

The Senate

Select Committee on
Health

Final report

Hospital funding cuts: the perfect storm

The demolition of Federal-State health
relations 2014–2016

May 2016

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978-1-76010-451-1

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Printed by the Senate Printing Unit, Parliament House, Canberra.

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Senator Sean Edwards (LP, SA)

Senator Jenny McAllister (ALP, NSW) (from 14 May 2015)

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Senator the Hon Doug Cameron (ALP, NSW) 29 April 2016

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¹ Membership arrangements for previous phases of this inquiry can be found in earlier interim reports.

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Terms of Reference

That a select committee, to be known as the Select Committee on Health, be established to inquire into and report on health policy, administration and expenditure, with particular reference to:

- a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
- b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
- d. the interaction between elements of the health system, including between aged care and health care;
- e. improvements in the provision of health services, including Indigenous health and rural health;
- f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- g. health workforce planning; and
- h. any related matters.

Acronyms and abbreviations

ABF	Activity based funding
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHCA	Australian Health Care Agreements
AMA	Australian Medical Association
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CPI	Consumer Price Index
ED	Emergency Departments
FAQ	Frequently Asked Questions
FOI	Freedom of Information
GDP	Gross Domestic Product
GP	General Practice
GPs	General Practitioners
IGA	Intergovernmental Agreement
IHPA	Independent Hospital Pricing Authority
LHN	Local Hospital Networks
MBS	Medicare Benefits Scheme
NDIS	National Disability Insurance Scheme
NEP	National Efficient Price
NHFB	National Health Funding Body
NGOs	Non-Government Organisations
NHA	National Healthcare Agreement
NHHNA	National Health and Hospitals Network Agreement
NHHRC	National Health and Hospitals Reform Commission
NHPA	National Health Performance Authority
NHRA	National Health Reform Agreement
NPA	National Partnership Agreement
NPP	National Partnership Payments
OECD	Organisation for Economic Co-operation and Development

PBO	Parliamentary Budget Office
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
SPP	Specific Purpose Payment

Hospital funding quotes¹

The 2014 budget did serious damage to Commonwealth-state relations and the confidence with which states could plan and manage health services. It did this by abrogating an agreement about public hospital funding which had been signed by governments of all political persuasions and unilaterally imposing a new funding model on the states.

Dr Stephen Duckett, Director, Health Program, Grattan Institute

The annual hospitals budget, from New South Wales, is about \$20 billion. That is one year's salary, effectively... You can close the system for a year or you can fund to meet demand... \$18.3 billion so it is, virtually, a year's New South Wales hospital budget worth of cuts.

Dr Andrew McDonald, paediatrician, Campbelltown Hospital

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.

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

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.

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

So you have longer waiting times and people are not seen acutely when they should be seen, so they are much sicker when they are seen, and then you end up having to fly them out. It is just a revolving door.

Dr Stephanie Trust, Kununurra Medical Centre

1 Full citations may be found at the beginning of each chapter.

Removing 600 hospital beds; or

- *Closing an entire hospital; or*
- *The cost of employing 3000 nurses; or*
- *Doubling elective surgery waiting times.*

South Australian Government

The cohort of patients are the complex elective surgery that needs to be performed, not the day cases—they have been raced through. The complex cases are still waiting. There are unacceptable time frames in Tasmania. People are often in pain, stopping the quality of life... So we actually have fewer beds in Tasmania than the average across the country. That is due to budget cuts... We also have the longest elective surgery waiting times. So you can see why we frame it as the perfect storm.

Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation,
Tasmanian Branch

The Commonwealth Government's abandonment of the National Health Reform Agreement has cut \$248 million from what we expected to receive for our hospitals over the next four years. In this Budget we have chosen not to pass on this Commonwealth cut and send our hospitals into chaos.

ACT Treasurer, Mr Andrew Barr MLA

Northern Territory hospitals are already performing below national benchmarks, mainly due to the high demand for acute care. The majority of hospital patients in the Northern Territory are Aboriginal, so reducing access to high quality hospital services will hurt Aboriginal people the most.

Mr John Paterson, Chief Executive Officer, Aboriginal Medical Services
Alliance Northern Territory

Recommendations

Recommendation 1

1.22 The committee recommends that the Senate Select Committee on Health be re-established in the 45th Parliament, and be provided with the terms of reference and support to undertake scrutiny of health policy, including Indigenous health.

Recommendation 2

3.51 The committee recommends that the Government reconstitute the National Health and Hospitals Reform Commission or a similar body to review hospital funding arrangements and build on the National Health Reform Agreement. This process should be guided by the principles of equity, fairness, adequate funding and long-term certainty to ensure the continuity of public hospital services.

Recommendation 3

3.53 The committee recommends that the Government urgently give an undertaking that the mechanisms for activity based funding, such as the Independent Hospital Pricing Authority, and the other structures put in place by the former government to implement activity based funding, will not be dismantled.

Chapter 1

Introduction

1.1 On 25 June 2014, the Senate established the Senate Select Committee on Health.¹ The final reporting date for the committee is 20 June 2016. However, given the likelihood of an early election, the committee has decided to bring forward the release of this final report.

Public hearings

1.2 Since its establishment, the committee has completed 52 public hearings. A full list of the committee's hearings is at Appendix 1.²

1.3 Through its extensive program of public hearings, the committee has taken evidence from many health experts, practitioners, consumers and communities. The public hearing program has also enabled the committee to engage the wider Australian community, including those in rural and regional areas which may not normally be able to directly engage with the parliamentary process.

1.4 Throughout the committee's inquiry, hospital funding and related issues have been raised by witnesses and submitters in connection with evidence about the primary and acute healthcare systems. In order to examine these issues in more detail, the committee has held eight hearings focussing specifically on hospital funding:

- 4 and 5 November 2015, Melbourne;
- 16 November 2015, Cairns;
- 17 November 2015, Rockhampton;
- 27 November 2015, Sydney;
- 23 March 2016, Campbelltown;
- 27 April 2016, Gladstone; and
- 29 April 2016, Devonport.

Submissions

1.5 The committee has received 205 submissions since the beginning of its inquiry. These are listed at Appendix 2.³

1.6 The committee's terms of reference are wide-ranging. Over the course of its inquiry, the committee's intention has been to explore various issues in depth and these have formed the basis for the committee's six interim reports.

1 *Journals of the Senate*, 25 June 2014, pp 996–998.

2 Public hearing details can also be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings.

3 The submissions received by the committee can be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Submissions.

1.7 Additional information, tabled documents, correspondence and answers to questions on notice received by the committee are listed at Appendix 3.⁴

Health Committee's first interim report

1.8 The committee's first interim report was tabled on 2 December 2014.⁵ That report detailed the committee's findings and conclusions at that time, focussing on issues raised during the committee's hearings and through submissions. Key areas of focus in the first report were:

- the Government's proposed patient co-payments, cuts to hospital funding and the abolition of the Australian National Preventative Health Agency;
- the Government's plan to close the 61 Medicare Locals and replace them with 30 Primary Health Networks; and
- the merger of the Organ and Tissue Authority and the National Blood Authority.

Second interim report

1.9 The committee's second interim report was tabled on 24 June 2015.⁶ That report encompassed the committee's findings regarding the government's primary healthcare and general practice policies. In particular the report was a record of the government's frequent changes of policy since the 2014-15 Budget. The second interim report focused on:

- the vital importance of general practice and primary healthcare, and the threat posed by the government's numerous policy changes since the 2014-15 Budget;
- the responses of GPs and the primary healthcare sector to the government's various primary care policies; and
- an examination of the 2015-16 Budget's health measures and commentary from stakeholders.

Third interim report (Australian Hearing)

1.10 The committee's third interim report was tabled on 17 September 2015.⁷ That report examined the government's proposed privatisation of Australian Hearing and the National Acoustics Laboratories. The proposal was originally recommended by the National Commission of Audit in February 2014.⁸ In the 2014-15 Budget, the

4 The submissions received by the committee can be accessed via the committee's website: www.apph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Additional_Documents.

5 *Journals of the Senate*, 2 December 2014, p. 1948. The report can be accessed at: www.apph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/First_Interim_Report.

6 *Journals of the Senate*, 24 June 2015, p. 2809. The report can be accessed at: www.apph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Second_Interim_Report.

7 *Journals of the Senate*, 17 September 2015, p. 3158. The report can be accessed at: www.apph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Third_Interim_Report.

8 National Commission of Audit, *Phase One Report*, paragraph 10.1 and recommendation 57.

government allocated funding for a scoping study for the proposed privatisation of Australian Hearing.⁹ The 2015-16 Budget included the postponement of a decision on the scoping study, pending further consultation.¹⁰

1.11 The third interim report outlined the evidence taken at a July 2015 public hearing and the related written submissions made by witnesses. It also examined:

- the impacts privatisation would have on users of the Australian Hearing services; and
- the National Disability Insurance Scheme (NDIS) and Australian Hearing.

Fourth interim report (Mental Health)

1.12 The committee's fourth interim report was tabled on 8 October 2015.¹¹ That report examined mental health issues in the context of the National Mental Health Commission's *National Review of Mental Health Programmes and Services Report* and the pending government response. The fourth interim report specifically focussed on:

- the findings of the Commission's report;
- the Government's response to the Commission's findings; and
- the importance of ensuring that there is a smooth transition of mental health programs into the NDIS.

Fifth interim report (Black Lung)

1.13 The committee's fifth interim report was tabled on 28 April 2016.¹² That report examined the recent re-emergence of the debilitating lung disease, Coal Workers' Pneumoconiosis (also known as black lung disease), in former Queensland coal miners. The report highlighted issues around safe exposure levels, dust monitoring regimes and worker screening practices.

Sixth interim report (Big Data)

1.14 The committee's sixth interim report was tabled on 4 May 2016.¹³ That report examined options to improve the use of 'big data' and data linkage in the development of health policy and public good medical research. In particular, the report examined:

9 Commonwealth of Australia, *2014-15 Budget, Budget Paper No. 2*, Budget Measure: Smaller Government—scoping studies for four operations of government, May 2014, p. 117.

10 Senator the Hon Mathias Cormann, Minister for Finance, media release, 'Further Consultation on Future Ownership Options for Australian Hearing', 8 May 2015.

11 *Journals of the Senate*, 12 October 2015, p. 3175. The report can be accessed at: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Fourth_Interim_Report.

12 *Journals of the Senate*, 2 May 2016, p. 4165. The report can be accessed at: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Fifth_Interim_Report.

13 *Journals of the Senate*, 4 May 2016, p. 4238. The report can be accessed at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Sixth_Interim_Report

- the new opportunities for governments to use big data in health policy development;
- the constraints applying to linking data from the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme; and
- issues relating to access to data including ethics approvals, issues faced by data custodians, and the 'linkage logjam'.

Structure of the final report

1.15 The committee's final report focuses on hospital funding arrangements in Australia. In the 2014-15 Budget, the government abandoned the National Health Reform Agreement and the underpinning funding arrangements for public hospitals which had been implemented under the previous government. This decision led to the unprecedented removal of \$56 billion in agreed hospital funding to the states over the eight year period of 2017-18 to 2024-25. Although the COAG agreement on 1 April 2016 has reallocated \$2.9 billion of funding over three years (2017-18 to 2019-20), state and territory governments have struggled to make up the significant funding shortfall.

1.16 In this final report, the committee looks at the impact of the Federal Government's decision to scrap the National Health Reform Agreement and the resulting funding uncertainty, which is putting at risk the viability and safety of Australia's public hospitals.

1.17 In addition to this introductory chapter, the report outlines the history of hospital funding in Australia (Chapter 2) and then examines the impact of the 2014-15 Budget on hospital funding (Chapter 3). The remaining seven chapters examine the specific impacts of the 2014-15 Budget on each state and territory.

Work of the Select Committee

1.18 Since its establishment on 25 June 2014, the committee has covered a broad range of health policy topics. By undertaking an intensive schedule of public hearings around Australia the committee has been able to respond to issues as they have emerged, and speak to those who are affected.

1.19 Due to the government's decision to call an early election, the committee is unable to table interim reports on the other issues it has examined, such as Indigenous health. The committee is also unable to scrutinise in detail the health measures in the 2016-17 Budget, as it has done on previous occasions.

1.20 The committee's final reporting date is 20 June 2016. However the committee has decided to bring forward its final report so as to highlight the critical issue of the government's unprecedented cuts to hospital funding. The committee is disappointed that the work undertaken on its Indigenous health report will not be tabled in this parliament.

1.21 Nevertheless, the committee believes that its work in this area is too important to be left unfinished. The issues that the committee found during its hearings and site visits demonstrate that Indigenous health urgently requires greater focus and funding from government.

Recommendation 1

1.22 The committee recommends that the Senate Select Committee on Health be re-established in the 45th Parliament, and be provided with the terms of reference and support to undertake scrutiny of health policy, including Indigenous health.

Notes on references

1.23 References to submissions in this report are to individual submissions received by the committee and published on the committee's website. References to committee Hansards are to the official transcripts, unless indicated otherwise.¹⁴

Acknowledgements

1.24 The committee thanks the many organisations and individuals who have participated in the committee's inquiry since 25 June 2014.

1.25 In particular, the committee wishes to thank:

- the communities who have hosted the committee's public hearings and shared their experiences with the committee,
- the organisations who have given their time to conduct site visits, and
- the organisations and individuals who have engaged with the committee by making submissions, responding to calls for supplementary submissions, and appearing at the committee's public hearings.

14 Committee Hansards can be accessed via the committee's website:
www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings.

Chapter 2

Background to hospital funding reform

Introduction

2.1 This chapter traces the history of hospital funding arrangements in Australia. It commences with an examination of the pre-Medicare and Medicare eras and concludes with an overview of the historic National Health Reform Agreement.

General

2.2 Australia's health system is funded and administered by several levels of government and supported in part by the non-government sector. Whilst the Commonwealth and the states and territories share many roles in policy, funding and regulation, service delivery is largely undertaken by the states and territories, local governments, and the non-government sector.¹

2.3 The Commonwealth is the largest contributor of government funding to health services and its direct areas of responsibility include:

- Medicare;
- Pharmaceutical Benefits Scheme;
- Medical Research Grants; and
- Education of Health Professionals.²

2.4 States and territories are mainly responsible for areas including the:

- Management and administration of public hospitals (including emergency care);
- Delivery of preventative services; and
- Funding and management of community and mental health services.³

2.5 Shared Commonwealth-state responsibilities include:

- Funding of public hospitals;
- Preventative services;

1 Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, pp 1–3 and 21–25.

2 Amanda Biggs, Parliamentary Library, *Health in Australia: a quick guide*, November 2013, pp 1–2; Council of Australian Governments, *National Healthcare Agreement 2012*; and Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, pp 1–3 and 21–25.

3 Amanda Biggs, Parliamentary Library, *Health in Australia: a quick guide*, November 2013, pp 1–2; Council of Australian Governments, *National Healthcare Agreement 2012*; and Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, pp 1–3 and 21–25.

- Registration and accreditation of health professionals;
- National mental health reform; and
- Aboriginal and Torres Strait Islander health services.⁴

2.6 Public hospitals are seen as the most significant area of shared funding between the Commonwealth and the states and territories.⁵ Since the First World War, efforts to reach agreement in terms of funding arrangements and funding priorities for public hospitals have highlighted the considerable differences between the levels of government.⁶ Past negotiations around new health funding models and the signing of new healthcare agreements between the Commonwealth and states and territories have often been marked by disputes and allegations of cost shifting. As a consequence, health and hospital funding has often been referred to as the "blame game".⁷

Hospital funding pre-Medicare

Federation – 1949

2.7 Demand for public hospitals increased between the world wars but many hospitals struggled to raise enough revenue to cover their costs. While private health insurance was in operation, it was very limited. In 1928 and 1938 national health insurance schemes were proposed by the respective governments but were successfully opposed by businesses and the medical profession.⁸

2.8 Following the Second World War, the relationship between the Commonwealth and the states and territories was impacted by a succession of attempts by the Commonwealth to gain additional heads of power, including a power for 'national health' in 1945. Whilst the 1945 referendum was defeated, the Commonwealth was able to provide funding to the States and Territories through the

4 Amanda Biggs, Parliamentary Library, *Health in Australia: a quick guide*, November 2013, pp 1–2; Council of Australian Governments, *National Healthcare Agreement 2012*; and Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, pp 1–3 and 21–25.

5 Department of Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, p. 21.

6 Greg Lewis, *Public Health and Commonwealth-State Relations*, Department of the Parliamentary Library Information and Research Services, 1998, p. 1.

7 House of Representatives Standing Committee on Health and Aging, *The Blame Game: Report on the inquiry into health funding*, November 2006.

8 Sidney Sax, *A Strife of Interests – politics and policies in Australian Health Services*, George Allen and Unwin, Sydney, 1984, pp 26, 36, 42 and 58; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp 15–22.

Hospital Benefits Act 1945.⁹ This legislation specified that all people must have access to the public wards of hospitals free of charge; however, there was no intrusion by the Commonwealth into the organisation and management of hospitals.¹⁰

2.9 A year later, the 1946 referendum to give the Commonwealth new powers for a range of social services was successful. This gave the Commonwealth authority to provide pharmaceutical, sickness and hospital benefits as well as deliver and fund medical and dental services.¹¹ It led to a new Pharmaceutical Benefits Scheme (PBS) but the medical profession could not be convinced of the proposed national health insurance scheme.¹²

2.10 In 1948, the Chifley government passed the *National Health Service Act 1948* which allowed the Commonwealth to 'maintain and manage hospitals, laboratories, health centres and clinics, and to take over any of these services from the states',¹³ but it was never fully implemented.¹⁴

1949–1984

2.11 Under Medibank, the predecessor to Medicare, hospital funding was delivered via a cost-sharing arrangement, with the Commonwealth providing conditional grants to the states equivalent to 50 per cent of gross operating costs. The states would be required to fund the remainder from their own revenue.¹⁵

9 This was through SPPs as the Commonwealth had no constitutional power over health services. Although the scheme stopped in 1949, Queensland continued to fund free hospital care; Sidney Sax, *A Strife of Interests – politics and policies in Australian Health Services*, George Allen and Unwin, Sydney, 1984, p. 52, 56, 58; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp ix–x and 22–35.

10 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, p. 27.

11 This was articulated as Section 51(xxiiiA) of the Constitution.

12 The Pharmaceutical Benefits Scheme was enacted under the Pharmaceutical Benefits Act 1948. Another scheme had been already in operation in early 1945 (the Pharmaceutical Benefits Act 1944), but it was declared unconstitutional in 1946. Parts of the 1948 Act would also prove to be unconstitutional in 1949; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp ix–x, 22–35; Scotton, Richard, B, *Medibank: from conception to delivery and beyond*, MJA Vol 173, 3 July 2000, pp 9–11.

13 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp ix–x and 22–35.

14 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp ix–x and 22–35.

15 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp 52–63; Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004 www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/medicare (accessed 1 March 2016).

2.12 To implement the hospital aspect of Medibank, the Whitlam government negotiated separate funding agreements with each of the states. These agreements sought to ensure:

- that all public patients in public hospitals received free treatments and access to medical services;
- hospital benefits were paid directly to hospitals not to patients;
- the end of the honorary system of hospital medical work; and
- grants were made to the states to compensate them for the loss of revenue that resulted from abolishing hospital fees and means-tests.¹⁶

2.13 It took until 1 October 1975 before all states had agreements in place with the Commonwealth and the hospital aspect of Medibank could be deemed as operating nationally.¹⁷

2.14 The Medibank program had only been operating for a few months when the Whitlam government was dismissed on 11 November 1975. Although the incoming Fraser government had indicated during the election that it would maintain Medibank, within months changes had been made. Medibank II was launched in 1976, Medibank III in 1978 and Medibank IV in 1979.¹⁸

2.15 In 1981, following the Jamison Committee of Inquiry into Efficiency and Administration of Hospitals,¹⁹ the nature of the funding for hospitals from the Commonwealth changed from specific purpose funding to per capita block grants.²⁰

16 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, p. 56; Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004.

17 The medical side of Medibank was effective nationally from 1 July 1975; Richard B. Scotton, *Medibank: from conception to delivery and beyond*, Medical Journal of Australia, Vol 173, July 2000, pp 9–11. Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004.

18 Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp 78–89.

19 This inquiry was established in 1979 to find ways of containing hospital costs and improving efficiencies. In doing so it looked at health insurance arrangements and the roles of the Commonwealth and states in the health sector. It reported in December 1980. Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp 78–89.

20 Stephen Reynolds, *Australian Health Insurance Arrangements 1969-81: the roles of public and private health insurance*, Legislative Research Service, Department of Parliamentary Library, Basic Paper No.4, 1981; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, p. 89.

Medicare Agreements

1984–1988

2.16 Following the election of the Hawke government in 1983, legislation was introduced to return to the original Medibank model, albeit with grant based funding. The 'new' universal scheme was named Medicare²¹ and began on 1 February 1984.²²

2.17 Under Medicare the Commonwealth signed bilateral agreements with the states and territories in which the basic arrangement consisted of the Commonwealth providing funding in exchange for the states and territories providing free public hospital treatment as public patients. The first agreement extended until 1988 and thereafter each agreement was for five years.

2.18 The first round of Commonwealth payments to the states and territories consisted of Identified Health Grants and a Medicare Compensation Grant.²³ The grants not only provided for funding for hospitals but also for new community health services.²⁴

2.19 By November 1986, the maximum gap²⁵ had increased from the initial \$10 to \$20; the in-hospital rebate was set at 75 per cent, with private health insurance to cover remaining 25 per cent.²⁶

1988–1993

2.20 The second round of Medicare agreements saw a return to specific funding grants with the Identified Health Grants and a Medicare Compensation Grant being replaced with new Hospital Funding Grants. These grants were 'absorbed' into the pool of general revenue assistance.²⁷

2.21 The base grant during this period of the agreements was adjusted for inflation and weighted population growth, as well as an adjustment for the treatment of

21 Relevant legislation introduced or amended included the *Health Legislation Amendment Act 1983*, *Health Insurance Act 1973*, *National Health Act 1953* and the *Health Insurance Commission Act 1973*; Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004.

