Inquiry by the References Committee into the Implementation of the National Health Reform Agreement

NSW GOVERNMENT SUBMISSION

Terms of Reference for the Inquiry

That the following matter was referred to the Finance and Public Administration References Committee for inquiry and report by 7 March 2013:

Implementation of the National Health Reform Agreement with regard to recently announced reductions by the Commonwealth of National Health Reform funding for state hospital services, in particular:

(a) the impact on patient care and services of the funding shortfalls;

(b) the timing of the changes as they relate to hospital budgets and planning;

(c) the fairness and appropriateness of the agreed funding model, including parameters set by the Treasury (including population estimates and health inflation); and

(d) other matters pertaining to the reduction by the Commonwealth of National Health Reform funding and the National Health Reform Agreement.

A. EXECUTIVE SUMMARY

Council of Australian Governments (COAG) Health Reform Principles

In August 2011 the States and the Commonwealth entered into an historic National Health Reform Agreement (NHRA) in which the Commonwealth and the States will work in *partnership* to improve the health outcomes for all Australians, ensure the sustainability of the Australian health system, introduce new financial and governance arrangements for primary health care and aged care *and, as set out in the agreement,* to work in *partnership* to implement new arrangements for a nationally unified and locally controlled health system.

The key objectives agreed to by all Governments under the NHRA include:

- Ensuring the sustainability of funding for public hospitals by increasing the Commonwealth's share of public hospital funding through an increased contribution to the costs of growth;
- Improving patient access to services and public hospital efficiency through the use of activity based funding;
- Improving the transparency of public hospital funding through a National Health Funding Pool and a nationally consistent approach to activity based funding;
- Improving performance reporting and improving accountability;
- Improving local accountability and responsiveness to the needs of communities through the establishment of Local Hospital Networks and Medicare Locals; and
- Improving the provision of general practitioner (GP) and primary health care services through the development of an integrated primary health care system and the establishment of Medicare Locals.

Commonwealth health funding for the States: Delivering on the NHRA commitments

Sustainable Commonwealth funding is critical to the delivery of the reforms over the life of the NHRA.

The Commonwealth's fundamental strategic commitment made in signing up to the NHRA is to the delivery of funding "*to ensure the sustainability of funding for public hospitals by increasing the Commonwealth's share of public hospital funding through an increased contribution to the costs of growth"* including:

- Additional growth funding of $16.4 billion between 2014-15 and 2019-20;

- A commitment that no state will be worse off in the short or long-term because they will continue to receive at least the amount of funding they would have received under the National Healthcare Specific Purpose Payment and their share of the $3.4 billion in funding available under the NPA on Improving Public Hospital services;
- An annual state-specific guaranteed proportion each year during the period from 2014-15 to 2019-20;
- A commitment to "maintenance of effort".

Commonwealth government support is provided through two significant tranches of funding to the States:

- *National Health Reform Funding*: Prior to the NHRA the Commonwealth provided health funding to the States through the National Healthcare Specific Purpose Payment. From 1 July 2012, the National Healthcare SPP was replaced with National Health Reform funding.
- *National Partnership Agreements (NPA):* This second critical tranche of Commonwealth health funding is provided through National Partnership Agreements to alleviate key pressure points to help meet the growing demand for hospital services.

However, the levels of both tranches of funding for NSW are now being significantly reduced or are likely to be reduced simultaneously by unilateral Commonwealth funding decisions. These funding decisions are at odds with the commitments required by the NHRA, place implementation of the NHRA at risk, and undermine the capacity of the States and local health services to deliver better patient outcomes.

Reduced National Health Reform Funding

The Commonwealth unilaterally reduced NSW National Health Reform funding by $641 million over four years in October 2012, as part of its Mid-Year Economic and Fiscal Outlook (MYEFO) for 2012-13. By selecting health as a target for budget cuts during the current 2012-13 to 2014-15 transition period, the Commonwealth has effectively shifted additional costs to States. (see Table 1) The impact of the National Health Reform funding reduction for NSW is compounded in 2012-13, because the Commonwealth clawed back $49 million funding it had provided to NSW in 2011-12 that NSW had already spent on patient care, and because the reduction has been imposed half way through 2012-13.

Having put new national health funding and governance arrangements in place to improve transparency of funding, it is regrettable that the Commonwealth has not effectively engaged with the States to redress this cut to National Health Reform funding and negotiate an outcome that ensures sustainability of funding for public hospitals.

This significant funding reduction to NSW's National Health Reform funding is based on a Commonwealth determination that there had been lower population and health price growth. The NSW Government is most concerned about the methods used to determine the reduction in the level of national health reform funding. The Commonwealth has used a rebasing of population estimates by the Australian Bureau of Statistics (ABS) due to the 2011 Census. By comparing the rebased ABS population data with prior population estimates that had not been rebased, the Commonwealth has effectively assumed there was no population growth in NSW over 2011-12.

