What happens when we fund hospitals to perform

AMA

June 2023

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OVERVIEW

In the last few years, the media has been filled with stories about people dying waiting to be seen in public hospitals that are operating at breaking point, and ambulances ramping outside public hospitals because there are not enough beds and staff to cope with demand. While many of these issues were exacerbated by the COVID-19 pandemic, public hospitals performance has been in decline since well before the pandemic.

The 2023 AMA Public Hospital Report Card revealed that hospital performance is continuing to stagnate or decline year-on-year, with some performance parameters reaching their lowest levels in more than three decades. Patients are waiting longer for emergency department treatment and planned surgery, and the number of available hospital beds per 1,000 people aged ≥65 years — an important measure of public hospital capacity — has been declining for decades. Reversing this trend will require significant reform to how public hospitals are funded in Australia. The current review of the National Health Reform Agreement Addendum 2020–25 presents a unique opportunity to drive this reform.

WHAT IS THE NATIONAL HEALTH REFORM AGREEMENT?

The National Health Reform Agreement outlines the shared responsibility of the Commonwealth and state and territory governments to work in partnership to "improve the health outcomes for all Australians and the sustainability of the Australian health system".[1] Signed by the Council of Australian Governments (COAG) in August 2011, this agreement introduced major reforms to the organisation, funding, and delivery of healthcare services in Australia.

The key aim of the agreement was to rationalise management and funding responsibilities between the Commonwealth and state and territory governments to end the political 'blame game' and:

- improve access to health services
- increase local ownership of healthcare services and responsiveness to the health needs of communities, with Medicare Locals (now Primary Health Networks) and Local Hospital Networks (LHNs) responsible for ensuring seamless care across hospitals and non-acute community settings
- improve the quality and safety of care through increased accountability
- improve funding efficiency, accountability, and transparency
- address system issues such as inadequate emphasis on prevention and health promotion, lack of services to those with chronic illness and older Australians, inequities experienced by diverse groups, and the limited role of the consumer voice in policy making and service delivery.[2]

It is important to note that several addendums to the original agreement have been signed to date. The changes implemented through these addendums have meant that much of the original intent and benefit of the original agreement has been lost. The impact of this on public hospital funding and performance is discussed in this report.

What is Activity Based Funding?

The National Health Reform Agreement resulted in a significant change in how public hospitals are funded in Australia. Prior to the agreement, the Commonwealth government contributed towards the cost of hospital services via 'block grants' to state and territory governments under the National Healthcare Specific Purpose Payment arrangements.[3] These grants were negotiated every five years and were calculated based on historical costs, negotiation, and government decisions. There was little transparency of the actual services delivered through this funding. In many states and territories, these historical allocations were insufficient to meet demand, creating a 'blame game' between the Commonwealth and state and territory governments. The arrangement was also considered to be unsustainable for states and territories, with projections estimating that health spending alone would be more than the states total budget by the year 2045–46.[4]

The National Health Reform Agreement replaced the National Healthcare Specific Purpose Payment arrangements with a system of retrospective activity-based funding (ABF), which was a recommendation of the National Health and Hospitals Reform Commission.[5] It also brought about increased funding from the Commonwealth, shifting from around 38 per cent of public hospital services to 45 per cent of the efficient growth of public hospital services.

The move to ABF funding was supported by the establishment of the Independent Hospital Pricing Authority (now the Independent Health and Aged Care Pricing Authority), and the creation of the National Efficient Price (NEP) — a set price for each episode of patient care, regardless of the setting in which that care is provided. The National Health Funding Body — an independent statutory authority responsible for holding and distributing funds to LHNs and state managed funds — was also established to support administration of public hospital funding, with an Administrator appointed as the office holder. It was estimated that the National Efficient Price as the basis for public hospital service funding would save $570 to $1,300 million per annum.[6]

Funding for performance improvement

One of the criticisms of ABF is that improved efficiency often comes at a cost to quality improvement and innovation. To address this the National Health Reform Agreement included a specific focus on improving transparency and accountability of performance and the National Health Performance Authority (NHPA) was established. The NHPA and its Performance and Accountability Framework provided consumers, clinicians, service providers and policymakers with national, consistent, regular, and locally relevant information on performance. Additionally, the Australian Commission on Safety and Quality in Health Care was tasked with monitoring and improving the standards of clinical care provided in hospitals.

