Chapter 6

Impacts on Queensland hospitals

What we know as an industry is that when you put more out-of-pocket costs for patients, patients choose not to come for their examination.[1]

Ms Bronwyn Nicholson, General Manager of the I-MED Radiology Network, Queensland

Introduction

6.1 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.

Reduction to Queensland hospital funding

6.2 As a result of the 2014-15 Budget, more than $10 billion will be cut from Queensland hospital funding over the eight years between 2017-18 and 2024-25. The PBO has calculated that Queensland will receive $10.7 billion less in hospital funding from the Commonwealth over that period than if hospitals were funded according to the 2011 agreement.[2] The annual funding differences are set out in Appendix 4.

6.3 The Queensland Department of Health (the department) provided a slightly higher estimate, calculating that the state's public hospital funding reduction would be $11.8 billion.[3] The department quantified the total cuts in the following terms:

> To put that in some perspective, the reduction would translate to 1.362 million fewer acute admitted patient separations, 125,000 fewer mental health separations, 2.155 million fewer emergency department presentations and 4.926 [million] fewer non-admitted occasions of service in Queensland alone over the period 2017-18 to 2024-25.[4]

6.4 The department cautioned that the Commonwealth Government's stated aim to 'improve the sustainability of health spending' would only occur 'by shifting the

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1 Ms Bronwyn Nicholson, General Manager, Queensland, I-MED Radiology Network, *Committee Hansard*, 27 April 2016, p. 8.

2 Parliamentary Budget Office, *Submission 91*, p. 5.

3 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

4 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

costs to states and territories, with the risk that services will have to be reduced if states and territories cannot find the alternative sources of funding'.[5]

6.5 Annual funding differences are set out in Appendix 4. The PBO has calculated funding cuts to Queensland in the year 2024-25 alone would amount to $2.7 billion.

Unsuitable funding model

6.6 The government's decision to allocate hospital funding according to population and CPI overturns an activity-based model that was increasing cooperation between jurisdictions and services.[6] The committee heard that it would:

> …break the link established in 2014-15 between Commonwealth funding and efficient growth in public hospital services, reducing the financial incentives for all aspect of the health system to work together to improve outcomes.[7]

6.7 The government's population-based funding model will have adverse effects for a number of Queensland hospitals, especially in areas of 'lower population with a high burden of disease'.[8] The department explained the shortcomings of the population-based model:

> The proposed funding model assumes that all population groups have the same need for public hospital services. For example, it does not take account of the greater health needs of Indigenous people and people from rural and remote locations. This is particularly important for Queensland, which has the most decentralised population in Australia. Nor does it take account of the ageing population or the changing cost of service provision due to technological advances.[9]

6.8 By way of example, the Cairns and Hinterland Hospital and Health Service (CHHHS) explained that rather than being funded in proportion to their 'efficient growth' as per the 2011 agreement, current government policy would reduce their funding by $609 million over the eight years to 2024-25. This is despite their level of 'significant unmet demand, particularly from the Torres and Cape communities'.[10]

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5 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

6 Mr Paul McGuire, Senior Director, Funding Strategy Unit, Strategy, Policy and Planning Division, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 18.

7 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

8 Ms Julie Hartley-Jones CBE, Chief Executive, Cairns and Hinterland Hospital and Health Service, *Committee Hansard*, 16 November 2015, p. 6.

9 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

10 Ms Julie Hartley-Jones CBE, Chief Executive, Cairns and Hinterland Hospital and Health Service, *Committee Hansard*, 16 November 2015, p. 5.