It has also become evident that the health price index used to index Commonwealth payments, although based on the formula set out in the Intergovernmental Agreement on Federal Financial Relations, is no longer appropriate and does not reflect the true price impacts on public hospitals.

Reduced National Partnership Agreement Funding

NSW is at risk of losing approximately $350 million per annum in NPA payments over the next two years.

The funding under the Health and Hospital Workforce NPA, worth $126 million in 2012-13, will terminate in just five months on 1 July 2013. A further $220 million in cash payments will be lost from the termination of

the NPAs on Improving Public Hospitals and Longer Stay Older Patients from 1 July 2014. NSW will need to consider how services can be continued without this Commonwealth funding (see Table 4).

The Commonwealth Government has given insufficient attention to the need to review the overall performance of the NPAs in moving the system towards the national health reform goals. Regrettably the Commonwealth is allowing its substantial financial support for these funding vehicles for reform to lapse - without careful consideration of the consequences for sustainable frontline service delivery.

NSW is especially concerned that requests by States to the Commonwealth to confirm continuation of NPAs have not been addressed and there is no certainty of Commonwealth funding required to maintain the additional services funded under the Health and Hospital Workforce Reform, Improving Public Hospitals and Longer Stay Older Patients NPAs.

Adverse Implications of Commonwealth Government funding reductions on NSW frontline health services

The adverse Commonwealth health funding decisions outlined above have significant implications for NSW, especially for the NHRA transition years from 2012-13 to 2014-15. They have the potential to undermine implementation of the patient and service delivery objectives set out in the NHRA and without greater certainty and stability in funding from the Commonwealth, NSW will be hard pressed to limit the impact on patient services from cuts to Commonwealth funding.

While the NSW Budget has absorbed the cut to National Health Reform funding in 2012-13 in order to minimise any immediate impact on patient care, the deterioration in revenue has put additional pressure on the state budget position and this will need to be addressed during the 2013-14 State Budget. NSW will find it harder to meet growth in health services because it has to fill a funding gap over the transition period from 2013-14 to 2014-15 if the Commonwealth does not deal with the problem of terminating NPAs.

The Commonwealth funding decisions mean, in effect, that the Commonwealth guarantee of additional growth funding above the previously agreed indexation, will not be contributing to NSW growth funding until 2016-17, rather than from 2014-15 as the provided for under the NHRA.

For NSW the Commonwealth funding shortfall will be over $300 million over two years with a shortfall of approximately $129 million in 2013-14, and $175 million in 2014-15. This creates a significant gap between the policy intent of the NHRA and the actual growth funding public hospitals will receive. It will effectively jeopardise the benefits promised under this major national health reform program and affect the care of patients.

As a result of these Commonwealth funding decisions, the additional National Health Reform growth funding that the Commonwealth has promised from 2014-15 above previously agreed indexation, will first have to be used by the NSW to fill the Commonwealth funding reductions imposed in 2012-13, and then be used to replace the NPA funding scheduled to terminate over the next two years.

While the NSW Government has provided additional growth funding, this state funding growth is intended to meet new cost and demand pressures, rather than fill the gap created by terminating NPAs. Effectively the Commonwealth has shifted much of the cost of its commitment to fund growth to the States.

The combined impact of the National Health Reform funding reduction by the Commonwealth, the termination of NPA funding, the uncertainty regarding the Improving Public Hospital Services NPA, and additional uncertainty concerning the scope of Commonwealth funding under the NHRA, is to create a significant risk for future service delivery, for maintaining the momentum of health reform, and for collaboration between the Commonwealth and State Governments.

In these circumstances, the NSW Government will find it harder to achieve the key strategic objectives of the NHRA, including improved access to services and public hospital clinical efficiency, at the same time as Commonwealth funding is reduced.

Section B provides further detail on the key areas of concern to NSW.

B. SUBMISSION ON THE TERMS OF REFERENCE

1. Commonwealth National Health Reform Funding Reductions for State Hospital Services

States signed up to the NHRA on the understanding that:

- All States will receive additional Commonwealth funding for public hospitals, relative to the former National Healthcare Specific Purpose Payment (SPP) from 2014/15, although no new funding is provided under the agreement in 2012/13 and 2013/14.
- No State will be worse off in the short or long term, because States will continue to receive at least the amount of funding they would have received under the former National Healthcare SPP and their share of the $3.4 billion in funding available through the NPA on Improving Public Hospital Services.

However in October 2012, as part of its Mid-Year Economic and Fiscal Outlook for 2012-13 (MYEFO), the Commonwealth unilaterally announced a reduction in the National Health Reform funding to NSW by a total of $641 million over four years due to a Commonwealth determination that there had been lower population and health price growth.