22 Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004; Richard B, Scotton, Richard, B, *Milestones on the road to Medibank and Medicare*, *Medical Journal of Australia*, Vol 173, July 2000, pp 5–7; Richard B, Scotton, *Medibank: from conception to delivery and beyond*, *Medical Journal of Australia*, Vol 173, 3 July 2000.

23 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, July 2000, pp 33–34.

24 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, July 2000, pp 33–34.

25 The gap is the amount paid for medical or hospital charges, over and above the rebate from Medicare or private health insurance.

26 Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004.

27 This is a practice that continued with all subsequent Medicare and AHCA agreements; Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, July 2000, pp 34–35.

HIV/AIDS patients and the development of incentives programs including 'casemix' systems,²⁸ day surgery and early discharge programs.

2.22 The *Medicare Agreements Act 1992* contained the key principles underpinning the agreements. These Medicare Principles specified that:

- Principle 1 (Choices of Services): Eligible persons must be given the choice to receive public hospital services free of charge as public patients;²⁹
- Principle 2 (Universality of Services): Access to public hospital services is to be on the basis of clinical need;³⁰ and
- Principle 3 (Equity in Service Provision): To the maximum practicable extent, a state will ensure the provision of public hospital services equitably to all eligible persons, regardless of their geographical location.³¹

1993–1998

2.23 The third round of Medicare Agreements commenced from 1 July 1993. The new agreements were still based upon the three principles in the *Medicare Agreements Act 1992*, however there were some changes to the funding arrangements between the Commonwealth and the states and territories. The base grant continued to be calculated in the same way—adjusted for inflation and for weighted population growth, but two bonus payment pools were introduced to encourage improved public access.³² There were also additional payments including incentives packages for reforms relating to improvements in quality and management of services.³³

2.24 These 'performance-based funding' measures were countered by penalty provisions which were enforced when levels of public patient access fell below the specified base threshold.³⁴

28 'Casemix' is a method of classifying the number and types of patients using hospital systems. Casemix funding is when hospitals are funded on the basis of their output, rather than on the level of funding provided from the previous year. This means that such funding is on the basis of how much each jurisdiction is prepared to pay for the care and treatment the casemix not actually how much it costs to care for and treat a particular mix of patients; Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, 2000, p. 39.

29 Subsection 26(2), *Medicare Agreements Act 1992*.

30 Subsection 26(2), *Medicare Agreements Act 1992*.

31 Subsection 26(2), *Medicare Agreements Act 1992*.

32 Bonus Pool A was to be distributed to States and Territories for additional public bed-days above a benchmark proportion of 51.5 per cent of total bed-days. Bonus Pool B was to be distributed to States and Territories that increased their share of public bed-days over the public share in 1990-91; Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, 2000.

33 Senate Community Affairs References Committee, *First Report: Public Hospital Funding and Options for Reform*, 11 July 2000, pp 35–37.

34 Senate Community Affairs References Committee, *First Report: Public Hospital Funding and Options for Reform*, 11 July 2000, pp 35–37.

Australian Health Care Agreements

1998–2003

2.25 The development of Australian Health Care Agreements (AHCAs) in 1998 were characterised by acrimonious disputes between the Commonwealth and the states and territories over the scope of the agreements.

2.26 Despite the fact that the AHCAs largely re-stated the Medicare Principles, the AHCAs were seen as a significant departure from the Medicare Agreements in that they encompassed greater scope for altering future funding levels and enabled flexibility in service provision. They also included a stronger focus on the provision of equitable access to public hospital services regardless of geographic location.³⁵

2.27 In contrast to the Medicare Agreements, variations to AHCAs base grant were made on the basis of a weighted population index, changes in hospital output costs, changes in the veteran population and private health insurance coverage.³⁶

2.28 Controversially, the agreements included a new provision which enabled grants of financial assistance to be made by the Commonwealth, to entities other than a State, such as a hospital or 'other person'.³⁷ The extension of the Minister's power to make grants to 'other persons' was seen at the time as a 'considerable departure from traditional and current arrangements'.³⁸

2003–2008

2.29 The negotiations for the AHCAs for 2003–2008 were characterised by fraught negotiations between the Commonwealth and the States and Territories that included a walk-out by the states over funding arrangements.³⁹

2.30 Preliminary negotiations at COAG in April 2002 Health Ministers established nine expert reference groups, to provide advice and recommendations on specific areas, such as the interaction between hospital funding and private health insurance, which would inform the process of negotiation for the new AHCAs. Notably, these reference groups were co-chaired by a non-government clinical expert and a senior

35 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, July 2000, p. 37; P. Mackey, *Health Care (Appropriation) Bill 1998, Bills Digest*, 1998 <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;orderBy=customrank;page=0;query=health%20care%20appropriation%20Bill%201998%20mackey;rec=1;resCount=Default> (accessed 5 April 2016).

36 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, 11 July 2000.

37 This meant that the funding was no longer composed of only 'direct' funding to the states and territories but also indirect funding; P. Mackey, *Health Care (Appropriation) Bill 1998, Bills Digest*, 1998.

38 P. Mackey, *Health Care (Appropriation) Bill 1998, Bills Digest*, 1998.

39 PM, *COAG Walkout* – Transcript www.abc.net.au/pm/content/2003/s935154.htm (accessed 6 April 2016); House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007: Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007.

government official. Unfortunately input from the reference groups ultimately had little substantive impact on the new agreements which were signed in August 2003.⁴⁰

2.31 An important condition of the new AHCA was that each State and Territory had to increase funding so that the growth in the States' and Territories' own funding for hospitals would match the cumulative rate of growth in Commonwealth funding over the five year life of the agreements.⁴¹

2.32 The Commonwealth contributed an estimated \$42 billion during the life of the 2003–08 agreements whilst the states collectively contributed about \$58 billion.⁴² However, in contrast to previous agreements, about 4 per cent of AHCA payments to the states and territories were conditional on the states complying with various accountability requirements.⁴³

2.33 The increased emphasis on accountability went further with the new AHCA requiring the Commonwealth to publish an annual report, *The state of our public hospitals*, which 'considers how the states...are performing in the delivery of public hospital services and records their expenditure on public hospitals.'⁴⁴

Development of the Intergovernmental Agreement

National Health and Hospitals Reform Commission

2.34 The National Health and Hospitals Reform Commission (NHHRC) was established in early 2008 to provide advice on progressing health reform.

2.35 Its reports consistently gave strong support for the use of activity-based funding:

40 Stephen J Duckett, *The Australian Health Care Agreements 2003-2008*, Australia and New Zealand Health Policy, 2004, p. 2; House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007): Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007.

41 House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007): Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007, p. 3; House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding*, November 2006, p. 20.

42 House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007): Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007, p. 2.

43 House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007): Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007, p. 20.

44 House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007) : Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007, p. 3; see also Minister's foreword, Department of Health and Ageing, *The state of our public hospitals, June 2006 report*, Commonwealth of Australia, 2006, p. iii.

...as the principal mode of funding for both public and private hospitals, where the level of funding is linked to the volume of services hospitals provide using casemix classifications.⁴⁵

2.36 The NHHRC also argued that activity based funding would provide a 'powerful incentive' for hospitals to perform as efficiently as possible.⁴⁶

2.37 In its first report, *Beyond the Blame Game* (April 2008), the NHHRC provided advice to inform the negotiations around the Australian Health Care Agreements. The report took a long-term view of the health system, identifying key health challenges, developing performance indicators and benchmarks and a set of design and governance principles to underpin the health system of the future.⁴⁷

2.38 The Final Report: *A Healthier Future For All Australians* (June 2009), built on the previous reports, making 123 recommendations and identifying three reform goals:

1. Tackling major access and equity issues that affect health outcomes for people now;
2. Redesigning our health system so that it is better positioned to respond to emerging challenges; and
3. Creating an agile and self-improving health system for long-term sustainability.⁴⁸

Intergovernmental Agreement on Federal Financial Relations

2.39 In 2007 the Rudd Government announced its intention to progress through COAG a range of reforms affecting intergovernmental financial arrangements. When COAG met in December 2007, it:

Recognised that there was a unique opportunity for Commonwealth-State cooperation, to end the blame game and buck passing, and to take major steps forward for the Australian community.⁴⁹

2.40 Following much negotiation, the *Intergovernmental Agreement on Federal Financial Relations* (IGA) was signed in November 2008. The IGA aimed to:

45 National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Interim Report*, December 2008, [www.health.gov.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/\\$File/NHHRC.pdf](http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/NHHRC.pdf), p. 23, (accessed 6 April 2016).

46 National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Interim Report*, December 2008, p. 23.

47 National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Final Report*, Introduction, June 2009, [www.health.gov.au/internet/nhhrc/publishing.nsf/content/1AFDEAF1FB76A1D8CA257600000B5BE2/\\$File/INTRODUCTION.pdf](http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/1AFDEAF1FB76A1D8CA257600000B5BE2/$File/INTRODUCTION.pdf) (accessed 6 April 2016).

48 National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Final Report*, Recommendations, June 2009.

49 Council of Australian Governments, *Communique*, Melbourne, 20 December 2007.

...improve the quality and effectiveness of government services by reducing Commonwealth prescription, aligning payments with the achievement of outcomes and/or outputs and giving States the flexibility to determine how to achieve those outcomes efficiently and effectively.⁵⁰

2.41 As part of this new COAG reform agenda, a program of major health reform was agreed, including targeting elective surgery waiting times, aged care, public dental programs and preventative health.⁵¹ Additionally, from 1 July 2012 the National Healthcare SPP was to be replaced by National Health Reform (NHR) funding, which would be subject to the terms and conditions agreed in the NHRA.

National Healthcare Agreement

2.42 Within the IGA the health sector was covered by the *National Healthcare Agreement* (NHA)⁵² which detailed the objectives, outcomes, outputs and performance indicators, and clarified the roles and responsibilities of the Commonwealth and the states and territories in the delivery of health services.⁵³

2.43 The respective roles and responsibilities of the different tiers of government were classified into three distinct categories:

...those shared by the Commonwealth with the states and territories; those for which the states and territories were solely responsible; and those for which the Commonwealth alone would be responsible.⁵⁴

2.44 The NHA also set out the key principles for the provision of a range of jointly funded health services. National objectives in prevention, primary and community care, hospitals, aged care, social inclusion and indigenous health, sustainability and the patient experience were agreed.

2.45 The IGA committed the Commonwealth to provide funding of \$60.5 billion over five years to the States and Territories to deliver health services. This included:

- the introduction of a more generous indexation formula of 7.3 per cent per annum;
- an additional \$750 million to relieve pressure on public hospital emergency departments;
- an increase to the SPP base of \$4.8 billion over the forward estimates; and
- a package of reforms under the new hospitals and health workforce reform National Partnerships of \$1.7 billion, including a \$1.1 billion health workforce package.⁵⁵

50 Council of Australian Governments, *The Federal Financial Relations Framework*, www.coag.gov.au/the_federal_financial_relations_framework (accessed 6 April 2016).

51 Council of Australian Governments, *Communique*, Melbourne, 20 December 2007.

52 Council of Australian Governments, *The Federal Financial Relations Framework*.

53 Council of Australian Governments, *The Federal Financial Relations Framework*; Council of Australian Governments, *National Healthcare Agreement 2012*.

54 Council of Australian Governments, *National Healthcare Agreement 2012*.

2.46 The NHAs also put into effect activity based funding (ABF) which had been agreed to by COAG in November 2005:

The Commonwealth and the States have also agreed to provide a basis for more efficient use of taxpayer funding of hospitals, and for increased transparency in the use of those funds through the introduction of Activity Based Funding. It will also allow comparisons of efficiency across public hospitals.⁵⁶

2.47 While the states and territories were not be able to redistribute Commonwealth health funding from one sector to another, neither the IGA or NHA specified any conditions in respect of how States or Territories allocated their own funding within sectors.⁵⁷ This was in contrast to the previous series of AHCA's.⁵⁸

National Partnerships

2.48 The IGA also established National Partnership Payments (NPPs) which were underpinned by National Partnership Agreements (NPAs). The NPPs encompassed defined payments for defined periods that could only be used for specific projects/priority areas as detailed in the agreements.⁵⁹

2.49 While the NHA set the broad policy and funding framework, NPPs were structured to drive more specific health outcomes such as those relating to Hospitals and Health Workforce Reform, Preventative Health, Public Hospitals and Indigenous Health. In later years they also expanded to cover health infrastructure, mental health, public dental services, vaccines and other health services such as bowel cancer screening, kids' health checks and antimicrobial surveillance.⁶⁰

55 Council of Australian Governments, *Communique*, Canberra, 29 November 2008.

56 Council of Australian Governments, *Communique*, Canberra, 29 November 2008.

57 Council of Australian Governments, *Intergovernmental Agreement on Federal Financial Relations*, 2008, www.federalfinancialrelations.gov.au/content/intergovernmental_agreements.aspx (accessed 6 April 2016).

58 Council of Australian Governments, *Intergovernmental Agreement on Federal Financial Relations*, 2008.

59 Under the Intergovernmental Agreement on Federal Financial Relations, National Partnership payments to the States are facilitated by the following types of agreements:

- National Partnerships, which support the delivery of specified projects, facilitate reforms or reward those jurisdictions that deliver on nationally significant reforms;
- Implementation Plans, which are not required for all National Partnerships, but may be required where there are jurisdictional differences in context or approach to implementation, or where information additional to the National Partnership is required to increase accountability and transparency; and
- Project Agreements, which are a simpler form of National Partnership, used for low value and/or low risk projects.

Council of Federal Financial Relations, *Agreements*, www.federalfinancialrelations.gov.au/content/npa/default.aspx (accessed 6 April 2016).

60 Council of Australian Governments, *Communique*, Canberra, 29 November 2008.

The National Health and Hospitals Network Agreement

2.50 The National Health and Hospitals Network Agreement (NHHNA) was signed on 20 April 2010 by all states and territories apart from Western Australia.⁶¹

2.51 The NHHNA was structured so as to establish:

- the Commonwealth as:
 - the majority funder of public hospital services...
- Local Hospital Networks (LHNs) with responsibility for the management of hospitals within their networks...
- the states as:
 - responsible for system-wide public hospital service planning, policy and performance (in conjunction with LHNs) and capital planning...⁶²

2.52 As the majority funder of public hospital services under the NHHNA, the Commonwealth agreed to fund 60 per cent of the national 'efficient price' for hospital services, as well as guaranteeing \$15.6 billion in top up funding over 5 years.⁶³

2.53 However, in 2010 the NHHNA arrangements were superseded and under the Gillard Government negotiations began for a National Health Reform Agreement. Although the funding arrangement has changed it was expected that various components of the NHHNA, such as the establishment of Local Hospital Networks would be retained under any new agreement.

National Health Reform Agreement

2.54 The *National Health Reform Agreement* (NHRA) was signed in August 2011. It implemented the National Health Reforms as agreed by COAG in February 2011 under a *Heads of Agreement on National Health Reform*. It also complemented the NHA and included the parties':

...commitments in relation to public hospital funding, public and private hospital performance reporting...⁶⁴

2.55 The provisions of the NHRA were enacted by the *National Health Reform Act 2011*. The NHRA was created with the aim of delivering a nationally unified and locally controlled health system through:

- Introducing a number of financial arrangements for the Commonwealth and states and territories in partnership

61 R de Boer & J Tomaras, *Bills Digest- National Health and Hospitals Network Bill 2010*, 2011, p. 4; R deBoer & R.Webb, *Bills Digest – Federal Financial Arrangements Amendment (National Health and Hospitals Network) Bill*, 2010, p. 3.

62 R deBoer & R.Webb, *Bills Digest – Federal Financial Arrangements Amendment (National Health and Hospitals Network) Bill*, 2010.

63 R deBoer & R.Webb, *Bills Digest – Federal Financial Arrangements Amendment (National Health and Hospitals Network) Bill*, 2010.

64 Council of Australian Governments, *National Healthcare Agreement 2012*.

- Confirming state and territories' lead role in public health and as system managers for public hospital services
- Improving patient access to services and public hospital efficiency through the use of activity based funding (ABF) based on a national efficient price
- Ensuring the sustainability of funding for public hospitals by the Commonwealth providing a share of the efficient growth in public hospital services
- Improving the transparency of public hospital funding through a National Health Funding Pool
- Improving local accountability and responsiveness to the needs of communities through the establishment of local hospital networks (LHNs) and Medicare locals
- New national performance standards and better outcomes for hospital patients.⁶⁵

2.56 As part of the NHRA several initiatives forecasted as part of the NHHNA were implemented. This included the establishment of Local Hospital Networks to deliver decentralised and specialised hospital services across jurisdictions and work with Medicare Locals to deliver integrated care.⁶⁶

2.57 Under the NHRA Commonwealth funding would be delivered via the following arrangements:

- on the basis of activity based payments where practicable, however block funding⁶⁷ and public health funding⁶⁸ will continue where applicable;⁶⁹
- 45 per cent of efficient growth⁷⁰ of activity based services would be funded by the Commonwealth from July 2014 whilst 50 per cent would be funded from 1 July 2017;⁷¹

65 Administrator, National Health Funding Pool, *National Health Reform Agreement summary*, www.publichospitalfunding.gov.au/national-health-reform/agreement, (accessed 11 March 2016).

66 Council of Australian Governments, *National Health Reform Agreement 2011, Schedule D*.

67 Block funding is for teaching and research and to fund small and regional hospitals.

68 Public health funding is paid by the Commonwealth to the states and territories for population health activities.

69 Clause A2, *National Health Reform Agreement 2011*.

70 Efficient growth consists of : a) the national efficient price for any changes in the volume of service provided; and b) the growth in the national efficient price of providing the existing volume of services; Council of Australian Governments, *National Health Reform Agreement 2011*.

71 Clause A3, *National Health Reform Agreement 2011*.

- 45 per cent of growth in the efficient cost⁷² of block grants would be funded by the Commonwealth from July 2014 whilst 50 per cent would be funded from 1 July 2017;⁷³
- an additional \$16.4 billion in Commonwealth funding would be provided through the revised funding arrangements between 2014-15 and 2019-20. This is in addition to what would have been provided through the National Healthcare SPP;⁷⁴ and
- Commonwealth funding would be dependent upon the provision of data by the state and territories to the National Bodies including data on the provision of services to patients; public or private status of the patient, the nature of the service provided and where the service was provided.⁷⁵

2.58 The following National Bodies were established under the NHRA to administer key financial arrangements:

- The Administrator of the National Health Funding Pool—its role is to administer the National Health Funding Pool, to oversee payments into and out of the state pool account for each state and territory, and to report on various funding and service delivery matters.⁷⁶
- National Health Funding Body (NHFB)—its primary function is to assist the Administrator of the National Health Funding Pool (the Administrator) in enabling and supporting more transparent and efficient public hospital funding and reporting.⁷⁷
- Independent Hospital Pricing Authority (IHPA)—its role is to implement Activity Based Funding for Australian public hospital services by delivering an annual National Efficient Price (NEP).⁷⁸

72 'Efficient cost will be determined annually by the Independent Hospital Pricing Authority, taking account of changes in utilisation, the scope of service provided and the cost of those services to ensure the LHN has the appropriate capacity to deliver the relevant block funded services and functions', Clause A4, *National Health Reform Agreement 2011*.

73 Clause A4, *National Health Reform Agreement 2011*.

74 Clause A5, *National Health Reform Agreement 2011*.

75 The requirements are articulated in Schedule B of the *National Health Reform Agreement 2011*; also see Clause A8, *National Health Reform Agreement 2011*.

76 Administrator of the National Health Funding Pool, *The Role of the Administrator*, www.publichospitalfunding.gov.au/administrator (accessed 8 April 2016).

77 National Health Funding Body, *Welcome from the CEO*, www.nhfb.gov.au/ (accessed 8 April 2016).

78 The NEP is a major determinant of the level of Australian Commonwealth Government funding for public hospital services and provides a price signal or benchmark for the efficient cost of providing public hospital services. Independent Hospital Pricing Authority, *What we Do*, www.ihipa.gov.au/what-we-do (accessed 8 April 2016).