6.9 Queensland is particularly affected by the policy change due to having a higher number of 'block funded hospitals' which have funding allocated differently in recognition of their high fixed costs.[11] The CEO of CHHHS, Dr Newland, explained:

> Our hospitals are block funded, so any changes in hospital funding will affect us in that our patients requiring secondary and tertiary care are transferred to Cairns... Any changes within bed availability or service availability in Cairns directly impact on the most disadvantaged populations in Australia.[12]

6.10 The department argued that if the government's aim of sustainable health spending is to be achieved, '[w]e need a funding mechanism that meets the needs of the people in a transparent and predictable way'.[13]

6.11 The Rural Doctors Association of Queensland called for a greater focus on community needs:

> …we ask that it not be reduced but, rather, that efficiencies be found in collaborative care models in response to community needs, rather than funding sourcing driving the model of care being delivered. We understand that in some sites this could well require a current service needs assessment and even service delivery assessment, and we would support this in the hope of better meeting the health needs of our regional, rural and remote communities.[14]

6.12 The department noted that states and territories signed a Heads of Agreement with the Commonwealth on 1 April 2016 outlining funding arrangements for the period 2017-18 to 2019-20, with a return to an '"efficient growth" model of sorts'. They noted, however, that the 6.5 per cent cap on Commonwealth funding would leave a shortfall:

> The new arrangements restore some of the public hospital funding that was withdrawn in the 2014-15 Budget – but only a small part. It is projected the Heads of Agreement would restore $445 million over 2017-18 to 2019-20, but that there would still be a shortfall of $1,190 million compared to the previous arrangements.[15]

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11 Mr Paul McGuire, Senior Director, Funding Strategy Unit, Strategy, Policy and Planning Division, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 19.

12 Dr Jill Newland, Chief Executive, Torres and Cape Hospital and Health Service, *Committee Hansard*, 16 November 2015, p. 4.

13 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 16.

14 Dr Tash Coventry, President, Rural Doctors Association of Queensland, *Committee Hansard*, 16 November 2016, p. 48.

15 Queensland Health, *Projected impact of Commonwealth funding cuts on the public hospital system*, p. 2, www.health.qld.gov.au/publications/system-governance/health-system/comm-funding-cuts-impact-budget.pdf (accessed 3 May 2016).

Impact on Queensland hospitals

6.13 As a result of the hospital funding cuts, the committee heard that Queensland would risk running out of hospital beds and have reduced capacity to provide services.[16] Departmental representatives provided a number of examples of the reduced ability of hospitals to provide services over the eight years between 2017-18 and 2024-25. They explained that 'if we had received the funding we would expect to be able to provide 2.155 million more emergency department presentations'.[17] In the area of mental health alone, they told of '125,000 times that we would have otherwise been able to provide that mental health service that we would not be able to provide that service in that period.'[18]

6.14 Job losses would be likely to result from hospital funding cuts, providing a further obstacle to providing quality care in Queensland hospitals. The department estimated that by 2024-25, the cuts to hospital funding in Queensland would have resulted in 'an annual average total impact of reduction in staff of 4,537'.[19] The committee heard evidence that, in the Gladstone region, hospital employees are 'stretched to the maximum' and concerned about positions not being filled.[20]

6.15 Servicing regional and remote areas of Queensland, the Royal Flying Doctor Service advised that the withdrawal of funding from hospitals would have a direct impact on health outcomes, explaining:

> …it will lead to worse health outcomes and a worsening of an ability to actually address chronic disease in terms of preventing—primary prevention, secondary prevention—complications of chronic disease. It will drive the medical services towards having to deal with the secondary complications of chronic disease, which will be acute presentations. It will be acute on chronic so it will end up costing money in the long run and it will be very expensive in terms of human cost as well...[21]

6.16 Ms Robin Saunders, a nurse appearing in a private capacity at the committee's hearing in Gladstone in April 2016, told the committee that lack of funding is preventing nursing staff from doing the best job they can. The Nursing Unit Manager, a staff member who forms the hub of a nursing unit, is a position which Ms Saunders described as being placed under enormous pressure, with staff occupying this position

16 Ms Robin Saunders, private capacity, *Committee Hansard*, 27 April 2016, p. 1.

17 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 16.

18 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 15.

19 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 15.

