Aligning Public Emergency Department Funding with Complexity

A Practical White Paper by the

Australian Institute of Health Executives (AIHE)

Release Date: February 2026

Aihexec.com | Enquiries@aihexec.com

Executive Summary

Public Emergency Departments (EDs) are no longer primarily high-volume, episodic care environments. They have become the **risk-absorbers of the health system**, managing patients with increasing clinical, cognitive, and social complexity—often without the commensurate funding, workforce, or system support.

Current Australian ED funding models in the public health sector remain largely **volume - and throughput-driven**, rewarding 'speed and activity' rather than complexity, coordination, and risk management. This mismatch is now a structural contributor to emergency department crowding, clinician burnout, access block, and patient harm.

This white paper proposes **four practical, implementable funding models** that align public ED funding with the reality of modern emergency care:

1. Complexity-Adjusted Activity Funding
2. Bundled Payments Across Care Settings
3. Integrated System Incentives
4. Workforce & Care Coordination Funding

These models are **not theoretical redesigns**. Each can be piloted within Australia's existing federated (bilateral) funding architecture, leveraging governance structures, based on accurate data that is patient outcome focussed.

The goal is not higher ED funding in isolation—but **smarter funding that reflects where complexity, risk, and coordination actually sits in the system**.

The Problem: Funding the Wrong Work

For decades, ED pressure has been framed as a demand ie 'input' and 'flow' problem:

1. Too many presentations
2. Fewer alternative options eg general practice
3. Not enough hospital beds

But this framing is incomplete.

What has changed most is not volume alone, it is **complexity**.

Modern EDs manage:

- Older, frailer patients with multimorbidity
- Mental health and substance-related crises
- Social instability and care gaps
- Diagnostic uncertainty requiring senior clinical judgment
- Patients failed by upstream and downstream services

This work is time-intensive, cognitively demanding, and coordination-heavy. Yet funding models still assume EDs deliver **short, discrete, standardised episodes of care**.

The result is a system that:

- Underfunds rational clinical decision making and risk management
- Rewards throughput over safety
- Pushes complexity onto already stretched clinicians
- Treats burnout as a workforce issue rather than a funding design flaw

Design Principles for Reform

Any sustainable ED funding reform must:

- **Recognise complexity explicitly**, not implicitly
- **Align incentives across care settings**, not re-enforce silos
- **Protect workforce capability**, not just physical capacity
- **Be implementable within Australia's federated system**

The following four models meet these criteria.

Model One: Complexity-Adjusted Activity Funding

Concept

Retain activity-based funding (ABF), but weight ED presentations based on **measurable patient complexity**, not just volume or triage category. This model accepts ABF as a foundation but corrects its blind spots.

Emergency departments are still funded on a logic that treats all presentations as broadly equivalent. One patient, one price. Yet anyone who has worked on the floor knows this is a fiction.

The cognitive, clinical, and social effort required to safely manage a frail older person with multimorbidity, diagnostic uncertainty, and no community supports, bears little resemblance to a straightforward injury or single-issue presentation.

Complexity-adjusted activity funding challenges this mismatch by making activity-based funding smarter, not abandoning it. Instead of paying solely for volume, it explicitly weights funding according to patient complexity, by recognising that some presentations demand substantially more thinking, coordination, and senior decision-making than others.

Implementation in Australia

Australia is unusually well placed to implement this approach. Much of the required data already exists within ED information systems; it simply has not yet been mobilised for funding purposes.

1. Define nationally consistent complexity markers

Using data already collected (or easily added) within ED systems, nationally consistent complexity markers could be defined using a small, pragmatic set of variables such as:

- Clinical Frailty Scale
- Multimorbidity counts
- Mental health and substance use flags
- Cognitive impairment or dementia
- Social vulnerability proxies e.g. aged care residence, housing insecurity
- Diagnostic uncertainty indicators e.g. undifferentiated presentations

This does not require perfect data from day one. Directionally accurate measures are sufficient to begin aligning funding with reality.

2. Apply complexity loadings to existing ED activity prices

Once defined, these markers could be applied as loadings to the existing ABF framework. A base ED activity price would remain, but complexity multipliers would be layered on top, recognising low, moderate, and high complexity care with graduated weightings.