Table 1

Financial impact of Commonwealth's adjustments to NSW National Health Reform Funding ($000)					
	2012-13	**2013-14**	**2014-15**	**2015-16**	**Four years**
	-138,752 (a)	-144,570	-166,893	-191,018	-641,233

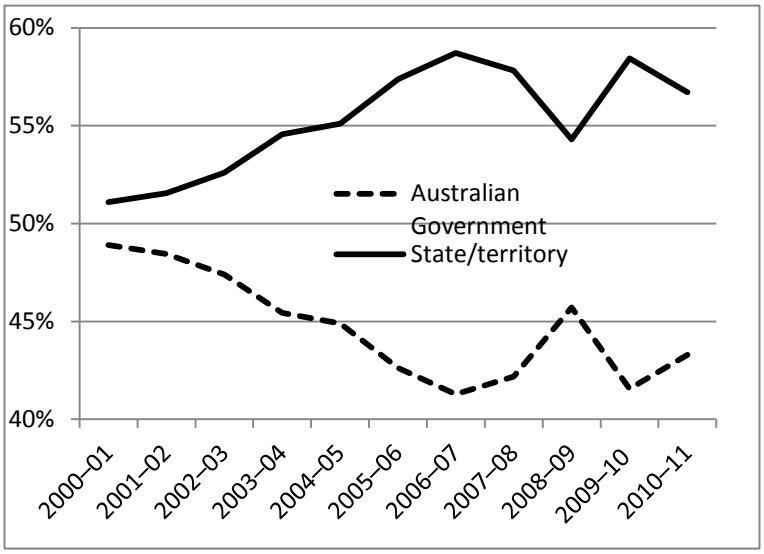
(a) The 2012-13 reduction includes $48.89m clawback of the 2011-12 Healthcare SPP

During the transition years of 2012-13 and 2013-14 before additional growth funding commences in 2014-15, the Commonwealth agreed to escalate the base funding for National Health Reform payments by growth factors used for the former National Healthcare SPP.

These growth factors were included in the Intergovernmental Agreement on Federal Financial Relations (IGAFFR) signed by COAG in 2008. The growth factors are based on a five-year average of the Australian Institute of Health and Welfare (AIHW) health price index, growth in Australian population estimates weighted for hospital usage, and a technological growth factor of 1.2 percent. These growth factors were intended to address a historic decline in the share of Commonwealth funding for public hospitals. The most recent AIHW Health Expenditure report shows that the Commonwealth share of government funding of public hospitals in Australia had declined from 49 percent in 2000-01 to only 41 percent by 2006-07. The Commonwealth share of government funding of public hospitals increased temporarily in 2008-09 but fell back to 43 percent in 2010-11 as shown in the following table.

Table 2

Funding of public hospitals - share of government funding



Source: AIHW Health Expenditure

Treasuries agreed that adjustments for these growth factors for each financial year would be based on the latest data available on 30 June of the year. NSW accepts that adjustments are required in accordance with the IGAFFR. NSW does not accept the method used by the Commonwealth for the 2011-12 adjustment as it is based on an incorrect application of ABS population data and is inconsistent with the undertakings under the NHRA that "no State will be worse off in the short or long term".

It would also be desirable to have information on the basis for the weights for hospital utilisation used to calculate the population estimates for growth purposes. Although the Commonwealth has not made available any information on its calculation of population weights, it is understood the weights are developed by the Department of Health and Ageing for the ABS based on the National Hospital Cost Data Collection, and it is understood that the specific contribution of hospital utilisation weights in 2011-12 was about half that used in the prior two years. However, no information has been provided to States on the rationale for this reduction.

The remaining reduction determined by the Commonwealth in the 2012-13 MYEFO is mainly due to the very low level of health price inflation of 0.9 percent that the AIHW reported for 2010-11. This rate has little relationship to the cost and wage pressures that are being experienced by public hospitals or the hospital price indexation determined by the Independent Hospital Pricing Authority (IHPA). The issues associated with the Commonwealth approach are outlined in more detail in Section 2.

2. Fairness and appropriateness of the agreed national health funding model, including parameters set by the Treasury (including population estimates and health inflation)

The Commonwealth decision to reduce its National Health Reform funding is based on inappropriate population and pricing measures. It raises fundamental concerns about how population growth is calculated and applied, whether the hospital utilisation weights are calculated appropriately, using relevant data, whether the most appropriate measure of health price inflation is used to grow National Health Reform funding, and whether the Commonwealth approach to National Health Reform funding reflects the principles agreed when States signed up to the collaboration embodied in the NHRA.

2.1 Inappropriate use of ABS population data to determine a lower population growth rate and thereby lower National Health Reform funding

In calculating the 2012-13 MYEFO it is understood that the Commonwealth incorrectly used the ABS population statistics and did not take account of the advice of the ABS on the appropriate use of the December 2011 population estimates released on 20 June 2012.

In calculating National Health Reform payments, the Commonwealth compared the December 2010 population estimate based on the 2006 Census with the December 2011 estimate based on the 2011 Census which included a downward revision of 294,000 for Australia (90,700 of which were from New South Wales). This revision was due to an unusually large "intercensal" error caused by improvements the ABS made to the Census Post Enumeration Survey.