As part of the agreement, national targets were set to improve access to elective surgery (known as the National Elective Surgery Target (NEST) and emergency departments (known as the National Emergency Access Target (NEAT).[7] As part of the agreement, the Commonwealth government agreed to provide incentive payments to encourage states and territories to meet these targets, with $1.55 billion available to states to achieve the targets over the eight-year life of the agreement.[8]

States and territories agreed to specific annual targets to progress towards meeting the NEST and NEAT performance targets.

National Elective Surgery Target

The targets for elective surgery were that 100 per cent of patients in each urgency category would be seen within the clinically recommended times:

- Urgent (Category 1): Needing treatment within 30 days.
- Semi-urgent (Category 2): Needing treatment within 90 days.
- Non-urgent (Category 3): Needing treatment within 365 days.

It also set targets for the number of days a patient should wait if the patient has already exceeded the clinically recommended times. It also requires the 10 per cent of patients who have waited the longest beyond the clinically recommended time for surgery to be seen within that year.[9]

National Emergency Access Target

Emergency departments have separate clinically recommended timeframes:

- resuscitation (Triage Category 1): requires treatment immediately
- emergency (Triage Category 2): requires treatment within 10 minutes
- urgent (Triage Category 3): requires treatment within 30 minutes
- semi-urgent (Triage Category 4): requires treatment within 1 hour
- non-urgent (Triage Category 5): requires treatment within 2 hours.

The NEAT requires that 90 per cent of all patients presenting to an emergency department either be admitted, referred to another hospital for treatment, or discharged within four hours.[10]

THE IMPACT OF FUNDING PERFORMANCE

In 2013 a change in government resulted in significant changes to hospital funding. The 2014–15 budget stripped $1.8 billion from public hospitals and cut $201 million in incentive payments.[11] Additionally, the National Health Performance Authority was abolished, with its reporting functions merged into the Australian Institute of Health and Welfare.[12]

Figures 1 and 2 show a clear association between performance funding and improvement in emergency department performance, with performance improving when the funding was introduced in 2011 and then deteriorating when it was removed in 2014. The median waiting time for planned surgery remained steady at around 36 days after the introduction of performance funding, and then deteriorated significantly once the funding was removed (Figure 3). The removal of performance-based funding and the National Health Performance Authority clearly marked a turning point for the performance of public hospitals.

Figure 1: Proportion of Triage Category 3 (Urgent) patients seen within the clinically recommended time[13]

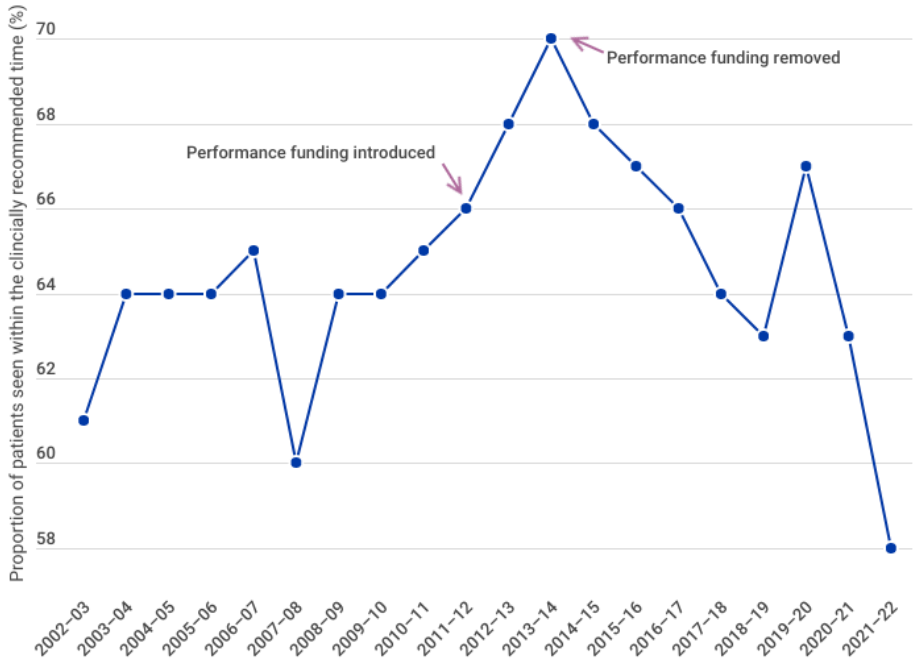


Figure 2: Proportion of emergency department presentations completed in four hours or less[14]

