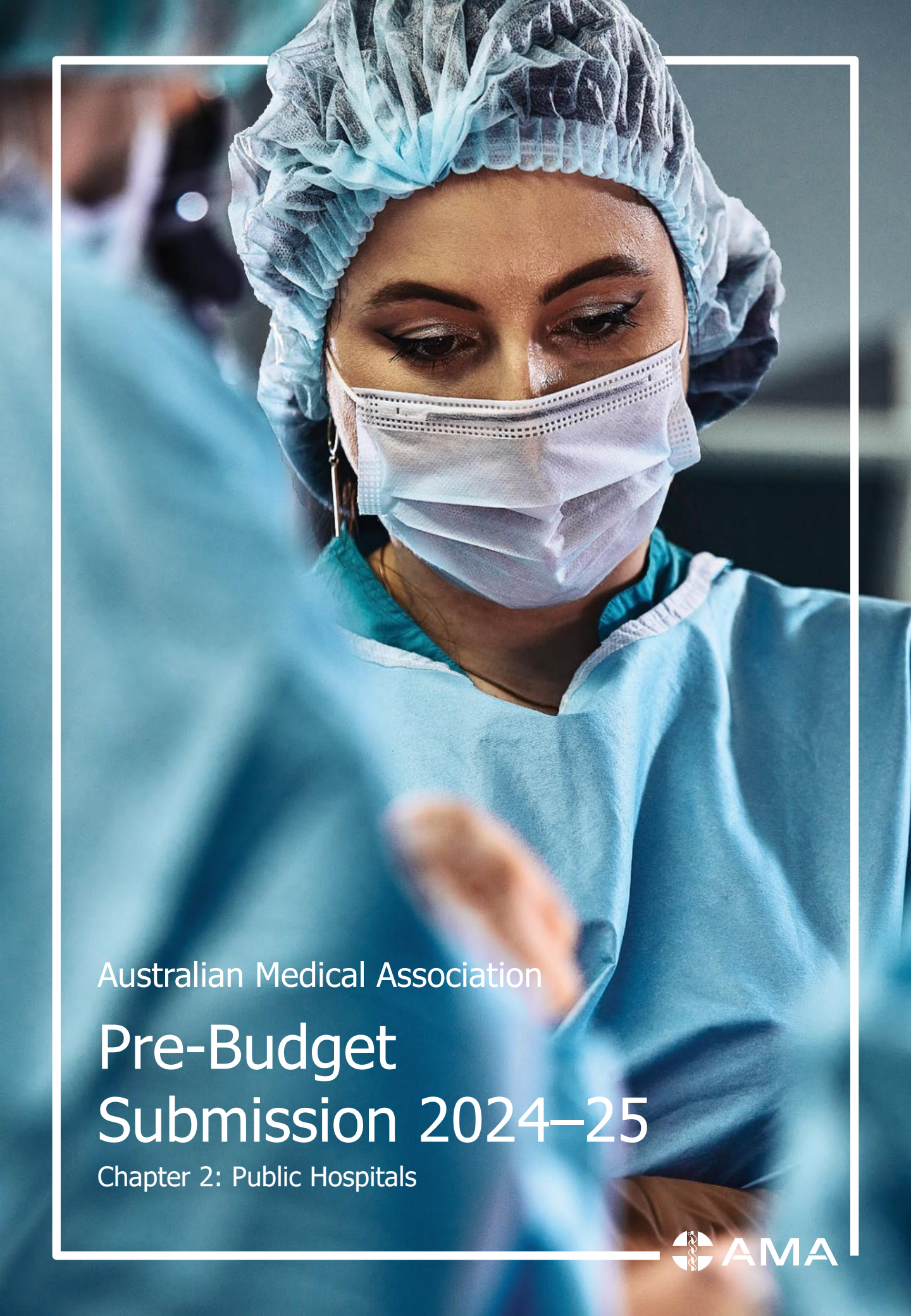

Australian Medical Association

Pre-Budget Submission 2024–25

Chapter 2: Public Hospitals

AMA

CHAPTER 2: PUBLIC HOSPITALS

Problem statement

The Australian public hospital system is in crisis. 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. This year we saw emergency departments face their toughest year since the AMA began tracking emergency department performance. Only 58 per cent of patients waiting to receive urgent care in the emergency department were seen within the clinically recommended 30 minutes, and one in three patients stayed longer than four hours in the emergency department.[1] We also saw times for planned surgeries continue to blow out in the last financial year, with only 63 per cent of patients referred for semi-urgent planned surgery treated within the recommended 90 days. That's more than one in three patients waiting longer than the clinically indicated time for essential surgeries like heart valve replacements or coronary artery bypass surgery.[2] Additionally, the number of available public hospital beds relative to the size of the Australian population has been in constant decline since 2016–17, with an average decline of 0.8 per cent per year.[3] As demonstrated by the AMA Public Hospital Report Card, 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.

In December 2023, National Cabinet announced significant changes to funding arrangements for public hospitals, which will be implemented in the 2025 National Health Reform Agreement.[4] In response to this development, the policy proposals outlined in this section aim to address the immediate issues of elective surgery backlog and exit block.

