Chapter 5

Impacts on Victorian hospitals

If implemented, the return to a population based funding arrangement would dismantle cost-sharing arrangements…in service delivery terms this lost funding commitment equates to the volume of services that at least two tertiary hospitals the size of Melbourne Health [which runs the Royal Melbourne Hospital]…could be expected to produce over that 10-year period.[1]

Ms Kym Peake, Acting Secretary of the Victorian Department of Health and Human Services

Introduction

5.1 As outlined in Chapter 3, the Parliamentary Budget Office's (PBO) submission provided a detailed state-by-state breakdown of the difference in Commonwealth hospital funding between the government's policy announced in the 2014-15 Budget and the former government's hospital funding arrangements under the National Health Reform Agreement 2011. The government's 2014-15 Budget marked a fundamental policy shift away from the previous government's activity based funding model, which established a national efficient price for hospital services. Instead, it reverts to the former block funding model based on CPI and population growth.

State-wide impacts

5.2 It is clear from the PBO's figures that Victoria will suffer a decade of significant hospital funding shortages due to the government's abandonment of the carefully negotiated national health agreement.

5.3 Over the eight year period from 2017-18 to 2024-25, the PBO found that Victoria would have a total of $13.5 billion cut from its hospital funding due to the government's 2014-15 Budget.[2] The annual funding differences are set out in Appendix 4.

5.4 According to Victorian Health Department officials, these multibillion-dollar funding cuts to Victoria's health system equate to the closing down two major tertiary hospitals, like the Royal Melbourne Hospital. Ms Kym Peake, Acting Secretary of the Victorian Department of Health and Human Services explained that:

> But in its 2014-15 budget the Commonwealth announced…that it would no longer honour the funding commitments made in the National Health Reform Agreement, which Victoria estimates will cost it over $17.7 billion in Commonwealth funding over the next decade. From July 2017 the

1 Ms Kym Peake, Acting Secretary, Victorian Department of Health and Human Services, *Committee Hansard*, 4 November 2015, p. 38.

2 Parliamentary Budget Office, *Submission 191*, p. 5.

> National Efficient Price formula will be replaced by indexation based on CPI and population growth only. By excluding a component for utilisation growth and technology, this is forecast to deliver the lowest ever rate of Commonwealth funding growth for hospitals—4.3 per cent growth per annum based on recent CPI and population growth estimates.
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> If implemented, the return to a population based funding arrangement would dismantle cost-sharing arrangements that incentivise both levels of government to keep people out of hospital and drive efficiency. To give you a sense, in service delivery terms this lost funding commitment equates to the volume of services that at least two tertiary hospitals the size of Melbourne Health [which runs the Royal Melbourne Hospital]…could be expected to produce over that 10-year period.[3]

5.5 Dr Anthony Bartone, President of the Australian Medical Association Victoria echoed Ms Peake's analysis of the significance of the Commonwealth government's cuts:

> Victoria is being hit hard. Hundreds of millions of dollars are being ripped out of the hospital system, and Victoria, like other states, will have to choose between reducing services and redirecting funding from other areas to accommodate the substantial losses…
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> Figures from this year's budget show that Victoria is set to lose more than $320 million in 2016-17. Over the next decade, the reductions in funding will equate to some $17.7 billion lost to the state. Victoria's health budget this year is $15.2 billion. This is simply not sustainable. In 2012, Victoria had $107 million in funding ripped out of the system with immediate effect. Upwards of 200 staff lost their jobs. Hospital beds were closed. Elective surgeries were cancelled. Inevitably, waiting lists went up. Unfortunately, by the time these cuts were reversed the damage to the system had already been done. The state does not have the capacity to assume responsibility for funding cuts of this scale.[4]

5.6 Dr Bartone, contrasted the 2014-15 Budget cuts to an earlier $107 million funding reduction to the Victorian health service:

> …the system came almost to a halt when it came to elective surgeries. If we are talking something in the vicinity of $18 billion up to 2024, we can only assume that the system will not cope and that either something will have to give in the system or expenditure on other parts of the Victorian economy will have to be foregone to alleviate the pressure on health. It is certainly a bleak outlook for the Victorian patient waiting for care as we speak.[5]

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3 Ms Kym Peake, Acting Secretary, Victorian Department of Health and Human Services, *Committee Hansard*, 4 November 2015, p. 38.