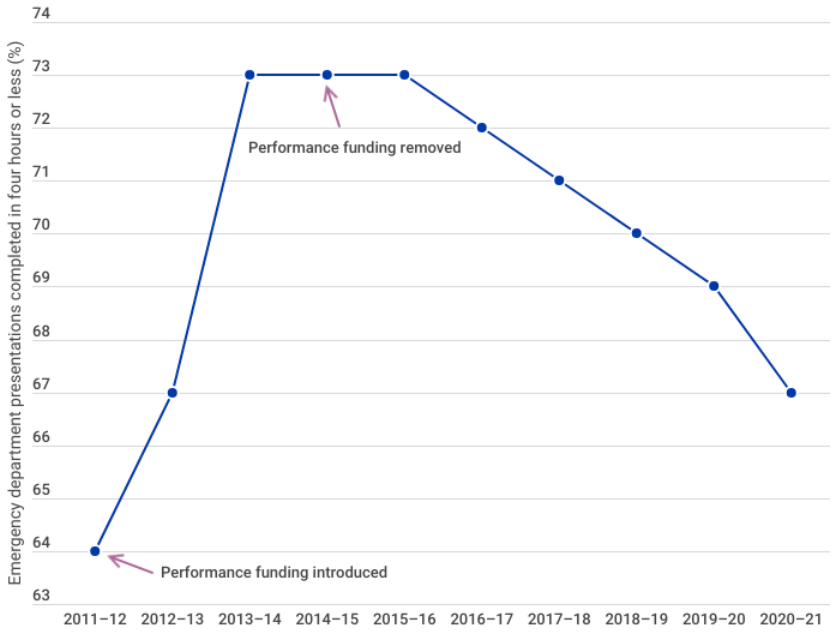
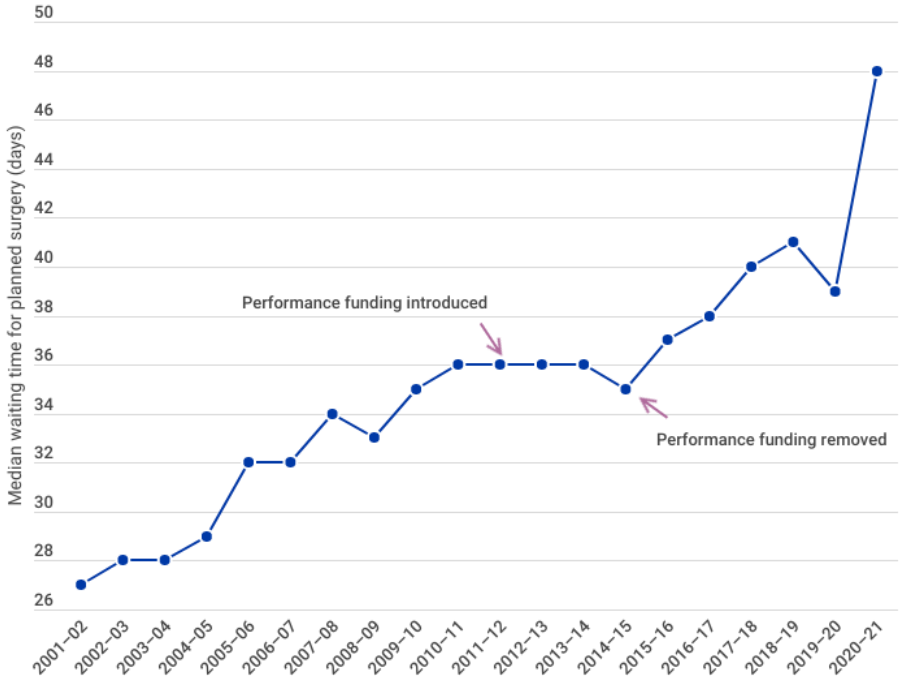


Figure 3: Median waiting time for planned surgery (days)[15]



Where are we now?

