deeble institute issues brief

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title **The National Emergency Access Targets: aiming for the target but what about the goal?**

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This issues brief examines the National Emergency Access Targets with a focus on the policy instruments used and their effectiveness. This brief argues against the use of financially incentivised process measures in isolation for performance evaluation. This summary paper should be read in conjunction with the issues brief for full details.

Context

Australia has seen increasing demand on hospital Emergency Departments (ED) with a 65% rise in presentations between 2001 and 2011 resulting in increased waiting times, prolonged stays, overcrowding and delayed admission. Prolonged ED stays can adversely impact patient outcomes leading to increased length of hospital admission and higher mortality.

Policy response

The National Emergency Access Target (NEAT) was adopted across Australia in 2011 under the premise that spending less than 4 hours in the ED would improve patient care. Its purpose was to increase the proportion of patients presenting to EDs who were discharged, admitted or transferred to another hospital within 4 hours. The target was intended to drive whole-of-hospital reform and improve patient flow, allowing patients to access an appropriate hospital bed and receive care in a timely manner.

The proportion of patients expected to meet the 4 hour timeframe was progressively increased for each State and Territory from their baseline, with the eventual national target in 2015 reaching 90% of ED patients being discharged, transferred or admitted within 4 hours. Jurisdictions received funding from the Australian Government for capital and process development, and were provided financial incentives if targets were achieved. This was anticipated to improve access, safety and quality of care in the ED, resulting in reduced mortality and morbidity, improved patient experience and increased efficiency to offset rising healthcare demand.

Considerations

Access block, that is when patients for admission remain in ED for more than 8 hours, is a problem that is not isolated to the confines of the ED. It requires whole-of-hospital reform,

with improvements necessary across the system including for patients moving out of the ED, and extending to the backend of hospitals including rehabilitation and residential care to ensure throughput. These changes also require adequate recognition of the variability in hospital case-mix across Australia, with appreciation of the considerable differences in presentations between different hospitals, for example between a tertiary metropolitan hospital, a children's hospital and a rural hospital. This necessitates site-specific mechanisms with a level of local autonomy to allow development and implementation of appropriate solutions.

4-hour targets in the United Kingdom

The 4-hour target was chosen in Australia to mirror targets employed in the United Kingdom (UK). The UK commenced their 4-hour rule in 2002 with a 98% target and financial penalties for non-compliance. A systematic review examining the UK's 4-hour rule found that there was no evidence for any change to the quality of healthcare nor the ED mortality rate, despite significant improvements in achieving the 4-hour target. Reports also found a static or increased average length of stay in the ED, with significant activity occurring in the last 20 minutes of the 4-hour stay and widespread evidence of data manipulation. As a result of these unintended outcomes, the UK relaxed the 4-hour rule to 95% in 2010. The 95% target has not been reached in quarterly measures since 2013 with the lowest levels yet occurring in 2016 at 88%.

Analysis of NEAT

The key performance target outlined in the *National Health Reform Agreement* was the proportion of patients who physically left the ED for admission, were referred to another service or were discharged. The advantage of using a process measures such as the 4-hour target is that they are generally easy to measure, transferable across different organisations and relatively objective. Additional stated intentions were to reduce hospital mortality as a result of improvements in ED overcrowding and access block, to improve quality of care, to improve patient experience and to reduce the number, source and percentage of unplanned re-attendances to ED within 48 hours. However, these objectives were not formally measured or evaluated as part of the NEAT performance framework.

Despite significant capital investment and organisational funding, all jurisdictions other than Queensland and WA were well behind achieving their federally mandated targets in 2013-14. Nevertheless by 2013-14 significant improvements had been made when compared with baseline, even if targets had not been met and this occurred in spite of growing rates of ED presentations. This has been confirmed in various individual hospitals with a reduction in ED length of stay, access block and reductions to ED representations. Success has not occurred in a uniform manner for all patients, across all jurisdictions, at all times of the day, indicating variation in hospital environments and the success of implementation. Factors contributing to this variability have been proposed, including staff enthusiasm and engagement, staffing levels, clinical and administrative leadership, the

underlying work ethos and culture, the mechanisms chosen and the success of their implementation, the location and variation in case-mix presentation.