Indicative example:

Base ED presentation: 1.0×

Moderate ED complexity: 1.2×

High ED complexity: 1.5–1.8×

These loadings could initially be capped to manage fiscal risk and run in parallel with current triage or urgency-based funding, rather than replacing it outright. In other words, this is an evolution of the current system, not a disruptive reset.

3. Pilot through IHPA and bilateral agreements

The most credible path forward would be through piloted implementation. The Independent Health and Aged Care Pricing Authority, working with states and territories, could trial complexity-adjusted funding in a small number of diverse sites e.g large metropolitan EDs alongside regional hospitals, using bilateral agreements.

These pilots would allow calibration of weights against real-world outcomes such as:

- Length of stay
- Admission avoidance
- Safety and quality indicators
- Cost neutrality or offset (overall financial sustainability)

Crucially, they would generate evidence rather than 'ideology'.

Risks and Mitigations

The risks are real as any funding model creates incentives, and complexity-based funding raises the possibility of 'gaming the system' such as upcoding. This can be mitigated through the use of simple, auditable measures, periodic independent review, and outcome-based guardrails.

Data quality variation across sites is another concern, best addressed by starting with a small number of robust variables, standardised training, and benchmarking between comparable hospitals.

And inevitably, there will be budget anxiety. Treasury concern about cost growth is understandable, but it can be contained through capped pilots and, critically, by

demonstrating avoided downstream costs: fewer admissions, reduced ICU utilisation, and shorter inpatient stays.

Risk	Mitigation
Upcoding or gaming	Simple, auditable metrics; periodic review
Variable data quality	Start small; standardised training
Treasury cost concerns	Pilots with capped exposure; downstream savings analysis

Strategic Value

Complexity-adjusted funding pays for **clinical judgment, coordination, and risk management.**

Systemically, this model matters because it pays for thinking, not just doing. It recognises the invisible work that dominates modern emergency care: managing diagnostic uncertainty, mitigating risk, coordinating across fragmented systems, and applying senior clinical judgment under pressure. Today, this work is largely unfunded, even as it consumes time, attention, and emotional labour and quietly fuels workforce burnout.

Model Two: Bundled Payments Across Care Settings

Concept

Fund complex patient care as a **single, shared journey**, rather than fragmented episodes across EDs, wards, community, and aged care.

Complex emergency department patients do not experience care in silos, even though funding systems still behave as if they do. For these patients, the ED is only one moment in a longer, more fragile care journey that often spans hospital wards, community services, primary care, aged care, and non-government providers.

Bundled payments challenge the fragmentation inherent in this model by paying once for the whole journey, rather than repeatedly for disconnected episodes. The premise being, if the system is responsible for the outcome, it should also be responsible for the funding across the pathway.

Implementation in Australia

Bundled payments are often dismissed as impractical in federated health systems, yet Australia already has precedents in joint commissioning and pooled funding pilots. The key is not to bundle everything at once, but to start where fragmentation is most damaging and costly.

1. Start with defined high-impact cohorts

High-impact cohorts are well known:

- Frail older adults presenting to ED
- Frequent ED presenters with complex psychosocial needs
- Mental health crisis cohorts
- Aged care residents transferred to ED

These groups disproportionately experience repeated handovers, duplicated assessments, and preventable deterioration precisely because no part of the system is funded to take end-to-end responsibility.

2. Map real care pathways and costs

The first practical step is to map the real care pathway these patients travel, not an idealised model, but the pathway as it actually operates. This includes:

ED - Inpatient services - Community health - Aged care - Primary care & NGOs

It's important to note that this is intended as a costing exercise rather than a redesign exercise. The goal is to understand where time, effort, and resources are already being consumed across the system, not to solve every service gap before funding reform begins.

3. Establish a shared funding envelope

A single bundled payment would be attached to an episode of care or a defined time window, often 30 to 90 days, reflecting the period during which coordinated intervention is most likely to change outcomes.

Funds could be administered through a lead provider model, typically a Local Health Network, or through formal pooled funding arrangements between partners. Either approach creates a locus of responsibility where none currently exists.

