
CLEAR THE HOSPITAL LOGJAM
AMA
Funding and reform needed to lift our hospitals out of logjam

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Problem statement

The Australian public hospital system is in crisis. Chronic underfunding at federal, state, and territory levels has led to declining performance. In the last few years, we have increasingly heard stories of people dying while 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 61 per cent of patients waiting to receive urgent care in emergency departments were seen within the clinically recommended 30 minutes, and approximately four in 10 patients stayed longer than four hours in emergency departments.[1] Beyond treatment in emergency departments, planned surgery waitlists continue to blow out, with only 71 per cent of patients referred for semi-urgent, Category 2 planned surgery treated within the recommended 90 days. That is approximately one in three patients waiting longer than the clinically indicated time for essential surgeries like heart valve replacements or coronary artery bypass surgery.[2] The national proportion of individuals receiving Category 2 planned surgery on time has fallen 18 per cent in just six years. While the number of public hospital beds in Australia has slowly been increasing over time, our population has been growing much faster. In total, 1,932 new public hospital beds became available between 2017–18 and 2022–23 (from 63,119 to 65,051), yet our population grew by more than a million people over the same period. Unfortunately, this means we have only installed 16 new beds for every 10,000 new Australians since 2018–19, far below our capacity of 25.3 beds for every 10,000 Australians in 2017–18.[3] As demonstrated by the AMA Public Hospital Report Card, these problems have existed for years, and the new funding agreement in 2025 offers the opportunity to address it.

Policy proposals

Fund public hospitals to improve their performance and increase capacity

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. This section draws on the original AMA report, *Public hospitals: cycle of crisis*,[4] with updated modelling adapted and extended to give estimates between 2024–25 and 2027–28.

Since that report was released, the federal government has agreed to increase their share of future funding to 45 per cent of activity, as well as lifting the cap on their contribution towards public hospitals in the next funding agreement. This is in line with previous AMA calls for an increase in federal funding.

As outlined in the AMA report, *What happens when we fund hospitals to perform*,[5] the introduction of activity-based funding (ABF) has resulted in improved efficiency, but it has also come at a cost to quality improvement and innovation, particularly with the removal of performance funding. The new funding agreement will need additional dedicated funding streams for performance improvement. It should be reintroduced with continuous monitoring of progress against appropriate performance targets, with the goal of at least reversing the decline in public hospital performance.

Unfortunately, despite this change in the funding split between the federal government and the states and territories, there has been no budgeted increase in overall funds, from the previous AMA predictions in 2021 (see chart below).

That is, the total funding envelope has remained consistent with projections under the AMA's earlier 'do nothing' scenario. The result of not increasing funding to match the call from the AMA has meant that hospital activity has been significantly falling behind community demand (see chart below).

This is because while the cap for the federal government has been increased, it appears to be coming from a lower base today than it should have been, if funding in past years had increased in line with AMA projections. The other issue that is clear is that unless states and territories commit additional funding, hospitals will not have the capacity to fully utilise the increase in the federal cap in funding. Finally, as a result of the increase in health inflation, a reasonable amount of the funding increase to the cap will be used to cover the increasing costs of services, rather than just increase the number of services provided.

Hospitals running near or at capacity have less scope to improve efficiencies. Without spare capacity (beds and staff), they can't plan blocks of surgical time dedicated to alleviating waiting lists efficiently. This is removing the effectiveness of the efficiencies that ABF funding has been able to deliver up to 2021–22. This