4 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, 4 November 2015, pp 21–22.

5 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, 4 November 2015, p. 23.

5.7 Ms Peake went on to explain the associated Commonwealth government cuts that will have flow on impacts to Victorian hospitals:

> In addition to this, there have been a range of other changes to Commonwealth contributions through National Partnership Agreements which will impact access to services and potentially the quality of those services. This includes the expiry of the NPA on Improving Public Hospital Services, impacting on our capacity to treat more elective surgery patients and leaving mainstreaming of subacute funding unresolved; the cessation of the NPA on Preventive Health, resulting in loss of funding for the very successful Healthy Together Victoria program; and the decision not to renew the Project Agreement on Indigenous Teenage Sexual and Reproductive Health and Young Parent Support.[6]

5.8 Ms Peake also outlined the losses across a range of Victorian health services:

> I can certainly give you a couple of really concrete examples. You might have heard from Melbourne Health this morning that they would lose $1.3 billion over the next 10 years. The Alfred would lose $1.4 billion. If we look regionally, Barwon Health would lose $840 million, Bendigo would lose $476 million, and Ballarat would lose $455 million. So the reduction in capacity would be significant across metropolitan and regional Victoria.[7]

5.9 Ms Frances Diver, Deputy Secretary of the Health Service Performance and Programs at the Victorian Department of Health and Human Services explained to the committee the practical impacts of the Commonwealth's cuts:

> Effectively, what will happen is that if the Commonwealth contribution is lower there will be less available for us to allocate to each service. The allocation of that funding to each service corresponds to the demand for the service. That growth funding allows them to open more beds, theatres and emergency department treatment spaces to enable that service to respond to the growing demand in the community. So if they are in a growth corridor it is difficult for that service if we are unable to allocate the required growth to meet the community demand.[8]

Elective surgery impacts

5.10 Victorian Health officials explained that, while the Victorian Government has diverted funding from other government priorities to both subacute and emergency department services, there are likely to be significant impacts on elective surgery:

> With the funding decisions of the Commonwealth and where the state has—in the most immediate budget—sought to reinvest, we have particularly prioritised the subacute beds and emergency department

6 Ms Kym Peake, Acting Secretary, Victorian Department of Health and Human Services, *Committee Hansard*, 4 November 2015, p. 38.

7 Ms Kym Peake, Acting Secretary, Victorian Department of Health and Human Services, *Committee Hansard*, 4 November 2015, p. 40.

8 Ms Frances Diver, Deputy Secretary, Health Service Performance and Programs, Victorian Department of Health and Human Services, *Committee Hansard*, 4 November 2015, pp 39–40.

> capacity. The value of the funding which has not flowed from the Commonwealth from the particular national partnership agreement has meant the difference of about 23,000 elective surgery procedures, which we have not been able to fill through this year's budget.[9]

5.11 In 2014-15, approximately 173 000 patients were admitted to Victorian public hospitals to undergo elective surgery.[10] As at September 2015, the department advised that there were approximately 43 000 patients awaiting elective surgery.[11] Obviously, 23 000 were additional treatments to be added to the existing list, this would lead to a significant increase in elective surgery waiting lists.

5.12 The Australian Nursing and Midwifery Federation provided a different but equally worrying estimation of the impact of the 2014-15 Budget on elective surgery in Victoria:

> CHAIR: In terms of the cuts in Victoria, in your submission you estimated that cuts at that point of $982 million to 2018 would equate to over 185,000 surgical procedures cancelled.
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> Ms Butler: Yes. They were calculations made by our Victorian branch. They estimated what impact it would have for them specifically over the next four years. That goes to the questions you were asking earlier about how it is going to blow out increased waiting times and reduce elective surgery. That is how many elective procedures they believe will not be seen to in a timely fashion over the next four years.
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> CHAIR: That is a lot of people.
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> Ms Butler: It is huge. It is enormous. And you can then calculate the subsequent costs that is going to have—increased costs. It is a false economy.[12]

5.13 Ms Lee Thomas, Federal Secretary of the Australian Nursing and Midwifery Federation explained the compounding negative health and fiscal impacts of delayed elective surgery:

> Every state has an elective surgery waiting list, and every state's waiting list is different. If you need a hip replacement it might be 18 months; if you need a knee replacement it might be 12 months…

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9 Ms Kym Peake, Acting Secretary, Victorian Department of Health and Human Services, *Committee Hansard*, 4 November 2015, p. 46. These impacts result from the cessation without review of the National Partnership Agreement on Improving Public Hospital Services and the expectation that ongoing funding would be rolled into the National Health Partnership Agreement (see p. 47).