The Target

Across Australia strategies have achieved reductions in the length of ED stay for non-admitted patients, but have made less of an impact for admitted patients, representing a mismatch between the primary problem of access block and the strategies employed. While some interventions to achieve reductions in access block may have been used, the evidence reflects that that hospitals were targeting ED patients for discharge whose length of stay could be more easily reduced, or colloquially speaking picking the low-hanging fruit. This raises concerns that persisting access block would continue perpetuate poorer outcomes for admitted patients.

Achieving the target but not the goal

Given the pressure to provide assessment and treatment within 4 hours, process changes have seen a major surge in the use of short-stay admission units, allowing the clock to stop and more time for investigations. These patients who would have formally been ED patients rather than admitted patients, are now low acuity patients and this dilutes the case-mix and consequently the hospital mortality rate. Short-stay units are often contained within or adjacent to the ED, which draws into question whether this is merely problem shifting to attain NEAT, without actually achieving changes to patient access or flow. Whether admission to short-stay units provides any clinical benefit over ED remains unknown.

NEAT has resulted in widespread and disproportionate increases in hospital admissions potentially adding to access block and reducing patient flow. Of concern is anecdotal evidence reporting increasing patient discharges occurring in the last 30 minutes of the time-target. This has also been problematic in the UK, conceivably indicating gaming or effort substitution. Data manipulation has also been recognised in at least one tertiary hospital emphasising the risk of incentivising a single output marker too heavily.

Limitations in the existing metrics, particularly those used in the measurement of national performance and accountability, make it difficult to achieve clear and conclusive statements regarding how NEAT has impacted quality. From the available data, there is no clear evidence of healthcare quality reducing, however it must be emphasised that there is currently no broad method in place for evaluating this, other than mortality rate which is open to dilutionary and external effects.

Future implications for NEAT

The utility of NEAT is questionable, with significant financial and resource investments achieving mediocre change. Changes to the NEAT performance framework could have improved its effectiveness through the addition of quality indicators to the time-target. This would involve measuring factors such as inappropriate admissions, access block, ED

representations and hospital standardised mortality rate for patients who are admitted through ED. Changes could also be made to modify time-targets to allow for the recognition of acuity or by having NEAT-free diagnoses. Any changes to performance indicators must be evidenced-based and well chosen as it is necessary for incentives to be linked appropriately to desired outcomes, to prevent unintended consequences. Further improvement in NEAT attainment is conceivable, particularly for admitted patients. However careful consideration is necessary to identify whether this target is worth attaining, including establishing whether it is effective at achieving the intended objectives and whether the additional expenditure is justified.

Implications for policy makers, health service leaders and clinicians

Analysis of NEAT has highlighted the importance of policy making processes in ensuring policy intentions are achieved. It is critical to ensure that appropriate policy instruments and evaluation methods are chosen in order to provide the appropriate incentives for institutional change. The use of process measures such as time targets for the evaluation of healthcare must be used with caution, as this describes healthcare processes but does not reflect the outcomes or quality of care. This is further complicated by the use of financial incentives as drivers of change.

NEAT was developed as a result of higher mortality and longer hospital admissions in those patients who were admitted to hospital after more than 8 hours in the ED. The premise was that spending less than 4 hours in the ED would lead to better patient outcomes. Despite improvement in NEAT attainment, hospitals broadly have been unable to achieve the targets particularly for admitted patients, the intended beneficiaries of the policy.

Reform using a single, incentivised, process-based mechanism is unlikely to achieve broad changes to the effectiveness, safety, quality and equity of care provision, and risks producing unintended consequences. It is for these reasons that the NEAT policy at present cannot be considered a complete success.

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