Under the Commonwealth approach the Australian population grew by only 0.03 percent in 2011, while the populations of NSW, Victoria, Queensland and South Australia all fell because of "intercensal error". But the Commonwealth's method is inconsistent with the advice of the ABS, which recommended that for the population level for the 2006-2011 period, the rebased series for 2006-11 is the best series to use and that for population growth over the same period, the comparison should focus on the components of growth (births, deaths and migration). (ABS 3101.0, Dec 2011, p69). The ABS has since advised that this unusually large intercensal error will be distributed over the last 20 years of population data and will issue a revised historical population series reflecting this in June 2013.

Had the ABS recommended approach been adopted a population growth of 1.5 percent in 2011 would have been recognised, Commonwealth National Health Reform funding would not have been reduced inappropriately.

NSW believes the Commonwealth should recalculate funding entitlements for the 2011-12 determination of payments based on the ABS advice to focus on the components of population growth when calculating growth in population.

2.2 National Health Reform Funding – Price Indexation

The NHRA aims to ensure a sustainable level of public hospital funding. The sustainability of public hospital funding depends on indexation keeping pace with the cost and wage pressures. While States agreed to a hospital price indexation based on the AIHW health price index, they did so with a reasonable expectation the index would reflect the underlying cost pressures on the hospital system. This is not the case with the most recent index.

The Commonwealth has adjusted National Health Reform funding for 2012-13 and forward National Health Reform funding projections based on a simple average of the last five years growth in the AIHW health price index. In 2010-11 (the latest year available), AIHW health price inflation slowed to 0.9 percent, from 2.4 percent in 2009-10. As a consequence the five year average went down from 3.1 percent to 2.3 percent.

This price indexation for 2010-11 is inconsistent with the cost and award increase experienced in public hospitals, and with the 5.1 percent indexation of hospital costs used by the IHPA in its 2012-13 National Efficient Price determination.

Previously the Healthcare SPP allowed States to use the funding across the entire health sector, including for capital purposes, and a broad based measure of inflation such as the AIHW index was appropriate. This is no longer the case. National Health Reform funding is limited to the public hospital services as defined by the IHPA and excludes capital funding. It is therefore no longer appropriate to index National Health Reform payments by the AIHW health price index which applies more broadly to all forms of health expenditure, including price movements for capital and recurrent expenditure for governments and individuals.

More than half of the AIHW price index is based on price increases which have little, if any, bearing on public hospital recurrent expenditure. This includes Medicare medical services fees, capital expenditure, and household expenditure on chemist goods and dental services, which have all benefited from the slowing in

price growth largely due to the impact of Australian dollar appreciation on prices of imported medical equipment and supplies. For example the slowing in growth appears to be due to the impact of Australian dollar appreciation, which has led to a 20 percent reduction in expenditure on medical supplies and a 1.5 percent reduction in pharmaceutical expenditure. On the other hand, wage costs which account for a significant portion of public hospital expenditure, have been growing by at least 2.5 percent per year.

Growth in National Health Reform Funding should use a more appropriate price index focused on public hospital service expenditure.

2.3 Scope of Commonwealth Funding for Public Hospitals

Under the NHRA, the IHPA will make a recommendation regarding the scope of Commonwealth funding for hospital services before 30 June 2013.

The Commonwealth has made submissions to IHPA to limit the scope of Commonwealth funding for hospital services in States. In a recent submission to IHPA the Commonwealth advised: "Any broadening of scope is likely to lead to an increased fiscal commitment for the Commonwealth. It is therefore appropriate that the Commonwealth be given the opportunity to review the list of services proposed by States to be in scope, and to ask the IHPA to further review services of concern".

A key concern is that State and Territory hospital services such as outpatient mental health services, rural outreach services, hospital avoidance services, and other services that could reasonably be considered hospital services, will not receive National Health Reform funding as envisaged. If the scope of National Health Reform funding is narrow, as suggested by the Commonwealth, it may have the effect of cost shifting to the States because services funded by the Commonwealth SPP may no longer receive Commonwealth funding. The Commonwealth does not acknowledge that there is another perspective – that any reduction in scope is likely to lead to an increased fiscal commitment for the States. The independent role of the IHPA as an expert decision maker in determining scope is therefore particularly critical.

Another key concern is the impact on acute and emergency department presentations and hospital costs, which will follow from inappropriate constraints to Commonwealth funding for hospital services delivered in community care settings. It would be useful to know if the Commonwealth has modelled the impact on the levels of emergency department presentations caused by a lack of out-of-hospital community based services arising from limiting the scope of Commonwealth funding.

3. Impact of the timing of the changes to Commonwealth National Health Reform Funding on hospital budgets and planning, and impacts of the funding reductions on patient care and services

The timing and magnitude of the changes to Commonwealth funding are outlined in the following table. While the NSW government budget has absorbed the $138.8 million reduction in 2012-13, the magnitude of the challenge is to adjust to the $641 million reduction over four years, which will influence the outcome of the 2013-14 NSW State Budget.

