CENTRAL QUEENSLAND RURAL DIVISION OF GENERAL PRACTICE Assn. Inc.

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SENATE FINANCE AND PUBLIC ADMINISTRATION REFERENCES COMMITTEE

Response to the inquiry into the implementation of the National Health Reform Agreement

Central Queensland Rural Division of General Practice

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:

There is currently a threat to every rural hospital in Queensland, and potentially Australia, as a result of the recent health reform processes. The funding model, which is intended to drive efficient operation, has put smaller and more isolated hospitals in a position where they are unable to compete economically.

The Local Hospital Networks, or in Queensland – the Queensland Health and Hospitals Services Boards, are statutory authorities formed as a result of the health reform process. The Health and Hospitals Boards (LHN's) are now responsible for the management of hospital budgets. Evidence suggests that these budgets were already inadequate and had not been well managed. The impacts of the reduced Commonwealth funding to Central Queensland has led to the proposed closure of inpatient services in Moura. The establishment of a 'treat and transfer' centre operating from 7am to 9pm and 'on call' services overnight has been proposed by local Health and Hospitals board. Moura has a resident population of over 3,500 people with several large industries operating locally. The intent is that Moura is the first community where this will occur. It is also understood that progressively another 7 rural hospitals within the Central Queensland Health and Hospitals Services Board jurisdiction will be affected. These communities include Springsure, Theodore, Blackwater, Baralaba, Mt Morgan, Woorabinda and Yeppoon where there will no longer be overnight admission but 'treat and transfer' facilities to manage all acute care. This will leave 4 admitting hospitals – Rockhampton, Gladstone, Emerald and Biloela in Central Queensland.

In Queensland the Medical Superintendent with the Right to Private Practice model ensures there are Medical staff covering hospitals and providing General Practice services to rural communities. As small facilities become "treat and transfer" centres, it is clear that the need for the State to fund these positions is removed. Consequently, rural communities will be faced with the situation where all health services must be funded through Medicare or through private funding.

Under the current Hospital board plans, small rural hospitals will no longer admit patients for overnight care. As such, the Health and Hospitals Board (LHN) will no longer be required to manage Multi-purpose Health Services. At present these facilities frequently provide the only residential aged care, and community aged care, in many rural communities. There has been no consideration to the timing, or planning, for the transition of services currently provided by the

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Health and Hospitals Board (LHN) in rural communities to other organisations; or if indeed there is capacity for other organisations to take on these roles.

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

The proposed changes will mean people living in rural and remote communities have no access to overnight hospital admissions, ante-natal or post natal care, palliative care, and aged care. Surgical and obstetrics services have previously been removed from these communities, although they have been available in the past. Communities are being told it is the Commonwealth Health reform and shortfalls in Commonwealth funding that are driving the changes in hospital services.

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

The timing of the funding reductions and changes in funding formulas has led to quick fix responses. Hospital Boards (LHN's) have to close a hospital to meet the funding reductions. Changes in the Commonwealth / State funding models only gives growth on an efficient activity basis and does not protect smaller "community benefit" facilities. This has put all of the smaller rural hospitals at risk. Activity targets are set for the larger Activity Based (ABF) hospitals where to increase funding the activity targets also need to increase. Increased activity in rural hospitals is funded in block increases in activity (based on the efficient price). For many smaller rural hospitals it will be difficult, if not impossible, to move between the blocks on the currently used efficient pricing structure. Therefore to ensure there are sufficient funds and increasing revenue Health and Hospital boards must increase activity targets in larger hospitals. In this scenario, all the resources and patients are being transferred to the larger hospitals. As a consequence smaller rural communities are left with poor or extremely limited access to health services.

State and Federal Governments need to protect rural hospitals. State Government's historical funding levels must remain in the rural communities where they currently fund services. There needs to be a clear consultative process and explicit criteria against which service models can be reviewed and changed. Until this process occurs access to current services must be protected. Commonwealth funds need to recognise the additional services currently provided in rural communities. They must also provide incentive funding to reward increased access to health services. These incentives for example, could target a planned development of services in key areas such as palliative and aged care, obstetrics and child health, procedural services, step down and home based models of care.

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

The current funding formulas drive increased activity and are based on Weighted Activity Units. This ensures the increased activity is cost effective. The Weighted Activity Units, do not accurately reflect the costs associated with the provision of services in rural communities. Furthermore, and more importantly they do not protect access to services for rural people. The proposed formulas could see acute care services centralised to the regional centres with as few as 6 rural facilities continuing to provide inpatient services in Queensland. The health reform proposed the right care, in the right place, at the right time. Is it right rural residents travel for all admitted patient care when they currently have hospitals in their communities now?

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

The timing of the reform process, in conjunction with the lack of publicised funding models and guidelines, has led to the targeting of rural services to meet budget shortfalls. This is unacceptable and an immediate hold must be put on the process to protect existing services and to allow the rural communities, LHNs, State and Federal providers and other health and aged care service providers adequate time to plan new service models. Any service model must protect existing services. It must allow the development of services to meet the identified needs in communities

whilst operating within existing budgets. Many of the current services are not as cost effective as they could be. However, they do provide a huge variety of services to the communities. Naturally it will take time to develop more efficient, integrated, multi-funded models. By taking the time to do this well, it will ensure that rural communities continue to have access to the health services they need. The Federal Government needs to slow the timing of the cost reductions to allow these models to develop. There also needs to be policies and funding models developed to protect Australians access to health services in rural communities.