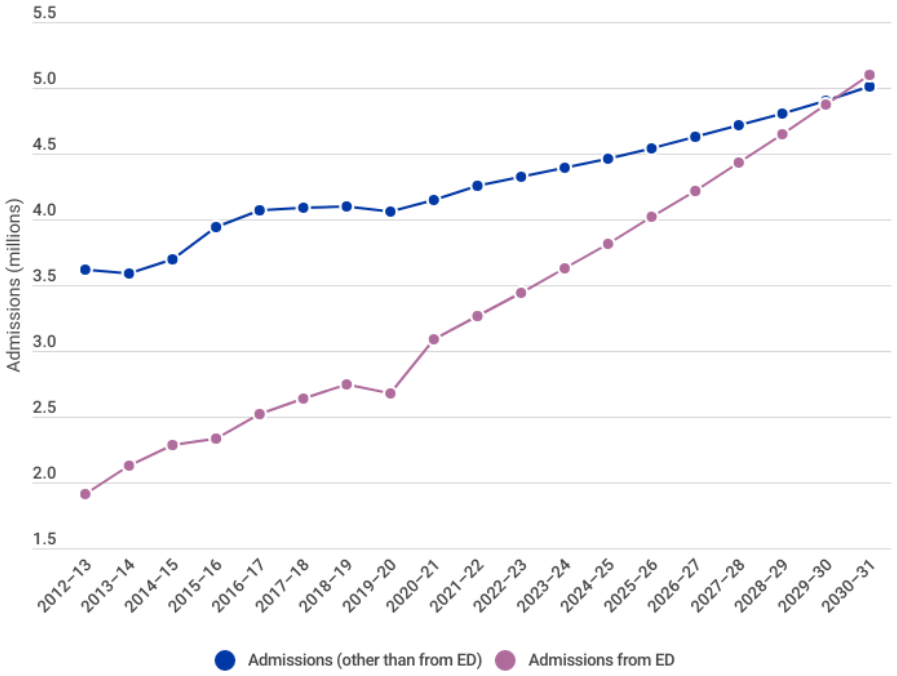
The original intention of the National Health Reform Agreement was that ABF would operate alongside performance-based funding. The current agreement — the National Health Reform Agreement Addendum 2020–2025 — outlines the shortfalls of the current funding formula:

> […] current models for commissioning and funding health care are fragmented and do not reward providers for planning, coordination, and integration of care across a treatment journey. […] Responding to the challenges the Australian health system will face in the future demands a financing system that is proactive, value-based and focused on individual and community needs. The current system does not afford the necessary funding flexibility and governance arrangements to address these challenges, provide best patient care and support contemporary models of care.[16]

In this addendum, Australian governments agreed to progress six long-term health reforms, including "paying for value and outcomes", however sufficient additional funding was not included to help state and territory governments progress the reforms required to improve performance. Additional funding may therefore be required to ensure all jurisdictions can make significant progress towards "paying for value and outcomes", in addition to national accountability mechanisms. In particular, the investment in digital infrastructure needed to transition public hospitals to providing value-based healthcare is substantial. This is unlikely to be achievable by all states and territories with the amount of funding currently available.

In the absence of performance funding, ABF drives the volume of individual treatment episodes, but not necessarily high-quality care or good patient outcomes. In fact, the current funding arrangement is an incentive to run hospitals at very high or full capacity which can negatively impact patient outcomes. AMA analysis reveals that between 2011–12 and 2019–20 (excluding 2020–21 due to COVID-19 impacts), the hospital system was operating with a capacity shortfall of between 22–32 per cent (i.e. hospitals would need to have operated at a current capacity of 122–132 per cent to meet community demand).[17] As hospitals should be operating at around 80–85 per cent occupancy rate (i.e. the whole system should be designed with at least 15–20 per cent more capacity than technically estimated to accommodate surge response requirements)[18,19,20] we therefore need 42–52 per cent more capacity in our hospitals to meet community demand in a safe and sustainable way.[21] Furthermore, the AMA estimates that over the next 10 years, the number of admissions from emergency departments will exceed all other hospital admissions, including for planned surgery (Figure 4). This will create a detrimental cycle, where the conditions of patients waiting for elective surgery become emergent, resulting in increased emergency department presentations. As a result, hospital will need to reduce their elective surgery capacity to increase emergency department capacity, and so the cycle continues.

