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AMA submission: Outcomes of the COAG Meeting held on 1 April 2016

The AMA provides this submission with respect to item 2 of the Committee's terms of reference: the outcomes of the COAG meeting held on 1 April 2016 in relation to hospitals funding.

COAG hospital funding agreement to 2020

In relation to hospital funding, COAG reached a Heads of Agreement for public hospitals funding from 1 July 2017 to 30 June 2020 ahead of consideration of longer-term arrangements.

The AMA understands that this agreement involves the Commonwealth providing an estimated additional $2.9 billion in funding for public hospital services, with growth in Commonwealth funding capped at 6.5 per cent a year. Elements of the existing system, including activity based funding (ABF) and the national efficient price (NEP), are preserved under the agreement.

From 1 July 2017 to 30 June 2020, the Commonwealth will fund 45 per cent of the efficient growth of activity based services, subject to a cap in the growth of overall Commonwealth funding not to exceed 6.5 per cent a year. The details of this cap will be determined by December 2016.

States will continue to determine their contribution for public hospital services and will meet the balance of costs over and above the Commonwealth contribution. States have agreed to maintain their current levels of funding for public hospitals.

All jurisdictions also agreed to take action to improve the quality of care in hospitals and reduce the number of avoidable admissions, by:

- reducing demand for hospital services through better coordinated care for people with complex and chronic disease;
- improving hospital pricing mechanisms to reflect the safety and quality of hospital services by reducing funding for unnecessary or unsafe care;
- reducing the number of avoidable hospital readmissions; and
- reforms to primary care to reduce potentially avoidable hospital admissions.

Jurisdictions committed to develop, and begin to implement, these reforms by 1 July 2017.

Rationale for Commonwealth public hospital funding reductions

The Commonwealth Government's ongoing justification for its extreme health savings measures, including its cuts to public hospital funding, has been that Australia's health spending is unsustainable.

This is simply not substantiated by the evidence.

The Government's own health expenditure figures (2013-14)[1] show that health spending grew by 3.1 per cent in 2013-14. This is almost 2 points lower than the average growth over the last decade (5 per cent), but more than the 1.1 per cent growth seen in 2012-13, which was the lowest annual growth since Government began reporting it in the mid-1980s.

There have now been two years where growth in health expenditure has been well below the long-term average annual growth of 5 per cent over the last decade.

Clearly, total health spending is not out of control. The health sector is doing more than its share to ensure health expenditure is sustainable.

Despite this, the growth in Commonwealth funding for public hospitals in 2013-14 was just 0.9 per cent, well below inflation and virtually stagnant. This is off the back of a 2.2 per cent reduction in Commonwealth funding of public hospitals in 2012-13.

Long term hospital funding agreement from 2020

The AMA also understands the agreement made by COAG on 1 April will form the basis of negotiations leading towards a time-limited addendum of the National Health Reform Agreement to commence on 1 July 2017, ceasing 30 June 2020. This agreement will be developed by the Commonwealth and all jurisdictions and will be considered by COAG before September 2018.

Reaction to the COAG agreement of 1 April

The AMA notes that while the States and Territories appear to have accepted the additional funding offered by the Commonwealth, in most cases they have also made very clear that the funding is not enough, arguing for the full amount of education and health reductions in the 2014-15 Budget to be restored. The specific effects of the new agreement for smaller States and Territories in particular is uncertain.

The AMA believes the COAG agreement is an inadequate short-term public hospital funding down-payment to appease desperate States and Territories ahead of the Federal election. It is an inadequate agreement that will not be sufficient to meet current and future demand for services which will put lives at risk.

The AMA has consistently argued Australia's public hospitals are under pressure and are not meeting key performance benchmarks, as clearly shown in the AMA's 2016 *Public Hospital Report Card*[2].

[1] Australian Institute of Health and Welfare, *Health expenditure Australia 2013-14*
[2] Australian Medical Association, *Public Hospitals Report Card 2016*

The Report Card shows that, against key measures, the performance of our public hospitals is also virtually stagnant or in many cases declining. This is the direct effect on patient care of reduced growth in hospital funding and capacity.

The most recent data shows waiting times are largely static, with only very minor improvement. Emergency Department (ED) waiting times have worsened. The percentage of ED patients treated in four hours has not changed, and is well below target. Elective surgery waiting times and treatment targets are largely unchanged. The ratio of public hospital beds to population has also deteriorated.

The Commonwealth's funding cuts are already having a real impact as a result of almost $2 billion being cut from programs to reduce emergency department and elective surgery waiting times.