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- National Health Performance Authority (NHPA)—its role is to monitor and report on the performance of public and private hospitals, primary health care organisations and other bodies that provide health care services to the community.⁷⁹
 - Australian Commission on Safety and Quality in Health Care (ACSQHC)—its primary function is to lead and coordinate national improvements in safety and quality in health care.⁸⁰

2.59 The funding from Commonwealth and state and territory governments under the NHRA is paid into a NHFP (administered by the NHFPA). Each state and territory also has a separate fund (known as its state managed fund) for receiving Commonwealth NHR block funding via the NHFP, receiving block funding directly from the state or territory itself, and for making payments of block funding by the state or territory to LHNs.⁸¹ Figure 1 below illustrates how the funding between the Commonwealth and the states and territories flows.⁸²

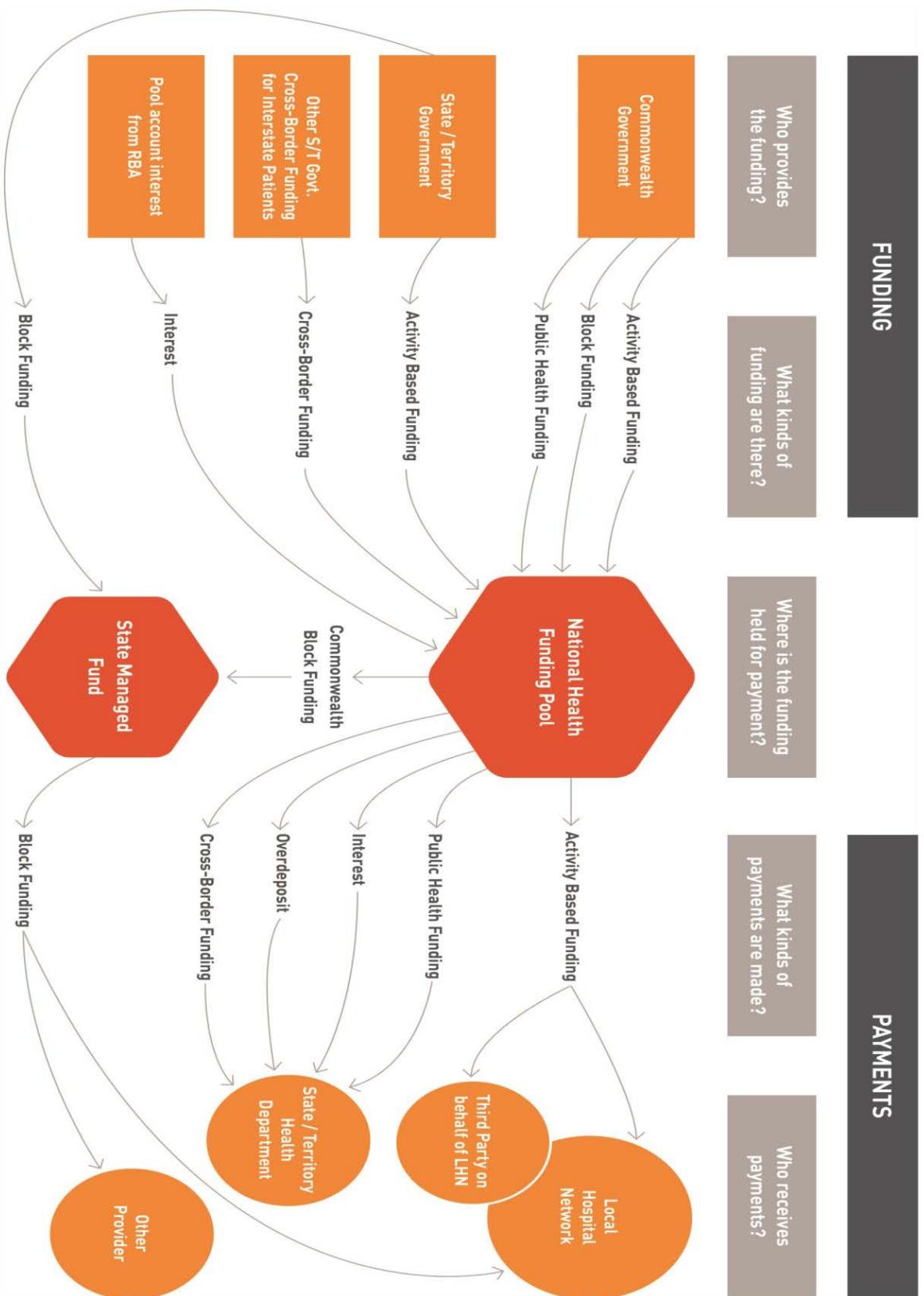
79 National Health Performance Authority, *About Us*, www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/About-us (accessed 8 April 2016).

80 Australian Commission on Safety and Quality in Health Care, *Governance*, www.safetyandquality.gov.au/about-us/governance/ (accessed 8 April 2016).

81 Administrator, National Health Funding Pool, *National Health Reform funding flows*, www.publichospitalfunding.gov.au/national-health-reform/funding-flows (accessed 11 March 2016).

82 Administrator, National Health Funding Pool, *National Health Reform funding flows*.

Figure 1—National Health Reform funding flows



Committee view

2.60 The signing of the NHRA by the states and federal governments in 2011 was an historic point for hospital funding in Australia. This was the first time that hospital funding arrangements were mutually agreed and set out for the longer-term. It was also the first time that a mechanism had been created that encouraged cooperation, through aligned incentives, between the states and federal government to ensure that funding was used efficiently.

2.61 Long-term certainty of funding for Australia's hospitals was a significant casualty of the disastrous 2014-15 Budget. Chapter 3 examines the impact that the 2014-15 Budget decision has had on hospital funding, while the remaining chapters of this report detail the effect on individual states and territories.

2.62 The Senate Select Committee on Health's examination of the issues around hospital funding, through its extensive hearings and the submissions received, has been relatively brief in comparison to the work which went into the National Health and Hospitals Reform Commission in 2008. The NHHRC's work was comprehensive, and laid the foundation for the NHRA; it mapped a way forward to end the 'blame game' between the states and federal governments on hospital funding.

2.63 However, the committee notes that the same issues that were identified by the NHHRC are coming to the fore since the 2014-15 Budget decision. The following chapters demonstrate that with one decision in the 2014-15 Budget, the Coalition Government has put hospital funding back ten years, to face the same issues all over again.

Chapter 3

Commonwealth hospital funding

*The 2014 budget did serious damage to Commonwealth-state relations and the confidence with which states could plan and manage health services. It did this by abrogating an agreement about public hospital funding which had been signed by governments of all political persuasions and unilaterally imposing a new funding model on the states.*¹

Dr Stephen Duckett, Director, Health Program, Grattan Institute

Introduction

3.1 The previous chapter provided the historical context of hospital funding in Australia, and the struggle to find an agreement between levels of government about funding responsibility. As noted in Chapter 2, a forum for cooperation between federal, state and territory governments was achieved in 2011 when all parties signed the National Health Reform Agreement (NHRA). As a result of this agreement, long term funding certainty, through until at least 2024-25 was achieved for hospital funding.

3.2 This chapter examines the impact of the Coalition Government's decision to cease the funding mapped out under the NHRA. The effects of this decision, made in the highly criticised 2014-15 Budget, have reached further than just the removal of funding. This chapter also looks at:

- the need for a mechanism that promotes cooperation between state and federal governments on hospital funding and planning;
- missed opportunities to promote reform in hospital funding;
- the need for long-term, sustainable funding which allows for workforce planning and infrastructure development; and
- issues that have emerged or been exacerbated by the removal of certainty in hospital funding.

2014 changes to Commonwealth hospital funding

Unsustainable health spending myth

3.3 A key element in the Coalition Government's justification of the cuts to hospital funding was the argument that government expenditure on health was unsustainable.² The same argument was used to justify the \$7 co-payment policy, later scrapped, and the continuing freeze on MBS indexation.³

1 Dr Stephen Duckett, Director Health Program, Grattan Institute, *Committee Hansard*, 4 November 2015, p. 1.

2 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

3 See the committee's first and second interim reports for further discussion of these policies.

3.4 This argument has been widely disputed. In its *Public Hospital Report Card 2015*, the Australian Medical Association (AMA) observed in relation to the Coalition Government's health and hospital funding cuts:

The Government has justified its extreme health savings measures on the claim that Australia's health spending is unsustainable. But Australia's health financing arrangements are not in crisis.

In 2012-13, Australia had the lowest growth (1.5 per cent) in total health expenditure since the Government began reporting it in the mid-1980s. Without any specific Government measures, there was negative growth (minus 2.2 per cent) in Commonwealth funding of public hospitals in 2012-13, and only 1.9 per cent growth in 2011-12. Our health sector is doing more than its share to ensure health expenditure is sustainable.

Australia's expenditure on health has been stable as a share of GDP, growing only one per cent over the last 10 years. Health expenditure does not demand radical changes to existing services.⁴

3.5 Compared to other OECD countries, Australia spends just below the OECD average for health funding. In 2015, Australia spent 9.7 per cent of GDP⁵ on health, while in comparison the US spent 16.4 per cent of GDP,⁶ Canada spent 10.2 per cent,⁷ and the UK spent 8.5 per cent.⁸ The OECD *Health at a Glance 2015* notes that Australia's health expenditure 'achieves good outcomes relatively efficiently'.⁹

2014-15 Budget cuts to hospital funding

3.6 The *2014-15 Budget Overview* incorrectly categorised hospital funding as primarily a state responsibility:

State Governments have primary responsibility for running and funding public hospitals and schools. The extent of existing Commonwealth funding to public hospitals and schools blurs these accountabilities and is unaffordable.¹⁰

4 AMA, *Public Hospital Report Card 2015*, April 2015, p. 2.

5 AIHW, *25 years of health expenditure in Australia: 1989-90 to 2013-14*, 5 February 2015, www.aihw.gov.au/publication-detail/?id=60129554398

6 OECD, *Country Note: How does health spending in the United States compare?*, 7 July 2015, www.oecd.org/unitedstates/Country-Note-UNITED%20STATES-OECD-Health-Statistics-2015.pdf

7 OECD, *Country Note: How does health spending in Canada compare?*, 7 July 2015, www.oecd.org/els/health-systems/Country-Note-CANADA-OECD-Health-Statistics-2015.pdf

8 OECD, *Country Note: How does health spending in the United Kingdom compare?*, 7 July 2015, www.oecd.org/unitedkingdom/Country-Note-UNITED%20KINGDOM-OECD-Health-Statistics-2015.pdf

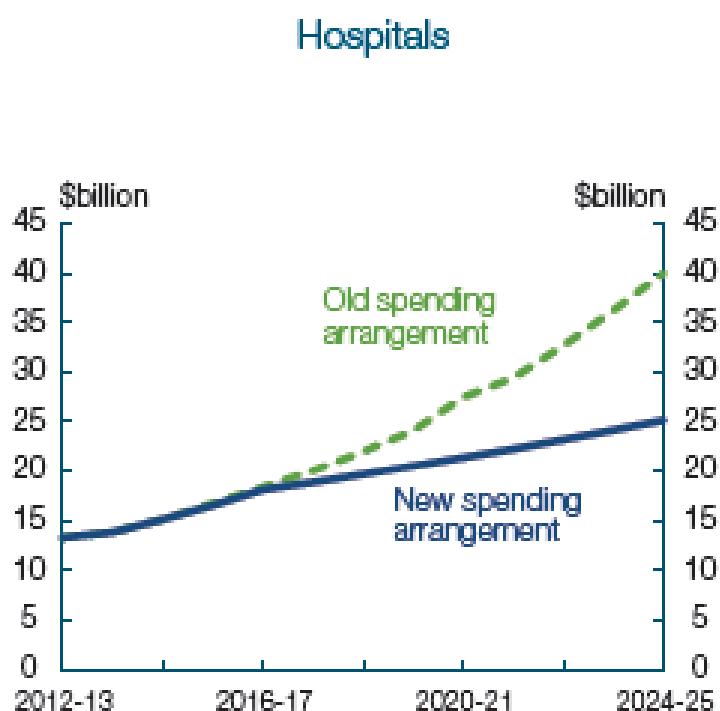
9 OECD, *Health at a Glance 2015: How does Australia Compare?*, p. 1. www.oecd.org/australia/Health-at-a-Glance-2015-Key-Findings-AUSTRALIA.pdf

10 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

3.7 On this argument, the government used the 2014-15 Budget to unilaterally cancel the NHRA, signed by the states and Commonwealth governments in 2011, and terminate various health-related National Partnership Agreements.¹¹ States were 'expected to continue contributing to these arrangements at their expense.'¹²

3.8 As part of the 2014-15 Budget, the Federal Government pledged that from 2017-18 Federal Government funding would revert to the former block funding model based on indexation at the Consumer Price Index (CPI) and population growth.¹³ Despite promising "no cuts to health", the Federal Government projected that this new funding arrangement would save over \$57 billion between 2017-18 and 2024-5.¹⁴ Figure 1, reproduced from the *2014-15 Budget Overview*, shows the government's projected reductions to hospital funding.

Figure 1—projected hospital funding cuts from the 2014-15 Budget¹⁵



11 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

12 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

13 Australian Government, 'Part 2 Expense Measures', *Budget measures: budget paper no.2: 2014-15*, www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm (accessed 5 April 2016); Administrator, National Health Funding Pool, *Basis of Commonwealth NHR Funding*, www.publichospitalfunding.gov.au/national-health-reform/reporting-basis-commonwealth (accessed 11 March 2016).

14 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7. The \$57 billion figure was used at the Senate Economics Committee Estimates hearings in 2014, while the \$56 billion figure was calculated by the PBO, based on information in the NHRA.

15 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7. In the graph, the green line of the 'old spending arrangement' represents the NHRA funding, while the blue line represents the indexed funding arrangements in the 2014-15 Budget.

3.9 The Coalition Government's 2014-15 Budget was widely criticised. For example Dr Stephen Duckett, Director of the Grattan Institute's Health Program, told the committee:

The 2014 budget provided that future indexation to the states would be in line with:

... a combination of the Consumer Price Index and population growth.

If this is taken at face value, then the 2014 proposal is the most parsimonious indexation arrangement that has ever applied to public hospital funding grants.¹⁶

3.10 The Budget Overview went on to explain that the responsibilities of the different levels of government would be the subject of a White Paper on the Reform of Federation, to be completed at the end of 2015.¹⁷ The recently abandoned White Paper process is discussed further below.

Impact of hospital funding cuts on states and territories

3.11 The committee sought a submission from the Parliamentary Budget Office (PBO) in order to gain a clearer understanding of the impact the Coalition Government's funding cuts will have on each state and territory. The submission is reproduced at Appendix 4. Figure 2, which is based on the PBO's findings, shows the funding each state and territory will lose as a result of the 2014-15 Budget.

3.12 The funding cuts calculated in the PBO's submission relate to the 2014-15 Budget decision. These preceded the April 2016 COAG agreement to partly reinstate funding out to 2020. While this COAG decision, discussed below, has partially mitigated the 2014-15 Budget cuts, the \$2.9 billion allocated across three years (2017-18 to 2019-20) is not adequate to address the \$7.9 billion shortfall over this same period created by the 2014-15 Budget cuts.

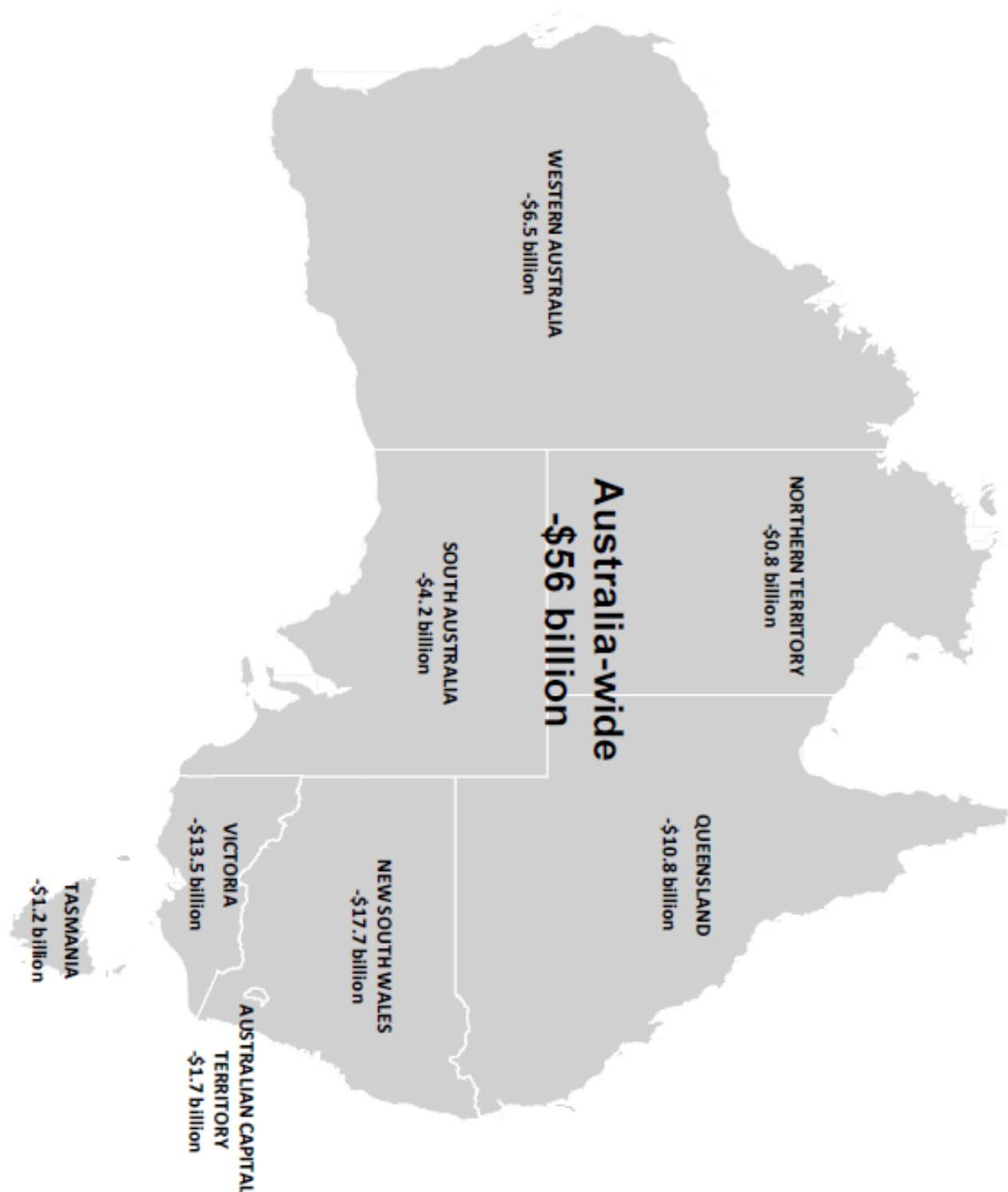
3.13 During its inquiry, the committee has undertaken 52 hearings and held public hearings and site visits in every state and territory. The following eight chapters focus on each of the states and territories, detailing the extent of the loss of funding and the issues which have arisen for each state. While state governments have, to a large extent, provided short-term additional funding to cover the immediate Commonwealth shortfall, this situation is unsustainable long term. The loss of certainty over long term funding has also meant that state governments are unable to forward plan workforce and infrastructure and must subsist from budget to budget.

3.14 In addition to state-specific issues, there are also some issues caused by the cuts to hospital funding that are Australia-wide. These range from high-level policy questions, such as the need for a mechanism for cooperation between the states and federal governments, to grassroots impacts, such as increased waiting times. These national implications are discussed throughout this chapter.

16 Dr Stephen Duckett, Director Health Program, Grattan Institute, *Committee Hansard*, 4 November 2015, p. 1.

17 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

Figure 2—Commonwealth hospital funding cuts from the 2014-15 Budget¹⁸



18 Source: Parliamentary Budget Office, *Submission 191*, Table 1, p. 5. Under the previous government, hospital funding was to be provided under the 2011 National Health Reform Agreement. The government policy introduced in the 2014-15 Federal Budget would have indexed funding by CPI and population growth from 2017-18 to 2024-25. Dollar amounts in the above diagram have been rounded.

'Skin in the game'

Removal of the mechanism for state and federal cooperation

3.15 As described in Chapter 2, the history of hospital funding in Australia has been marked by a struggle to find a means of settling the respective contributions of the state and federal governments. Of particular importance has been the need to avoid short-term funding agreements and instead establish sustainable long-term funding arrangements.

3.16 The Coalition Government's unilateral abandonment of the long-term NHRA did more than remove Commonwealth hospital funding. It caused the loss of goodwill in state-federal cooperation on health. Dr Stephen Duckett, Director of the Grattan Institute's Health Program, described the 2014-15 Budget as having done 'serious damage to Commonwealth-state relations and the confidence with which states could plan and manage health services.' It did this by:

...abrogating an agreement about public hospital funding which had been signed by governments of all political persuasions and unilaterally imposing a new funding model on the states. The funding model promulgated in the 2014 budget was presented in the budget papers as saving more than a billion dollars over the forward estimates, with savings described as being in the tens of billions over the ensuing decade. The words 'saved' and 'savings' are an example of creative accounting. They are savings to the Commonwealth budget only, but are not real savings to the public purse at all. Instead, they are simply a massive and unsustainable transfer of costs from the Commonwealth budget to state budgets.¹⁹

3.17 Dr Duckett categorised the NHRA as having 'dealt with some of the dysfunctional aspects of federalism in health care'. The agreement had done this by:

...creating an alignment of incentives. It made the Commonwealth share directly in the costs of activity growth in health care, which gave it an incentive to develop policies in its sphere that might mitigate that growth. For example, the Commonwealth traditionally funds primary care, while the states fund hospital care. Making the Commonwealth share responsible for hospital funding gave it a stronger incentive to improve primary care and reduce the number of avoidable and expensive hospital visits, generating actual savings to the public purse. The 2014 budget removed that alignment of incentives.²⁰

3.18 Professor Mike Daube, Director of Public Health Advocacy Institute of Western Australia at Curtin University, agreed with Dr Duckett. Professor Daube described the situation after the 2014 cancellation of the NHRA funding agreement as:

There is a whole lot in limbo now. I must say I think it created distrust of central government, because if you have agreements that are supposed to be

19 Dr Stephen Duckett, Director Health Program, Grattan Institute, *Committee Hansard*, 4 November 2015, p. 1.

20 Dr Stephen Duckett, Director Health Program, Grattan Institute, *Committee Hansard*, 4 November 2015, p. 1.

lasting and suddenly they are cut then the state governments which had to implement them will have people on contracts and so on, because they would have assumed that the funding would continue. So it creates distrust for them. It creates uncertainty out in the community...²¹

3.19 In the two years since the 2014-15 Budget, there has been much debate about the role of the Federal Government in hospital funding. The Reform of the Federation White Paper process has been part of that debate, although not to the same extent as the ongoing criticisms of the 2014-15 Budget by groups like the AMA.