20 Ms Robin Saunders, private capacity, *Committee Hansard*, 27 April 2016, pp 1–2.

21 Dr Oscar Whitehead, Director, Medical Services, Queensland Section, Royal Flying Doctor Service, *Committee Hansard*, 16 November 2015, p. 29.

at extreme risk of burn out.[22] Ms Saunders told the committee that the removal of staff due to funding cuts placed patients at high risk. In particular, should the Nursing Unit Manager positions continue to be massively overworked, or fail to be staffed, Ms Saunders told the committee that:

> Death is the ultimate risk, and that can happen to babies and has probably happened to other people. It is danger to the client but it is also burnout to the nursing staff. To operate in a position like that all the time really burns out people fairly quickly. Or, actually, here they do not get burnt out quickly; they get burnt out slowly. But they get burnt out. People do not want to cooperate as much, and they are all on call a lot because it is a small area that is a busy place. I think morale also becomes low. People feel they are trying to do their best at work, they have all this education and they are doing all these things to keep themselves up to a high standard so they can give a high standard of care, which promotes the whole community. So there is feeling unsafe and burnt out…When you listen to nurses, they actually are blaming the fact that there is not enough money, that they do not have enough staff, because not enough money is being allocated to their areas and so they cannot have enough doctors, staff, beds and equipment that they need.[23]

6.17 Ms Saunders described to the committee the situation in hospitals when staff, such as unit nurses, had to backfill vacant positions as well as continuing their own work:

> …people [for example unit nurses] being taken away from their proper jobs—what their job description is—and doing other work where they have to be clinical. It means the work they were doing is left undone. They are not backfilling, so vacancies are not being filled. People have to work longer. People are called in more often. That is really the complaint from staff. The positions are not being filled. The savings are being made by not filling the positions. I think nurses, like most people, always have to try to be aware of budget constraints et cetera, but it has gone a little bit far now in that people are working too much for too long and not filling the positions they are supposed to. And a lot of the positions are being cut and taken to Rockhampton way of board health management, which is different from how it was before. We had an infection control nurse and a quality assurance nurse—they were actually full positions—and we had patient complaints and risk. There were three positions and those positions have been taken to Rockhampton.
>
> Other people have had it become part of their role to start doing audits as well as doing their clinical work so those positions that are not filled are still having some response from the Gladstone area. They have been given extra jobs. I think we have 1.5 positions instead of three, but they have gone to Rockhampton, which is quite hard. If you have a problem—say, someone has been exposed to TB—that is a lot of follow-up. All the staff, all the

22 Ms Robin Saunders, private capacity, *Committee Hansard*, 27 April 2016, p. 4.

23 Ms Robin Saunders, private capacity, *Committee Hansard*, 27 April 2016, p. 4.

> people, all the clients who have been exposed to that one person need follow-up for a long time. If you do not have someone locally, that is a very difficult thing to do.[24]

Impact on vulnerable populations

6.18 The impact of the hospital funding cuts would be most acute in regional and remote Queensland, according to witnesses and submitters.[25] Representatives of the CHHHS discussed the 'big impact' of the changes given the 'significant burden of chronic disease and significant issues around the ageing population' per capita in the area.[26]

6.19 The CHHHS witnesses discussed the challenge of providing ongoing hospital care for patients waiting for placement in aged care or mental health facilities, or people with disabilities waiting for supportive accommodation. This led to 'bed block' in a number of CHHHS hospitals, which prevents them from meeting other performance targets:

> High numbers of longer stay patients do increase bed block within the Cairns and Hinterland Hospital and Health Service, and this adds to the risks that the hospital and health service will fail to meet its National Emergency Access Targets, and the National Elective Surgery Targets, due to a shortage of acute beds. More importantly, the lack of these residential aged-care places and home care packages also affects the welfare of our patients and the care experience within our facilities.[27]

6.20 Witnesses and submitters emphasised that the effects of hospital funding cuts will have a widespread impact across the community, and will place greater pressure on primary health providers. A CHHHS representative told the committee:

> As you are aware hospitals are complex systems, so we have experienced many occasions where increasing activity in one area has put pressure on another part of the system which was less resourced or developed, so that has required significant investment and redesign.[28]

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24 Ms Robin Saunders, private capacity, *Committee Hansard*, 27 April 2016, p. 5.

