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The special case of smaller and regional hospitals

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There are 762 public hospitals in Australia. Of these, 209 (27%) have 10 or less beds (see Table 1). A further 337 (44%) have between 10 and 50 beds. However, due to their small size, these 71% of hospitals represents only 17% of all public hospital beds (AIHW, 2009). Contrary to popular perception, only 10% of public hospitals in Australia have more than 200 beds.

Table 1 Public hospital size and distribution in Australia

Size	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
10 or fewer beds	23	42	79	40	7	17	1	0	209
More than 10 to 50 beds	126	48	63	33	58	7	0	2	337
More than 50 to 100 beds	29	21	11	5	6	0	0	1	73
More than 100 to 200 beds	23	19	10	8	2	1	0	1	64
More than 200 to 500 beds	20	14	9	6	5	1	1	1	57
More than 500 beds	7	4	5	2	2	1	1	0	22
Total	**228**	**148**	**177**	**94**	**80**	**27**	**3**	**5**	**762**
10 or fewer beds	10.1%	28.4%	44.6%	42.6%	8.8%	63.0%	33.3%	0.0%	27.4%
More than 10 to 50 beds	55.3%	32.4%	35.6%	35.1%	72.5%	25.9%	0.0%	40.0%	44.2%
More than 50 to 100 beds	12.7%	14.2%	6.2%	5.3%	7.5%	0.0%	0.0%	20.0%	9.6%
More than 100 to 200 beds	10.1%	12.8%	5.6%	8.5%	2.5%	3.7%	0.0%	20.0%	8.4%
More than 200 to 500 beds	8.8%	9.5%	5.1%	6.4%	6.3%	3.7%	33.3%	20.0%	7.5%
More than 500 beds	3.1%	2.7%	2.8%	2.1%	2.5%	3.7%	33.3%	0.0%	2.9%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: AIHW (2009) *Australian hospital statistics 2007-08 Health services series no. 33*

Not every small hospital is the same. There are:

- 185 very small hospitals that treat less than 200 patients a year
- 131 sub-acute and non-acute hospitals including palliative care hospices, rehabilitation centres and extended care centres
- 111 small acute hospitals in regional towns
- 40 small acute hospitals in remote towns
- 79 multipurpose centres

Some small hospitals can be expected to be very 'profitable' under ABF. This is particularly the case for those small hospitals that only cater for planned admissions.

But many small hospitals will be in the reverse situation. With the exception of specialist sub-acute hospitals, many small acute care hospitals represent a special case in the ABF context.

There are several reasons:

- They cannot achieve the **economies of scale** that large hospitals can
- The cost of goods and services is often higher due to **transport** and related costs
- They often need to recruit **'fly-in, fly-out'** staff because they cannot be staffed in any other way. The associated staffing and travel costs are considerably more expensive than an equivalent service in an urban area
- Their major costs are fixed and are not based on their activity. Many very small hospitals, particularly in regional and remote areas, have to be staffed with the **capacity** to treat patients who may present at their door even if, on some days, they actually have no patients at all
- They have **Community Service Obligations**. Without the local hospital, the town would die
- In many cases, they act as **the de facto nursing home and GP service**, carrying the cost of services funded in other locations by the Commonwealth through other funding streams.

There are several options for the funding of small hospitals in the ABF context:

- Exempt small hospitals from ABF completely and fund them based on their actual expenses. These actual expenses can be subjected to independent review to ensure that the hospital is working as efficiently as possible.
- Recognise this group of hospitals as a hospital peer group for the purposes of ABF and determine different 'efficient prices' for this category of hospital. These 'efficient prices' would need to take account of the six special cost factors listed above. The COAG agreement has at this point only recognised the need for special arrangements for Community Service Obligations, although the other five factors also need to be taken into account. There are international and national precedents for this type of approach.
- For very small hospitals and those with an unpredictable workload, this 'efficient price' will need to be paid based on their **capacity** to undertake an agreed level of activity, with marginal payments for any activity beyond that level. That is, the capacity to undertake a specified level of activity will need to be prospectively determined each year. This is necessary because the majority of their costs are not dependent on the actual activity they subsequently undertake. With their fixed costs already funded, any activity above the agreed level can then be funded at the marginal cost (typically 60% of the full average cost).