AMA

2026–2027 Pre-Budget Submission

Chapter 2: Public hospitals

Problem statement

The Australian public hospital system is in crisis. Chronic underfunding by both federal and state and territory governments has led to declining performance. In the past few years, public hospitals have been operating at breaking point, with patients waiting years for essential surgery and ambulances ramping outside hospitals because there are not enough beds and staff to cope with demand.

Australia's public hospitals are funded through a combination of federal and state and territory government contributions, as defined by the National Health Reform Agreement (NHRA). While state and territory governments manage and set their own budgets, the federal government provides some funding to them through activity-based funding — paid to hospitals according to the volume of services delivered — and through block grants. Prior to 2011, all federal funding to the states and territories was provided through block grants, but the introduction of the NHRA established an activity-based model aimed at improving efficiency and transparency. Block funding continues to support services not considered suitable for activity-based funding, such as teaching, training, research, and certain public health programs. It also supports smaller rural and regional hospitals where activity-based funding may be impractical due to lower patient volumes.

This year, we saw emergency departments face their toughest year since the AMA began tracking performance. In 2023–24:

- 61 per cent of patients waiting for urgent care in the emergency department were seen within the clinically recommended 30 minutes[1]
- 45 per cent of patients spent longer than four hours in the emergency department[2]
- 1.6 million patients — or 4,370 a day —, presented to the emergency department with either an immediate or imminently life-threatening condition (Category 1 and Category 2) that must be treated within 10 minutes. This is almost double the 832,500 in 2013–14.

Beyond treatment in the emergency department, planned surgeries continue to blow out. In 2023–24, only 65 per cent of patients referred for semi-urgent Category 2 planned surgery were treated within the recommended 90 days.[3] That means more than one in three patients waited longer than the clinically indicated time for essential surgeries such as heart valve replacements or coronary artery bypass surgery.

Apart from the pressures on resources, health professionals working in public hospitals are increasingly subject to harassment while performing their duties — with verbal and physical violence against staff becoming alarmingly common. Safe Work Australia identifies healthcare as an industry with an elevated risk of workplace violence. Some estimates suggest up to 95 per cent of Australian healthcare professionals have experienced physical and verbal abuse.[4] The medical workforce is therefore at serious risk of burnout and attrition, and the AMA continues to call on all governments to fund and implement the Hospital Registrar and Career Medical Officer (CMO) Framework, developed through the Medical Workforce Reform and Advisory Committee.[5]

Policy proposals

Clear the logjam

This section draws in part on the AMA report Hospital exit block: a symptom of a sick system from 2023, updating the relevant data points.

A lack of government funding has left public hospitals in logjam — with ambulances ramping, emergency departments at capacity, and long waits for essential surgery. Bed capacity (the number of beds available to treat the population) is not keeping pace with population growth, and the beds Australia does have are increasingly occupied by patients well enough to be discharged but with nowhere to go.

While the number of public hospital beds in Australia has slowly increased over time, population growth has outpaced it. Between 2018–19 and 2022–23, 1,932 new public hospital beds became available (rising from 63,119 to 65,051).[6] Yet the Australian population grew by more than a million over the same period.[7] As a result, the rate of hospital beds fell to 2.5 beds per 1,000 population in 2022–23, down from 2.53 per 1,000 only five years earlier.[8] Since 2018–19, the number of beds per 1,000 population in public hospitals has declined by an average of 0.3 per cent each year.[9]

Public hospitals are also experiencing exit block — a situation where patients who are well enough to be discharged but have no safe destination are kept in hospital due to a lack of better options. The most common reason for this occurs when a person's care needs change during their hospital admission, and they must then wait for appropriate care to become available, such as:

- appropriate aged care, like placement in a residential aged care facility or access to a home care package at the right level
- disability care (often linked to National Disability Insurance Scheme (NDIS) funding).

Exit block is a symptom of a healthcare system struggling to meet community demand for health and social services. However, it has a significant impact on hospital capacity. Exit block reduces the number of beds available for inpatient services, which ultimately leads to increased waiting times for ambulance, emergency department services, and essential planned surgeries.