Table 3

Commonwealth SPP/National Reform Payments	$M	$M	$M	$M	$M
	2011-12	2012-13	2013-14	2014-15	2015-16
2012-13 Budget	4,137.8	4,381.2	4,608.2	5,079.7	5,589.5
2012-13 MYEFO	4,137.8	4,242.4	4,463.6	4,912.8	5,398.5
Change		-138.8[1]	-144.6	-166.9	-191.0
Change due to population revisions		*-98.2*[1]	*-49.0*	*-48.8*	*-48.2*

(b) The 2012-13 reduction includes $48.9m clawback of the 2011-12 Healthcare SPP

Of the $138.8 million reduction in National Health Reform funding in 2012-13 resulting from the MYEFO adjustments by the Commonwealth, $48.9 million is actually a claw back of the Commonwealth SPP payment for 2011-12. The money allocated in 2011-12 has already been spent on essential health services, and equates to more than 1500 cardiac bypass procedures, 2600 hip replacements or around 900 kidney transplants.

This Commonwealth approach (that permits major funding adjustments during the budget year and claws back funding from a prior year) undermines the State and Local Health District (LHD) budget processes and planning to support frontline services and keep the system safe and sustainable.

The NSW Health budget is set as part of annual budget process with the NSW State Budget released in June based on advice from the Commonwealth in its May Budget. LHD budgets are developed at the same time with activity and budget linked to service agreements signed in July, following the State Budget. Frontline service activity and performance targets are calculated based on the funding agreed and provided through the National Health Funding Pool set up as agreed in the NHRA.

The Commonwealth decision to reduce NHRA funding from 2012-13 has resulted in an unanticipated and unjustified reduction in Commonwealth funding in 2012-13 and forward years, particularly when reductions are made after State and Territory budgets have been settled and LHDs funded based on National Health Reform funding set out in the May Commonwealth Budget Statement. This unilateral Commonwealth reduction impacts directly on the funding capacity of NSW Health and the LHDs to meet the frontline services agreed in the State Budget. The NSW Budget has absorbed this cut in 2012-13 but it raises funding risks for the State and for the LHDs, and it will have an impact on NSW's ability to respond to growth in frontline services from 2013-14 unless it is reversed.

4. Other matters pertaining to the reduction by the Commonwealth of National Health Reform funding and the National Health Reform Agreement

4.1 National Partnership Agreements (NPAs) - Combined Impacts on Budgets, Planning and Patient Services of the National Health Reform Funding Reduction and NPA Termination and Uncertainty

Although the National Health Reform Agreement makes it clear that continuation of Commonwealth funding is an option once any NPA expires, Commonwealth funding from NPAs is at risk and the continuation of Commonwealth funding is uncertain, affecting the ability of States to plan and budget for health services.

NPAs have provided critical funding for important health services which are core to national health service reforms such as subacute services, and services in Emergency Departments. This funding and the services it delivers, has raised jurisdictional service delivery levels to meet national objectives, and enabled jurisdictions to embed better, more efficient evidence-based models of patient care, and to continue to improve service delivery.

The outcomes of actions under the NPAs on Health and Hospital Workforce Reform, Improving Public Hospital Services, and Long Stay Older Patients provide strong evidence for the effectiveness of the programs in lifting activity levels and elevating outputs, and for improved patient care. Increased service levels achieved in areas such as subacute care and Emergency Departments provide the bedrock for the significant National Health Reforms agreed in 2011. Commonwealth NPA funding for sub-acute beds and services has resulted in the expansion of services by over 20 percent,

Attachment A provides a case example of the direct frontline subacute services provided in the South East Sydney LHD by the Health and Hospital Workforce Reform and Improving Public Hospital Services NPAs. This example shows how NPA funding enabled an additional 460,000 occasions of subacute care over three years in one NSW LHD alone.

NSW will experience significant funding gaps for these services from 2013-14 onwards following the expiry of two major NPAs. At this stage funding for the NPA on Health and Hospital Workforce Reform will cease on 30 June 2013, while funding under the NPA on Improving Public Hospital Services will cease on 30 June 2014 (apart from a small amount of high risk reward funding). Funding under the NPA on Long Stay Older Patients also concludes on 30 June 2014.