The additional funding agreed at COAG will help relieve some pressure, but will not be sufficient to meet the demand for services. Data published by the independent Parliamentary Budget Office shows that funding under the original National Health Reform Agreement would have delivered $7.9 billion in additional funding to June 2020 *(PBO Submission to Senate Select Committee on Health)*. Both major parties committed to continue health and hospital funding at that level before the 2013 election.

Providing a small amount of additional funding for three years goes nowhere near meeting the long term needs of the nation's public hospitals, and falls well short of replacing the funding taken away from the States in the 2014 Federal Budget. Funding certainty is required for at least the next decade for public hospitals.

Implications of the COAG agreement

<u>For patients</u>

At current public hospital funding levels, 32 per cent of people presenting to an Emergency Department who are classified as 'Urgent' are not seen within the recommended time (30 minutes). Doctors will always do the best they can by their patients. But because of chronic underfunding the system as a whole simply isn't able to meet the demand.

For a patient requiring urgent attention for abdominal pain, this could mean they are seen one to two hours after they present to ED. Their symptoms could be consistent with indigestion or could be a perforated bowel. The quicker a doctor can see them and make a diagnosis, then the quicker they can receive relief from their pain and prevent their condition deteriorating, potentially to a very serious situation. It is precisely patients like this who will not be seen in a timely manner because of underfunding.

Currently patients requiring elective surgery wait 35 days (at the median). This has already blown out more than 22 per cent compared to 15 years ago. Only 78 per cent of people having elective surgery receive their treatment in the clinically recommended time.

A real life example of what this could mean is an older patient waiting well beyond the clinically recommended time for elective hip replacement surgery who has a fall at home and fractures her hip. She will inevitably be taken by ambulance to an ED where she will undergo

emergency surgery to replace her hip. In these circumstances her surgery is more expensive and far more disruptive to the system. Of course it is also more stressful to the patient, also leading to a longer and often only partial recovery.

Continuation of Activity Based Funding – 2017-2020

ABF arrangements will be maintained over this period. The Commonwealth contribution to public hospital funding will be determined using ABF and the NEP, multiplied by 45 per cent (or a lower rate if the funding cap of 6.5 per cent growth is reached). The Independent Hospital Pricing Authority (IHPA) will continue to set the NEP and NEC and the single national health funding pool arrangements will continue. The continued use of ABF is clearly preferred to the Commonwealth's original decision to switch to annual indexation by CPI and population growth, however, ABF and the NEP as currently implemented have shortcomings.

The AMA has advocated the following shortcomings of ABF and the NEP as currently implemented should be addressed:

- omitting appropriate regard to quality, performance and outcomes;
- locking in the historically low costs of an underfunded and underperforming system;
- focusing on reducing costs to the lowest common denominator; and
- providing inadequate indexation through the NEP methodology.

Funding of other reform initiatives

Based on a draft of the COAG Heads of Agreement it appears possible that $70 million per year will be 'retained' from public hospital funding for the chronic disease coordinated care trials.

In addition, resources for the two following reforms are not yet specified:

- the ACSQHC will develop a model to integrate quality and safety into hospital pricing; and
- the Commonwealth will work with states, territories, ACSQHC and IHPA to develop a funding model that incorporates a mechanism to reduce avoidable readmissions.

More detail on these initiatives is required, but it is recommended that such matters should be funded in their own right **if they are worthwhile**, and not by retention of public hospital funding.

For example, penalising hospitals financially for not meeting safety and quality standards is counterproductive. Inadequate resource levels are a key factor in poor safety and quality and further reducing resources to hospitals further compounds existing problems. The AMA, hospital clinicians and hospitals are actively engaged in the need to reduce hospital acquired complications and associated readmissions.

Whilst it remains unclear how the Commonwealth's primary care trials will be funded and why the final Heads of Agreement omitted any reference to $210 million in reduced hospital funding, it is a nonsense to suggest that by putting a small amount of money into primary care there will be a significant reduction in hospital presentations, especially when hospitals already cannot meet the demand for services.

What is needed for public hospital funding – key points

Rather than a short term fix that is both inadequate for public hospital needs and postpones a long term solution to public hospital funding, the AMA believes there is a clear need for:

- significant new investment in public hospital funding, with reinstatement of the reductions to the NHRA funding as an upper benchmark;
- a long term plan that provides certainty of sufficient funding for at least a decade, and removes hospital funding from vulnerability to the short term political cycle;
- essential improvements to ABF and the NEP process, as consistently identified and advocated by the AMA;
- detailed information on proposed reform initiatives referred to in the 1 April Agreement, and clear confirmation they will be funded in their own right, not by diversion of scarce public hospital funding;
- public understanding of the impact of chronic under-funding for public hospitals, expressed in terms of practical clinical examples and case studies that are directly accessible to the general public.

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