Currently, there is no regular publicly available reporting of the number of NDIS-eligible patients waiting for disability services through the NDIS. Nonetheless, data sourced from the NDIS indicates the operational plan has generally improved discharge planning for NDIS-eligible patients.

Risk and implementation

Our hospitals no longer have capacity to surge and meet increased demand — meaning exhausted hospital staff must work harder, and patients experience delays in care, sometimes for many months. Australians can no longer wait. Urgent action is needed to establish a long-term, sustainable funding plan.

Our health system must be funded for the future to resolve current logjams.

AMA analysis shows targeted programs addressing hospital exit block could save Australian governments an estimated $811.6 million to $2.17 billion each year.

Risk of not taking action

In 2022–23 (the most recent data available), 26,758 hospitalisations were attributed to patients waiting for residential aged care nationally (either a place in a residential aged care facility or an appropriate home care service).[10] Of these patients, more than 15 per cent waited more than 35 days.[11]

The number of hospitalisations attributed to patients waiting for residential aged care — and therefore the number of patients waiting for aged care services — has been trending upwards since 2012–13, when it was just above 12,000.[12] It has more than doubled in a decade.

Before the operational plan was implemented in June 2022, there were 1,433 NDIS-eligible patients in public hospitals waiting to be discharged. On average, patients waited about 160 days — more than five months — for appropriate supports to be put in place through the NDIS so they could leave hospital. Of these 1,433 patients, 44 per cent had a discharge plan in place.

Public hospitals cannot afford to keep operating with this level of exit block, particularly as they already have limited capacity and are struggling to meet demand. The federal, state, and territory governments need to work together to refine the current arrangements for transitioning people out of inpatient wards into appropriate care.

Timeframe and costing

The AMA plan to deal with our struggling, logjammed hospitals is:

- **Expand capacity:** Provide public hospitals with additional funding for extra beds (along with the necessary staff) and support them to expand capacity to meet community demand, respond to surges when required, improve treatment times, and end ambulance ramping.

- **Addressing demand for out-of-hospital alternatives**: Fund alternatives to hospital care so patients whose needs can be better met in the community are treated outside hospital. Programs that work with GPs to reduce avoidable admissions and readmissions should be prioritised.
- **Increase funding and remove the funding cap:** Increase the federal government's financial contribution to hospital activity, allowing states and territories to reinvest the freed-up funds to improve performance, capacity, and innovation. Remove the artificial cap on funding growth shared between states and territories so funding can meet community health needs based on real demand.

If the latest National Efficient Price (NEP) Determination indexation rate of 5.6 per cent is maintained throughout the five-year agreement to 2030-31, the extra funding required is as follows:

Table 1: Impact of selected hospital funding reform measures on federal, state, and territory budgets (no efficiency)

	2026–27	2027–28	2028–29	2029–30	2030–31	Total
Australian Government ($billion)	$1.6	$4.3	$7.5	$11.2	$15.6	$40.2
State and territory governments ($billion)	$4.0	$5.5	$7.1	$9.0	$11.1	$36.7
Australian Government ($billion) Legacy price adjustment for 2021–22, 2022–23 indexation	$1.7	$1.8	$1.9	$2.0	$2.2	$9.6

Alternatively, if we are able to 'clear the logjam' and hospital price indexation can be contained through efficiency at 2.5 per cent per annum, the impact is as follows:

Table 2: Impact of selected hospital funding reform measures on federal, state, and territory budgets, better efficiency

	2026–27	2027–28	2028–29	2029–30	2030–31	Total
Australian Government ($billion)	$1.6	$3.1	$4.8	$6.7	$8.9	$25.1
State and territory governments ($billion)	$4.0	$3.8	$3.6	$3.3	$2.9	$17.6
Australian Government ($billion) Legacy price adjustment for 2021–22, 2022–23 indexation	$1.7	$1.8	$1.9	$2.0	$2.2	$9.6

The AMA is calling for an increase in the Australian Government's share to **45 per cent by 2030–31**, which is reflected in the above estimates. This is faster than the government proposal. The costing tables includes five years of estimates instead of four, to align with the term of the NHRA.