Table 4

IMPACT OF EXPIRING NATIONAL PARTNERSHIP AGREEMENTS

	$ million	$ million	$ million	$ million	$ million	$ million
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**
National Partnership Funding Flow by year for frontline health services						
Health and Hospital Workforce Reform[1]	118	126	Terminated	Terminated	Terminated	Terminated
Improving Public Hospitals[1]	127	152	191	Terminated[1]	Terminated[1]	Terminated
Long Stay Older Patients	29	29	29	Terminated	Terminated	Terminated
Total NP Funding Flow	**274**	**306**	**220**	**0**	**0**	**0**
Total terminated NP funding (with 2.5% indexation)			129	358	367	376
Total NHR Guaranteed growth funding for the year (NSW Estimates)				183	385	621
Annual Funding Gap = Total Terminated NP Funding less Guaranteed Growth Funding (2.5% indexation pa from 2013/14)			129	175		
Annual Funding Benefit = Guaranteed Growth Funding less Total Terminated NP Funding					18	245

1. *Estimates are on a recurrent expenditure basis and exclude capital expenditure. The expenditure in any given year may differ from the Commonwealth funding received because funds have been adjusted to match the expenditure profile required by NSW Health to meet its NPA obligations. All funding under the NPA on Improving Public Hospital Services finishes on 1 July 2014 except for a small amount of high risk reward funding.*

The table above shows NSW is at risk of a funding gap of $126 million for NPA services in today's dollars from 1 July 2014: a $126 million gap following the expiry of the Health and Hospital Workforce Reform NPA on 1 July 2013 and an additional $220 million gap from 1 July 2014 following the expiry of the Improving Public Hospitals NPA and the Longer Stay Older Patients NPA. Allowing for normal cost indexation of 2.5 percent pa, this represents a cumulative funding gap of $358 million for NPA services from 1 July 2014.

One option for NSW would be to use the Commonwealth guaranteed growth funding under the NHRA for what is essentially maintenance funding. However, this is not a viable option because there is no Commonwealth guaranteed additional growth funding available under the NHRA in 2013-14 to cover the gap in that year. Using the Commonwealth growth funding for 2014/15 would still leave a shortfall of $175 million as shown in the table above. In 2015-16, the guaranteed growth funding could cover the gap, but this would then leave just $18 million to fund increased demand for health services in that year.

The consequence of the funding gap and the use of the Commonwealth funds to replace terminating NPAs is the Commonwealth's growth guarantee to the States, the centrepiece of the NHRA which is scheduled to commence in 2014/15, will in effect not provide the additional growth funding promised to the State health systems until 2016/17 with States needing to invest their own growth funds to make up the shortfall.

This will mean that the States will be diverting State growth funds to maintain existing services established under NPAs. It will compromise the State's capacity to be able to adequately meet year on year critical growth pressures for both Emergency Departments and admitted services in each of the years 2013/14, 2014/15 and 2015/16, and to deliver on the performance targets that were negotiated at the same time as the NHRA.

It will also compromise the potential for NSW to meet emerging priorities and introduce new models of care, and NSW's ability to improve health outcomes for its citizens.

In this context, it is essential that the Commonwealth Government engages with States to assess and address:

- The combined impacts on frontline health services and State and Territory health budgets associated with the reduction in Commonwealth National Health Reform funding, the recent retrospective adjustment to SPP funding calculations, the impact of NPA terminations, and the impacts of price and indexation levels established by the IHPA.

- The sustainability of services and activities established under Commonwealth NPA funding.

- The impact on patients, activities and services of National Health Reform funding reductions and removing NPA funding for frontline acute, emergency, sub acute and mental health services funded under these agreements.

- The impact on the sustainability of the National Elective Surgery Targets (NEST) and National Emergency Access Targets (NEAT) established by the NPA on Improving Public Hospital Services when funding for recurrent surgery and Emergency Department services which is intended to help fund the clinicians and services to meet those targets ceases from 1 July 2014, and additionally whether the small amount of "reward funding" attached to those targets is unattainable as a result of the cessation of funding under the Health and Hospital Workforce Reform NPA.

4.1.1 Hospital and Health Workforce Reform (HHWR) NPA

Funding for the HHWR NPA will cease from 1 July 2013.

The HHWR NPA funding has lifted the base level of public hospital activity and system performance through increased supply, accessibility and quality of subacute care services, increased Emergency Department activity and improved waiting time performance for patients, increased supply, skills and productivity of health professionals and multidisciplinary teams, and enhanced capacity to implement activity-based funding for public hospital services. In NSW, Commonwealth funding has supported a substantial expansion of subacute beds, services and activities over the last five years.

For example, the aim of the funding for the subacute services component of the HHWR NPA was to reform and improve the volume and quality of subacute services. This aim built on the advice of the *National Health and Hospitals Reform Commission*, which saw subacute services as a fundamental element in redesigning our health system to meet emerging challenges. The Commission identified the inadequacy of subacute services in Australia and called for a substantial investment in and expansion of subacute services – the "missing link" in care.

The intended outcomes and outputs of the HHWR funding were clearly outlined in the NPA and in the subsequent NSW implementation plan. Essentially States were to expand service provision levels by 5 percent annually over the period 2009/10 to 2012/13. Performance indicators included measurement of patient

outcomes, quality and continuity of care, and efficiency. NSW achieved its target in 2009/10 to 2011/12, and is expected to pass the overall target of 20 percent by the end of 2012/13.