Reform of the Federation White Paper

3.20 The White Paper process was begun in the first half of 2014. Its main objective was to 'clarify roles and responsibilities to ensure that, as far as possible, the states and territories are sovereign in their own sphere.'²² Other objectives included reducing duplication between levels of government and improving the efficiency of the federation.²³

3.21 As part of the White Paper process, issues papers regarding various aspects of the federation, including health and hospital funding, were produced in the second half of 2014. However the Green Paper, which was to be released in the first half of 2015, was not published until after it had been leaked in June 2015.²⁴

3.22 The 'discussion paper', as the leaked Green Paper was titled, lists five options for reform of hospital funding. These range from a shared responsibility for funding between the state and Federal governments to sole funding responsibility resting on state and territory governments:

- establishment of a benefit scheme similar to the Medicare Benefits Schedule for all hospital treatments;
- Commonwealth and states jointly fund individualised care packages for chronic or complex conditions;
- establishment of regional purchasing agencies to source health services geographic areas;
- Commonwealth becomes solely responsible for funding; or

21 Professor Mike Duabe, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, 10 October 2014, p. 27.

22 Department of Prime Minister and Cabinet, *Reform of Federation White Paper: Terms of Reference*, website, <https://federation.dpmc.gov.au/terms-reference>

23 Department of Prime Minister and Cabinet, *Reform of Federation White Paper: Terms of Reference*.

24 Phillip Coorey, Australian Financial Review, *Leaked proposal suggests states may lose \$18b healthcare funding*, 22 June 2015, www.afr.com/news/politics/leaked-proposal-suggests-states-may-lose-18b-healthcare-funding-20150621-ghu001; Dan Conifer, ABC News Online, *Federal Government plays down discussion paper's 'secret plan' to strip billions in hospital funding from states and territories*, 23 June 2015, www.abc.net.au/news/2015-06-23/states-and-territories-could-lose-billions-in-health-funding-an/6565810

- states take full responsibility for public hospitals.²⁵

3.23 It had been anticipated that federation reform would be part of the COAG leaders' retreat on 23 July 2015, but the topic was not covered in the communique for that meeting. Reform was discussed at the 11 December 2015 COAG meeting, but leaders only agreed to further consideration of health funding at the first COAG meeting of 2016.²⁶

3.24 The White Paper on federation reform had been scheduled for publication at the end of 2015, but this did not happen. Instead, a variation of the options in the 'discussion paper' was put to the COAG meeting held on 1 April 2016, leading to an agreement to extend activity based funding to 2020 (discussed further below).

3.25 On 28 April 2016, the Prime Minister confirmed that the Reform of Federation White Paper process had been scrapped, with no White Paper to be released.²⁷ The cost of the process was reported to be in excess of \$5 million.

3.26 The Reform of the Federation White Paper website explains that:

...work to improve federal financial relations and the transparency of government spending will be progressed by the Council on Federal Financial Relations, and the Commonwealth, state and territory Treasuries. A progress report will be brought to the next COAG meeting.²⁸

Committee view

3.27 The Reform of Federation White Paper could have been a valuable process for rebuilding state-federal relations after the disastrous 2014-15 Budget. Instead, it has been significant waste of public money, and has only resulted in returning state-federal relations back to the often combative forum of COAG.

April 2016 COAG agreement

3.28 On 1 April 2016 the Prime Minister, the Hon Malcolm Turnbull MP, faced a hostile COAG meeting with states and territories concerned that the 2014-15 Budget cuts to hospital funding would leave them unable to provide adequate hospital services.²⁹ The Prime Minister's proposal to the states was for an additional \$3 billion

25 Department of Prime Minister and Cabinet, *Reform of Federation White Paper: Discussion Paper*, website, <https://federation.dPMC.gov.au/publications/discussion-paper>

26 COAG, 11 December 2015, *Communique*, www.coag.gov.au/node/529

27 Eliza Borrello, ABC News Online, *Malcolm Turnbull scraps federation white paper after \$5 million work*, 28 April 2016, [www.abc.net.au/news/2016-04-28/malcolm-turnbulls-\\$5-million-tax-white-paper-scrapped/7367204](http://www.abc.net.au/news/2016-04-28/malcolm-turnbulls-$5-million-tax-white-paper-scrapped/7367204)

28 Department of Prime Minister and Cabinet, *Reform of Federation White Paper*, website, <https://federation.dPMC.gov.au/>

29 Liz Jackson, ABC Radio PM Program, *Thousands will go untreated in SA public hospitals under current funding: report*, 29 March 2016, www.abc.net.au/pm/content/2016/s4433224.htm

over three years for hospital funding, and the possibility that the states could raise their own income taxes as funding for the longer term.³⁰

3.29 While the income tax proposal was rejected by the states, COAG did agree to a Heads of Agreement for hospital funding to run from 1 July 2017 to 30 June 2020 'ahead of longer-term arrangements'.³¹ Additional Commonwealth funding under the agreement was to be \$2.9 billion between 2017-18 to 2019-20, with growth capped at 6.5 per cent per year.³² The funding was to be provided primarily on the basis of activity based funding and block funding under certain circumstances as set out under the NHRA.³³

3.30 For their part in the agreement, states undertook to:

- reduce demand for hospital services through better coordinated care, particularly for people with complex and chronic diseases;
- improve hospital pricing mechanisms; and
- reduce the number of avoidable hospital readmissions.³⁴

3.31 Although the April 2016 agreement provides partial and short-term respite from the full force of the 2014-15 Budget funding cuts, the additional funds in the agreement fall well short of the funding states would have accessed under the NHRA. Instead of the NHRA's funding increase of 9 per cent per annum, the states will see funding growth capped at 6.5 per cent, only 2 per cent improvement on the 4.5 per cent rate unilaterally imposed by the 2014-15 Budget.³⁵

3.32 As discussed earlier, the additional \$2.9 billion figure compares poorly with the funding increase of \$7.9 billion which would have flowed to the states had the government not abandoned the NHRA.³⁶

30 Lenore Taylor, *The Guardian Australia*, *Turnbull looks to income tax-raising powers for states to fix school and hospital funding*, 30 March 2016, www.theguardian.com/australia-news/2016/mar/29/states-offered-5bn-hospitals-funding-income-tax-raising-powers

31 COAG, 1 April 2016, *Communique*, www.coag.gov.au/sites/default/files/COAG_Communique.pdf

32 COAG, 1 April 2016, *Communique*.

33 Heads of Agreement 1 April 2016, www.coag.gov.au/sites/default/files/Heads%20of%20Agreement%20between%20the%20Commonwealth%20and%20the%20States%20on%20Public%20Hospital%20Funding%20-%201%20April%202016_0.pdf

34 COAG, 1 April 2016, *Communique*.

35 Lenore Taylor, *The Guardian Australia*, *Malcolm Turnbull promises states hospital funding in budget after Abbott cuts*, 24 February 2016, www.theguardian.com/australia-news/2016/feb/24/malcolm-turnbull-promises-states-hospital-funding-in-budget-after-abbott-cuts

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

Need for long-term, sustainable funding

3.33 The April 2016 COAG agreement is welcome in that it is an improvement on the hospital funding cuts contained in the 2014-15 Budget. However, it does not go towards solving the larger problem: that a long-term funding agreement is urgently needed to replace the NHRA which was abandoned in the 2014-15 Budget.

3.34 Since May 2014, state and territory governments have been forced to operate in an atmosphere of uncertainty. States have faced the fact that Commonwealth funding will decrease from the expected NHRA levels, and have been planning how to mitigate the worst impacts of the loss. In South Australia, representatives of the Department of Health and Ageing told the committee that their ability to plan for future hospital services is compromised by the uncertainty around funding:

It is clear that where the Commonwealth provides funding it is welcome by the state. However, South Australia and SA Health is keen to ensure that any benefits of reform measures...are durable in the long term. SA Health's ability to undertake budgetary and service planning is compromised by uncertainty created by the Commonwealth. Uncertainty remains about public hospital funding. National Health Reform Agreement arrangements are unlikely to be clarified until the release of the Commonwealth's white paper on the reform of the federation in 2016.

SA Health looks forward to the ideas to be presented by the Commonwealth about future roles and responsibilities for the health system as part of this process. The present situation leaves the state bearing the risks associated with growing demands on hospital costs and without the resources to meet the expected growth. The state has had limited ability to influence the full range of policy levers across the health system as a whole that drive demand and public hospital services. This is not a sustainable process for the health system in the future.³⁷

3.35 In Victoria, representatives from the Department of Health and Human Services told the committee that the Commonwealth is a 'critical partner' for states in providing high quality hospital services:

The adoption of activity based funding as the basis for Commonwealth funding contributions in 2011 signalled a commitment to carry a share of hospital demand growth. To give that some perspective, Commonwealth funding for public hospitals grew by an average of 6.6 per cent per annum for the decade to 2010-11, growing to 7.1 per cent per annum to 2013-14. And growth was estimated at 9.4 per cent beyond the 2013-14 forward estimates, based on projected growth for Victorian public hospitals published in the 2013-14 MYEFO.³⁸

37 Ms Skye Jacobi, Director, Intergovernment Relations and Ageing, Department for Health and Ageing, South Australia, *Committee Hansard*, 11 June 2015, p. 21.

38 Ms Kym Peake, Acting Secretary, Victorian Department of Health and Human Services, *Committee Hansard*, 4 November 2015, p. 39.

3.36 The experience was similar in Queensland. Ms Kathleen Forrester, Deputy Director-General Department of Health, told the committee that the NHRA had provided a 'new and very different Commonwealth funding methodology' which:

...created the financial incentives for all levels of government to work together to ensure the health system functions efficiently and holistically to improve overall health outcomes. Furthermore, the methodology accounted for all the main drivers of public hospital service cost growth, because it is based on the actual increase in the volume of public hospital services provided to patients.³⁹

3.37 In comparison, the 2014-15 Budget decision to base funding on indexation of CPI and population growth would 'break the link established...between Commonwealth funding and efficient [growth] in public hospital services, reducing the financial incentives for all aspects of the health system to work together to improve outcomes.'⁴⁰ The result would be:

...the major costs associated with other drivers of healthcare demand would be borne by the states and territories, leading to an ever-increasing share of state funding and a declining Commonwealth share. 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.⁴¹

State issues

3.38 Chapters 4 to 10 of this report provide details of the impact of the Federal Government's hospital funding cuts on each state and territory. While the cuts had not been due to begin until 2017-18, the announcement of the decision in the 2014-15 Budget included the removal of many of the National Partnership Agreements which had provided funds to states and territories as part of the NHRA. The effect of the funding cuts was therefore immediate, and states had to begin planning for how to make up the shortfall in funds.

3.39 National Partnership Agreements, such as that relating to improving hospital services, provided significant benefit, particularly to smaller states and territories. In these cases, the funding cuts were felt most acutely. The Northern Territory Chief Minister, the Hon Adam Giles MLA, described the loss of the National Partnership Agreement funding:

39 Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

40 Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 15.

41 Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

Contrary to comments made by the Prime Minister today, the pain from these front line service cuts will start being felt by the States and Territories from July 1, 2014.

Let's look at two examples. In 43 days time, the Territory stands to lose \$1.4 million in Federal funding for pensioner concessions and health funding will be cut by \$33.8 million or the equivalent of a minimum of ten hospital beds.

These funding decisions will have a real and immediate impact on the front line services offered to Territorians.⁴²

3.40 Many states pledged to cover the immediate funding gap themselves; however, that situation is not sustainable beyond the very short term. Issues have already begun to emerge which demonstrate that without a state-federal funding partnership, the states cannot adequately support Australia's hospitals.

Committee view

3.41 Since its establishment in June 2014, the Senate Select Committee on Health has seen other disastrous health policies from the 2014-15 Budget scrapped or put on hold. But while the government has reversed ill-conceived policies like the \$7 co-payment, the cuts to hospital funding have lasted until 2016, when backlash from the states forced the government to make a temporary and partial extension of funding.

3.42 Before the NHRA was agreed in 2011, respective hospital funding contributions had been a struggle between the state and federal governments. The reforms to hospital funding implemented by the previous government allocated virtually equal responsibility for funding to the state and federal governments, and created a mechanism for all parties to work together to ensure that funds were used efficiently.

3.43 When the Federal Government unilaterally tore up the NHRA in the 2014-15 Budget, the action set hospital funding arrangements back ten years. The decision obliterated states' confidence in any federal-state funding negotiation process. State hospital infrastructure and workforce planning, which was appropriately based on the long-term funding agreement in the NHRA, was thrown into uncertainty. State governments struggled to figure out how to make up the shortfall in funding; many admitting that it would not be possible unless funding was taken from other areas.

3.44 The defining achievements of the NHRA were to:

- provide long-term funding and continuity of funding to enable workforce and infrastructure planning;
- create a forum for states and federal governments to work together on hospital funding; and

42 Chief Minister, the Hon Adam Giles MLA, 'Territory Health and Education Funding Under Threat', media release, May 2014, www.chiefminister.nt.gov.au/media-releases/territory-health-and-education-funding-under-threat

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- establish an activity based funding model and the associated national efficient price for hospital services.

3.45 The Government's 2014-15 Budget decision to allocate federal hospital funding based on indexation of CPI and population growth, and unilaterally scrap the NHRA, has:

- destroyed state and territory government confidence in negotiation with the federal government;
- removed the best forum for state-federal partnership and cooperation over hospital funding; and
- created a shortfall in hospital funding that the state governments are struggling to cover.

3.46 The Federal Government claimed in 2014 that the Budget measures were put in place because health funding was unsustainable. In actual fact, the 2014-15 Budget has created the situation where hospital funding, with the burden shifted significantly to the states, is unsustainable.

3.47 Although the COAG agreement of April 2016 has partially mitigated the damage done by the 2014-15 Budget, the future of hospital funding is bleak. At best the three year agreement has created space for the federal government to work to rebuild the confidence of the states and establish a long-term agreement on hospital funding, backed by fair, equitable and sustainable federal funding.

3.48 As the following chapters of this report show, the NHRA had been working effectively to distribute funding in a responsible and equitable way to public hospitals. The Coalition Government unilaterally scrapped the NHRA and replaced it with what can only be described as an omnishambles or 'a situation that has been comprehensively mismanaged, characterised by a string of blunders and miscalculations'.⁴³

3.49 The committee believes that there is only one way Commonwealth-state hospital funding arrangements can be repaired, and that is to work through the NHRA. The committee's recommendations go towards this goal.

3.50 In building on the NHRA, rather than the omnishambles created by the 2014-15 Budget and the Government's misguided actions since, the committee believes that the Federal Government needs be a partner with the states in terms of hospital funding. Without 'skin in the game', there is no incentive to work with state governments to ensure that funding is used efficiently. The Federal Government needs to urgently build goodwill with the state and territory governments, in order to create a solid foundation for any future funding agreement.

Recommendation 2

3.51 The committee recommends that the Government reconstitute the National Health and Hospitals Reform Commission or a similar body to review hospital funding arrangements and build on the National Health Reform Agreement. This process should be guided by the principles of equity, fairness, adequate funding and long-term certainty to ensure the continuity of public hospital services.

3.35 While the committee is pleased that the Federal Government has made a temporary agreement with the states until 2020, which partially restores the withdrawn NHRA funding, the committee believes that this is not sufficient. Until recently, the Federal Government was actively working to remove the mechanisms by which activity based funding was set up. The committee urges the government to halt the closure of the Independent Hospital Pricing Authority, and the other structures put in place by the former government to implement activity based funding.

3.52 The committee supports activity based funding as the best means of delivering limited funds in a manner that drives greater efficiencies and provides a strong incentive for the Commonwealth to improve primary care and reduce the number of avoidable and expensive hospital visits.

Recommendation 3

3.53 The committee recommends that the Government urgently give an undertaking that the mechanisms for activity based funding, such as the Independent Hospital Pricing Authority, and the other structures put in place by the former government to implement activity based funding, will not be dismantled.

Chapter 4

Impacts on New South Wales hospitals

*The annual hospitals budget, from New South Wales, is about \$20 billion. That is one year's salary, effectively... You can close the system for a year or you can fund to meet demand... \$18.3 billion so it is, virtually, a year's New South Wales hospital budget worth of cuts.*¹

Dr Andrew McDonald, paediatrician, Campbelltown Hospital

Introduction

4.1 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.

4.2 The PBO's figures show that New South Wales (NSW) will lose the most of any state or territory, with \$17.6 billion in hospital funding lost over an eight year period due to the government's abandonment of the carefully negotiated national health agreement.² The annual funding differences are set out in Appendix 4.

State-wide impacts

4.3 After the 2014-15 Budget cuts were announced, the NSW Government's reaction was similar to other states and territories, with the Premier, the Hon Mike Baird MP, expressing anger over the cuts:

Mr Baird said it was a “kick in the gut” for people in the state.

“What services would (they) like us to cut here in NSW on the back of the funding cuts that we’ve seen overnight?” he asked.³

4.4 The NSW Treasurer, the Hon Andrew Constance MP, estimated that to make up the loss from the 2014-15 Budget decision to scrap the NHRA, including the

1 Dr Andrew McDonald, private capacity, *Committee Hansard*, 23 March 2016, p. 39.

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

3 Charis Chang and Mal Farr, News.com.au, *Federal Budget 2014 cuts to health and education spending sparks talk of GST increases*, 14 May 2014, www.news.com.au/finance/economy/federal-budget-2014-cuts-to-health-and-education-spending-sparks-talk-of-gst-increases/story-fn84fgcm-1226917445787

immediate cessation of several National Partnership Agreements, NSW would have to find an additional \$1.2 billion over the next four years.⁴

4.5 Professor Bradley Frankum, Vice President of the AMA NSW Branch, told the committee that the AMA estimated the impact of the 2014-15 Budget cuts as equivalent to closing five and a half hospitals the size of the Westmead Hospital:

This would happen over a period of time between 2017-18 and 2024-25. That is short enough that the effects will be felt keenly and immediately but long enough to be sufficiently insidious that the true cause would be masked by the political cycle.⁵

4.6 Professor Frankum explained that the funding cuts would make it impossible for NSW hospitals to keep up with population growth and demand for services. Using the Westmead Hospital as an example, he told the committee:

We could have chosen others, but Westmead is a large and well-known hospital that saw nearly 1½ million patients in 2014-15. It is a hospital in Western Sydney where the numbers of people with multiple chronic illnesses are growing and demand for hospital services is growing rapidly. It, like Blacktown, Bankstown and many other centres in Western Sydney, is seeing surges in patient numbers that are outpacing population growth. I personally live and work in Campbelltown and I see firsthand the impact of a system that is struggling to keep up with growth. After July 2017, it is the federal government's plan to link state health funding to population growth, even though it is demonstrably the case now that demand for health service is rising faster than the population. There is no reason to think that will not continue.⁶

4.7 Professor Frankum also observed that the funding cuts impacted the ability of state governments to plan for the health services needed in the future:

...the longer the uncertainty over funding continues, the worse the federal government is making it for hospitals. To plan for the health needs of a community the size of New South Wales, you need to be able to plan years in advance. The way things are currently, we have a public health system with a plan up until next year, really. Obviously it is not a problem unique to our state, but New South Wales has the highest population of any state in the country.⁷

4 Charis Chang and Mal Farr, News.com.au, *Federal Budget 2014 cuts to health and education spending sparks talk of GST increases*, 14 May 2014.

5 Professor Bradley Frankum, Vice President, Australian Medical Association (NSW), *Committee Hansard*, 27 November 2015, p. 17.

6 Professor Bradley Frankum, Vice President, Australian Medical Association (NSW), *Committee Hansard*, 27 November 2015, p. 17.

7 Professor Bradley Frankum, Vice President, Australian Medical Association (NSW), *Committee Hansard*, 27 November 2015, p. 17.

Lack of funding is impacting clinical effectiveness and patient care

4.8 Professor Frankum's colleagues, Dr Andrew Pesce and Dr Antony Sara, told the committee that in NSW hospitals there was already a tough budgetary choice to be made between forward planning for workforce and infrastructure, and day-to-day delivery of services:

Senator McLUCAS: Funding to drive the change, is that what you are talking about?

Dr Pesce: Yes. If the priority is to save money, it is very hard to reform the system.

Dr Sara: It becomes impossible. Essentially, the managers and doctors in those hospitals and districts go into further spiralling into a pit of despair. You would be unable to do any of the strategic planning stuff [workforce planning and infrastructure] that [Dr Andrew Pesce] has talked about; it just becomes a race to the bottom. That has been happening in South Australia over the last couple of years, and it is a nightmare. They are not looking at reconfiguration, they are just looking at slashing and burning. Then people start thinking about their jobs. They start thinking about which patients gets the care and which do not. Any rational basis for planning delivery of health services just goes out the door.⁸

4.9 At a grassroots level, the impact of funding cuts is severe. At the committee's hearing in Campbelltown in March 2016, Dr Karuna Keat and Dr Andrew McDonald, both appearing in a private capacity, provided examples of the impact of budget cuts on services levels:

Dr McDonald: I will tell you a story. I was phoned at 11 o'clock last night by the mother of a child who I had sent home that morning. She brought her back because I had given her my mobile number on the off chance that this child is not well, and it was not. She rang me in tears because she could not get a bed. There were two beds in that department which were not being used. They were not being used because the staff to open them had not been employed for the night shift. That is what happens if you cut money out of the budget. You shave staff, and people cannot get help when they need it. All this four-year-old child needed was a bed to lie down on—that was it. She did not even have a flat surface so she cuddled a mother in the waiting room even though she had only been sent home from hospital that morning and was not well. This is what happens if you cut funding on an individual patient basis.