Figure 4: Actual and projected growth of hospital admissions from emergency departments and other (non-emergency department) admissions, 2012–13 to 2030–31[22]



In addition, while the addendum includes Commonwealth government funding penalties to incentivise state and territory governments and public hospitals to minimise serious adverse patient outcomes, there are no other accountability mechanisms to ensure parties uphold their end of the agreement. For example, under the addendum, the Commonwealth agreed to fund the Medicare Benefits Schedule to ensure equitable and timely access to affordable primary health care and specialist medical services — a key enabler for keeping patients out of hospital in the first place. It is arguable that this has not been met by the Commonwealth over the last three years,[23] but this is point is largely redundant as there are no mechanisms for states and territories to hold the Commonwealth accountable for this.

RECOMMENDATIONS

More of the same will not help improve patients' timely access to public hospital treatments. Without reform, public hospital performance will only get worse as demand increases. Australia's population is growing and ageing, and the burden of chronic and complex disease is increasing. Emergency department presentations are also increasing, as is the urgency of treatment required when patients arrive at the emergency department. Urgent action must be taken.

Implement a new National Health Reform Agreement

Running a hospital well is about much more than just treating patients that come through the door as quickly as possible, yet this is the only aspect of public hospitals that the current funding formula rewards and remunerates. Hospitals are not sufficiently incentivised to focus on their performance or the quality of care provided, nor do they have the time or the money to do so.

The current review of the National Health Reform Agreement presents a unique opportunity to reflect on the effect on public hospitals of the removal of performance funding and the National Health Performance Authority. The AMA's submission to this review calls for a full restructure of the national governance arrangements as they apply to the oversight and operation of the Addendum, including:

- designing, then reinstating dedicated funding streams targeted towards performance improvement, and then continuously monitoring progress against appropriate targets
- an independent body to implement regular assessments against performance and accountability that would be binding for parties to implement, including by addressing poor performance and rewarding improved performance and achievement of targets in emergency departments and elective surgery
- transparent and public reporting on general practice and primary health care services, including urgent care centres, and outcomes at Primary Health Network level, including on local demography and health status, local services and health outcomes, as well as how primary health services interact with public hospitals and Local Hospital Networks
- transparent and public reporting on public hospital service staffing, financial resources and performance outcomes and standards, as well as establishment of a statutory and independent health workforce planning and analysis agency that produces robust supply and demand models.

Improving performance will require reforms across capacity, process, systems, staffing, digital integration, avoidable admissions, and out-of-hospital care. The AMA's four-point plan for hospital reform proposes targeted reforms to stem the crisis in public hospitals, funded through new partnership between the Commonwealth and state and territory governments:

1. **Improve performance**
   Evidence increasingly supports the use of performance-based funding as a driver of quality improvement and clinical outcomes in health systems. Funding for performance improvement should therefore be re-introduced, with the goal of at least reversing the decline in public hospital performance. This Commonwealth funding would be in addition to, and separate from, ABF funding.

2. **Expand capacity**
   Fund extra beds and staff in a partnership between the Commonwealth and states and territories so that hospitals have a chance to end ambulance ramping, meet community demand and improve treatment times.

3. **Address demand**
   Fund more out-of-hospital care, so that people whose needs can be better met in the community, can be treated outside hospital. Programs that work with general practitioners throughout design and implementation to address avoidable admissions and readmissions should be prioritised. Additionally, initiatives that have been shown to reduce pressure on hospitals, such as virtual care, should be funded and supported beyond the limited innovation funding that currently exists.

4. **Increase funding and remove funding cap**
   An increase in the Commonwealth's contribution to 50 per cent for activity, with state and territory governments required to reinvest the 5 per cent of 'freed-up' funds on improving performance and capacity. Eliminate the artificial 6.5 per cent cap on growth, so funding can meet community demand for hospital services. Moving to 50–50 funding and removing the 6.5 per cent cap would represent investment of $20.5 billion over four years between 2022–23 and 2025–26.

It is likely that the reforms needed to reverse the decline in performance will vary between states and territories, Local Hospital Networks, and even individual hospitals. For this reason the AMA is proposing that specific project-based funding is initiated by the state/territory and funded through a partnership model, rather than led by the Commonwealth.

Address the current backlog in care

Elective surgeries have been postponed several times during the COVID-19 pandemic to prevent the public hospitals from being overwhelmed by surges in COVID-19 cases. This was considered a necessary step initially, as our public hospitals were not equipped with appropriate protective equipment and protocols and did not have the capacity to scale up and meet increased demand.

