Closing the Gap: Discharge against medical advice across public hospital wards by Indigenous status

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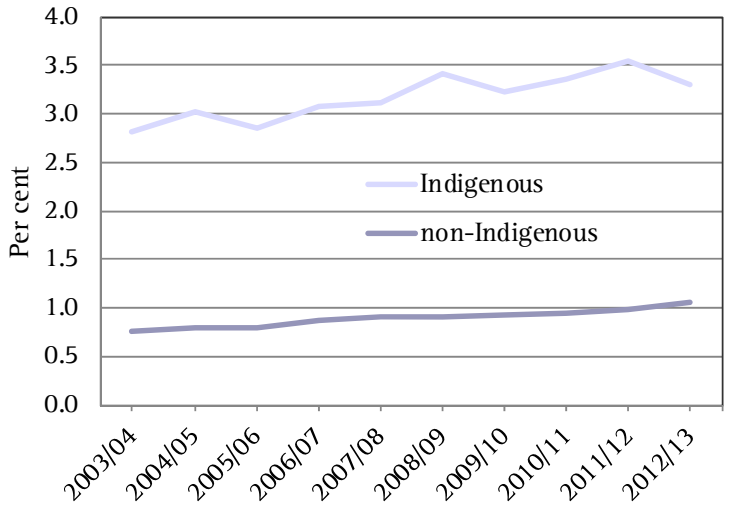
In 2008, the Council of Australian Governments (COAG) committed to the *Closing the Gap* strategy to reduce health inequities and social disadvantage between Australia's Indigenous* people and other Australians. The Queensland Government's plan to implement and monitor *Closing the Gap* is outlined in the document series *Making Tracks*[1], which identifies discharge against medical advice (DAMA) as one of the indicators in the "Healthy lives" target area. In addition, patients who discharge themselves against their physicians' advice have also been found to cost the health system up to 50% more than patients who are discharged by medical staff[2]. Since 2009, DAMA has been a key performance indicator that is measured within all public facilities. In this paper we extend on previous research published in 2009[3] by investigating whether rates of DAMA are improving and examining how DAMA rates differ across hospital wards.

Figure 1. Percentage of episodes that ended in DAMA, by Indigenous status, Queensland, 2003/04 to 2012/13[a]



Source: Queensland Hospital Admitted Patient Data Collection.
[a]Excludes episodes of care for renal dialysis (DRGV50 L61Z), unqualified newborns, posthumous organ procurement, boarders and episodes ending in episode change or death.

Table 1. Percentage of episodes that ended in DAMA, by public acute hospital ward, Queensland, 2007/08-2012/13[a,b,c]

	Indigenous DAMA patients		Non-Indigenous DAMA patients	
	Count	Per cent	Count	Per cent
Intensive Care Unit	57	10.7	261	4.8
High Dependency Unit	58	6.3	206	1.7
Stroke Unit (available from 2012/13)	19	6.1	167	2.2
Coronary Care Unit	122	5.6	484	1.3
Mixed Wards – Critical Care Service Types	37	5.4	316	1.8
Emergency	886	4.9	5677	1.6
Mental Health Acute Psychiatric	270	3.9	2696	2.7
General Wards	6891	3.8	24656	1.0
Mixed Wards – Non-Critical Care Service Types	360	3.2	2417	0.8
Observation	76	2.5	952	0.9
Maternity	496	2.4	1899	0.8
Designated Snap Unit	52	2.2	605	0.6
Paediatric	107	0.4	542	0.2

Source: Queensland Hospital Admitted Patient Data Collection.
[a]Excludes episodes of care for renal dialysis (DRGV50 L61Z), unqualified newborns, posthumous organ procurement, boarders and episodes ending in episode change or death.
[b]Percentage of all episodes from listed ward type.
[c]Last ward that the patient attended within their episode of care. Episodes with no standard ward code recorded were classified as *General Wards*. Includes wards with a DAMA count of at least 10 for Indigenous and non-Indigenous populations.

As seen in Figure 1, from 2003/04 to 2012/13 Queensland DAMA rates have steadily increased for both Indigenous and non-Indigenous patients, with Indigenous DAMA rates increasing from 2.8% to 3.4% (Annual Percentage Change 2.1%; 95% CI: 1.5%-2.7%) and non-Indigenous DAMA rates increasing from 0.8% to 1.0% (Annual Percentage Change: 3.4%; 95% CI: 3.1% - 3.6%). However, there are significant differences by Hospital and Health Service (HHS). In 2012/13, Indigenous DAMA rates ranged between 0.4% and 5.7% and between 0.0% and 1.8% for non-Indigenous patients.

* *The term Indigenous is used when referring to Aboriginal and Torres Strait Islander people collectively.*

While the rates have increased for both Indigenous and non-Indigenous patients since the last paper was published, Indigenous patients are still on average 3.5 times more likely to discharge against medical advice than non-Indigenous patients. Cohort characteristics (i.e. length of stay, age and gender) of patients who are discharging against medical advice are also consistent with those reported in 2009, with Indigenous males and Indigenous persons aged 25 to 39 years still the most likely cohort to discharge themselves.

Anecdotal evidence suggests that DAMA rates are higher in particular wards. Table 1 identifies DAMA rates by ward in Queensland public facilities. Particularly concerning is the rate at which Indigenous patients are discharging themselves from high care wards, including *Intensive Care Units* (10.7%), *High Dependency Units* (6.3%), *Stroke Units* (available from 2012/13; 6.1%) and *Coronary Care Units* (5.6%). Further investigation showed that patients discharging themselves from intensive care units were most frequently admitted with drug and alcohol poisoning and type 1 diabetes mellitus.

While Indigenous patients within *Paediatric* wards have the lowest proportion of DAMA (0.4%), it is still of concern that 107 Indigenous and 542 non-Indigenous young patients left the hospital against medical advice during the six year period examined. Furthermore, 81% of these were aged 14 or under. Aside from *General Wards*, *Emergency*, *Mental Health Acute Psychiatric*, *Non-Critical Mixed* and *Maternity* wards had the largest counts of patients discharging themselves.

In Summary, the excess rates of DAMA amongst Indigenous people, relative to non-Indigenous people, have persisted. There was significant variation in DAMA rates when wards were compared. Of particular concern are those patients discharging from high care wards, due to their high acuity, and young patients given that the majority are minors.

Data Limitations

Care needs to be taken when interpreting these data as Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status[4].

In this study, ward was defined as specialisation of a discrete area based on ward codes assigned in admitted patient data[5]. Reporting of ward information is not mandatory for episodes of care that do not require a high level of service capability. As a result, ward information is not reported for the majority of episodes and such episodes were classified as *general wards* in this analysis. Overall, ward information (for the final ward admitted to within an episode of care) was more likely to be missing for Indigenous DAMA patients (72.9%) than for non-Indigenous DAMA patients (60.2%). It is possible that Indigenous DAMA patients are under-represented in ward-specific estimates, and caution should be exercised when interpreting this data.

References

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