In both presented scenarios, additional funding excludes the historic cost increases already announced in the 2025–26 NEP, which are not reflected in the current Budget. The impact of the NEP increase is about $9.6 billion across all five years.

The results in the two tables make the stakes very clear. If we cannot clear the logjam, cost escalation will continue, and the impact on all government budgets will be significantly higher. While cost escalation as measured by the Independent Health and Aged Care Pricing Authority (IHACPA) in past years (2021–22 and 2022–23) is now locked in, the forecast IHACPA rate is still being determined by the efficiencies hospitals are able to achieve. Hospitals that are given the resources to effectively plan and deliver should be able to rein in costs to a reasonable level of 2.5 per cent per annum from 2027–28. In past years, under the previously uncapped ABF, hospitals consistently delivered cost control below these estimates.

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 that supplements the current focus on activity-based funding — one that supports positive improvement, increases capacity, reduces demand, and puts an end to the blame game.

This section draws on the original AMA report, Public hospitals: cycle of crisis**,** with updated modelling adapted and extended to provide estimates between 2026–27 and 2030–31.[13]

Since the AMA report was released, the federal government has agreed to increase its share of future funding to 45 per cent of activity, as well as lift the cap on its contribution towards public hospitals in the next funding agreement. This aligns with previous AMA calls for increased federal funding. As outlined in the AMA report, What happens when we fund hospitals to perform, the introduction of activity-based funding has improved efficiency, but it has also come at a cost to quality improvement and innovation, particularly with the removal of performance funding. It is critical the federal government adheres to its commitment to fund 45 per cent of activity, and that all governments work to finalise the next NHRA, with the aim of improving patient access to care and ensuring a quality working environment for the many health professionals working in our public hospital system.

The AMA calls for the new funding agreement to include 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 the change in the funding split between the federal government and the states and territories, there has been no budgeted increase in overall funds compared with the AMA's 2021 predictions (see Figure 1 below). With the exception of small improvement in the single Budget year 2025–26, the total funding envelope has remained consistent with projections under the AMA's earlier 'do nothing' scenario.

The failure to increase funding in line with the AMA's call has meant hospital activity is falling behind community demand (see Figure 2 below). However, the single year of promised additional funding, together with contributions from some states, allowed activity to keep pace with the underlying trend and achieve slight improvement, rather than falling further behind.

This is because, while the federal government cap has been increased, it appears to be starting from a lower base than it should be, had funding in past years risen in line with the AMA's projections. Another issue is that unless states and territories commit additional funding, hospitals will not have the capacity to take advantage of the increase in the federal cap.

Finally, due to increasing health inflation, a part of the funding increase will be absorbed by higher service costs, rather than expanding the number of services provided. Hospitals operating near or at capacity have limited scope to improve efficiencies. Without spare capacity in terms of beds and staff, they cannot schedule blocks of surgical time dedicated to reducing waiting lists effectively. This undermines the efficiencies activity-based funding was able to deliver up to 2021–22 and further restricts the amount of activity achievable with the same level of funding.

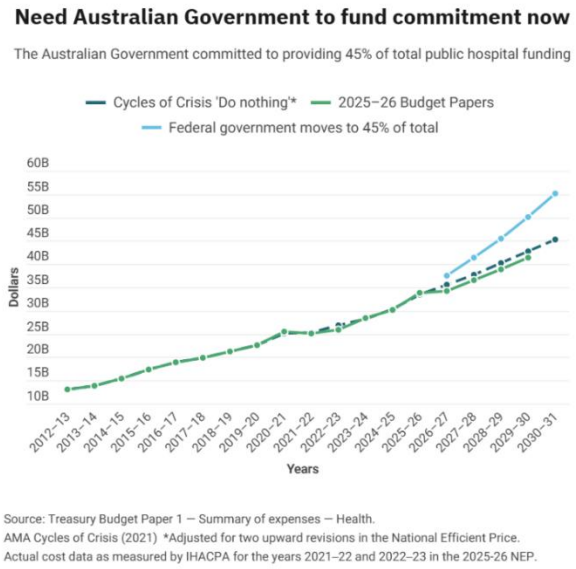

Figure 1: Historic and projected funding for public hospitals versus the AMA's projected 'do nothing' scenario

Figure 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.
- Hospital admissions and emergency department demand will continue to grow, putting more pressure on public hospitals.
- Beds will increasingly be taken up by emergency admissions.
- Emergency admissions will continue to struggle to find a bed in a timely manner, leading to more significant ambulance ramping.
- Waiting lists for elective surgery will continue to increase.
- Appropriate staffing levels will be harder to maintain while funding remains inadequate.