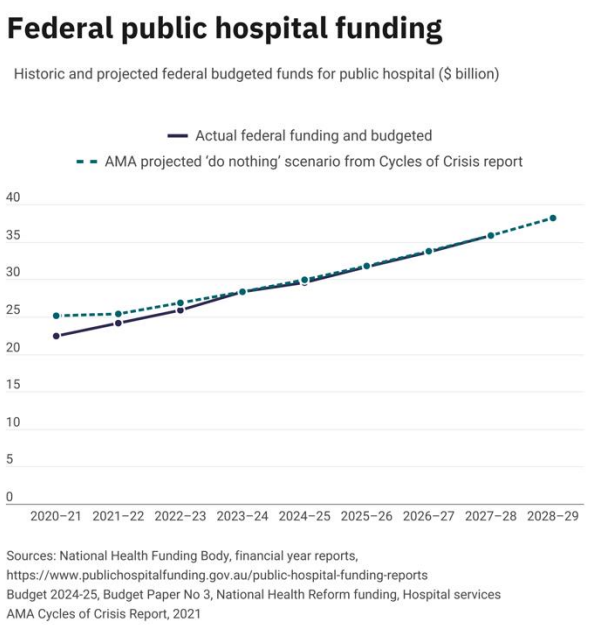

Figure 2.1: Historic and projected activity for public hospitals vs AMA projected 'do nothing' scenario. This graph was produced in time for a Budget submission and therefore pre-dates the $1.8 billion additional funding in the Budget for the single year of 2025-26

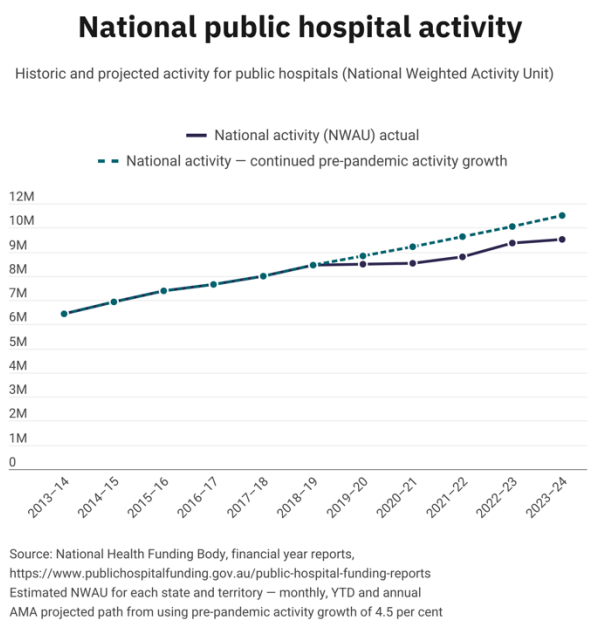

Figure 2.2: Actual activity for public hospitals vs trend

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.
- Hospital admissions and emergency department demand will continue to grow and put more pressure on public hospitals. There is sustained growth in emergency department presentations and 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 more than 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 emergency departments are already exceeding 10 per cent of total public hospital bed capacity.
- Those emergency admissions will continue to struggle to find a bed to admit in a timely manner, leading to even more significant ambulance ramping than we have now.
- Waiting lists for elective surgery will continue to increase, as surgeries are cancelled to accommodate urgent admissions.
- Appropriate staffing levels will be harder to maintain the longer funding remains inadequate.

Risks and implementation

State and territory government expenditure

Given the nature of state and territory government finances across Australia, budgets are under increasing pressure. The states may need to look for additional permanent revenue sources to sustain larger hospital expenditure.

Urgently increase funding to meet community need

While the federal government has agreed to increase its share of future funding to 45 per cent of all activity, as well as lifting the cap on their contribution towards public hospitals in the next funding agreement, states and territories will need to increase their capacity, and their funding/funding caps, to fully utilise this opportunity. Furthermore, the agreement should recognise and allow for periods where some of the additional funding cap is used up in the increasing costs of delivery of services, and accounts for this.

Expand capacity

State and territory governments should use additional 'freed-up' funds resulting from greater federal funding to invest in evaluation and improvement activities to increase their capacity through improved processes. In addition, public hospitals should also be given separate funding to expand their capital infrastructure and staffing where needed. The additional funds must lift planned capacity and not simply fund outsourced surgeries. The federal 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. The risk is that without this, states and territories may not be in a position to utilise the additional funding on offer.