25 Ms Julie Hartley-Jones CBE, Chief Executive, Cairns and Hinterland Hospital and Health Service, *Committee Hansard*, 16 November 2015, p. 6.

26 Ms Julie Hartley-Jones CBE, Chief Executive, Cairns and Hinterland Hospital and Health Service, *Committee Hansard*, 16 November 2015, p. 6.

27 Dr Edward Strivens, Clinical Director, Older Persons Health Services, *Committee Hansard*, 16 November 2015, p. 3.

28 Ms Julie Hartley-Jones CBE, Chief Executive, Cairns and Hinterland Hospital and Health Service, *Committee Hansard*, 16 November 2015, p. 2.

6.21 The Apunipima Cape York Health Council explained the interrelationship between primary health care and hospital admissions as follows:

> …the investment in primary health care is going to make a difference to what is needed in secondary care—everything from preventable to avoidable hospital admissions, including some of the mental health things as well. It would be a shame to disinvest in primary health care and continue to pay for acute care.[29]

Mr Cleveland Fagan, Chief Executive Officer and Dr Mark Wenitong, Public Health Medical Advisor from the Apunipima Cape York Health Council, and Mr Brian Stacey, Head of Policy, Cape York Partnership, spoke to the committee at a public hearing in Cairns on 16 November 2015.

6.22 The CHHHS witnesses told the committee that providing efficient hospital service would become increasingly difficult following the cuts, and would require alternative funding arrangements 'through privatisation and potential disinvestment in other services'.[30]

Privatisation

6.23 Future privatisation of the health sector was of concern to some witnesses and submitters. The Queensland Nurses Union and the Public Hospitals Health and

29 Dr Mark Wenitong, Public Health Medical Adviser, Apunipima Cape York Health Council, *Committee Hansard*, 16 November 2015, p. 39.

30 Ms Julie Hartley-Jones CBE, Chief Executive, Cairns and Hinterland Hospital and Health Service, *Committee Hansard*, 16 November 2015, p. 2.

Medicare Alliance of Queensland elaborated, both submitting that 'creating a crisis in health spending provides the Federal Government with the impetus to promote and implement its agenda to privatise the health sector.[31] They warned the cuts to hospital funding pose 'massive financial risk for most low and middle income Australians'.[32]

Diagnostic services

6.24 The Federal Government's decision to remove bulk-billing incentives for diagnostic imaging and pathology services[33] has to be considered in the context of hospital funding. Any increase in out-of-pocket cost which flow from this decision will mean patients are unable to or less likely to utilise imaging and pathology services and as a result more likely access more costly hospital services. Ms Bronwyn Nicholson, General Manager of the I-MED Radiology Network in Queensland described the situation that providers of diagnostic imagining and pathology are facing, with the Federal Government's cuts planned to take effect on 1 July 2016:

> If the bulk-bill incentive is removed then all of those patients who are currently bulk-billed, what we call general patients, will most likely have to incur a gap. There has been no increase in the Medicare levy for diagnostic imaging for more than 18 years. As an industry, we have spent a lot of time and money making our services as efficient as possible. The continued increase in the cost of wages and other things and the costs of running our business mean that the margins in our industry are small—sub double figures—and it continues to be difficult for us to maintain a profitable business and provide these services in the community.
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> The removal of the bulk-bill incentive will most likely see some providers, in my opinion, drop out because they will not be able to sustain the service. They will have to introduce gaps. What we know as an industry is that when you put more out-of-pocket costs for patients, patients choose not to come for their examination. So there is a relatively large discretionary component to health care and patients choose not to attend for an examination recommended by their doctor on the basis of cost. That has health outcome issues. People choose not to have the test and they have a delay in diagnosis; therefore, their health outcomes are reduced over time. I guess that is an issue for us and we are concerned about that.[34]

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31 Queensland Nurses' Union, *Submission 44*, p. 5; Public Hospitals Health and Medicare Alliance of Queensland, *Submission 15*, p. 4.

