government. It was this political will that achieved significant changes to EDs in the United Kingdom.

The health system as a whole must own and address this problem, by implementing improvements ranging from effective chronic disease management within the community, to basic inhospital processes such as efficient bed turnaround time. Patient flow must be maintained 24 hours a day, 7 days a week to achieve a hospital bed occupancy of 85% — a level that should be viewed as the most effective way to manage patient flow.[11] This nominated spare bed capacity is essential for the effective management of emergency admissions, and to have surge capacity. This approach will enhance patient safety in the ED and throughout the hospital stay.

It is essential that the nation's performance on access block is included in the Council of Australian Governments' ambitious health reform agenda for implementation from 2009, and is part of the agenda of the National Health and Hospitals Reform Commission. Key performance indicators with agreed nationwide criteria must be developed, implemented and collected at all levels to monitor this problem. At the same time, more research is needed to inform changes to improve the health system.

The bottom line is that it's all about available beds. Access block is best addressed by increasing the capacity of the system, most directly by increasing the number of beds available at all levels of care within hospitals. This means having more inpatient beds and optimising patient flow processes to increase bed availability. Only a small part of the solution to access block resides within EDs.[8]

While the science of access block is compelling, it is important to remember always that it is associated with a large amount of preventable human suffering. A fundamental precept of Hippocrates is *primum non nocere*. Access block is harming our patients and harming our health system. It is time to fix the problem. Australians expect and deserve better.

Author details

Daniel M Fatovich, MB BS, FACEM, Professor[1]
Geoff Hughes, FRCP, FCEM, FACEM, Director of Critical Care Services[2]
Sally M McCarthy, MB BS, FACEM, MBA, Director of Emergency Medicine,[3] and President[4]

1 Department of Emergency Medicine, University of Western Australia, Perth, WA.
2 Royal Adelaide Hospital, Adelaide, SA.
3 Prince of Wales Hospital, Sydney, NSW.
4 Australasian College for Emergency Medicine, Melbourne, VIC.
Correspondence: daniel.fatovich@health.wa.gov.au

References

1 Fatovich DM. Emergency medicine. *BMJ* 2002; 324: 958-962.

2 Forero R, Hillman K. Access block and overcrowding: a literature review. Prepared for the Australasian College for Emergency Medicine, 2008. http://www.acem.org.au/media/media_releases/Access_Block_Literature_Review_08_Sept_3.pdf (accessed Mar 2009).

3 Derlet RW, Richards JR. Overcrowding in the nation's emergency departments: complex causes and disturbing effects. *Ann Emerg Med* 2000; 35: 63-68.

4 Derlet RW. Overcrowding in emergency departments: increased demand and decreased capacity. *Ann Emerg Med* 2002; 39: 430-432.

5 Organisation for Economic Co-operation and Development. Health care at a glance. 2007: OECD indicators. Health care resources and utilisation. 4–5. Acute care hospital beds, availability and occupancy rates. Acute care hospital beds per 1000 population, 1990 and 2005. http://oberon.sourceoecd.org/vl=4658752/cl=24/nw=1/rpsv/health2007/g4-5-01.htm (accessed Mar 2009).

6 Australian Government Department of Health and Ageing. Australian Health Care Agreements. The state of our public hospitals report. The state of our public hospitals, June 2008 report. http://www.health.gov.au/internet/main/publishing.nsf/Content/state-of-public-hospitals-report.htm (accessed Mar 2009).

7 Roxon N, Minister For Health and Ageing. Speech. The case for change. National Press Club of Australia. Canberra. 13 August 2008. http://www.health.gov.au/internet/ministers/publishing.nsf/Content/D236999C1BECC7AACA2574A500098B90/$File/SPNR130808.pdf (accessed Mar 2009).

8 Richardson DB, Mountain D. Myths versus facts in emergency department overcrowding and hospital access block. *Med J Aust* 2009; 190: 369-374.

9 Richardson D. 2008–2 access block point prevalence survey. Carried out by the Road Trauma and Emergency Medicine Unit, Australian National University on behalf of the Australasian College for Emergency Medicine. September 2008. http://www.acem.org.au/media/media_releases/September_2008_Snapshot_Report.pdf (accessed Mar 2009).

10 Cameron PA, Joseph AP, McCarthy SM. Access block can be managed. *Med J Aust* 2009; 190: 364-368.

11 Australasian College for Emergency Medicine. Access block and overcrowding in emergency departments. April 2004. http://www.acem.org.au/media/Access_Block1.pdf (accessed Mar 2009). ❑