

Waiting times worsen in Australian public hospitals

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The Australian Medical Association (AMA) 2017 Public Hospital report card, issued last month, reveals dangerously lengthening waiting and treatment times in public hospital emergency departments, as well as for supposed “elective surgery,” which often involves painful and debilitating illnesses and injuries.

The report by the doctors’ organisation points to a worsening of waiting times over the past decade, as a result of the last Labor government’s cuts and restructuring, which have deepened since 2013 under the current Liberal-National Coalition government.

Based on Australian Institute of Health and Welfare statistics, the AMA report shows that during 2016, only 67 percent of emergency department patients classified as Category 3 or urgent were seen within the recommended 30 minutes, a decline since the previous year. Only 73 percent of all emergency department visits were completed in four hours or less, a percentage that has not improved over the past three years, and is well below the official target of 90 percent.

Waiting times for “elective surgery” have increased during the past 10 years, with the national median waiting time (the time within which 50 percent of all patients were admitted) increasing to 37 days. This is the longest waiting time reported since 2001–02, when the figure was 27 days.

Many of these patients are suffering potentially life-threatening conditions, including those who require coronary artery bypass operations, or are waiting in agony for procedures such as hernia operations, and knee or hip replacements.

Primary responsibility for this decline can be sheeted home to funding cuts initiated by the previous Labor government, from 2007 to 2013. The report notes that “the Commonwealth Government’s total health

expenditure continues to reduce as a percentage of the total Commonwealth Budget. In the 2014-15 Commonwealth Budget, health was 16.13 percent of the total, down from 18.09 percent in 2006-07. It reduced to 15.97 percent in the 2015-16 Budget, and reduced further to 15.85 percent of the total Commonwealth Budget in 2016-17.”

AMA president Dr Michael Gannon said Australia’s public hospitals in every state and territory were in a constant “state of emergency.” He commented: “Our overstretched and over-stressed public hospitals are suffering because of inadequate and uncertain Commonwealth funding, which is choking public hospitals and their capacity to provide essential services.”

Under its 2011 National Health Reform Agreement, the Gillard Labor government instituted a “health care reform” agenda that removed block funding for hospitals and imposed “casemix” funding, based on each activity performed and according to nationally-set “efficiency” prices. This system is designed to continually drive down the funding allocated for each medical procedure.

In its 2014-15 budget, the Coalition government initially abandoned these arrangements to base funding instead on a Consumer Price Index (CPI) adjustment and population growth. The difference in the two formulae amounted to a \$57 billion funding cut over a decade.

Then, in April 2016, the Coalition government and the states and territories, which have frontline responsibility for public hospitals, agreed at a Council of Australian Governments (COAG) meeting to revert to the casemix system, but at lower rates of payment.

The AMA report notes: “At least until June 2020, Commonwealth funding will continue on an activity

based funding approach, although at a lower rate than would have operated under the National Health Reform Agreement, and with a cap on growth.”

Announced in the lead-up to last July’s federal election, this cost-cutting was camouflaged by claims of a \$2.9 billion boost to funding. The AMA states: “The additional Commonwealth funding announced at COAG in April 2016 of \$2.9 billion over three years is welcome, but inadequate.

“Data published by the independent Parliamentary Budget Office (PBO) shows that funding under the original National Health Reform Agreement would have delivered \$7.9 billion in additional public hospital funding to June 2020 compared to funding by CPI indexation and population growth (as announced in the 2014-15 Budget).”

In other words, the “restoration” of \$2.9 billion locked in \$54 billion in cuts from a total that was insufficient in the first place. In line with demands from the corporate elite, the Labor Party dropped its previous promises to restore these cuts during the campaign for last July’s election. At the same time, there was bipartisan agreement on a massive increase in military spending, pouring an extra \$195 billion into the acquisition of new war ships, planes and weapons systems over the next decade.

The years of cost-cutting under successive governments has adversely impacted on patient care, precisely when there is a growing demand for hospital services, driven by an increasing and ageing population, higher rates of chronic and complex disease and greater public awareness of health problems.

There is an especially high demand for the treatment of young people in emergency departments. For example, in Victoria over the past five years, children aged four or under accounted for the greatest number of emergency department presentations, followed by 20–24 year-olds.

The ongoing government freeze on Medicare rebates paid to general practitioners is forcing increasing numbers of the latter to eliminate bulk-billing, effectively ending the ability of patients to receive medical advice and treatment without paying upfront fees. This, plus sweeping cuts to pathology and diagnostic test rebates, is forcing more patients to seek emergency treatment in public hospitals.

The AMA report also details the “hidden waiting

lists.” Elective surgery waiting list data hide the actual times that patients are waiting to be treated in the public hospital system. The time from when patients are referred by their general practitioner to when they finally see a specialist for assessment is not counted.

It is only after patients have seen a specialist that they are added to the official waiting lists. Some people wait longer for assessment by a specialist than they do for surgery.

As well as meeting the demands of the financial elite for ever-deeper social spending cuts, the hospital and Medicare cutbacks are intended to coerce more people into paying for their own care, via private health insurance, driving up the profits of private hospital and health care companies.

This health crisis facing millions of ordinary working people will intensify as the further cuts are implemented. Facing rising fees and longer waiting times, working class, poor and vulnerable patients will inevitably delay or avoid treatment and testing, preventing timely diagnoses and giving rise to more serious diseases, complications and, ultimately, unnecessary deaths.



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