32 Queensland Nurses' Union, *Submission 44*, p. 5; Public Hospitals Health and Medicare Alliance of Queensland, *Submission 15*, p. 4.

33 www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley151.htm

34 Ms Bronwyn Nicholson, General Manager, Queensland, I-MED Radiology Network, *Committee Hansard*, 27 April 2016, p. 8.

6.25 Ms Nicholson gave the committee an example of the effects of the cuts to pathology services specific to the Gladstone area:

> …for a patient who requires an imaging guided biopsy, which is quite a common procedure for us, the radiologist would need to be in the room with the patient and put the needle in, using the imaging to guide that and draw a sample for pathology. So these are services that require a radiologist to be in attendance. For some of those procedures, in order for us to have radiologists in regional areas, there is a particular cost to having medical specialists, and we need to try to offset some of the cost of providing those services. So we do have some gaps for some things but, as I said, the majority of our procedures in CT, ultrasound and nuclear medicine are bulk-billed services. So if the bulk-billing incentive for those services to be provided to general patients is removed then that is a 10 per cent drop in our revenue for those patients, and we would most likely have to backfill that with an out-of-pocket expense to those patients. So whilst it would not affect patients who are pensioners and healthcare card holders—we would still be able to offer them bulk-billed services—there would be a large cohort of general patients who would not be able to access services without having to pay a gap in a private sector. I think that would inhibit a lot of people from choosing us. We have certainly seen in Gladstone a change in the demographic of the patients here over the last two to three years. As the industry and some of the projects here have come to the end, there has certainly been a drop in the patients' ability to pay in our community here in the last, probably, 18 months. So that has impacted us. Similarly, we see the same in Rockhampton… I think that probably what we would see is more patients pushing into the public sector. As Senator Moore said, a patient in Gladstone would be able to go to casualty, seek medical help there, get a referral and come through the public sector, so the cost of that examination would fall back onto the public hospital.[35]

35 Ms Bronwyn Nicholson, General Manager, Queensland, I-MED Radiology Network, *Committee Hansard*, 27 April 2016, p. 11.

The committee attended a site visit at Central Queensland Medical Imaging in Gladstone on 27 April 2016.

State government response

6.26 The Queensland Minister for Health and Ambulance Services, the Hon Cameron Dick MP, described the hospital funding cuts as a 'sick blow' to Queensland, stating they are 'widespread, come without consultation, and will hit Queensland hard'.[36]

6.27 In responding to the Federal Government's cuts in the Queensland 2015-16 Budget, the Queensland Government allocated $11.6 billion to public healthcare services at 81.6 per cent of the department's budget, including an additional $2.3 billion over four years 'to ensure that health and ambulance services keep pace with the ongoing growth in demand'.[37]

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36 The Hon Cameron Dick, Minister for Health and Ambulance Services, Queensland Government, *Canberra cuts a sick blow to our health system*, Media release, 15 December 2015, http://statements.qld.gov.au/Statement/2015/12/15/canberra-cuts-a-sick-blow-to-our-health-system (accessed 3 May 2016).

37 Queensland Government, *Managing the Queensland Health System: Budget*, www.health.qld.gov.au/system-governance/health-system/managing/budget/default.asp (accessed 3 May 2016).

Committee view

6.28 The committee commends the Queensland Government for refusing to pass on the most immediate impacts of government's funding cuts to public hospitals across the state, but notes that the shortfall in funding remains considerable.

6.29 The message from Queensland witnesses and submitters was loud and clear: funding cuts would reduce the capacity of hospitals to meet the growing needs of their patients. With an ageing population set to grow by 20 per cent over the next decade, and an increasing share of the nation's chronic disease burden,[38] the government cannot afford to reduce the resources it dedicates to Queensland hospitals.

6.30 The committee believes that the Queensland Government cannot continue to cover the Commonwealth's planned funding reductions, which will grow steadily over time to a total of $10.7 billion by 2024-25.

6.31 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.

6.32 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.

38 Ms Kathleen Forrester, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 13.