Risks and *implementation*

Blame game

Past NHRA negotiations have often deteriorated into a blame game, with governments frequently trying to pass the buck. Patients deserve better and should not be caught in the middle. It is time for all governments to work together to deliver a durable agreement that places our public hospitals on a sustainable footing and supports access to care within clinically appropriate timeframes.

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, and to lift the cap on its contribution towards public hospitals in the next funding agreement, states and territories will need to increase their capacity and funding to fully utilise this opportunity. Furthermore, the agreement should recognise and allow for periods where some of the additional funding is absorbed by the increasing costs of service delivery, and account 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 that increase capacity through improved processes. In addition, public hospitals should receive additional funding to expand capital infrastructure and staffing where needed. The additional funds must lift planned capacity and not simply pay for outsourced surgeries. The federal government should fund this in partnership with the states and territories; with the understanding it will improve both hospital efficiency and patient outcomes. This additional money could be allocated on a matched-funding basis, following proposals from the states and territories. The risk is that, without this, states and territories may not be able to use the additional funding on offer.

Funding to address demand

Activity-based funding should remain the primary funding model for most patients, but it should be supplemented by alternative models of care better designed for the holistic treatment of people with chronic and complex disease. Some alternative models of care have been trialled, but time and resources are needed to support and scale successful pilot projects into state-wide services and to enable further trials of innovative approaches. The federal government should partner with state and territory governments to provide additional up-front funding for this purpose. The return on investment would be realised through reduced public hospital costs, fewer admissions and readmissions, and improved patient outcomes.

Performance improvements

It is possible reforms will only stabilise performance (i.e. prevent further decline), rather than improve it. This is a risk given the dire situation public hospitals are facing 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 directed at targeting emergency department performance and capacity improvement, noting some state and territory governments have undertaken reviews into what is required.[xiv] However, there is no 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 additional funding called for in table 3 incorporates a higher level of funding than was provided in the most recent Budget. Following the early timing of the Budget, the IHACPA released the NEP Determination, which further increased the measured historic price of a National Weighted Activity Unit (NWAU) by more than 5 per cent above previous estimates. This has been incorporated into the AMA's 'Do Nothing' scenario costing.

The figures below include the additional funding necessary to lift activity to 'catch-up' to underlying demand, in addition to further performance improvement. Therefore, much of this ask is in addition to the $13 billion the federal government committed in December 2023 for the future five-year period. Going forward, a greater commitment will be required from the federal, state, and territory governments.

Costings for performance improvement, increased capacity, and addressing avoidable admissions and readmissions are not provided at this stage in this submission, as each state and territory remains 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 or matched funding under these streams. It is envisaged the requirements for each state and territory will differ, as will the timelines for development, implementation and expenditure.

In considering future outlays, the potential savings that will accrue over a longer term to the health system from more effective management of chronic disease should be acknowledged. Performance and infrastructure improvements will undoubtedly require additional expenditure — and are likely to increase patient throughput — however, they will also generate benefits for individuals and for productivity 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 3: Impact of select hospital funding reform measures on federal, state, and territory budgets

	2026–27	2027–28	2028–29	2029–30	2030–31	Total
Australian Government ($billion)	$1.6	$3.1	$4.8	$6.7	$8.9	$25.1
State and territory governments ($billion)	$4.0	$3.8	$3.6	$3.3	$2.9	$17.6

The AMA is calling for an increase in the Australian Government's share to 45 per cent by 2030–31, which is included in the above estimates. This is faster than the government proposal.

Additional funding excludes the historic cost increases already announced in the 2025–26 NEP, which are not reflected in the most recent Budget. The impact of the NEP increase is about $9.6 billion across all five years.

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