10 Victorian Department of Health and Human Services, *Answer to question on notice*, 4 November 2015, received 1 December 2015.

11 Victorian Department of Health and Human Services, *Answer to question on notice*, 4 November 2015, received1 December 2015.

12 Ms Annie Butler, Assistant Federal Secretary, Australian Nursing and Midwifery Federation, *Committee Hansard*, 5 November 2015, p. 21.

> The issue really is that the longer you wait the more frail you become because of your illness, and then one of two things happens. You become so ill that you need to present to an emergency department and then you are an emergency admission, or you hang in at home because it is your knee that does not work so you might not have walked or been able to walk long distances, so your weight increases and your physical health decreases. By the time you get to have your general anaesthetic to have your knee done, you have got co-morbid issues going on. You might have developed type 2 diabetes. You might have some sort of cardiac condition, or at least you are under a bit of cardiac pressure because your weight has ballooned because you have not been able to exercise. Whatever it is, the sum total of that is that at least some people in that position will end up with complications postoperatively—not all, but some definitely will—and that blows costs out. It blows out length of stay. It blows out medication costs. You might have a complication that requires you to go back to surgery. You end up with another theatre, another general anaesthetic. You might have an infection. You end up in hospital longer. All of this is a sum total of driving cost up.
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> If we had a system that was well funded and could provide not only elective surgery but emergency cooperatively, together, then the elective cost blow-outs would be much less... But the issue is that, if we get people electively to have their surgery in good time, there will be fewer complications and, therefore, the driving of costs up will be lessened.[13]

5.14 Ms Alison Verhoeven, Chief Executive of the Australian Healthcare and Hospitals Association reminded the committee of the disproportionate impact that longer elective surgery waiting lists have on socio-economically disadvantaged Australians:

> What we see on the ground is that it is particularly disadvantageous for those who have the most need of the health system and who can least afford it. For them it is really problematic. Increasing waiting list times, for example, in elective surgery in public hospitals is going to be really problematic for the marginalised and for the disadvantaged in our communities, and we need to do something about it.[14]

Committee view

5.15 The committee commends the Victorian Government for refusing to pass on the most immediate impacts of government's funding cuts to public hospitals across the state. Initially, the Victorian Government has been able to restrict the impact of the cuts to elective surgery. However, as witnesses explained, excessive delays for elective surgery ultimately puts greater financial pressure on the wider health system and leads to poorer patient health.

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13 Ms Lee Thomas, Federal Secretary, Australian Nursing and Midwifery Federation, *Committee Hansard*, 5 November 2015, pp. 18–19. See also Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, 4 November 2015, pp 23–24.

14 Ms Alison Verhoeven, Chief Executive, Australian Healthcare and Hospitals Association, *Committee Hansard*, 4 November 2015, p. 58.

5.16 The committee believes that state and territory governments cannot continue to cover the Commonwealth's planned funding reductions, which will grow steadily over time to a total of $13.5 billion by 2024-25.

5.17 Long term funding certainty allows for better planning for infrastructure, managing staffing, waiting times and lists, and delivers increased efficiencies overall. When hospitals are forced to operate on year-to-year budgets, there is no capacity for planning ahead and making efficient investment in staff and services.

5.18 The committee believes that without long term funding, state and territory public hospitals will not be able to achieve efficiencies and adequately serve Australians. The committee calls on the Federal Government to create a long term, sustainable, funding model for hospitals which allows for appropriate contributions from governments, both state and federal.

The committee speaks with Mr Jason Chuen, Chair of the Victorian Regional Committee and Fellow of the Royal Australian College of Surgeons, at a hearing in Melbourne on 4 November 2015.