Dr Keat: ...If you do not have the nursing staff to open those beds, you get an overflow. There have been situations whereby we have had patients waiting in corridors for a bed on a ward or for a designated bed in a full bed ward. This particularly happens over the winter period. Planners try to anticipate for that and the hospital does try and anticipate for that but we have a turnover where a third of our presentations in emergency end up in a

8 Dr Andrew Pesce, and Dr Antony Sara, Councillors, Australian Medical Association (NSW), *Committee Hansard*, 27 November 2015, p. 19.

hospital bed; they need to be in a hospital bed. We have more rapid turnover beds than pretty much any other hospital in the state in the number of patients per bed. There are always points. There are better days but there are bad days. I get a text message from the executive saying: 'Please can review your [patients] for discharge.' It is not like we do not review our patients for discharge but the executive want it more urgently so there are circumstances where you go, 'Hold on, I might send that patient home a bit earlier even I am not completely comfortable because I need to get another patient in for another procedure.' In winter there are no beds for elective procedures.⁹

4.10 Dr Keat gave the committee a further example regarding elective surgery:

We have patients who need muscle biopsies to make a diagnosis for changes in treatment or for aggressive treatment we need to give but we need a bed for that because it needs anaesthetic but we cannot necessarily book that patient in for an elective procedure which would save hospital beds to a degree. We know if it is going to happen that day, we will bring the patient in that evening. The next morning they have the procedure and potentially go home the next evening. We cannot plan that well. We tell the patient we will give them a call if there is a bed available in maybe a week or two weeks. As it goes on, the patient becomes weaker or we cannot initiate the appropriate treatment in time and they may end up in hospital and a vicious cycle develops.¹⁰

4.11 Drs Keat and McDonald explained that a hospital can only run if it has adequate staff and those in government need to remember that staff includes all staff from clerical to doctors. As an example Drs Keat and McDonald advised the committee of a situation at the Campbelltown Hospital:

Dr McDonald: We have 16 built rooms in our Outpatients, and we can open five.

Dr Keat: Why?... Basically clinicians who are employed to be paediatric endocrinologists want to open a clinic and they cannot because they do not have clerical support for it. They are not allowed to.

CHAIR: That is the back office, is it?

Dr McDonald: You need somebody to greet the patient, to call Medicare, to get the notes out. Because we do not have clerical support, we have got a built Outpatients with 16 rooms, of which five are being used.

CHAIR: This is a really important part of demythologising the language around the front-line staff and the backroom work.

Dr McDonald: And the clerk is front-line staff. The cleaners are front-line.

Dr Keat: They are. For example, in our Outpatients, there are issues with the hand sanitisers not being filled.

9 Dr Andrew McDonald, private capacity, and Dr Karuna Keat, private capacity, *Committee Hansard*, 23 March 2016, pp 33–34.

10 Dr Karuna Keat, private capacity, *Committee Hansard*, 23 March 2016, p. 34.

Senator MOORE: The neurologists would not be doing that!

Dr Keat: The neurologists would not be?

Senator MOORE: No. They would not be filling that up.

Dr Keat: But the crux of it is: these are all the little things which build up. You are right about front-line. Everyone is front-line staff. It is not just medical; it is all those other things which are important. A hospital does not function without that. If I try and get the district to give me benchmarks, or the ministry to give me benchmarks, about what is expected for a particular support—we have about 30 to 40 medical staff specialists in the department of nursing and we have the equivalent of 1.8 or two full-time secretaries to help provide that support, so people are posting out their own—

Dr McDonald: I pay to get my typing done, because I have got a medical duty of care. It costs me 50 bucks a week to get my typing done, but I am not going to put it through the system and have the letter arrive two weeks later, when I can pay 50 bucks to a lady in Narellan to get the typing of the hospital letters done.¹¹

4.12 The evidence from Drs Keat and McDonald demonstrates concerning examples of highly inefficient and ineffective delivery of health care. This evidence reveals the personal impacts of the pressures that the Federal Government's funding cuts have placed on the hospital system. Dr McDonald told the committee that the cost of making up the shortfall of the Federal Government's cuts was almost equivalent to the cost of the entire NSW hospital budget for a whole year:

Dr McDonald: The annual hospitals budget, from New South Wales, is about \$20 billion. That is one year's salary, effectively. The total Commonwealth spend on health is about nine-point-something per cent of the GDP, about \$140 billion a year, so a cost of \$56 billion must affect patient care. You cannot possibly cut that much and not affect patient care.

CHAIR: Or we could stop doing anything for one whole year.

Dr McDonald: You can close the system for a year or you can fund to meet demand. But that is, virtually, a year's budget. The last time I looked it was \$18.3 billion so it is, virtually, a year's New South Wales hospital budget worth of cuts.¹²

11 Dr Andrew McDonald, private capacity, and Dr Karuna Keat, private capacity, *Committee Hansard*, 23 March 2016, pp 36–37.

12 Dr Andrew McDonald, private capacity, *Committee Hansard*, 23 March 2016, p. 39.



The committee speaks to GPs, Medicare Local representatives, and health consumers at a public hearing in Penrith, Sydney on 12 March 2015.

Impacts on access to health care

4.13 The impact of the funding cuts will reach many areas of health, as the following discussion with Professor Frankum demonstrates. Lack of access to quality general practice health care, whether in metropolitan or rural areas, drives people to seek care at hospitals. If the hospitals are not adequately funded, and people cannot afford private care, access to health care is effectively denied:

CHAIR: ...what is the impact currently on your work practices in the areas out of the city in the New South Wales, where particular medical problems are emerging, and, as a plea for those people, what needs to happen going forward?

Prof. Frankum: You would be aware that I think seven of the 10 most disadvantaged suburbs in Australia—or New South Wales; I am not sure which—are in south-western and Western Sydney. Campbelltown has I think three of the most severely deprived suburbs in the state. The problem for those people is access to services generally, but also access to quality general practice and specialist services which are not always provided by the public system and are unaffordable for some people.

Senator WILLIAMS: Is this in suburban Sydney?

Prof. Frankum: Absolutely.

Senator WILLIAMS: You ought to go and live in a country or rural area like I have done all my life!

Prof. Frankum: I am not disputing that. That is a problem as well, but—

Senator WILLIAMS: At least they can travel half an hour or so to get to specialists.

Prof. Frankum: Many cannot afford to go to specialists.

CHAIR: Exactly. They cannot afford the out-of-pockets.

Prof. Frankum: The waiting lists, for example, at some of our public hospitals are enormous. I am an allergist and I do paediatric allergy as well as adults. Our waiting list to have a food challenge for a child who we are not sure is able to eat egg or milk or something, because of a previous allergy, is two years. So this kid is at risk of anaphylaxis if they do eat it and has to wait two years to find out if it is safe for them to eat it. If your child has a complex surgical problem, access to Westmead or Randwick children's hospitals is very problematic. There is good evidence that if you live in the poorer suburbs there is much less access to all of those services. That is what happens if funding does not continue to grow.¹³

4.14 At its hearing in Gosford in March 2015, the Australian Paramedics Association (APA) told the committee of the serious impacts that increasing resource pressures are having on paramedics. Due to at-capacity emergency departments, ambulances are being forced to 'ramp' until an emergency bed becomes available.¹⁴ Mr Jeff Andrew, Vice President of the APA explained that a two hour ramp at peak periods is not unusual, and that a recent experience of a six hour 'ramp' would become common.¹⁵ Mr Andrew went on to state that 'it is fair to say the whole system is overwhelmed.'¹⁶

4.15 When asked what additional pressures would result from the government's decision to cut \$56 billion over eight years from the hospital system combined with the government's interventions in primary care, Mr Andrew responded:

I think we will get more sick patients if the primary health care is not attended to. I mentioned some patients, like asthma patients and patients with a chronic disease like emphysema, who have been better managed because there are good strategies and care plans in place for them. Any budget cuts in that area will only reflect to us getting them at a sicker state. There will be a higher burden on the presentations in the health system.¹⁷

4.16 At its hearing in Lismore in September 2014, the committee heard evidence of the harsh reality that the pressures from funding cuts place on the hospital system. Mr Gil Wilson, a clinical nurse specialist at the Lismore Base Hospital, appearing in a private capacity, told the committee:

13 Professor Bradley Frankum, Vice President, Australian Medical Association (NSW), *Committee Hansard*, 27 November 2015, pp 24–25.

14 In this context "ramp" refers to an ambulance waiting with a patient until the patient can be received by the Emergency Department.

15 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 43.

16 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 43.

17 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 45.

On funding, I have gone from a situation in my health career of over 20 years of saying to people sitting in hospital, 'Ducky will be home soon; she's fine,' to seeing people like that shoved out the door a day or two early sometimes. I had a situation at the hospital the other night while I was the after-hours manager. We were chockers. We have people lining up in the ED. When I was handing over to the night manager, I said, 'I'm really sorry. We have only three beds left and these patients are going to need them,' and then the ward phoned up and said, 'Mr Jones has just died, so we have another bed.' That is the wrong attitude to have. I hate the situation we are in now where things are so tight that that is the sort of thing people are saying—'Yes, I can give this guy in the ED a bed, but a poor old 92-year-old has had to pass away for him to get it.' That is the reality of our world.¹⁸

4.17 Mr Wilson's evidence also highlighted the major issue of cross-border cost shifting, a situation in which hospitals in one state try to reduce their costs by shifting patients across the border to another state:

Mr Wilson: ...Senator O'Neill, you mentioned something about the border crossings before. I have an example for you. There was a patient in Tweed Hospital. I cannot use names because of confidentiality. He was having a big gastric bleed. Instead of being transferred to the Gold Coast where they could have done something about it, he was transferred all the way down to Lismore in the back of an ambulance—with a doctor and a bag full of blood, just in case something happened. I raised this with the JCC, so this is on record there too.

Senator McLUCAS: Where was he from?

Mr Wilson: It was at Tweed Hospital. I do not know where he was actually from, but he came from Tweed Hospital. Gold Coast is where? Lismore is where? They put him in the ambulance. If you do not know about that situation, you can bleed out inside your stomach and have no external signs very quickly. What was a doctor in the back of an ambulance with a box full of blood going to do? That has been happening progressively since the change of government in Queensland—the blocking of the border—but that is nothing to do with this.¹⁹

Committee view

4.18 As the most populous states in Australia, NSW faces a crisis as a result of the Coalition Government's hospital funding cuts. By forcing the state government to scrape together funds year-to-year for hospital services, the Federal Government cuts make forward planning virtually impossible. Without the ability to invest with long-term certainty in health-related infrastructure and training, state governments ability to make the hospital system more efficient is severely curtailed.

18 Mr Gil Wilson, clinical nurse specialist, private capacity, *Committee Hansard*, 15 September 2014, p. 7.

19 Mr Gil Wilson, clinical nurse specialist, private capacity, *Committee Hansard*, 15 September 2014, p. 7.

4.19 The committee believes that the New South Wales Government is not able to sustain the increased funding needed for adequate hospital services without adequate contributions from the Commonwealth. In NSW, the Commonwealth's planned funding reductions will have grown to a total of \$17.6 billion by 2024-25, and could easily threaten to overwhelm the NSW State Budget.

4.20 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.

4.21 The committee believes that without long-term funding, state and territory public hospitals will not be able to achieve efficiencies and adequately serve their citizens. 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 to a panel of GPs at a public hearing in Strathfield, Sydney, on 19 February 2015.

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.

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...

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

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.

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.

CHAIR: That is a lot of people.

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...

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, received 1 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.

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.

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.

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

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

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

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

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 services³³ 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 imaging 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.

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

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

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.

Chapter 7

Impacts on Western Australian hospitals

So you have longer waiting times and people are not seen acutely when they should be seen, so they are much sicker when they are seen, and then you end up having to fly them out. It is just a revolving door.¹

Dr Stephanie Trust, Kununurra Medical Centre

Introduction

7.1 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.

7.2 The PBO's figures show that Western Australia (WA) will lose \$6.5 billion in hospital funding over a decade due to the government's abandonment of the carefully negotiated national health agreement.² The annual funding differences are set out in Appendix 4.

State-wide impacts

7.3 The WA Health Minister, Dr Kim Hames, was critical of the 2014-15 Budget decision to cut hospital funding, telling a Western Australian budget estimates hearing that the decision was 'unfair'.³

7.4 However, the WA Premier, Mr Colin Barnett, was more sanguine about the cuts, describing the 2014-15 Budget as:

If you look at the totality of the federal budget, which includes a slightly better position on GST for Western Australia and some funding in particular areas, the net impact on the West Australian bottom line is positive and not negative.⁴

1 Dr Stephanie Trust, General Practitioner, Kununurra Medical Centre, *Committee Hansard*, 28 April 2015, p. 13.

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

3 Stephanie Dalzell, ABC News Online, *WA hospital funding cuts criticised by health minister*, 22 May 2014, www.abc.net.au/news/2014-05-21/perth-hospitals-to-lose-24300m-over-four-years/5468844

4 Stephanie Dalzell, ABC News Online, *WA hospital funding cuts criticised by health minister*, 22 May 2014.

7.5 The Premier was absent from a meeting of other state leaders held to discuss the hospital funding cuts, shortly after the 2014-15 Budget was handed down.⁵

7.6 Recently, the AMA criticised the WA hospital system in its *Public Hospital Report Card 2016*, which showed that there had been no improvement on key performance targets, such as waiting times, over the last year. The AMA also found that Western Australian hospitals had failed to improve on elective surgery waiting times.⁶

7.7 The AMA WA President, Dr Michael Gannon, has stated that the Commonwealth Government cuts to hospital funding were a large part of the problem. He called on the Western Australian Government to lobby for adequate Commonwealth funding.⁷

7.8 The Western Australian Government has, however, categorised the problem as one of inefficiencies within the state health system. In January 2016, the Western Australian Government announced that over 1100 full time equivalent hospital jobs would be cut from the Western Australian hospital system. The AMA WA disputes this figure, arguing that as many as 3000 hospital staff could lose their jobs or have their hours reduced as a result of the state government's cuts.⁸

7.9 Professor Mike Daube, Director of the Public Health Advocacy Institute of Western Australia at Curtin University, told the committee that he had concerns regarding the reduction of Commonwealth Government funding to health spending:

The implication of that is inevitably that the states will have to carry a greater burden. We are already talking about 28 per cent, or thereabouts, of state budgets [allocated to health] and in the unique system that we have in Australia inevitably if one player reduces their contribution, then the burden is going to fall on others and it will fall on the states because the states are the ones who have to face the day-to-day pressures from population, from media and so on. I speak as a former Director-General of Health in this state and I am aware of the day-to-day pressures that we have. The pressures are on the states to address those, much less on people in faraway Canberra.⁹

5 Stephanie Dalzell, ABC News Online, *WA hospital funding cuts criticised by health minister*, 22 May 2014.

6 Australian Medical Association, 'Public Hospital Report Card 2016', January 2016, pp 21–23.

7 Charlotte Hamlyn, ABC News Online, *WA hospitals cannot afford cuts*, *Australian Medical Association says*, 28 January 2016, www.abc.net.au/news/2016-01-28/wa-public-hospital-system-cannot-afford-cuts-ama-says/7121264

8 Australian Associated Press, *The Guardian Australia*, *Western Australia to cut 1,100 jobs in south Perth hospitals*, 3 January 2016, www.theguardian.com/australia-news/2016/jan/03/western-australia-to-cut-1100-jobs-in-south-perth-hospitals

9 Professor Mike Daube, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, 10 October 2014, p. 21.

7.10 Dr Stephanie Trust, from the Kununurra Medical Centre, told the committee she believed that the situation for acute care, particularly in remote parts of Western Australia, was already dire:

It is crucial. From just sitting on the sidelines and listening to the DMOs [District Medical Officers], I know that, even though their workload has increased at regional hospitals, certainly numbers of doctors and DMOs in the hospitals have not. In fact, they are trying to centralise again. Things tend to go to Broome and that tends to leave the rest of the Kimberley. But, even then, Broome services have been reduced as well and Broome is very busy. So you have longer waiting times and people are not seen acutely when they should be seen, so they are much sicker when they are seen, and then you end up having to fly them out. It is just a revolving door. The stress on services like the RFDS [Royal Flying Doctors Service], in terms of getting people out, just increases.¹⁰



Ms Josephine (Josie) Farrer, Member for Kimberley, Western Australian Legislative Assembly gave a Welcome to Country before the committee's public hearing in Halls Creek, Western Australia, on 28 April 2015.

Committee view

7.11 It is clear that the Coalition Government's hospital funding cuts have placed the Western Australian Government in a desperate situation. From the evidence the committee heard, the Western Australian hospital system can ill afford to lose trained staff. The committee is concerned that the savage job cuts in the Western Australian hospital system will lead to a reduced quality of care.

7.12 The committee believes that the Western Australian Government is not well placed to sustain the funding needed for adequate hospital services by itself. By

10 Dr Stephanie Trust, General Practitioner, Kununurra Medical Centre, *Committee Hansard*, 28 April 2015, p. 13.

2024-25, the Commonwealth's planned funding reductions will have grown in total to \$6.5 billion for Western Australia.

7.13 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.

7.14 The committee believes that without long-term funding, state and territory public hospitals will not be able to achieve efficiencies and adequately serve their citizens. 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.

Chapter 8

Impacts on South Australian hospitals

Removing 600 hospital beds; or

- *Closing an entire hospital; or*
- *The cost of employing 3000 nurses; or*
- *Doubling elective surgery waiting times.*¹

South Australian Government

Introduction

8.1 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 South Australian hospital funding

8.2 The PBO calculates that South Australia will receive \$4.2 billion less in hospital funding from the Commonwealth over the period 2014-15 to 2024-25 than if hospitals were funded according to the 2011 agreement.² The annual funding differences are set out in Appendix 4.

8.3 Consistent with PBO figures, South Australian (SA) public hospital services would see 'a loss of around \$4.6 billion over the next 10 years' as a result of the 2014-15 Budget, according to the SA Government's submission.³

8.4 The 2014-15 Budget had forecast \$444 million less in SA public hospital funding over the forward estimates.⁴ In addition, the SA Government identified that the SA health sector would lose a further \$211 million from the termination of agreements that directly support public hospitals, including:

1 South Australian Government, *Submission 24*, p. 6. See also, the Hon. Jay Weatherill, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 1.

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

3 South Australian Government, *Submission 24*, p. 6. See also, the Hon. Jay Weatherill, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 1.

4 Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 1.

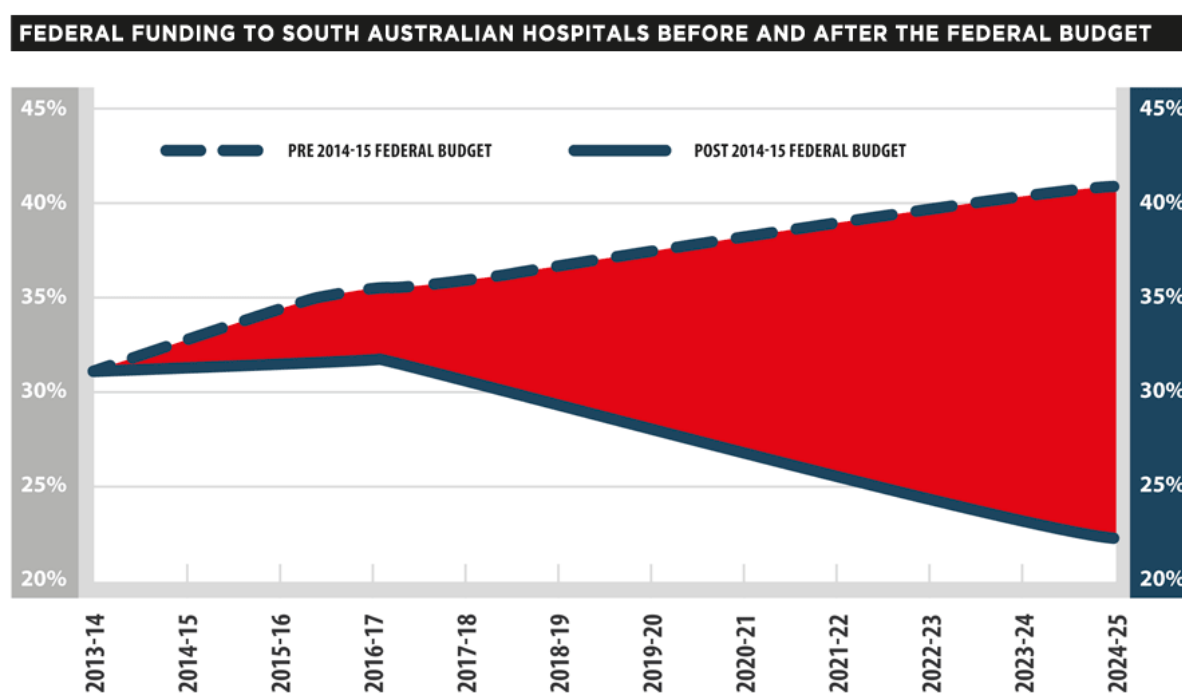
- \$120 million from the National Partnership Agreement on Improving Public Hospital Services; and
- \$42 million from the National Partnership Agreement on Financial Assistance for Long-stay Older Patients.⁵

8.5 The SA Government's submission equated the combined reduction of funding to the health sector from the 2014-15 Budget (\$655 million over four years) with:

- Removing 600 hospital beds; or
- Closing an entire hospital; or
- The cost of employing 3000 nurses; or
- Doubling elective surgery waiting times.⁶

8.6 Figure 3 below shows the difference in funding for South Australian hospitals between the AHRA and the 2014-15 Budget.

Figure 3—Impact of 2014-15 Budget on South Australian hospital funding⁷



5 South Australian Government, *Submission 24*, p. 10.

6 South Australian Government, *Submission 24*, p. 6. See also, the Hon. Jay Weatherill, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 1.