4. Measure outcomes, not just utilisation

Crucially, success under a bundled model is measured by outcomes rather than throughput. Metrics shift away from isolated service utilisation toward system-level indicators such as:

- ED re-presentations
- Avoidable admissions
- Functional outcomes
- Patient and carer experience

These measures reflect whether the system has genuinely stabilised the patient, not simply moved them on. Bundled payments change the core question from "*How do we move this patient out of our service?*" to "*How do we stabilise this patient across the system?"*

In doing so, they align incentives that are currently misaligned and reduce the cost-shifting behaviours that quietly undermine performance in a siloed funding environment.

Risks and Mitigations

The challenges are significant but not insurmountable. Governance complexity is an obvious risk, particularly disputes over who holds and manages the bundle. This can be mitigated by initially vesting responsibility with Local Health Networks and establishing clear accountability frameworks.

Provider resistance is also predictable, especially concerns about financial loss or exposure to risk. Early gain-sharing arrangements and risk corridors can help build confidence while models mature.

Attribution of outcomes presents a further challenge, but this can be addressed by focusing on cohort-level performance and shared metrics rather than individual provider blame.

Risk	Mitigation
Governance complexity	Clear lead provider models
Provider resistance	Gainsharing; risk corridors
Attribution disputes	Cohort-level accountability

Strategic Value

Bundled payments reduce cost-shifting and incentivise **shared responsibility for complexity**, rather than pushing risk onto EDs.

They force the system to confront a basic truth: complex patients need coordinated care, and coordination will not happen at scale until funding makes it someone's job to deliver it.

Model Three: Integrated System Incentives

Concept

*Layers outcome-based incentives onto existing funding to reward **safe, coordinated, high-quality care**, not just throughput.*

Most performance incentives in healthcare still reward speed, volume, and local optimisation. Emergency departments are measured on flow, offload times, and throughput, even when the safest decision is to slow down, coordinate care, or hold risk on behalf of the wider system.

Integrated system incentives seek to correct this imbalance by rewarding safe, coordinated outcomes rather than isolated activity. Importantly, this model does not replace existing funding arrangements; it layers targeted incentives on top of them to reshape behaviour without destabilising the system.

Implementation in Australia

1. Define integration-focused metrics

The first step is to define a small number of integration-focused metrics that reflect what good system performance actually looks like for complex patients. These might include:

- Safe ED discharge with documented follow-up,
- Reduced 7 - to 30 day re-presentations,
- Fewer ambulance offload delays, and
- Improved patient-reported experience for complex cohorts.

The emphasis is not on creating new administrative burden, but on selecting measures that capture whether care is genuinely connected beyond the ED doors.

2. Apply incentives at system or regional level

Incentives should be tied to system-level performance rather than the results of individual services or sites. Payments would be linked to shared outcomes across hospitals and community providers, assessed at a regional level rather than pinning success or failure on a single ED.

This shifts the focus from local target-hitting to collective responsibility, encouraging services to work together and avoids penalising individual services acting alone.

3. Adjust for equity and context

Equity adjustment is essential to making this model credible. Performance targets must be weighted for socioeconomic complexity, rurality, and Indigenous health contexts so that services caring for the most disadvantaged populations are not penalised for taking on harder work. Without this adjustment, incentives risk reinforcing inequity rather than correcting it.

Risks and Mitigations

Metric overload can quickly disengage clinicians if incentives become too numerous or abstract. This is best mitigated by using fewer, sharper measures developed in partnership with frontline staff.

Perverse incentives, such as avoiding complex patients to protect performance, are another real concern and must be addressed through complexity-adjusted targets and transparent monitoring.

Finally, there is the risk of 'short-termism' - chasing incentive payments at the expense of longer-term care planning. Multi-year incentive horizons can help counter this by signalling that sustainable outcomes, not quick wins, are the goal.

Risk	Mitigation
Metric overload	Few, high-signal measures
Perverse incentives	Complexity-adjusted targets
Short-term focus	Multi-year incentive horizons

Strategic Value

Integrated incentives rebalance accountability so EDs are no longer the default risk sink for system failures. At present, EDs absorb clinical and organisational risk so that other parts of the system can meet their own KPIs.

Integrated incentives acknowledge this reality and begin to reward prevention, coordination, and clinical judgment - not just speed. They legitimise the work of holding complexity safely, even when it does not translate into rapid throughput.