Policy proposals

Address the elective surgery backlog

This section draws on the AMA research report *Addressing the elective surgery backlog* and *Health is the best investment: shifting from a sickcare system to a healthcare system*, with some of the modelling adapted and extended to give estimates between 2024–25 and 2025–26.

Overview

Before the COVID-19 pandemic, patients were waiting longer than the clinically recommended time for elective surgery in public hospitals, which indicates there was already unmet need for surgical care (also referred to as a backlog of care) before the pandemic. Elective surgeries were then postponed several times during the COVID-19 pandemic to prevent public hospitals being overwhelmed by surges in COVID-19 cases. This was considered a necessary step initially, as our public hospitals were not equipped with sufficient medications, medical equipment, appropriate personal protective equipment and protocols, and did not have the capacity to scale up and meet increased demand created by the pandemic.

Despite most hospitals recommencing elective surgery in 2021–22, public hospitals are still finding it challenging to meet demand and haven't been able to return to pre-pandemic service volumes. These surgeries — commonly referred to as elective surgeries — are not optional procedures that a patient elects to have. They are essential surgeries that are often performed to address life-threatening conditions that prevent a patient from living a normal life due to severe pain or disability. Common elective surgeries for adults include joint replacements to support mobility or cataract extractions to improve vision, whereas common procedures for children include insertion of gromets or cleft lip and palate repair, both of which are essential for speech development.

Unfortunately, reporting of the number of patients waiting for elective surgery (and waiting for an out-patient appointment to be placed on the elective surgery waiting list) varies between jurisdictions. Using the data available, it is estimated that there were around 640,560 patients waiting for elective surgery in June 2023, although the number of patients is likely to be more than this due to poor reporting (particularly reporting of the outpatient waiting list).

We are now at a critical point where access to timely elective surgery is out of reach for many Australians. A national plan is urgently needed to address the growing and increasingly critical backlog of elective surgeries. This plan needs to be funded by both states and territories and the federal government, backed by long-term funding commitments that deliver permanent expanded capacity in our public hospital system.

Risks and implementation

The national plan should be a time limited (potentially up to 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. The plan should also contain the following features:

- 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, developed 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.

Risks of not taking action

Elective surgeries are not optional. They are surgeries that address life-threatening conditions as well as conditions that impact quality of life. The current backlog of elective surgeries is therefore devastating for many patients, and may result in a patient's condition deteriorating and requiring emergency surgery. Delays in diagnostic and screening procedures can also mean that the opportunity for early intervention is missed, resulting in patients presenting with more advanced illness and poorer prognosis. This ultimately results in worse health outcomes for Australians, higher healthcare costs, and increased burden on the economy.

Additionally, research suggests that up to 20 per cent of patients waiting for elective surgery are unable to work. Many are also unable to engage socially and contribute to their communities in other ways, such as volunteering and community service. This has a significant impact on our economy through lost wages, as well as the costs related to personal pain and stress for both the patient and their loved ones, the costs associated with caring for the patient while they are waiting for surgery (i.e. pain management, medical appointments etc.), or the costs associated with reduced social and community engagement.

Timeframe and costing

The AMA estimates that the time limited (potentially up to two years) addendum to the National Health Reform Agreement to address the elective surgery backlog will cost the Commonwealth and state and territory governments a combined $4.12 billion, and therefore only cost the Commonwealth government $2.06 billion over two years (costed over two years until the new agreement is implemented in 2025). It is recommended that 60 per cent of the funding be provided in the first year so that an advance payment can be provided by the Commonwealth Government to support state and territory governments to expand their capacity.

Table 4: Cost of the national plan to address the elective surgery backlog, and savings from preventing lost wages

	2024–25	2025–26	Total
Commonwealth funding to address the elective surgery backlog ($b)	1.02	1.04	2.06
Potential savings from reducing lost wages for patients waiting for elective surgery ($b)	2.45	2.51	4.96
Total cost to government ($b)	**1.02**	**1.04**	**2.06**

Estimated potential savings assume a conservative 20 per cent of patients on the waiting list are not able to work. Lost wages were calculated using waiting time statistics for elective surgery admissions, the number people waiting on the waiting list, and average weekly earnings. The estimate also assumes the average cost per elective surgery on the backlog is one National Weighted Activity Unit (NWAU).

Note: this analysis uses the Australian Institute of Health and Welfare (AIHW) elective surgery data from 2021–22.

Address hospital exit block

This section draws on the AMA research report *Hospital exit block: a symptom of a sick system*, with some of the modelling adapted and extended to give estimates between 2024–25 and 2027–28.

Overview

'Exit block' is a term commonly used to describe the situation when patients receiving hospital inpatient care are medically able to be discharged but have no safe destination. The most common reasons for this are that people's care needs have changed during their hospital admission, and they are now waiting for appropriate aged care (such as a place in a residential aged care facility or a home care package at the right level), or for disability care (often related to National Disability Insurance Scheme (NDIS) funding).

