AMA Pre-Budget Submission 2022-23

Chapter 1: Public hospitals in crisis

OVERVIEW

This chapter of the *AMA Pre-Budget Submission 2022-23* draws on a recent paper by the AMA – *Public hospitals: cycle of crisis* – with some of the modelling adapted to give estimates of impact over the four year forward estimates. More detail is contained in the paper.

PROBLEM STATEMENT

Chronic underfunding of public hospitals has led to declining performance, putting lives at risk.

In 2021, doctors have been reporting that the access crisis in public hospitals is the worst it has been in 30 years.[1] We have heard stories of people dying waiting to be seen in public hospitals that are operating at breaking point, and ambulance ramping at public hospitals because there aren't enough beds and staff to cope with demand.

There are both human and financial costs to our public hospitals operating in crisis mode. Access block and emergency department (ED) overcrowding appear to be getting worse, and this is associated with increased mortality, morbidity and length of hospital stay.[2]

This is happening in an environment where we don't have a large demand from COVID-19 cases and we have had a very quiet flu season[3] due to COVID measures. 2018 was a comparatively moderate flu season and yet 10.5 per cent of available hospital beds (in FluCAN monitoring hospitals) were occupied by patients with confirmed influenza.[4]

Public hospitals do not have the capacity to scale up to meet the demands of a widespread COVID-19 outbreak or a typical flu season. Urgent funding reform must happen now to prevent serious adverse outcomes for our population.

Health and growth of population

- Australia's population is growing and ageing.
- The burden of chronic and complex disease is increasing.

Public hospital capacity

- ED presentations are increasing, as is the urgency of treatment required when patients arrive at the ED.
- The median waiting time for elective surgery is increasing.
- The number of available hospital beds per 1,000 people aged ≥65 years – an important measure of public hospital capacity – has been in a trend of decline for decades.
- Across 93 Australian EDs in September 2020, an average of 67 per cent of current patients waiting for inpatient admission were suffering access block.[5]

Public hospital finances

- Public hospital finances are being squeezed, as cost growth (inflation) plus demand growth for public hospital services start to exceed government funding growth (AMA projection).

POLICY PROPOSAL

Urgent reform of public hospital funding is needed. The AMA's vision is for a new funding approach to supplement the current focus on activity-based funding – one that includes funding for positive improvement, increased capacity, and reduced demand, and puts an end to the blame game.

While broader reform is needed in the long term, the AMA is calling for targeted reforms that are needed right now to stem the public hospital crisis. This includes:

Increase funding and the funding cap

- The Commonwealth contribution should increase to 50 per cent for activity (as per current COVID-19 partnership agreement), with States and Territories to use the 5 per cent of 'freed-up' funds on improvement.
- The annual growth cap (6.5%) on the Commonwealth's contribution should be removed, allowing funding to meet demand for hospital services.

Address demand

- Activity-based funding should still be the funding model for the majority of people, but should be supplemented by an alternative model of care better designed for holistic treatment of patients with chronic and complex disease. Some alternative models of care have been trialed, but time and money are needed to support and scale successful pilot projects to state-wide services, and enable further trials of innovative models of care.
- The Commonwealth should partner with the States and Territories to provide additional up-front funding for this purpose. Return on investment would be realised through reduced public hospital costs, over time. Improved patient outcomes would also be achieved through reduced admissions and re-admissions.

Improve performance

- Select pay-for-performance targets should be reintroduced and monitored with the goal of at least reversing the decline in public hospital performance. This Commonwealth funding would be in addition to, and separate from, activity-based funding.
- In the short term there should be immediate Commonwealth funding targeting ED performance and capacity improvement, noting that some State and Territory governments have undertaken reviews into what is required,[6] but there is not a mechanism for large scale/state-wide cost sharing of this work with the Commonwealth, within the parameters of the current hospital funding agreement.

Expand capacity

- States and Territories should use the 5 per cent of 'freed-up' funds to invest in evaluation and improvement activities to increase their capacity through improved processes.
- Public hospitals should also be given additional funding to expand their capital infrastructure where needed. The Commonwealth Government should fund this in partnership with the States and Territories, in the knowledge that it will improve both hospital efficiency and patient outcomes. This additional money could be allocated on a match funding basis, following proposals from the States and Territories.