Integrated system incentives are ultimately about cultural change. They send a clear message about what the system values: not just how fast patients move, but how safely and coherently the system responds to complexity.

Model Four: Workforce & Care Coordination Funding

Concept

*Explicitly funds **expertise and coordination**, rather than relying on overstretched operating budgets to absorb complexity.*

Modern emergency care depends as much on expertise and coordination as it does on physical capacity, yet funding models continue to assume these elements will somehow be absorbed into already overstretched operating budgets.

Workforce and care coordination funding makes this invisible work explicit. Rather than treating expertise as a by-product of throughput, it recognises it as a core input to safe care for complex patients and funds it accordingly.

Implementation in Australia

1. Define the complexity workforce

The first step is to clearly define the complexity workforce. This includes:

- Senior ED clinicians
- Allied health professionals
- Mental health clinicians
- Social workers
- Care coordinators

These roles are central to managing frailty, psychosocial complexity, diagnostic uncertainty, and safe discharge, yet they are often the first to be stretched or withdrawn under fiscal pressure.

2. Link workforce funding to complexity mix

Once defined, staffing profiles can be explicitly linked to the complexity mix of the ED population. Using routinely captured complexity data, services can justify funding:

- Senior medical and nursing decision-maker presence
- Extended allied health coverage beyond business hours
- Embedded care coordination roles within the department

This creates a direct line of sight between patient need and workforce design, rather than relying on historical staffing models that no longer reflect reality.

3. Create protected funding streams

Critically, this requires protected funding lines. Workforce resources tied to complexity should sit in explicit funding streams that cannot be quietly absorbed into general cost pressures or repurposed to meet short-term efficiency targets, with transparent reporting requirements. Without this protection, the system inevitably erodes the very capability it relies on to manage risk safely.

4. Monitor workforce and safety outcomes

Monitoring must also extend beyond traditional activity measures to include human outcomes:

- Burnout and turnover
- Sick leave
- Staff retention
- Clinically significant events
- Patient outcomes

These indicators provide early signals of whether the workforce is sustainable, and should be treated as system performance measures, not individual failings.

Risks and Mitigations

Workforce shortages mean there is a risk of funding roles that cannot immediately be filled, which argues for staged implementation aligned with training and pipeline development.

There is also a persistent perception that senior staff slow down flow rather than enable it. This can be countered by evidence demonstrating that early senior input improves safety, reduces unnecessary admissions, and shortens overall length of stay.

Finally, workforce funding is often the first target during fiscal tightening. Quarantined funding agreements and transparent reporting are essential to ensure that investment in expertise is not quietly dismantled when budgets come under pressure.

Risk	Mitigation
Workforce shortages	Staged rollout; training alignment
Perceived inefficiency	Evidence linking senior input to safety
Budget erosion	Protected funding agreements

Strategic Value

This model recognises that **safe care for complex patients depends on expertise, not just capacity**.

Safe care for complex patients cannot be delivered with a workforce model designed solely for throughput. Explicitly funding expertise makes senior clinical judgment visible, protects decision-making capacity at the point of care, and reduces the moral injury that arises when clinicians are asked to manage unmanageable risk without adequate support.

Bringing the Models Together

These four models are not mutually exclusive.

In practice, they work best when layered:

- Complexity-adjusted funding pays for harder work
- Bundles align care across settings
- Incentives reward coordination and outcomes
- Workforce funding protects capability

Together, they form a **coherent funding strategy for modern emergency care**.

Conclusion: Funding Reality, Not Rhetoric

Emergency Departments are doing the most complex, risky, and coordination-heavy work in the health system. Funding models that treat them as high-volume transactional services are no longer fit for purpose.

Reform does not require tearing the system down. It requires:

- Naming complexity
- Paying for it explicitly
- Aligning incentives across care
- Protecting the workforce that carries the risk

If EDs are doing the hardest work in the system, funding must stop pretending they are doing the simplest.

Acknowledgements

This white paper is intended to support policymakers, health executives, and system leaders seeking practical, evidence-aligned pathways to ED funding reform in Australia. It was developed by the Australian Institute of Health Executives, and reflects our commitment to advancing a healthcare system that is safe, effective, accountable, and financially sustainable.

For enquiries please contact: enquiries@aihexec.com