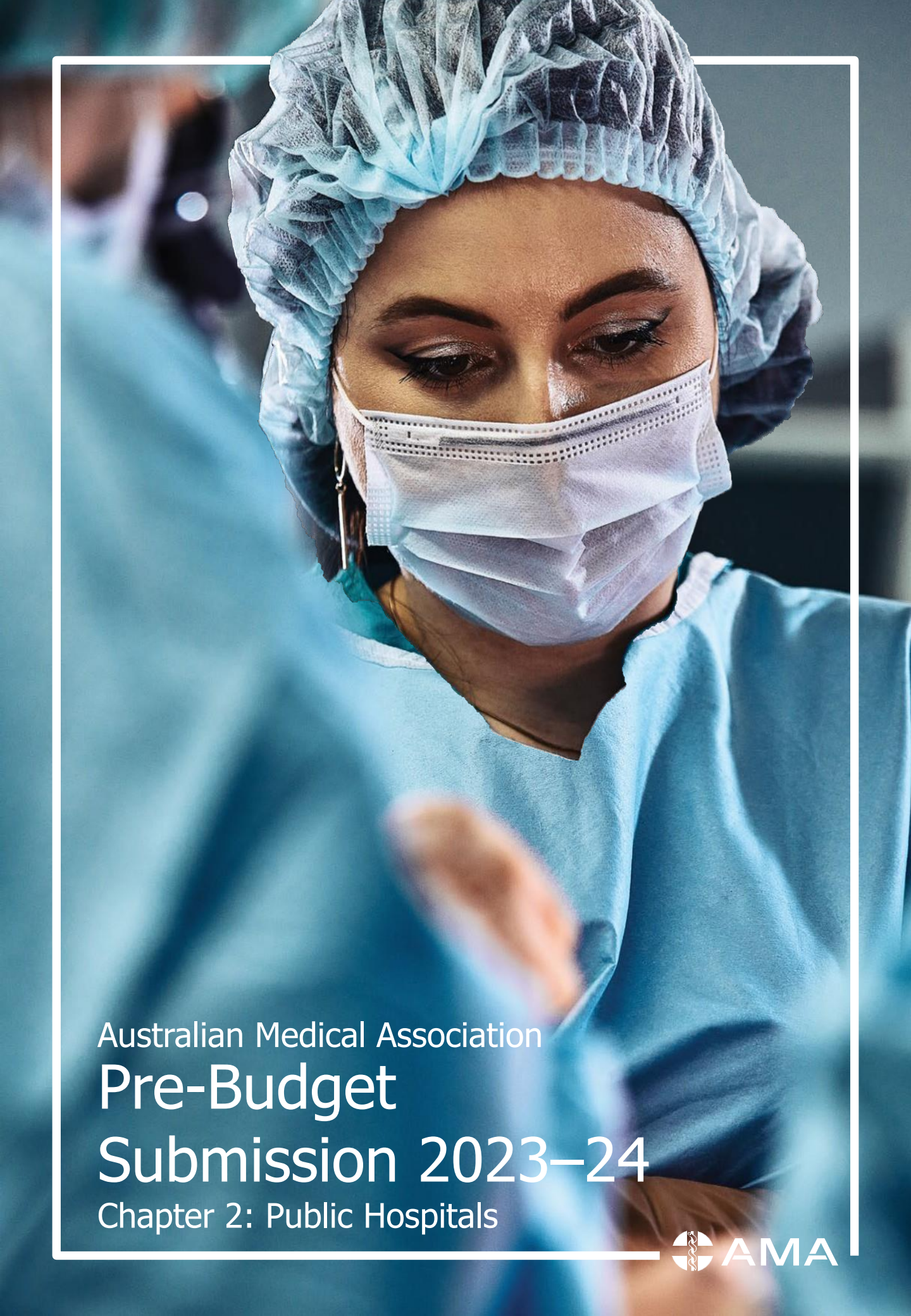

Australian Medical Association

Pre-Budget Submission 2023–24

Chapter 2: Public Hospitals

AMA

CHAPTER 2: PUBLIC HOSPITALS

Overview

This chapter of the *AMA Pre-Budget Submission 2023–24* draws on the AMA research report *Public hospitals: cycle of crisis* with some of the modelling adapted and extended to give estimates between 2022–23 and 2025–26.

Note: some of the costings in this budget submission are estimates from 2022–23 to 2025–26 to align with the costings outlined in the related AMA research report.

Problem statement

The Australian public hospital system is in crisis, with patients caught in logjam. Chronic underfunding at both state and territory and Commonwealth levels has led to declining performance. In the last few years we have increasingly heard stories of people dying waiting to be seen in public hospitals that are operating at breaking point, patients waiting years for essential surgery, and ambulances ramping outside hospitals because there are not enough beds and staff to cope with demand. Only 63 per cent of patients waiting to receive urgent care in the emergency department will be seen within the clinically recommended 30 minutes, a decrease of four per cent from the previous year.[1] For those patients who require Category 2 essential elective surgery — procedures like heart valve replacements or coronary artery bypass surgery — one in three will wait longer than the clinically indicated 90 days.[2]

Since 2008 we have lost six public hospital beds for every 1000 persons over the age of 65.[3] 30 years ago we had more than 30 beds in our public hospital system per 1000 people over the age of 65, whereas now we now have less than 15.[4] At the same time our population is growing, ageing, and increasingly developing more chronic and complex health needs. We expect that by 2035 more than one million people will be older than 85, almost double what it is today.[5] The cost of health delivering health care is also increasing, with cost growth (inflation) plus demand growth for services likely to start exceeding government funding growth (AMA projection). These problems have existed for years, and COVID-19 has only amplified the problem. Australia urgently needs a recovery plan to address the backlog of elective surgeries, build enough capacity to meet the growing needs of the community, and clear the hospital logjam.

Policy proposals

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 per cent) 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 trialled, 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. Additionally, most state and territory governments have committed either publicly or in writing to the AMA that they would reinvest the 5 per cent into improving public hospital performance. This risk could be mitigated by including a requirement to reinvest the additional 5 per cent in a revised 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 cent 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 7: Impact of select funding reform measures on Commonwealth budget

	2022–23	2023–24	2024–25	2025–26	Total
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
Net 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.

References

[1] Australian Institute of Health and Welfare. (2021-2022). *Emergency department care 2020–21: Australian hospital statistics.* Retrieved 21/09/2022 from: https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed

[2] Australian Institute of Health and Welfare. (2021-2022). *Emergency department care 2020–21: Australian hospital statistics.* Retrieved 21/09/2022 from: https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed

[3] Australian Institute of Health and Welfare. (2008-2022). *Australian Hospital Statistics: Hospital Resources 2019-20*, *Table 4.6.* Retrieved 21/09/2022 from: https://www.aihw.gov.au/getmedia/fb227d5e-0084-487d-b921-0ac5c6f65803/Hospital-resources-2019-20-data-tables-17-August-2021.xlsx.aspx

[4] Australian Medical Association. (2022). *Public Hospital Report Card 2022.* Retrieved 21/09/2022 from: https://www.ama.com.au/articles/ama-public-hospital-report-card-2022

[5] Australian Government Parliament of Australia. (2010). *Population projections 2007 to 2057.* Retrieved 21/09/2022 from: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook43p/ageingpopulationfigure

[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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