Exit block is a symptom of a healthcare system that is struggling to meet community demand for health and social services, however it has a significant impact on hospital logjams. Exit block means there are less beds for inpatient services, which ultimately results in increased waiting times for ambulance services, emergency department services, and essential elective surgeries.

In June 2022, the Minister for the NDIS announced a new agreement with state and territory governments to improve the hospital discharge process for NDIS-eligible patients. The operational plan includes:

- increasing the number of dedicated hospital discharge staff supporting each state and territory, with 52 Hospital Liaison Officers (HLOs) and 54 hospital discharge planners (HDPs)
- the development of transition plans to support NDIS-eligible patients transition from hospital to long-term accommodation
- increasing the delegation of those staff and streamlining processes to facilitate quicker decision-making
- a commitment from the National Disability Insurance Agency (NDIA) to contact every NDIS participant (or their authorised representative or nominee) within four days of being notified of their admission
- a commitment from the NDIA that an NDIS discharge plan will be approved within 30 days
- enhanced data collection and reporting to measure progress against these commitments and identify reasons for any delay.

The AMA report *Hospital exit block: a symptom of a sick system* demonstrates that this program has successfully reduced the number of days NDIS-eligible patients waiting to be discharged.

Risks and implementation

As outlined in the AMA's submission on data and information needs in aged care, there are issues with data transparency and availability at both a national and state and territory level that make it difficult to properly understand the scale of exit block. This was also a finding and recommendation by the Royal Commission into Aged Care Quality and Safety. There is also currently no publicly available information on the number of NDIS-eligible patients waiting for appropriate NDIS supports.

To properly address exit block, regular data on the number of patients waiting for aged care services or disability care will need to be gathered and made available. Additionally, there needs to be improved use of the My Health Record and interoperability between other systems (such as My Aged Care) to improve care coordination. This will require the Commonwealth and state and territory governments to collaborate as hospitals are managed by state and territory governments whereas most disability and aged care services are managed by the Commonwealth government.

Reporting of data on patients waiting in hospital for aged care services and disability care will enable governments to implement targeted out-of-hospital solutions that address exit block. The NDIS operational plan announced by the Minister for the NDIS in June 2022 (in particular, the increased number of dedicated hospital discharge staff with increased delegation) is an example of the types of solutions that can be implemented to improve the discharge process for NDIS-eligible patients.

In designing programs to address hospital exit block, effort should be made to co-design these programs with hospitals to ensure they meet the needs of care providers and the patient. Programs should explore how existing infrastructure can be modified to meet the out-of-hospital needs of patients, and ensure new infrastructure meets appropriate standards. Mechanisms to ensure assessment and approval processes are efficient and effective should also be implemented, including appropriate accountability mechanisms, performance indicators, and continuous monitoring and evaluation.

Risks of not taking action

Hospital exit block is one of the key contributors to hospital logjam, as it means there are less beds for inpatient services, resulting in increased waiting times for ambulance services, emergency department services, and essential elective surgeries. Not only is this a significant financial cost to the system, but it is also a cost to patients — many of whom are vulnerable members of our community — as the hospital is not the most appropriate care setting for their recovery and long-term care needs.

Timeframe and costing

It is estimated that addressing exit block could save $4.94 billion over the forward estimates. One way this could be achieved is by expanding the current NDIS operational plan to include patients waiting for residential aged care services (as well as other patient groups). To estimate this expansion, the AMA has estimated what it would cost to double current HLOs and HDPs (i.e. an additional 52 HLOs and 54 HDPs). These estimates assume the HLOs earn $101,705–$115,272 annually and HDPs earn $72,000–$83,031 annually, the number of HLOs and HDPs increase each year to account for growth in patient days (1.3 per cent per year), and wages increase by 1.95 per cent each year.

Table 5: Estimated cost and savings from addressing hospital exit block for residents in aged care facilities

	2024–25	2025–26	2026–27	2027–28	Total
Cost of expanding the current NDIS operational plan ($m)	13.20	13.63	14.08	14.54	55.44
Potential savings from addressing exit block for those waiting for residential aged care services ($m)	1,175.00	1,213.00	1,253.00	1,294.00	4,935.00
Total cost to government ($m)	**13.20**	**13.63**	**14.08**	**14.54**	**55.44**

CHAPTER 2 REFERENCES

[1] Australian Medical Association (2023). *Public Hospital Report Card 2023.* Retrieved 03/10/2023 from: https://www.ama.com.au/clear-the-hospital-logjam/phrc

[2] Australian Medical Association (2023). *Public Hospital Report Card 2023.* Retrieved 03/10/2023 from: https://www.ama.com.au/clear-the-hospital-logjam/phrc

[3] Australian Medical Association (2023). *Public Hospital Report Card 2023.* Retrieved 03/10/2023 from: https://www.ama.com.au/clear-the-hospital-logjam/phrc

[4] The Hon Anthony Albanese MP (2023, December 6). Meeting of National Cabinet – the Federation working for Australia. Retrieved 12/12/2023 from: https://www.pm.gov.au/media/meeting-national-cabinet-federation-working-australia

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