RISKS AND IMPLEMENTATION

State and Territory government expenditure

It is a possibility that the State and Territory governments would not choose to spend the 5 per cent of 'freed-up' funds on public hospitals. This is unlikely given the crisis situation that public hospitals are experiencing right now. However, this risk could be mitigated by including a requirement to reinvest the additional 5 per cent in a revised Commonwealth-State funding agreement.

Performance improvements

It is possible that reforms will only result in performance of public hospitals being stabilised (no further decline), rather than improved. This is a risk given the dire situation that public hospitals are facing right now and the fact that funding reform is overdue – additional funding may initially be absorbed into stabilising the current crisis. This risk is inversely proportional to the scale of reform and new investment; if funding reform lacks ambition the risk of minimal impact will be greater.

The risks of not taking action

The AMA has modelled what public hospital performance will look like in the future under a 'do nothing' scenario, and the risks of not taking action are significant:

- **Bed numbers will continue to decline relative to the population.** Without an increase in the rate of additional beds (currently 1% per year), the number of beds per 1,000 people aged 65 and over can be expected to fall from 14.9 in 2019-20 to 12.7 by 2030-31.
- **Growing hospital admissions and ED demand will put even more pressure on public hospitals.** There is sustained growth in ED presentations and also in the share of those presentations which are then admitted to hospital. The combined effect of strong growth across both measures begins to paint a disturbing picture. When growth is projected out to 2030-31, it shows admissions from ED will grow to over 5 million per year in 2030-31 from only 2 million in 2012-13.
- **Beds will increasingly be taken up by emergency admissions.** Average daily admissions from the ED are already exceeding 10 per cent of total public hospital bed capacity. Due to the projected increase in admissions from ED, without an increase in the rate of new beds being added, this will reach 20 per cent by 2030-31.
- **Waiting lists for elective surgery will increase.** When a stretched hospital needs to accommodate ever increasing admissions from ED, those beds, doctors and nurses become unavailable for any other form of admission. The resulting impact will be that other admissions will be increasingly deprioritised, leading to even longer waiting lists for elective surgery and non-emergency medical treatments.
- **There will be significant unmet demand for non-emergency public hospital services.** When faced with beds which are increasingly occupied by admissions from the ED, hospitals do their best to accommodate all other admissions. This capacity constraint combined with the 6.5 per cent funding cap will lead to fewer admissions than there otherwise would be. By 2030-31 unmet demand will rise to approximately 14 per cent of all hospital activity or around 1.4 million admissions. For comparison, this is larger than the current size of all elective surgery. This is a significant amount of unmet demand for hospital treatment that can be expected within ten years if no action is taken.

TIMEFRAMES AND COSTING OVER FOUR YEARS

The figures below are in nominal dollars, and are in addition to the Government's budgeted funding outlined in the 2021-2022 Budget.

Table 1: Impact of select funding reform measures on Commonwealth budget

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Additional hospital activity (remove 6.5% cap) ($b)	1.5	1.8	2.1	2.5	7.8
Increase Commonwealth share of hospital funding to 50% ($b)	2.8	3.1	3.3	3.5	12.7
Total cost to government ($b)	4.3	4.8	5.4	6.0	20.5

Costings for performance improvement, capacity increases and avoidable admissions and re-admissions are not provided at this stage, as each State and Territory would remain responsible for identifying current and future capacity needs, models of alternative care and areas for improvement, before the Commonwealth would be required to provide partnership/matched funding under these funding streams.

It is envisaged that each State and Territories' mix of requirements would differ, as would the timelines for development, implementation and therefore expenditure. In considering future outlays, it should be recognised the potential savings that will accrue over a longer period of time to the health system from more effective management of chronic disease, and therefore lower levels of hospital admissions and re-admissions than would otherwise be the case. Performance and infrastructure improvements will no doubt require additional expenditure, and likely increase volumes of patient throughput, but will also generate some benefits for the individual and the economy from improved health outcomes, less unmet demand, and fewer delayed hospital presentations from the community.

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[6] For example, NSW Health carried out a review to discover what current models of care are in place in EDs and the effectiveness of these models for managing demand for their services. The intention was for Hospital Executives and the ED to use the document to assess their own models of care, and to introduce models to their hospitals that may improve patient care and flow, the patient experience and clinical outcomes. NSW Ministry of Health (2012). Emergency Department Models of Care. Retrieved 29/04/2021 from: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0005/273794/emergency-department-models-of-care-july-2012.pdf

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