Combined with the ongoing impact of the pandemic and increased hospitalisations for COVID-19 patients, this resulted in the significant number of patients languishing for too long on elective surgery waiting lists. The latest Australian Institute of Health and Welfare (AIHW) data shows Australians are waiting longer than ever for essential surgery, across a range of categories and conditions.

In 2021–22, 622,988 patients were admitted for elective surgery in public hospitals, the lowest number of admissions over the last decade. Assuming that elective surgery admissions should otherwise be growing by 2.1 per cent each year, by the end of 2021–22 there was an estimated elective surgery backlog of 306,281 patients nationally (AIHW data is available only to June 2022), representing a backlog of almost five months.[24] We estimate that if hospitals are not supported to expand their capacity to address this backlog, there will be an estimated backlog of 507,764 patients by the end of this financial year (2022–23). This represents a backlog of eight months.[25]

In addition to official waiting lists, the exact number of patients waiting for an initial public outpatient appointment — a perquisite for inclusion on a waiting list — is unknown (referred to as the elective surgery 'hidden waiting list'), but could exceed 400,000.[i,26,27,28]

This backlog of care will need to be addressed for hospitals to improve elective surgery performance. The AMA is calling for a national plan to address the growing and increasingly critical backlog of elective surgeries. This plan must be funded by both state/territory and federal governments and be backed by long-term funding commitments that deliver permanent expanded capacity for our public hospital system. The plan should have the following features:

- A time limited (two years) addendum to the existing National Health Reform Agreement, until a new National Health Reform Agreement is established in 2025. This would require the states/territories to meet specific performance targets related to clearing waiting lists and would be over and above normal levels of activity.
- Funding dedicated to clearing the elective surgery backlog. AMA analysis estimates that it will cost $4.4 billion in total, shared between states/territories and the Commonwealth, over two years (with the Commonwealth therefore funding around $1 billion per year for two years).

[i]Extrapolated from publicly available data (December 2022) for Victoria, Queensland, and Tasmania which is 395,755 patients for outpatient appointments.

- An advance payment (as part of the aforementioned funding) provided by the Commonwealth to support state and territory governments to expand their capacity.
- 50:50 funding between state/territory and Commonwealth governments, and removal of the 6.5 percent cap on funding growth, as some states and territories will likely go above the cap while clearing the backlog, which under the current arrangements would mean any excess surgery would have to be funded by them alone.
- A review of the current backlog in both public and private health sectors to ensure it is accurate and to identify where alternative care pathways may be appropriate.
- A strategy that encourages innovative ways of service delivery and health infrastructure utilisation that improve efficiencies, in partnership between the public and private health sectors. This would include sharing the consulting and surgical load between the sectors.
- Flexibility in funding so state and territory governments can utilise excess capacity in private hospitals where it can be managed equitably and not worsen backlogs within the private sector. This should be undertaken within institutions where there is demonstrable capacity to perform the work and does not displace private surgeons who work in those hospitals from accessing required operating lists. It could be done by state and territory governments entering into agreements with private hospitals in their jurisdictions, under specified terms regarding clinical workforce and other employees, facilities and professional indemnity insurance.
- Support, evaluation, and accountability for state and territory governments to reduce the backlog of hospital outpatient appointments (the hidden waiting list).
- A robust and regular reporting framework under the addendum that reports on the number of patients on the waiting list (including the hidden waiting list) and demonstrates the increase in activity directly from the funding, with feedback to the relevant National Cabinet/subcommittees. Reporting should be made publicly available where appropriate.
- Develop arrangements with hospitals, in both public and private sectors, to ensure trainees are provided with appropriate opportunities to build essential surgical skills to care for the communities' needs.

CONCLUSION

There are both human and financial costs to our public hospitals operating in crisis mode. Access block and emergency department overcrowding appear to be getting worse, and this is associated with increased mortality, morbidity and length of hospital stay. The AMA believes that the current crisis in public hospitals is not just a Commonwealth or state/territory problem. It is a national problem. Significant effort will therefore be required from both the Commonwealth and the state and territory governments to turn things around. The AMA's four-point plan provides a blueprint for this. The AMA stands ready to advocate on this issue and provide advice and support to governments to improve the performance of Australia's public hospitals.

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