Continued Commonwealth funding is necessary to sustain the increased base levels of services and activities established under the NPA and upon which the national health reforms rely upon for success, particularly those components that have driven activity in a hospital setting. The capacity of States to deliver on the national health reforms will be significantly diminished without this funding if it is not replaced by national health reform funding or other NPA funding. If services are not sustained, this also will impact on States' ability to meet new access targets under the Improving Public Hospital Services NPA. The starting point attained by the HHWR NPA is also the foundation for the NPA on Improving Public Hospital Services. Both NPAs set very clear targets for subacute services. If the HHWR funding is not continued, the NPA on Improving Public Hospital Services will not deliver the anticipated benefits as the new targets under the IPHS NPA build on those already delivered under the HHWR NPA.

Major NSW reforms and services at risk when Commonwealth funding for the HHRW NPA ceases on 30 June 2013 include:

- Funding for community and hospital based palliative care and rehabilitation services.
- Funding to older people to leave hospital earlier - freeing up acute care beds.
- 69 short stay (<48 hour) Medical Assessment Unit beds treating around 17,000 patients per year.
- 8,300 Hospital in the Home packages.
- Contribution to salaries for Emergency Physicians.

The Commonwealth has given no indication if it will roll the funding under this NPA into the National Health Reform funding base or continue the NPA. States have unsuccessfully sought confirmation from the Commonwealth that the funding provided under this expiring National Partnership would continue. States have followed the clear process for reviewing NPAs as set out in the NHRA and other official documentation. However it is uncertain how this process will play out. The matter was put to COAG at its last meeting in December 2012, but not resolved.

Experience with the MYEFO funding reduction suggests the Commonwealth may expect States to manage the service impacts of terminating this NPA funding. Given the need to manage the impact on services, States have now had to prepare for and anticipate a loss of funding from the Commonwealth and are waiting for the Commonwealth Budget on 14 May 2013 to find out if NPA funding will be continued from 1 July 2013. NSW has approached the Commonwealth to initiate discussions at Treasury and Health Department level to get greater certainty over this funding.

Commonwealth funding and policy decisions concerning this funding are putting at risk the capacity of States to meet health performance standards agreed by COAG and to maintain the level of services put in place as a result of the NPA. If this NPA funding ceases and States are required to cover the Commonwealth funding gap, State growth funds will be diverted from other health service priorities including Emergency Departments and acute care services.

4.1.2 Improving Public Hospital Services NPA

While this NPA technically expires in 2016-17, the core program funding ceases on 30 June 2014, with only a small stream of reward funding available in 2015-16 and 2016-17. In 2013-14 Commonwealth funding to NSW under this NPA is $191.2 million, but this declines to only $31.6 million for high risk reward funding in 2015-16 and 2016-17.

Recurrent (facilitation) funding provided to States under the NPA ceases from 1 July 2014 unless the funding is rolled into the National Health Reform funding base and an appropriate adjustment made to the National Health Reform funding baseline. This will be dependent on the outcomes of a Commonwealth review of the

NPA required by the NHRA. The outcomes of the review must be considered by COAG by December 2013. At this stage the Commonwealth has not commenced its review of the NPA. This increases the risk that there will be insufficient evidence and time for the Commonwealth, through its Budget process, to agree on future funding to support the services established under the NPA.

The NPA has delivered very significant enhancements to NSW health services at the frontline such as 462 subacute care beds, which have enhanced access to services such as palliative care, rehabilitation and mental health. Assuming 90 percent occupancy and a 14-day average length of stay, 462 beds provide capacity for over 13,000 patients to access sub-acute services.

Major NSW reforms and service delivery implemented under the NHRA will be at risk if the Commonwealth does not extend the recurrent (facilitation) funding or roll it into the National Health Reform funding base. This includes funding for the subacute beds outlined above, funding for the clinical staff for acute, subacute and ED services that have improved access to essential surgical services and eased bed blockage across the public hospital system; and funding which has enabled improvements in ED activity levels and access.

The capacity for the State to meet current NEST and NEAT targets without this funding will also be compromised, and this in turn will increase the risk that NSW will not be able to meet the targets necessary to achieve the small amount of reward funding available under the NPA in 2015-16 and 2016-17. NSW's capacity to meet these targets will also be affected by the loss of Commonwealth funding for sub acute services delivered under the HHW NPA and the Long Stay Older Patients NPA.

4.1.3 Financial Assistance for Long Stay Older Patients NPA

It has long been acknowledged that there is a cohort of older people in hospitals beds who have completed their acute and sub-acute care and cannot be discharged from hospital until an appropriate Commonwealth subsidised aged care place is available (for example residential aged care services orcommunity packaged aged care services). In recognition of this inpatient cohort, the Longer Stay Older Patient (LSOP) initiative was agreed by COAG in 2006 and funded from 2006-7 to 2011-12. A third round of funding was made available through the NPA on Financial Assistance for Longer Stay Older Patients for the three years 2011-12 to 2013-14. This NPA expires on 30 June 2014.