7 South Australian Government, *Submission 24*, p. 9. See also South Australian Government, *Federal cuts hurt – the facts*, <http://www.federalcutshurt.com.au/the-facts/>

Departure from shared commitments

8.7 The SA Government expressed the view that the Commonwealth was 'reneging' on funding commitments,⁸ stating that:

The South Australian Government has demonstrated a strongly collaborative approach to national health reforms and has been disappointed at the Commonwealth reneging on its commitments under the National Health Reform Agreement and associated National Partnership Agreements.⁹

8.8 SA Premier, the Hon Jay Weatherill MP, was critical of the manner in which the Federal Government had announced the cuts, particularly because the government avoided discussion of the proposed cuts at a COAG meeting just days before the budget.¹⁰ The Premier explained his reaction:

It was a shock to every minister, chief minister and first minister around the table. I think I speak for all of them when I say that they were angry about the fact that they had been misled in that way. At its very lowest, it was misleading to have a briefing about the budget and not flag such dramatic changes that were on the way.¹¹

8.9 The SA Government submitted that the end of the 2011 agreement would increase the 'potential for cost-shifting' between the Commonwealth and states and territories.¹² The submission highlighted that the Commonwealth's contribution to national hospital funding would reduce from 31 per cent in 2014-15 to 23 per cent in 2024-25, whereas the 2011 agreement had aimed to 'gradually increase the Commonwealth share of hospital funding to 50 per cent'.¹³

8.10 Rather than contributing to the solution, their submission argued that Commonwealth funding decisions 'leave the State bearing the risks associated with growing public hospital costs but without the resources required to meet the expected growth'.¹⁴ The SA Government submitted that future Commonwealth funding:

...does not fully address the expected growth in public hospital expenditure, taking into consideration population growth and the ageing of the population, health CPI and increased costs for medical technology.¹⁵

8 South Australian Government, *Submission 24*, p. 8.

9 South Australian Government, *Submission 24*, p. 2.

10 The Hon. Jay Weatherill, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 2.

11 The Hon. Jay Weatherill, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 3.

12 South Australian Government, *Submission 24*, p. 8.

13 South Australian Government, *Submission 24*, p. 8.

14 South Australian Government, *Submission 24*, p. 8.

15 South Australian Government, *Submission 24*, p. 7.

8.11 The end of funding under the National Partnership Agreement on Improving Public Hospital Services was regarded by the SA Government as a significant departure from earlier agreement. Despite not meeting emergency and elective surgery targets, the committee heard that 'South Australia expected to continue to receive reward funding acknowledging its significant efforts against these ambitious targets for the remaining two years'.¹⁶ It was submitted that the Commonwealth was incorrect in treating '[a]ny failures... to meet the targets' as 'a breaking of the agreement'.¹⁷

Community impacts

8.12 According to the SA Government, decisions in the 2014-15 Budget, including cuts to hospital funding, 'would be felt at the community level, particularly by the most vulnerable'.¹⁸ This includes older Australians who often 'remain in hospital longer than would otherwise be necessary' while they wait for suitable aged care.¹⁹ The SA Government urged the Commonwealth's:

Careful consideration of the impacts of primary health care services, preventive health and high quality aged care and disability services... on the demand for public hospital services.²⁰

8.13 The Health Consumers Alliance of SA submitted that the additional funding cuts to hospitals would 'add further stress to an already strained public hospital system'.²¹ For example, even before the federal government's cuts, the following stressors had been identified:

Over the last few months we have seen the queuing of ambulances at the Royal Adelaide Hospital, as the public hospital system has exceeded capacity. Patients have been triaged by Emergency Department staff while still in ambulances, in the hospital car park. Also of concern are the continuing reports of mental health patients being held in Emergency Departments for many days, being isolated in windowless rooms, physically and chemically restrained. This has all occurred prior to the impact of the Commonwealth Government's 2014 Budget cuts being felt.²²

8.14 Emergency waiting times would significantly increase following the cuts to hospital funding, according to the SA Government:

16 South Australian Government, *Submission 24*, p. 2.

17 South Australian Government, *Submission 24*, p. 2.

18 South Australian Government, *Submission 24*, p. 2; Australian Workplace Innovation and Social Research Centre (WISeR, University of Adelaide) for the Department of Premier and Cabinet, *Impacts of the 2014-15 Federal Budget Measures on South Australia* (2014), p. 43, <http://federalcutshurt.com.au/wp-content/uploads/2014/08/fed-budget-oct2014-n.pdf> (accessed 2 May 2016).

19 South Australian Government, *Submission 24*, p. 15.

20 South Australian Government, *Submission 24*, p. 14.

21 Health Consumers Alliance of SA, *Submission 92*, p. 3.

22 Health Consumers Alliance of SA, *Submission 92*, p. 3.

SA Health modelling shows the average emergency department wait times in South Australia are likely to increase to at least 66 minutes - up from the average current 20 minute waiting time.²³

8.15 In addition, SA public hospitals would see increasingly complex cases as a result of funding cuts, with a 'significant impact on wait times for public procedures.'²⁴ An Ernst & Young analysis commissioned by the SA Government explained that:

It is estimated that acuity (or complexity of illness) would increase as public hospitals triage cases as normal – but under greater financial constraints. This would cause the less complicated cases (e.g. dental extractions, other knee procedures) to seek out the private system. This would in turn leave the more complicated cases (liver and heart transplants) inside the public system.²⁵

8.16 Premier Weatherill summarised that '[b]y 2019-20, more than 56,000 patients per year will be left untreated in the public system, growing to more than 107,000 patients per year by 2024-25'.²⁶

8.17 Further, the committee heard that elective surgery waiting lists times in SA would increase, reversing a 'consistent improvement' seen in recent years.²⁷ For example, a total hip replacement would have occurred after 99 days in 2014-15 but increase to 213 days in 2017-18.²⁸ Table 1 below shows the full extent of the elective surgery waiting times. The SA Government told the committee that:

...it is reasonable to expect that if Commonwealth funding had continued that further improvements to waiting times could have been made... The South Australian government had made a commitment to deliver a new strategy to keep waiting times low and focus on areas of growing demand over the next four years.²⁹

23 South Australian Government, *Submission 24*, p. 9. See also South Australian Government, *Federal cuts hurt – the facts*, www.federalcutshurt.com.au/the-facts/ (accessed 2 May 2016).

24 South Australian Department of the Premier and Cabinet, *Public Health Expenditure and Distribution of Benefits – Technical Note* (Ernst & Young, 2016), p. 4.

25 South Australian Department of the Premier and Cabinet, *Public Health Expenditure and Distribution of Benefits – Technical Note* (EY), p. 3.

26 The Hon Jay Weatherill, Premier, South Australian Government, 'Report highlights dire consequences of Fed health cuts, Media release, 29 March 2016, www.premier.sa.gov.au/index.php/jay-weatherill-news-releases/321-report-highlights-dire-consequences-of-fed-health-cuts, (accessed 6 May 2016).

27 South Australian Government, *Submission 24*, p. 11.

28 South Australian Government, *Federal cuts hurt – the facts*, www.federalcutshurt.com.au/the-facts/ (accessed 2 May 2016).

29 South Australian Government, *Submission 24*, p. 11.

Table 1—Growth of elective surgery waiting times in South Australia due to funding cuts³⁰

ELECTIVE SURGERY		
GROWTH IN DAYS WAITED DUE TO 2014-15 COMMONWEALTH BUDGET		
MEDIAN WAITING TIME	2013-14 DAYS	2017-18 DAYS
EAR NOSE THROAT	54	116
TOTAL HIP REPLACEMENT	99	213
TOTAL KNEE REPLACEMENT	152	327
LENS EXTRACTION	75	161
GALL BLADDER REMOVAL	33	71
TONSILLECTOMY	70	150
HYSTERECTOMY	44	95

8.18 Faced with more patients and more acute cases, hospitals in SA could be less prepared to treat them, as the state would 'have difficulty adopting new and more expensive life-saving technology'.³¹

8.19 Hospital redevelopment was also slowed by the 2014-15 Budget, with the SA Government submitting that it had suspended projects at the Queen Elizabeth Hospital (stage 3A), Modbury Hospital, Noarlunga Health Service (stage 2A) and Flinders Medical Centre, redirecting funding into a 'Health Capital Reconfiguration Fund'.³²

State Government response

8.20 Like several other states and territory governments, the SA Government has reallocated funding to mitigate the effects of reduced Commonwealth hospital funding, but cannot entirely address the shortfall. The SA Government website 'Federal cuts hurt' summarises measures proposed by the 2015-16 State Budget:

In our State Budget we have committed to make up for half of the cuts with the removal of the emergency services rebate and other income measures.

But a shortfall of \$332 million still remains.³³

8.21 Before the Council of Australian Governments met in April 2016, Premier the Hon Jay Weatherill reiterated that 'the states and territories simply cannot afford to bear the brunt of these cuts'.³⁴

30 South Australian Government, *Submission 24*, p. 9. See also South Australian Government, *Federal cuts hurt – the facts*, <http://www.federalcutshurt.com.au/the-facts/>

31 South Australian Government, *Federal cuts hurt – the facts*, www.federalcutshurt.com.au/the-facts/ (accessed 2 May 2016).

32 South Australian Government, *Submission 24*, p. 11.

33 South Australian Government, *Federal cuts hurt – the facts*, www.federalcutshurt.com.au/the-facts/ (accessed 2 May 2016).

Committee view

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

8.23 SA public hospitals must be supported in their efforts to reverse worrying trends in the length of waiting times and the number untreated patients. In 2016, SA was one of only two states (along with Tasmania) assessed as not meeting any targets in the Australian Medical Association's *Health and Hospitals Report Card 2016*. Particularly concerning for the committee was the marked decrease in the number of SA urgent emergency department patients seen within the recommended time, falling from 70 per cent in 2011-12 to approximately 58 per cent in 2014-15.³⁵

8.24 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 \$4.2 billion by 2024-25.

8.25 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.

8.26 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.

34 The Hon Jay Weatherill MP, Premier, South Australian Government, 'Report highlights dire consequences of Fed health cuts', Media release, 29 March 2016, www.premier.sa.gov.au/index.php/jay-weatherill-news-releases/321-report-highlights-dire-consequences-of-fed-health-cuts, accessed 6 May 2016.

35 Australian Medical Association, *Public Hospital Report Card 2016*, p. 25.

Chapter 9

Impacts on Tasmanian hospitals

*The cohort of patients are the complex elective surgery that needs to be performed, not the day cases—they have been raced through. The complex cases are still waiting. There are unacceptable time frames in Tasmania. People are often in pain, stopping the quality of life... So we actually have fewer beds in Tasmania than the average across the country. That is due to budget cuts... We also have the longest elective surgery waiting times. So you can see why we frame it as the perfect storm.*¹

Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation ,
Tasmanian Branch

Introduction

9.1 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.

9.2 The PBO's figures show that Tasmania will lose \$1.2 billion in hospital funding over the eight year period from 2017-18 due to the government's abandonment of the carefully negotiated national health agreement.² The annual funding differences are set out in Appendix 4.

9.3 As in other states and territories, the committee has held public hearings in Tasmania over the period from shortly after the 2014-15 Budget to April 2016. This has allowed the committee to compare evidence from November 2014, April 2015, and April 2016. The evidence, as laid out in this chapter, clearly demonstrates that the dire predictions the committee heard about in November 2014 regarding the 'perfect storm' facing the Tasmanian health and hospital system, have come to pass in 2016.

State-wide impacts

9.4 Tasmanian Premier, the Hon Will Hodgman MP, reacted similarly to other state premiers after the announcement in the 2014-15 Budget that the NHRA and associated National Partnership Agreements (NPA) would be scrapped. The loss of the NPA funding was to have an immediate effect, described by the Premier as the

1 Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation, Tasmanian Branch, *Committee Hansard*, 29 April 2016, p. 21.

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

loss of \$27 million in the next financial year, an amount equivalent to 59 hospital beds or 5000 surgical procedures.³

9.5 Premier Hodgman lamented the decision in the 2014-15 Budget:

What was previously agreed to – a ‘no worse-off guarantee’ that was part of the arrangement between my state and the Commonwealth – no longer exists. We’ve been blindsided by a unilateral agreement and it leaves us exposed.⁴

9.6 Despite the cuts to federal funding, the Tasmanian Premier promised that the state government would keep to the health measures it had promised on election.⁵

9.7 The committee held public hearings in Hobart and Launceston in November 2014 to gather evidence about the effect that the 2014-15 federal budget measures had had on Tasmania. It was clear from these hearings that the impact on the state would be devastating, particularly on those most in need. For example, Dr Pauline Marsh from TasCOSS told the committee that:

...reduced Commonwealth funding for hospital and other health services will have negative impacts on Tasmanians who live on low incomes—people who do not have the luxury of choosing private or user-pays services. Proposed additional costs on Medicare services will be felt the most by people who are already having difficulty meeting the costs of living. We know that people are already going without some essentials.

Our reasoning behind these arguments is that it is well established that areas of socio-economic disadvantage have correspondingly higher health risks, higher rates of preventable hospitalisations, higher rates of chronic disease and higher avoidable mortality rates—all evidence of health inequities relative to income. Frighteningly, I think, a report by Catholic Health demonstrated that ‘the most poor are twice as likely to suffer chronic illness and will die on average three years earlier than the most affluent’.⁶

9.8 At the same hearing, Professor Tim Greenaway, President of the AMA Tasmania, told the committee:

The AMA's federal position is that the federal government's budget [2014-15] is actually predicated on an incorrect assumption. It is predicated on an assumption that health expenditure in this country is out of control. It is not...the actual percentage of government revenue that is spent on health

3 Emma Hope, The Tasmanian Mercury, *Premier Will Hodgman hits out at Federal Government's health cuts*, 19 May 2014, www.themercury.com.au/news/tasmania/premier-will-hodgman-hits-out-at-federal-governments-health-cuts/story-fnj4f7k1-1226922051939

4 Emma Hope, The Tasmanian Mercury, *Premier Will Hodgman hits out at Federal Government's health cuts*, 19 May 2014.

5 Lucy Shannon, ABC News Online, *Tasmania's health sector to bear brunt of 'tough love' federal budget*, 19 May 2014, www.abc.net.au/news/2014-05-19/tasmania27s-health-sector-to-bear-brunt-of-27tough-love27-fe/5461224

6 Dr Pauline Marsh, Policy Officer, TasCOSS, *Committee Hansard*, 3 November 2014, p. 29.

has actually been falling over time and that our actual expenditure is marginally under the OECD average for percentage of GDP.

The proposed measures that, if passed by the Senate, will be put in place by the federal government would have a major detrimental impact on the most vulnerable in our community. This has been shown in other jurisdictions when this has been done. Modelling by the AMA and others have shown that co-payments for medications, for example, and co-payment for GP visits will target the older, poorer, and those with chronic disease who are least able to afford these measures and will result in patients not attending general practice...in Tasmania we not only have an older and more disadvantaged community; we have higher rates of chronic disease such as diabetes, obesity and chronic heart disease. Any measures that are put in place that deter from patients attending general practice would be detrimental. We have fewer public hospital beds per head of population than Western Australia. Bed occupancy rates in both the south and the north of the state are well above the recommended 85 per cent. For the last six months at the Royal Hobart Hospital, which is where I work, we have been running at 99 per cent bed occupancy rates, which is obviously not safe or sustainable long term.

The AMA, both federally and at a state level, is extremely concerned that measures suggested in this budget based on incorrect assumptions without acknowledging evidence, if put in place, would substantially harm the Tasmanian community.⁷

9.9 At the committee's most recent hearing, held in Devonport on 29 April 2016, the committee found that the situation had not changed. Speaking to the committee again, Professor Greenaway provided the following update:

The Parliamentary Budget Office has calculated...that the effect of the 2014 budget would be that Tasmania would lose \$1.151 billion over the eight-year period from 2017-18 to 2024-25. Of the additional \$2.9 billion from the [April 2016] COAG agreement, \$54 million over three years will go to Tasmania. But if you look at the AIHW data, Tasmania has fewer public hospital beds per thousand patients, increased activity and an older, sicker and poorer demographic which relies on the public hospital system more. The shortfall, even allowing for the additional \$54 million from the COAG agreement, is still going to be quite devastating to Tasmania. The AMA, on both the state and federal levels, will be obviously pursuing the issue of securing adequate funding for the public hospital system into the future as a major item in the forthcoming election.⁸

7 Professor Tim Greenaway, President, AMA Tasmania, *Committee Hansard*, 3 November 2014, p. 37.

8 Professor Tim Greenaway, President, AMA Tasmania, *Committee Hansard*, 29 April 2016, p. 1.

Elective surgery

9.10 Professor Greenaway told the committee that the effect of this shortfall in funding would be felt most severely with regard to elective surgery, as acute care took priority for the available resources:

We have inadequate capacity, so any funding shortfall means that elective procedures are put on the backburner, as it were. We do not deal with elective cases; we are forced to deal with acute cases. If I can give you an example from my own hospital today, as at 29 April we do not currently have any beds. At about 7.30 this morning an SMS was sent to every consultant on call saying that we have a crisis in the bed situation at the Royal Hobart Hospital, and could everybody work especially hard to try to discharge any patients who would be suitable. And we are not even in winter!

The effect of funding shortfalls in the public hospital system will be felt more acutely in Tasmania than in large metropolitan areas on the mainland—Sydney, Melbourne, Brisbane et cetera. We have an older, sicker, poorer population who rely more on the public hospital system, and yet we have fewer public hospital beds per 1,000 of the population. So any funding shortfall is going to be acutely felt in Tasmania, and it will be the acute services affected, the waiting times will increase and elective surgery lists will be cancelled, as they have been already. This is the future that we see.⁹

9.11 In November 2014, Mrs Neroli Ellis, Branch Secretary of the Australian Nursing and Midwifery Federation's Tasmanian Branch, told the committee that Tasmanians already faced lengthy waiting times for elective surgery:

Overall Tasmania has marginally fewer hospital beds per capita than the Australian average, and the rate of public hospital access is lower than the national average. There are long waiting times and an alarming number of patients on elective surgery waiting lists. The number of patients overdue for surgery in Tasmania has remained near or above 50 per cent for at least six years, and the total overdue number of patients make up 15.1 per cent of the total number of overdue patients Australia wide. The proportion of overdue patients on Tasmanian waiting lists far exceeds that of any other state. A concern to us is that the rate of hospital initiated postponements in Tasmania for 2012-13 was 16.3 postponements per 100 scheduled admissions. In Victoria the rate is only 6.2 to 6.8 postponements per 100 scheduled admissions. There is no doubt this is a direct impact of the closure of those acute beds over the last three years due to the budget reductions. There is ongoing tension between elective surgery and acute admissions fighting for that limited bed capacity left in our acute public hospitals.¹⁰

9 Professor Tim Greenaway, President, AMA Tasmania, *Committee Hansard*, 29 April 2016, p. 2.

10 Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation, Tasmanian Branch, *Committee Hansard*, 4 November 2014, p. 14.

9.12 At the committee's hearing on 29 April 2016, Mrs Ellis advised that the situation regarding elective surgery waiting times was getting worse:

The Australian Institute of Health and Welfare statistics for 2014-15 show that, actually, we are treating fewer patients than other states despite having a sicker population. The cost weights are showing that we are treating much more complex and expensive cases in Tasmania. That is actually demonstrated on our waiting lists. The majority of our elective surgery waiting lists are showing very large over-boundary numbers. The cohort of patients are the complex elective surgery that needs to be performed, not the day cases—they have been raced through. The complex cases are still waiting. There are unacceptable time frames in Tasmania. People are often in pain, stopping the quality of life. There are only 2.3 public hospital beds in Tasmania per 1,000 population, whereas the national average is 2.5. So we actually have fewer beds in Tasmania than the average across the country. That is due to budget cuts. We have lost beds and we have closed entire wards in the north-west, in the north and in the south due to budget cuts. That has given us now a situation where we have fewer available public hospital beds for Tasmanians than anywhere else in the country. We also have the longest elective surgery waiting times. So you can see why we frame it as the perfect storm. We have a sicker population requiring more care, we have lower budgets actually providing less care, and we have growing demand for our hospital beds.¹¹

9.13 Mrs Ellis told the committee that the lack of funding was also contributing to the waste of resources which could otherwise be used for elective surgery. While the infrastructure exists in Tasmania, Mrs Ellis explained, a lack of funding meant that it sat idle:

I would just reiterate that we have unused theatre suites in Tasmania and we have capacity here that we could use if we had the funding. We have closed ICU beds. We have new state-of-the-art ICUs that have been built. We have closed beds there because of a lack of funding. We have a new state-of-the-art short-stay surgery unit built at the Launceston General Hospital. It was completely closed for the first six months post commission because of a lack of funding, and it was opened up for the first time only in January. It is going very well, but it is not at full capacity. All of this infrastructure is available for us to complete surgeries and start managing our elective surgery list, if we had the funding to staff it.¹²

Mental health

9.14 The committee heard evidence that funding cuts to preventative health programs, particularly mental health, were driving more people to seek treatment in

11 Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation, Tasmanian Branch, *Committee Hansard*, 29 April 2016, p. 21.

12 Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation, Tasmanian Branch, *Committee Hansard*, 29 April 2016, p. 22.

hospital emergency departments. This situation stretches already limited resources, and as a result many do not get the level of care they require. Mr Stephen Hayes, a Social Worker with the Tasmanian Health Service told the committee that:

It [mental health patients entering emergency] is probably about triaging, because there is always a group of people—in our world anyway, in mental health—that are engaged in self-harming behaviours. Is that self-harming behaviour suicidal behaviour or is it self-harming behaviour to alleviate emotional pain? That comes down to a call. Particularly when resources are tight, you have just got to make sure that you make the right call and you triage it appropriately so that you are following up on the people that you think really are going to suicide and you are not following up upon the people. But you do not always get it right.¹³



Mrs Neroli Ellis, Branch Secretary, and Mr Shane Rickerby, State, North and North-West Organiser Coordinator from the Australian Nursing and Midwifery Federation (Tasmanian Branch) spoke at the committee's hearing in Devonport on 29 April 2016.

13 Mr Stephen Hayes, Social Worker, Tasmanian Health Service, *Committee Hansard*, 29 April 2016, pp 16–17.

Committee view

9.15 The cuts to federal funding in the 2014-15 Budget have seen the Tasmanian hospital system hit by a perfect storm. The state government cannot hope to sustain its funding of the shortfall from the Federal Government's cuts. The need to stretch limited resources further is forcing hospitals to prioritise only the most urgent cases, while elective surgery waiting lists continue to grow. This situation is compounded further when mental health patients, who cannot access appropriate care and support in the community, are forced into hospital emergency departments.