Funding to address demand

Activity-based funding should still be the funding model for the majority of people, but it 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 federal government should partner with state and territory governments to provide additional up-front funding for this purpose. Return on investment would be realised through reduced public hospital costs, reduced admissions and readmissions, and improved patient outcomes.

Performance improvements

It is possible that reforms will only stabilise performance (i.e. no further decline), as opposed to improve performance. This is a risk given the dire situation public hospitals are facing right now and the fact funding reform is overdue. Funding for performance improvement should be in addition to, and separate from, activity-based funding. In the short term there should be immediate federal government funding targeting emergency department performance and capacity improvement, noting 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 federal government — within the parameters of the current hospital funding agreement.

Timeframe and costing

The AMA is calling for funding in addition to the latest federal announcement. The federal government made a commitment of $13 billion as part of National Cabinet process to lift the federal government's proportion of hospital expenditure to 45 per cent. A further commitment is needed by the states and territories. Extra funding for hospitals is needed to lift activity to make use of this pool of 'matched funding' under the new NHRA to ensure these budgeted funds flow through to hospital bottom lines. In doing so, there would be additional funding required by the federal government to match this.

The funding commitment by the federal government is forecast to increase the growth of overall activity (separations) from where we are now. This does not back date the growth in funding to account for the unfunded growth in activity across 2019–20 to 2024–25. Underlying/pre-capped activity continued to grow at around 4–4.5 per cent over this period. This underlying activity growth reflects strong recent population growth (1.5–2 per cent), ageing of baby boomers into age cohorts of higher demand (~1 per cent) and greater co-morbidities, complexity and technology improvement (1–1.5 per cent). This created a gap in activity from where we are to the level needed to address underlying demand.

In addition, hospitals have experienced a period of strong cost growth against a capped total funding envelope. Unfortunately, this has meant some of the additional funds put on the table by the federal government have been absorbed by cost increases in the sector along with a failure by states to increase funding.

Following recommendation from the response to the COVID-19 inquiry,[7] the federal government committed to:

> *Immediate actions – Do in the next 12–18 months:*
>
> *Health Ministers should coordinate a 'COVID Catch-up' strategy in response to a decline in the delivery of elective surgery and cancer screenings, including:*
> - *a national plan to reduce the elective surgery backlog, in consultation with the private and public hospital sectors*
> - *additional funding and an implementation strategy to re-engage regional, rural and remote and other high-risk populations in preventive care to help address undiagnosed cases of cancer, diabetes and other illnesses.*

The figures below incorporate the additional funding necessary to lift activity to 'catch-up' to underlying demand which is in addition to further performance improvement — therefore, much of this ask is in addition to the $13 billion the federal government has already committed for the future five-year period. Going forward, a greater commitment will be necessary from the federal and state governments, recognising the share of federal funds are now 45 per cent.

Costings for performance improvement, increasing capacity, and addressing avoidable admissions and re-admissions are not provided at this stage in this submission, 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 federal government would be required to provide partnership/matched funding under these funding streams.

It is envisaged that the requirements for each state and territory will be different, as would the timelines for development, implementation and therefore expenditure. In considering future outlays, the potential savings that will accrue over a longer period of time to the health system from more effective management of chronic disease should be acknowledged. Performance and infrastructure improvements will no doubt require additional expenditure — and likely increase volumes of patient throughput — however, they will also generate benefits for the individual and the economy through improved health outcomes, less unmet demand, and fewer delayed hospital presentations from the community.

The figures below are in nominal dollars and are in addition to the government's budgeted funding outlined in the 2025–2026 federal budget.

Table 6: Impact of select hospital funding reform measures on federal and state budgets

	2025–26	2026–27	2027–28	2028–29	Total
Federal budget, additional	2.70	3.0	3.3	3.6	12.5
State governments, additional	3.30	3.6	4.0	4.4	15.3
Total cost to governments ($b)	**6.0**	**6.6**	**7.3**	**7.9**	**27.8**

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