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for Emergency Medicine

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ACEM Response to the IHACPA Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-26

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Introduction

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide feedback on the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26.

As the peak body for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.

ACEM has a long-standing interest in acute health system function, in particular hospital emergency department (ED) overcrowding, long ED wait times, and the management of patient flow throughout hospitals, which have all compounded in recent years. Our submission highlights how funding issues directly impact EDs and provides advice on how IHACPA's pricing framework could better reflect the complexity of funding for services provided in EDs.

1. Section 3.3 Emergency Care

1.1 Australian Emergency Care Classification

In responses provided by ACEM to the IHACPA's previous pricing framework consultations, the College has welcomed the introduction of the Australian Emergency Care Classification (AECC). We see the potential for this classification to better understand and reflect the complexity of the work that occurs in EDs.

The burden of disease in our population is changing, and as a result the complexity of patient presentations, and the type of workforce and infrastructure required to provide safe, high-quality care has changed too. In the context of an ED, working almost exclusively with undifferentiated patients, activity-based funding must reflect the complexity of patient presentations. The ED is also responsible for teaching and training the health workforce at all levels and this important role must be taken into account in any funding consideration.

ACEM notes that work has been undertaken to develop an updated version of AECC Version 1.0 and awaits further detail on the inclusion of a *complexity model* as part of a suite of refinements when AECC Version 1.1 is released by the IHACPA in 2024.

2. Section 6 Data Collection

2.1 Access Block

Access block is the biggest issue facing EDs across Australia. Access block refers to the situation where patients who have been admitted and need a hospital bed are delayed from transferring to a ward or another

appropriate health facility for more than eight hours because of a lack of inpatient bed capacity. Access blocked patients also include those who were planned for an admission but were discharged from the ED without reaching an inpatient bed, transferred to another hospital for admission, or who died in the ED while awaiting admission.

Recent research has shown that new patients presenting to an ED had a 10% greater risk of dying within seven days when more than 10% of current patients waiting for admission were suffering access block. Data from the Australian Institute of Health and Welfare (AIHW) shows that in 2022-2023, 36% of ED patients waiting for admission were experiencing access block across Australia.

The cause of this concerning rise in delays to definitive care is multifaceted. The number of available public hospital beds in Australia per 1,000 population, reduced by 2.4% between 2017-18 (2.53) and 2021-22 (2.47), while presentations to EDs requiring hospital admission increased by 2.5% over this time. There has been a severe lack of investment in aged care beds, especially for older people with complex needs. Additionally, the investment in both community and bed-based mental health services has not sufficiently matched the burden of disease.

2.2 Growing Demand

While EDs were meeting ACEM's recommended 4-hour length of stay targets for discharged patients (80%) until 2018-19, the percentage of admitted patients who have a length of stay in the ED has always been well below the target (60%). Worryingly, the percentage of both discharged and admitted patients who have a length of stay under 4 hours has significantly deteriorated since 2019-20. In 2021-22 the 90th percentile length of stay for non-admitted patients was 6 hours and 38 minutes, whilst for admitted patients it was almost 2.5 times longer at 15 hours and 37 minutes. The 90th percentile length of stay for admitted patients has also risen significantly since 2019-20.

When resourcing and capacity do not match demand for inpatient services, EDs become crowded. Addressing capacity factors within the hospital system is a vital area of focus, as the lack of capacity behind the ED is the root cause of the majority of pressure placed upon EDs.

2.3 Hospital Access Targets

The continuing rise of ED presentations and hospital admissions at a time when hospital bed capacity is on the decline has meant that EDs are looking after patients for longer, which reduces the capacity of staff to meet the needs of other patients, due to lack of both time and available space.

Access block also represents a large cost to individual EDs and consequently to the overall healthcare system. ACEM believes that a more carefully constructed set of time-based targets, will compel health services to seek increases in efficiency, which will reduce the time patients spend in EDs and help move patients to definitive care more, and ultimately delivering budgetary savings. As a matter of urgency IHACPA should track the ED costs for prolonged length of stay and ensure that pricing adequately reflects activity for these patients.

ACEM's Hospital Access Targets (HAT) are an evidence-based, tiered set of targets that consider the complexity of possible patient pathways from the ED more appropriately, and will help limit gaming of the system that has occurred with the current single timepoint four-hour target.[1]

For patients needing to be admitted to hospital or transferred to another hospital:

- ≥60% should have an emergency department length of stay no greater than four hours;
- ≥80% should have an emergency department length of stay no greater than six hours;
- ≥90% should have an emergency department length of stay no greater than eight hours; and

[1] ACEM 2021, *A new approach to time-based targets and why we need one,* *https://acem.org.au/getattachment/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-(1)/Hospital-Access-Targets/It-s-About-Time_Abridged.pdf?lang=en-AU*

- 100% should have an emergency department length of stay no greater than twelve hours

For discharged patients:

- ≥80% should have an emergency department length of stay no greater than four hours;
- ≥95% should have an emergency department length of stay no greater than eight hours; and
- 100% should have an emergency department length of stay no greater than twelve hours.

For patients who need to be admitted to a short stay unit (SSU) for observation:

- ≥60% should have an emergency department length of stay no greater than four hours upon SSU admission;
- ≥90% should have an emergency department length of stay no greater than eight hours upon SSU admission; and
- 100% should have an emergency department length of stay no greater than twelve hours upon SSU admission.

The HAT very deliberately refers to hospital access rather than emergency access, reflecting our desire for patients that are unwell enough to need admission into hospital to be seen in the appropriate environment, such as the inpatient ward, and by the right people for their health needs.

3. Contact Information

To discuss any of the issues raised in this submission, please contact Hamish Bourne, Manager, Policy and Advocacy (policy@acem.org.au).

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