9.16 The committee is greatly concerned that this circumstance will entrench a crisis management scenario in Tasmania which looks only for the next dollar and does not have the resources to plan ahead and deliver long-term efficiencies.

9.17 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.

9.18 The committee believes that without long-term funding, state and territory public hospitals will not be able to achieve efficiencies and adequately serve their citizens. 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.

Chapter 10

Impacts on ACT and NT hospitals

The Commonwealth Government's abandonment of the National Health Reform Agreement has cut \$248 million from what we expected to receive for our hospitals over the next four years. In this Budget we have chosen not to pass on this Commonwealth cut and send our hospitals into chaos.¹

ACT Treasurer, Mr Andrew Barr MLA

Northern Territory hospitals are already performing below national benchmarks, mainly due to the high demand for acute care. The majority of hospital patients in the Northern Territory are Aboriginal, so reducing access to high quality hospital services will hurt Aboriginal people the most.²

Mr John Paterson, Chief Executive Officer, Aboriginal Medical Services Alliance Northern Territory

Australian Capital Territory

10.1 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 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.

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

10.3 Over the eight year period from 2017-18 to 2024-25, the PBO found that the ACT would have a total of \$1.7 billion cut from its hospital funding due to the government's 2014-15 Budget.³ The annual funding differences are set out in Appendix 4.

1 ACT Treasurer, Mr Andrew Barr MLA, *Australian Capital Territory Budget 2014-15 Budget in Brief*, pp 2–3, http://apps.treasury.act.gov.au/_data/assets/pdf_file/0014/601115/Budget-Paper-2-Budget-in-Brief.pdf (accessed 30 April 2016).

2 Mr John Paterson, Chief Executive Officer, Aboriginal Medical Services Alliance Northern Territory, *Committee Hansard*, 27 April 2015, p. 25.

3 Parliamentary Budget Office, *Submissions 191*, p. 5.

10.4 By the end of the period examined by the PBO (2024-25), the \$356 million of funding that the government will to remove from the ACT hospital budget would be greater than the entire Commonwealth hospital funding allocation to the ACT for the 2015-16 financial year of \$316 million.⁴

10.5 Soon after the government's 2014-15 Budget, the ACT government strongly criticised its Federal counterpart for the major cuts to hospital funding in the ACT:

The Commonwealth Government's abandonment of the National Health Reform Agreement has cut \$248 million from what we expected to receive for our hospitals over the next four years. In this Budget we have chosen not to pass on this Commonwealth cut and send our hospitals into chaos. We have instead met the funding gap left by the Commonwealth by increasing our budget deficit. We believe Canberrans should not suffer inferior health services because the Commonwealth Government has abandoned its responsibilities to our community. We will continue to campaign for the restoration of our share of the national growth in public hospital funding.⁵

Committee view

10.6 The committee commends the ACT Government for refusing to pass on the immediate impact of the government's funding cuts to public hospitals in Canberra.

10.7 However, the committee believes that the ACT Government cannot continue to cover the Commonwealth's planned funding reductions, which will grow steadily over time to a total of \$1.7 billion by 2024-25.

10.8 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.

10.9 The ACT hospital system is in desperate need of efficiencies. When the National Hospitals Performance Authority's recent report into the costs of acute admitted patients in public hospitals from 2011-12 to 2013-14, the ACT's two public hospitals were in the top 10 per cent. This means that acute care in the ACT's public hospitals costs twice as much as in other states.⁶

10.10 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,

4 Australian Medical Association, *Public Hospital Report Card 2016*, January 2016, p. 32.

5 ACT Treasurer, Mr Andrew Barr MLA, *Australian Capital Territory Budget 2014-15 Budget in Brief*, pp 2-3, http://apps.treasury.act.gov.au/_data/assets/pdf_file/0014/601115/Budget-Paper-2-Budget-in-Brief.pdf (accessed 30 April 2016).

6 National Hospitals Performance Authority, 'Costs of acute admitted patients in public hospitals from 2011-12 to 2012-14', April 2016, p. 4, www.myhospitals.gov.au/docs/default-source/our-report-pdfs/cost-of-acute-admitted-patients/april-2016/hp_costs_of_acute_admitted_patients_2011-12_to_2013_14_rpt.pdf?sfvrsn=8 (accessed 1 May 2016).

sustainable, funding model for hospitals which allows for appropriate contributions from governments, both state and federal.



Mental health advocates, services groups, and experts spoke at the committee's public hearing in Canberra on 26 August 2015.

Northern Territory

10.11 As outlined in Chapter 3, the PBO's 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 also 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.

10.12 The PBO's figures show that the Northern Territory will lose around \$1.0 billion in hospital funding over a decade due to the government's abandonment of the carefully negotiated national health agreement.⁷ The annual funding differences are set out in Appendix 4.

Territory-wide impacts

10.13 Shortly after the 2014-15 Budget cuts were announced, the Northern Territory Chief Minister, the Hon Adam Giles MLA, participated in an emergency meeting of states and territories to discuss the funding cuts.⁸

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

8 Chief Minister, the Hon Adam Giles MLA, 'Territory Health and Education Funding Under Threat', media release, May 2014, www.chiefminister.nt.gov.au/media-releases/territory-health-and-education-funding-under-threat

10.14 In a media release about the funding cuts, the Chief Minister said that the Northern Territory would lose \$652.2 million in health funding over the decade to 2024-25, a shortfall 'equivalent to 60 hospital beds or a Palmerston Hospital'.⁹

10.15 Two years after the 2014-15 Budget cuts decision, the AMA's *Public Hospitals Report Card* found that smaller states and territories, including the Northern Territory, were struggling to meet hospital performance targets.¹⁰

Territory-specific circumstances

10.16 The Northern Territory Government's submission to the committee outlined the drivers of health expenditure impact the Northern Territory more than other states. These include:

- Burden of disease: an increasing gap between the general Australian population and Indigenous people from remote areas of the Northern Territory. The submission notes that the total burden of disease is 3.5 times greater for Northern Territory Indigenous people than the national burden.
- Indigenous patients have greater numbers of co-morbidities than the average, which impacts both on the initial reason for admission and the care required.
- Remoteness is a major driver of health expenditure in the Northern Territory. The submission provides an example of the costs incurred if a patient from Kalkarindji (approximately 400 South West of Katherine) needs a chest x-ray:
 - Transport plus accommodation, approximately \$740 (double cost if a partner escorts the patient)—this includes transport to the airport; light plane to Katherine; collection from Tindal Airport and transport to Katherine Hospital; chest x-ray; night's accommodation in a hostel; and a return trip.¹¹

10.17 During the committee's public hearing in October 2015, Mr Michael Kalimnios, Chief Operating Officer of the Top End Health Service, explained that the issues driving health expenditure in the Northern Territory have meant that provision of health services is largely left to the Northern Territory Government:

...over time, in an imbalance in the amount of Commonwealth funding that is directly provided to the NT to provide services. When we moved into the current funding model around activity based funding in particular, over

9 Chief Minister, the Hon Adam Giles MLA, 'Territory Health and Education Funding Under Threat', media release, May 2014 <http://www.chiefminister.nt.gov.au/media-releases/territory-health-and-education-funding-under-threat>

10 Australian Medical Association, 'Public Hospital Report Card 2016', January 2016, p. 11. See also Harriet Alexander, The Sydney Morning Herald, *Hospital Performance getting worse and now facing budgetary 'black hole'*, says AMA, 28 January 2016, www.smh.com.au/national/health/hospital-performance-getting-worse-and-now-facing-budgetary-black-hole-says-ama-20160127-gmf8xg.html

11 Northern Territory Government, *Submission 148*, p. 14.

time that Commonwealth imbalance would have been addressed simply because it was moved into a normalised funding model.

The major difference for us in terms of funding under the current model, as opposed to the per capita model, is that factors such as remoteness and Indigenous status are recognised and funded at a differential rate. So, if that system were to stop and we went back to per capita funding, the allowances and loadings we currently get for being Aboriginal, effectively, or being in remote or very remote areas would cease, and the burden of that funding would probably fall back on the Northern Territory.¹²

10.18 The changes to Commonwealth hospital funding therefore pose a significant problem for the Northern Territory Government. Mr Kalimnios told the committee:

The major impact for us going into the future is that ABF component. In terms of our current budget, our total budget for the NT will be up to \$1.4 billion a year. So the \$650 million over the period of 10 years is \$65 million a year, which is around about five per cent. So it is a fairly significant portion.¹³

10.19 The Danila Dilba Health Service, represented at the committee's public hearing in Darwin on 27 April 2015 by Ms Joy McLaughlin, Senior Project Officer, told the committee that the removal of Commonwealth funding and shared responsibility for hospitals would impact on work to close the gap between Indigenous and non-Indigenous Australians:

There are a lot of demands on funding in small population places like the Northern Territory. Without targets, without limitations on what government can do and without shared responsibilities we will continue to see decisions made that may move funds away from health to other more immediate priorities of government, and I think we will see a decline in health status.

If you look population-wide at the Northern Territory, we are the only jurisdiction that is on track to achieve the COAG target of closing the gap in life expectancy. That is largely down to improvements in primary health care... If we have significant changes to health funding in the Northern Territory, that will not happen. We will go on to a different track.

CHAIR: So significant changes, whether it is in the acute or the primary setting, the whole thing is so intertwined that any change at any point will lead to negative outcomes.

Ms McLaughlin: Yes, and it will risk that—that we will not achieve that closing of that gap in the Northern Territory.¹⁴

12 Mr Michael Kalimnios, Chief Operating Officer, Top End Health Service, Northern Territory Department of Health, *Committee Hansard*, 8 October 2015, p. 10.

13 Mr Michael Kalimnios, Chief Operating Officer, Top End Health Service, Northern Territory Department of Health, *Committee Hansard*, 8 October 2015, p. 13.

14 Ms Joy McLaughlin, Senior Project Officer, Danila Dilba Health Service, *Committee Hansard*, 27 April 2015, p. 18.

10.20 The Aboriginal Medical Services Alliance Northern Territory raised similar concerns, with their Chief Executive, Mr John Paterson, arguing for a reversal of the Commonwealth hospital funding cuts as they will:

...reduce acute and specialist care to Aboriginal people. Northern Territory hospitals are already performing below national benchmarks, mainly due to the high demand for acute care. The majority of hospital patients in the Northern Territory are Aboriginal, so reducing access to high quality hospital services will hurt Aboriginal people the most.¹⁵

Committee view

10.21 The committee believes that the Northern Territory is not well placed to sustain the funding needed for adequate hospital services by itself. By 2024-25, the Commonwealth's planned funding reductions will have grown in total to approximately \$1.0 billion for the Northern Territory.

10.22 Smaller states and territories have fewer resources to draw on, and the Northern Territory in particular faces the added challenge of delivering services over large distances to remote populations, often with high proportions of indigeneity.

10.23 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.

10.24 The committee believes that without long-term funding, state and territory public hospitals will not be able to achieve efficiencies and adequately serve their citizens. 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.

15 Mr John Paterson, Chief Executive Officer, Aboriginal Medical Services Alliance Northern Territory, *Committee Hansard*, 27 April 2015, p. 25.



The committee visited the Wurli Wurlinjang Health Service in Katherine, Northern Territory on 29 April 2015.

Senator Deborah O'Neill
Chair

Appendix 1

Witnesses who appeared before the committee¹

Thursday, 21 August 2014 – Townsville

Cootharinga North Queensland

Mr Brendan Walsh, Chief Executive Officer

Mental Illness Fellowship NQ Inc.

Ms Alison Fairleigh, Area Manager, Townsville

College of Medicine and Dentistry, James Cook University

Associate Professor Sarah Larkins, Director of Research and Postgraduate Education

Supported Options in Lifestyle and Access Services Limited

Ms Cathy O'Toole, Chief Executive Officer

Thursday, 28 August 2014 – Canberra

South Australian Government

The Hon. Jay Weatherill MP, Premier

Department of Health

Mr Richard Bartlett, Acting Deputy Secretary

Ms Kerry Flanagan, Deputy Secretary

Department of the Treasury

Mrs Leesa Croke, General manager, Social Policy Division, Fiscal Group

Mr Peter Robinson, General Manager, Commonwealth-State Relations Division, Fiscal Group

¹ www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings.

Thursday, 4 September 2014 – Canberra

Organ and Tissue Authority

Ms Yael Cass, Chief Executive Officer

Ms Judy Harrison, Chief Financial Officer

Monday, 15 September 2014 – Lismore

Northern Rivers Women and Children's Services Inc.

Ms Sandra Handley, Manager, Lismore Women's Health and Resource Centre, Wellbeing and Community Division

Individual statements from public – Those speaking include private individuals, allied health practitioners and medical professionals

Dr Jane Barker, Private capacity

Ms Elizabeth Doolan, Private capacity

Ms Kate Greenaway, Private capacity

Dr Danielle Pirera, Private capacity

Ms Cathy Ridd, Private capacity

Ms Janelle Saffin, Private capacity

Mr Gil Wilson, Private capacity

Northern Rivers Social Development Council

Mr Tony Davies, Chief Executive Officer

University Centre for Rural Health

Professor Lesley Barclay, Director

Dr Michael Douglas, Deputy Director Education

North Coast NSW Medicare Local

Mr Vahid Saberi, Chief Executive Officer

Dr Dan Ewald, Clinical Advisor

Interrelate

Ms Fleur Bradburn, Personal Helpers and Mentors Service Manager

Ms Julie Leete, Area Manager, Lismore

Tuesday, 16 September 2014 – Moruya**Southern NSW Medicare Local**

Ms Kathryn Stonestreet, Chief Executive Officer

Ms Jo Risk, Integration and Planning

Dr Martin Carlson, Moruya General Practitioner and Chair

Eurobodalla Shire Council

Ms Kathy Arthur, Divisional Manager, Community, Arts and Recreation

Moruya Chiro and Wellness

Mr Ifo Ahlquist, Chiropractor

Mr Brad Rossiter, Private capacity

NSW Nurses' and Midwives' Union

Mrs Annetee Alldrick, Secretary and Delegate, Shoalhaven Branch

Dr David Rivett, Private capacity

Thursday, 25 September 2014 – Canberra**National Blood Authority**

Mr Leigh McJames, General Manager

Mr Peter Executive Director and Chief Information Officer

Tuesday, 30 September 2014 – Canberra**Central Queensland Medicare Local**

Mrs Jean McRuvie, Chief Executive Officer

Thursday, 2 October 2014 – Canberra**Consumers Health Forum of Australia**

Mr Adam Stankevicius, Chief Executive Officer

Ms Priyanka Rai, Policy and Communications Officer

Tasmania Medicare Local

Mr Phil Edmondson, Chief Executive Officer

Goldfields-Midwest Medicare Local, Western Australia

Mrs Brenda Ryan, Chief Executive Officer

Perth South Coastal Medicare Local, Western Australia

Mr Paul Hersey, Chief Executive Officer

Bayside Medicare Local, Victoria

Dr Elizabeth Deveny, Chief Executive Officer

Murrumbidgee Medicare Local, NSW

Mrs Nancye Piercy, Chief Executive Officer

Country North Medicare Local, South Australia

Mr Kim Hosking, Chief Executive Officer

Department of Health

Ms Sharon Appleyard, Assistant Secretary, Primary Health Networks Branch

Ms Mary McDonald, Acting Deputy Secretary

Department of Health

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Ms Mary McDonald, Acting Deputy Secretary

Monday, 6 October 2014 – Geelong**Medicare Local Barwon**

Mr Jason Trethowan, Chief Executive Officer

Dr Ajeet Singh, Private capacity

Colac Area Health

Mr Geoff Iles, Chief Executive Officer

Mrs Marg White, Director Community Services

Lorne Community Hospital

Ms Kate Gillan, Chief Executive Officer

Ms Andrea Russell, Acting Chief Executive Officer

Australian Diabetes Educators Association

Ms Tracy Aylen, President

Tuesday, 7 October 2014 – Melbourne**Victorian Medicare Action Group**

Ms Meredith Carter, Spokesperson

Benetas

Mr Stephen Burgess, Innovation, Policy and Research Officer

Ambulance Employees Australia Victoria

Mr Danny Hill, Assistant Secretary

Victorian Health Promotion Foundation (VicHealth)

Dr Bruce Bolam, Executive Manager, Programs Group

Federation of Rural Australian Medical Educators

Professor Judith Walker, Chair

Australian Medical Association (Victoria) Limited

Dr Anthony Bartone, President

Loddon Mallee Murray Medicare Local

Mr Matthew Jones, Chief Executive Officer

Wednesday, 8 October 2014 – Melbourne**Royal Australasian College of Physicians**

Professor Nicholas Talley, President

Dr Nick Buckmaster, Policy and Advocacy Committee

Services for Australian Rural and Remote Allied Health

Mr Rod Wellington, Chief Executive Officer

Mr Rob Curry, Deputy Chair

Australasian College of Emergency Medicine

Dr Anthony Cross, President

Ms Alana Killen, Chief Executive Officer

Dr Simon Judkins, Victorian Councillor

Grattan Institute

Dr Stephen Duckett, Director, Health Program

Mr Peter Breadon, Health Fellow

Allied Health Professions Australia

Ms Lin Oke, Executive Director

Mr Damian Mitsch, Director

Australian Diagnostic Imaging Association

Dr Christian Wriedt, President

Ms Pattie Beerens, Chief Executive Officer Mr Chris Kane, Senior Policy Adviser

Department of Health

Ms Kerry Flanagan, Deputy Secretary

Ms Mary McDonald, Acting Deputy Secretary

Mr Richard Bartlett, Acting Deputy Secretary

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Treasury

Mr Peter Robinson, General Manager, Commonwealth-State Relations Division

Mr Rob Montefiore Gardner, Manager, Health and Disability Unit

Department of Finance

Mr Mark Thomann, First Assistant Secretary, Social Policy Division

Mr Nicholas Hunt, Assistant Secretary, Budget Group

Department of Human Services

Mr Barry Sandison, Deputy Secretary

Thursday, 9 October 2014 – Adelaide

Department of Health and Ageing (South Australia)

Mr Steve Archer, Deputy Chief Executive, Finance and Business Services

Mr Jamin Woolcock, Chief Finance Officer

Ms Skye Jacobi, Director, Intergovernment Relations and Ageing

Medicare Locals (South Australia)

Mr Kim Hosking, Chief Executive Officer, Country North SA Medicare Local

Ms Debra Lee, Chief Executive Officer, Northern Adelaide Medicare Local

Mr Chris Seiboth, Chief Executive Officer, Central Adelaide and Hills

Population Health Research Network

Professor Brendan Kearney, Chair, Management Council

Dr Merran Smith, Chief Executive Officer

Australian Nursing and Midwifery Federation (SA Branch)

Mr Rob Bonner, Director, Operations and Strategy

Ms Jennifer Hurley, Manager, Professional Programs

Adjunct Associate Professor Elizabeth Dabars AM, CEO and Secretary

University Department of Rural Health

Associate Professor Martin Jones, Director

Aboriginal Health Council of South Australia

Mr Shane Mohor, Acting Chief Executive Officer

Ms Amanda Mitchell, Health Development Coordinator

Mr Paul Ryan, Senior Project Officer, Member Support

Health Consumers Alliance of South Australia

Ms Stephenie Miller, Executive Director

Mr Michael Cousins, Manager, Policy and Advocacy

Friday, 10 October 2014 – Perth**Health Consumers' Council of Western Australia**

Dr Martin Whitely, Acting Executive Director

Dr Ann Jones, Policy Officer

Medicare Locals Western Australia

Mr Paul Hersey, Chief Executive Officer, Perth South Coastal

Ms Brenda Tyan, Chief Executive Officer, Goldfields-Midwest

Curtin University, Western Australia

Professor Mike Daube, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; Director, McCusker Centre for Action on Alcohol and Youth

Western Australian Centre for Rural Health

Professor Sandra Thompson, Director

Associate Professor Judith Katzenellenbogen, Research Associate Professor

Monday, 3 November 2014 – Hobart

Dr Robert Ware, Private capacity

Mental Health Council Tasmania

Mr Darren Carr, Chief Executive Officer

Ms Elida Meadows, Policy and Research Officer

Royal Australian College of General Practitioners

Dr Bastian Seidel, Deputy Chair, Tasmanian Faculty

Mr Martyn Goddard, Private capacity

Social Determinants of Health Advocacy Network

Ms Miriam Herzfeld, Convenor

TasCOSS

Dr Pauline Marsh, Policy Officer

Australian Medical Association Tasmania

Professor Tim Greenaway, President

Aged and Community Services Tasmania

Mr Darren Mathewson, Chief Executive Officer

Tuesday, 4 November 2014 – Launceston

Tasmanian Medicare Local

Mr Phil Edmondson, Chief Executive Officer

Australian Nursing and Midwifery Federation Tasmanian Branch

Mrs Neroli Ellis, Branch Secretary

University of Tasmania

Dr Martin Harris, Lecturer, Centre for Rural Health

Mr Stuart Auckland, Lecturer and Program Manager, Centre for Rural Health

Rural Doctors Association of Tasmania

Dr Paul Fitzgerald, Treasurer

Family Based Care Association North West Inc.