In NSW these funds have been used to develop improved models of care to minimise the length of stay of older patients waiting for discharge to another form of care. A Commonwealth conducted census showed that, because of the concerted effort of both the Commonwealth and NSW, the numbers of older people waiting in public hospitals unnecessarily has decreased by half.

NSW specifically used these funds to expand its Aged Care Services in Emergency Teams program; to establish its Acute to Age-Related Care Services program; and to expand the COMPACKs program through the Hospital-2-Home. All of these services aim to improve the continuum of care for older people and to reduce the risk of extended lengths of stay in the acute care setting, including in the Emergency Department. Hence, LSOP funds have directly assisted the care and management of older people presenting to Emergency Departments, as well as the care of older inpatients waiting for Commonwealth-subsidised care services.

In NSW, a review of these services in 2011 demonstrated significant benefits to the hospital system with the potential to be a highly cost effective way of delivering quality aged care services in NSW hospitals for this target group. Analysis of NSW Health Emergency Department data also indicates the average length of stay for older people in NSW public hospital Emergency Departments has fallen since the introduction of LSOP Initiative funding.

Desirably any decision to terminate this NPA would be evidenced based, informed by knowledge of the reduction across Australia in numbers of older people waiting in public hospitals for residential support, and informed by modelling of the impact of ceasing the NPA on hospital inpatient services, and of the numbers of

residential aged care places in residential aged care facilities and in the community, required on a sustainable basis to maintain the reduction in long stay older patient numbers once funding to States ceases.

At this stage States have not seen any evidence to support termination of this funding. Nevertheless, there is no Commonwealth commitment to roll this funding into the National Health Reform Funding Base or extend the NPA. There also appears to be no Commonwealth strategy in place to address the needs of these clients if Commonwealth funding ceases, even though under the NHRA the Commonwealth has accepted responsibility for funding and policy for people aged 65 years and over (NHRA Clause F7).

The consequences of a cessation of Commonwealth funding or lack of an alternative Commonwealth strategy are likely to include:

- The continuum of care for older people will be adversely affected with likely increases in their lengths of stay in the acute care setting, including in the Emergency Department. With an increase in the length of stay in the acute care setting, including in Emergency Departments, unnecessary admissions may rise.
- The number of older people in public hospitals waiting for Commonwealth-subsidised care services (i.e. AARCS) will increase. More resources will be required as the cost structure of hospitals is higher than residential aged care facilities.
- There will be an adverse impact on service delivery across the hospital setting including increases in bed blockage in the public hospital system.
- The services at risk when the Commonwealth funding for this NPA ceases in 2014 are those that have resulted in 86,175 older people in NSW public hospitals referred to the Aged Care Services in Emergency Teams program, and 20,644 older people in NSW public hospitals referred to the Acute to Age-Related Care Services program.
- Higher costs in the health system to deliver care to the older people via the public hospital system, while they are waiting to be discharged home with Commonwealth aged care support or to an aged care facility.

These consequences will influence the States' ability to implement health reform initiatives and contradict other policy endeavours to divert patients from EDs and to meet the four-hour NEAT. The preferred position would be for the Commonwealth, in accordance with Schedule F of the National Health Reform Agreement, to permanently fund all patients over the age of 65 who are medically ready for discharge and who are waiting for another form of care.

4.2 Private Health Insurance - Cost Shifting to the States

The recent decisions by the Commonwealth in relation to Private Health Insurance also appear to be shifting costs to public hospitals.

For example, Medibank Private has recently reduced the benefits it will pay for members in State public hospitals. This has been done to reduce costs in response to MYEFO changes.

CONCLUSION

The NSW Government remains strongly committed to the principles, objectives and intent of the NHRA. The NSW Government is committed to this long-term strategic partnership agreed by all Australian Governments.

The recent Commonwealth funding decisions to reduce National Health Reform funding and the risk of funding under the NPAs ceasing creates strategic implementation risks for this important partnership.

The funding decisions undermine the strategic capacity of the States to address and respond to growth in the demand for and cost of health services, and to deliver improved health outcomes.

The NSW Government urges the Commonwealth Government to re-examine its funding decisions on National Health Reform funding, engage in urgent comprehensive negotiations with the States on the extension of National Partnership Agreement funding, and ensure that this important collaborative partnership can continue moving forward.

Attachment A:

Council of Australian Governments Subacute Programs – Rehabilitation – Inpatient Programs 2009/10-11/12
NSW Health South Eastern Sydney Local Health District

- http://www.seslhd.health.nsw.gov.au/COAG/Report_SESLHD_EvaluationCOAG_NationalPartnershipAgreementSubacuteInpatientRehabPrograms.pdf
- http://www.seslhd.health.nsw.gov.au/COAG/Report_SESLHD_OverviewCOAG_SubacuteNationalPartnershipAgreements.pdf