Ms Justine Barwick, Operations Manager

Thursday, 5 February 2015 – Canberra

Australian Medical Association

Associate Professor Brian Owler, President

Royal Australian College of General Practitioners

Dr Frank Jones, President

Dr Zena Burgess, Chief Executive Officer

Rural Doctors Association of Australia

Ms Jennifer Johnson, Chief Executive Officer

Charlestown Square Medical Centre

Dr Colin Pearce, Clinical Director

Whitebridge Medical Centre

Dr Richard Terry, Practice Principal

Dr Ian Kamerman, private capacity

Graduate School of Medicine, University of Wollongong

Professor Andrew Bonney, Roberta Williams Chair of General Practice

Claremont Village Medical Centre

Dr Graeme Alexander, General Practitioner

Hunter General Practitioners Association

Dr Fiona Van Leeuwen, Vice Chair

Consumers Health Forum of Australia

Mr Adam Stankevicius, Chief Executive Officer

Ms Josephine Root, Policy Manager

Public Health Association of Australia

Professor Michael Moore, Chief Executive Officer

National Rural Health Alliance

Mr Gregory Gordon, Chief Executive Officer

Dr Anne-marie Boxall, Senior Policy Adviser

Australian College for Emergency Medicine

Mrs Alana Killen, Chief Executive Officer

Dr Simon Judkins, Councillor

Australian Healthcare Reform Alliance

Mr Russell McGowan, Secretary

Mr Sebastian Rosenberg, Member, Executive Board

Grattan Institute

Dr Stephen Duckett, Director, Health Program

Doctors Reform Society

Dr Con Costa, President

Dr Tim Woodruff, Vice President

Department of Health

Mr Andrew Stuart, Acting Secretary

Dr Anthony Hobbs, Acting Deputy Secretary

Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division

Ms Fifine Cahill, Assistant Secretary, Primary Care and Pathology Branch, Medical Benefits Division

Department of Treasury

Ms Leesa Croke, General Manager

Mr Robert Montefiore-Gardner, Senior Adviser

Department of Finance

Mr Mark Thomann, Acting Deputy Secretary

Mr Nicholas Hunt, Assistant Secretary

Friday, 13 February 2015 – Canberra**Indigenous Allied Health Australia**

Ms Donna Murray, Chief Executive Officer

Ms Anna Leditschke, Senior Policy Officer

Kidney Health Australia

Ms Anne Wilson, Chief Executive Officer and Managing Director

Associate Professor Tim Mathew, Medical Director

Mr Luke Toy, General Manager, Public Affairs

Ms Donisha Duff, National Manager, Indigenous Affairs

Central Australian Aboriginal Congress Aboriginal Corporation

Ms Donna Ah Chee, Chief Executive Officer

Dr John Boffa, Chief Medical Officer Public Health

Australian College of Rural and Remote Medicine

Associate Professor David Campbell, Censor-in-Chief

Rural Health Workforce Australia

Mr Greg Mundy, Chief Executive Officer

National Rural Health Students' Network

Ms Danielle Dries, Indigenous Health Officer

Royal Australian College of General Practitioners

Associate Professor Brad Murphy, Chair, National Faculty of Aboriginal and Torres Strait Islander Health

Dr Timothy Senior, Medical Adviser, National Faculty of Aboriginal and Torres Strait Islander Health

Australian Indigenous Doctors' Association Ltd

Dr Tammy Kimpton, President

Ms Kate Thomann, Chief Executive Officer

National Aboriginal Community Controlled Health Organisation

Ms Lisa Briggs, Chief Executive Officer

Department of Health

Mr Martin Bowles PSM, Secretary

Dr Wendy Southern PSM, Deputy Secretary, National Programme Delivery Group

Ms Maria Jolly, Acting First Assistant Secretary, Indigenous and Rural Health Division

Mr Rodney Schreiber, Acting Assistant Secretary, Indigenous Health Reform Task Force, Indigenous and Rural Health Division

Dr Masha Somi, Assistant Secretary

Ms Meredith Tailor, Assistant Secretary, Rural, Remote and Indigenous Access Branch, Indigenous and Rural Health Division

Ms Alison Killen, Assistant Secretary, Indigenous Health Programmes Branch

Department of the Prime Minister and Cabinet

Ms Caroline Edwards, First Assistant Secretary

Mr Brendan Gibson, Acting Assistant Secretary, Health Branch, Indigenous Affairs Group

Mr Matthew James, Assistant Secretary, Information and Evaluation Branch

Thursday, 19 February 2015 – Strathfield

Inner West Sydney, Medicare Local

Dr Michael Moore, Chief Executive Officer

Aboriginal Health and Medical Research Council of New South Wales

Ms Sandra Bailey, Chief Executive Officer

Ms Victoria Jones, Member, Senior Policy Group

Aboriginal Medical Service Western Sydney

Mr Frank Vincent, Chief Executive Officer

Ms Joanne Delaney, Deputy Chief Executive Officer

Being – Mental Health and Wellbeing Consumer Advisory Group

Ms Ka Ki Ng, Senior Policy Officer

Ms Karina Ko, Policy Officer

Dr Aline Smith, private capacity

Dr Annabel Kain, private capacity

Dr Linda Mann, private capacity

Mr Umesh Garg, private capacity

Dr Marie Healy, private capacity

Dr Charlotte Hespe, private capacity

General Practice New South Wales

Professor Tracey McDonald, Deputy Chair

Mr Ian Sinnott, Interim Executive Director

Ms Agnes Levine, Board Member

National LGBTI Health Alliance

Dr Gavi Ansara, Manager, Research and Policy

Australian Federation of AIDS Organisations

Ms Linda Forbes, manager, Policy and Communications

AIDS Council of New South Wales

Mr Dean Price, Policy Officer

Anwernekenhe National HIV Alliance

Mr Neville Fazulla, Chair Person

Mr Michael Costello-Czak, Executive Officer

Family Planning New South Wales

Ms Ann Brassil, Chief Executive Officer

Ms Ann-Marie Ashburn, Director, Communications, Government and Community Affairs

Dr Deborah Bateson, Medical Director

Tuesday, 10 March 2015 – Rockdale**New South Wales Nurses and Midwives' Association**

Mr Brett Holmes, General Secretary

Ms Angela Garvey, Professional Officer

Ms Shirley Lee, Organiser

Ms Renatta Di Staso, Organiser

Mr Stephen Mierendorff, Member

Inner West Sydney Medicare Local

Dr Michael Moore, Chief Executive Officer

University of New South Wales

Professor Mark Harris, Professor of General Practice

South Eastern Sydney Medicare Local

Ms Lynelle Hales, Chief Executive Officer

Dr Wayne Cooper Board Chair

South Eastern Sydney Medicare Local

Dr Wayne Cooper, Board Chair

Dr Sharyn Wilkins, Board Member

Ms Jacky Peile, Occupational Therapist

North Sydney Medicare Local

Mr Paul Hussein, Director, Community and Strategy

Regal Home Health

Adjunct Associate Professor Anna Shepherd, Chief Executive Officer

Ms Jude Foster, Director, Clinical Excellence and Business Development

Cancer Voices New South Wales

Mr Peter Brown, Advocate

Exercise and Sports Science Australia

Ms Mia Kacen, Exercise Physiologist

Leichhardt Women's Community Centre

Ms Roxanne McMurray, Manager

Macarthur Gateway Resource Services

Ms Marilyn Fogarty, Executive Officer

B Miles Women's Housing

Ms Jane Bullen, Secretary, Management Committee

National Heart Foundation of Australia

Mr Rohan Greenland, General Manager, Advocacy

Ms Vicki Wade, Leader, National Aboriginal Health Unit

Wednesday, 11 March 2015 – Gosford

Dr Ian Charlton, General Practitioner, Kincumber, New South Wales, private capacity

Reliance GP Super Clinic, West Gosford

Dr Rodney Beckwith, Director

Terrigal Medical Centre and Avoca Beach Medical Centre

Dr Karen Douglas, General Practitioner

Dr Paul Duff, General Practitioner

Central Coast Disability Network

Ms Sally Jope, Chairman

Ms Xylia Ingham, Manager

Central Coast Disability Network

Mrs Jenny Mackellin, Chief Executive Officer

Cancer Council Australia

Mr Paul Grogan, Director, Public Policy and Advocacy

Cancer Council New South Wales

Mr Shayne Connell, Regional Manager

Australian Paramedics Association

Mr Jeff Andrew, Vice President

Australian Medical Association (New South Wales)

Dr Saxon Smith, President

New South Wales Nurses and Midwives' Association

Ms Michelle Cashman, Member

Hunter General Practitioners Association

Dr Fiona Van Leeuwen, General Practitioner and Clinical Director, Hunter Medicare Local and Vice Chair, Hunter General Practitioners Association

Dr Colin Pearce, General Practitioner

Dr Stephen De Lyall, General Practitioner

Thursday, 12 March 2015 – Penrith**Nepean-Blue Mountains Medicare Local**

Dr Andrew Knight, Board Chair

Mrs Lizz Reay, Chief Executive Officer

Ms Jillian Harrington, Clinical Psychologist, private capacity

GP Synergy

Mr John Oldfield, Chief Executive Officer

Royal Australasian College of Physicians

Dr Tamara Mackean, Chair, Aboriginal and Torres Strait Islander Committee

Mr Paul Wright, Senior Policy Officer

New South Wales Nurses and Midwives' Association

Ms Louise Stammers, Aged Care Nurse

Ms Jocelyn Hofman, Aged Care Nurse

Consumer Reference Group Blue Mountains GP Network

Mr John Haydon, Acting Chair, Blue Mountains

Mrs Diana Aspinall, Member, Blue Mountains

Ms Kerrie Jackson, Member, Blue Mountains

Mr Barry Funnell, Chair, Medicare Local Lithgow

Mr Peter Gooley, Member

Ms Anita Griffiths, Member, Penrith

Doctors Action Group – Supporting Family Doctors

Dr Adrian Sheen, President

Dr Barry Kroll, General Practitioner

Tindale Family Practice

Mr Gary Smith, Practice Manager

Nepean General Practice Division

Dr Stephen Wong, Vice Chairman

Mr Michael Edwards, Company Secretary

University of Western Sydney

Professor Andre Renzaho, Professor of Humanitarian and Development Studies

Tuesday, 14 April 2015 – Canberra

Professor Jacqueline Cumming, private capacity

University of Otago, Dunedin

Professor Robin Gauld, Centre for Health Systems, Department of Preventive and Social Medicine, Dunedin School of Medicine

Canterbury District Health Board

Ms Carolyn Gullery, General Manager, Planning, Funding and Decision Support

Dr Graham McGeoch, Clinical Adviser

Australian Healthcare and Hospitals Association

Ms Alison Verhoeven, Chief Executive Officer

Dr Linc Thurecht, Senior Research Leader

Grattan Institute

Professor Hal Swerissen, Fellow

The Menzies Centre for Health Policy, University of Sydney

Associate Professor Adam Elshaug, HCF Research Foundation Principal Research Fellow; Director, Value in Health Care Division

NPS MedicineWise

Dr Lyn Weekes, Chief Executive Officer

Ms Kerren Hosking, Executive Manager, Corporate Affairs and Governance

Doctors Reform Society

Dr Con Costa, National President

Australian Health Care Reform Alliance

Mr Tony McBride, Chair

Mr Russell McGowan, Secretary

National Association of Primary Care, United Kingdom

Dr Charles Alessi, Co-Chairman

Wednesday, 15 April 2015 – Canberra**Lowitja Institute**

Mr Romlie Mokak, Chief Executive Officer

CHIK Services Pty Ltd

Ms Sally Glass, Managing Director

Australian Association for Academic Primary Care

Professor Kirsty Douglas, Professor of General Practice

Dr Katrina Alford, Independent health economist with expertise in Indigenous health services and funding**Consumers Health Forum of Australia**

Ms Leanne Wells, Chief Executive Officer

Ms Jo Root, Policy Manager

Australian College of Nursing

Dr Marlene Eggert, Policy Manager

Australian College of Mental Health Nurses

Adjunct Associate Professor Kim Ryan, Chief Executive Officer

Australian College of Midwives

Ms Sarah Stewart, Professional Officer

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

Ms Colleen Gibbs, Senior Policy and Research Officer

Professor Roianne West, Board Member

Dr Lesley Russell, private capacity

Centre for Policy Development

Dr Jennifer Doggett, Health Policy Analyst and Consultant

Thursday, 16 April 2015 – Colac**Colac Area Health**

Mr Geoff Iles, Chief Executive Officer

Mrs Libby Fifis, Director of Nursing and Midwifery

Corangamarah Residential Aged Care

Ms Pamela Matheson, Manager

Mrs Karen Aucote, Financial Accountant

Mr David Henry, Proprietor, RetireInvest

Mrs Nola Creece, private capacity

Dr Ian Mackay, private capacity

Hume City Council

Councillor Adem Atmaca, Mayor

Mrs Margarita Caddick, Director, City Communities

Ms Elizabeth Young, Prevention Partnership Program Manager

City of Wodonga

Ms Patience Harrington, Chief Executive Officer

Ms Claire Taylor, Coordinator, Healthy Together Wodonga

Knox City Council

Councillor Peter Lockwood, Mayor

Dr Graeme Emonson, Chief Executive Officer

Ms Michelle Hollingworth, Program Manager, Healthy Together Knox

Ms Kathy Parton, Community Wellbeing Department

City of Greater Geelong

Ms Karen Pritchard, Manager, Aged and Disability

Ms Monica Evans, Acing Coordinator, Healthy Together Geelong

Healthy Together Grampians Goldfields

Mrs Sharon Ruyg, Manager, Preventive Health

Ararat Rural City

Councillor Paul Hooper, Mayor

Ms Angela Hunt, Manager, Community Development and Client Services

Ambulance Employees Australia, Victoria

Mr Danny Hill, Assistant Secretary

Health Services Union Victoria No.4 Branch

Mr Paul Elliott, Secretary

Mr Alexander Schlotzer, Communications and Campaigns Officer

Friday, 17 April 2015 – Burnie

Rural Clinical School – University of Tasmania

Associate Professor Lizzi Shires, Co-Director

Dr Marielle Ruigrok, Emergency Staff Specialist

Burnie City Council

Mrs Anita Dow, Mayor

Mr Andrew Wardlaw, General Manager

Rural Health Tasmania

Mr Robert Waterman, Chief Executive Officer

Mrs Sue McTurk, Podiatrist**Dr Emil Djakic, General Practitioner**

Dr James Wilson, private capacity

Australian Medical Association Tasmania

Associate Professor Timothy Greenaway, President

Royal Australian College of General Practitioners

Dr Bastian Seidel, member

Monday, 27 April 2015 – Darwin**Menzies School of Health Research**

Professor Alan Cass

Australian Indigenous Doctors' Association Ltd

Dr Kiarna Brown, Board Director

Danila Dilba Health Service

Ms Olga Havnen, Chief Executive Officer

Dr James Stephen, Senior Medical Officer

Ms Joy McLaughlin, Senior Project Officer

Aboriginal Medical Services Alliance of the Northern Territory

Mr John Paterson, Chief Executive Officer

Mr David Cooper, Manager, Research, Advocacy and Policy

Dr Liz Moore, Public Health Medical Officer

Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation

Ms Heather Hall, Manager. Panuku

Mr Lachlan Ross, Indigenous Patient Preceptor and Cultural Adviser

Flinders University, Northern Territory

Professor John Wakerman, Associate Dean

Red Dust

Mr Darren Smith, Chief Executive Officer

Ms Colette Davis, Programs Manager

Mr Jonathan Hermawan, Central Australia Manager

Northern Territory Medicare Local

Dr Andrew Bell, Chair

Ms Judy Davis, Deputy Chief Executive Officer

Ms Debra Blumel, private capacity

Tuesday, 28 April 2015 – Halls Creek

Western Australian Legislative Assembly

Ms Josephine (Josie) Farrer, Member for Kimberley

Halls Creek Health Service

Dr Rajkumar Ramasamy, District Medical Officer

Yura Yungi Medical Service

Ms Donna Smith, Chairperson

Kimberley Language Resource Centre

Mrs Patsy Bedford, Chairperson

Halls Creek Peoples Church Frail Aged Hostel

Mr Peter Vincent, Acting Chief Executive Officer

Mr Greg Tait, private capacity

Halls Creek Hospital

Mrs Robyn Cotterill, Acting Director of Nursing

Dr Dele Orebanwo, Permanent General Practitioner

Ms Angela Llewellyn, Chronic Disease Nurse and Diabetes Educator

Kimberley Population Health Unit

Ms Tama Howard, Community Health Nurse Manager, Halls Creek

Shire of Halls Creek

Mr Rodger Kerr-Newall, Chief Executive Officer

Shire of Halls Creek Council

Councillor Malcolm Edwards

Tuesday, 28 April 2015 – Kununurra**Boab Health Services**

Ms Margie Ware, Chief Executive Officer

Ms Tracey Raymond, Allied Health Manager

Wyndham Early Learning Activity Centre

Ms Jane Parker, Manager

Ms Elaine McLean, Assistant Manager

Ord Valley Aboriginal Health Service

Mr Graeme Cooper

Mr Henry Councillor

Wunan

Ms Natasha Short, Staff Member

Kununurra Medical Centre

Dr Stephanie Trust, General Practitioner

Wednesday, 29 April 2015 – Katherine**Sunrise Health Service**

Mr Graham Castine, Chief Executive Officer

Binjari Health Clinic

Mr Peter Gazey, Health Service Manager

Roper-Gulf Regional Council

Ms Lara Brennan, Community Services Regional Manager

Wurli-Wurlinjang Health Service

Ms Marion Scrymgour, Chief Executive Officer

Kalano Community Association Incorporated

Mr Rick Fletcher, Chief Executive Officer

Ms Carol Dowling, Treasurer

Thursday, 30 April 2015 – Galiwin'ku

Ms Stephanie Yikaniwuy, Interpreter; private capacity

Miwatj Health

Mr John Morgan, Chairperson

Mr Eddie Mulholland, Chief Executive Officer

Mr Karl Dyason, Acting Deputy Chief Executive Officer and Director of Business Services

Dr Lucas de Toca, Director of Medical Services and Public Health

Ms Paula Myott, Regional Health Reform Director

Mr John Maher, Mental Health Coordinator

Mr Charlie Yibirrir Dhamarrandji

Mr Johny Wurur Dhurrkay

Dr Kylie Strate

Marthakal Homelands Clinic

Ms Yvonne Sutherland, Chief Executive Officer

Ms Helen Nyomba, private capacity

Mr Trevor Gurruwiwi, Interpreter; private capacity

Mr Alan Maratja, Interpreter; private capacity

Dr Elaine Mayptlama, private capacity

Friday, 1 May 2015 – Mt Isa

Mount Isa Centre for Rural and Remote Health, James Cook University

Professor Sabina Knight, Director

Mr Shaun Solomon, Head of Indigenous Health

Gidgee Healing

Mr Shaun Solomon, Chairperson

Mr Dallas Leon, Chief Executive Officer

Ms Diana Terry, Clinical Director

Ms Rachel Yates, Primary Health Care Director, Mount Isa Aboriginal Community Controlled Health Service

North West Hospital and Health Service

Ms Sue Belsham, Chief Executive Officer

Associate Professor Alan Sandford, Executive Director of Medical Services

Mr Brett Oates, Chief Financial Officer

Royal Flying Doctor Service (Queensland Section)

Ms Jaya Ganasan, General Manager – Integrated Operations

Ms Lauren Jesberg, Regional Manager North West

Blue Nursing

Mrs Helen Davis, Multi Service Manager

Laura Johnson Home

Mrs Betty Kiernan, Chief Executive Officer

Miss Loribeth Allison, Director of Nursing

Anglicare North Queensland Mental Health Service

Ms Leeanne Harris, Manager

North West Queensland Indigenous Catholic Social Services

Father Michael Lowcock, Director

Tuesday, 9 June 2015 – Melbourne**Australian Medical Association**

Dr Stephen Parnis, Vice President

The Royal Australian College of General Practitioners

Dr Morton Rawlin, Vice President and Victorian Faculty Chair

Hepatitis Australia

Ms Helen Tyrrell, Chief Executive Officer

Australian Healthcare and Hospitals Association

Ms Alison Verhoeven, Chief Executive Officer

General Practice Registrars Association

Dr Jomini Cheon, Chair

Mrs Sarah Kincaid, Chief Executive Officer

National Complex Needs Alliance

Ms Lyn Morgain, Chair

Public Health Association of Australia

Ms Melanie Walker, Acting Chief Executive Officer

Wednesday, 10 June 2015 – Broken Hill**Broken Hill University Department of Rural Health**

Professor David Lyle, Head of Department

Ms Debra Jones, Director of Primary Health Care

Dr Susan Kirby, Senior Research Fellow

Maari Ma Health Aboriginal Corporation

Mr Bob Davis, Chief Executive Officer

Dr Hugh Burke, Director Medical Services

Ms Cathy Dyer, Director Corporate Services

Ms Kaylene Kemp, Manager Community Engagement

Dr Steve Flecknoe-Brown, Consultant Physician and Clinical Pathologist, private capacity

Nachiappans

Dr Ramu Nachiappan, Medical Principal

Far West NSW Medicare Local

Mr Stuart Gordon, Chief Executive Officer

Ms Michelle Pitt, Manager for Clinical Services

Outback Pharmacies

Mr Jason Harvey, Partner

Broken Hill City Council

Councillor Wincen Cuy, Mayor

Royal Flying Doctor Service

Dr Malcolm Moore

Thursday, 11 June 2015 – Adelaide**Campbelltown City Council**

Ms Tracy Johnstone, Manager, Community Services and Social Development

Mr Gavin Fairbrother, Manager, OPAL

Aboriginal Health Council of South Australia Inc.

Ms Amanda Mitchell, Acting Deputy Chief Executive Officer

Ms Michele Robinson, COAG Workforce Liaison Officer

Australian Nursing and Midwifery Federation, South Australia Branch

Ms Jennifer Hurley, Manager, Professional Programs

Mr Robert Bonner, Director, Operations and Strategy

Department for Health and Ageing, South Australia

Mr Steve Archer, Deputy Chief Executive, Finance and Corporate Services

Ms Skye Jacobi, Director, Intergovernment Relations and Ageing

Ms Rachel Newrick, Manager, Intergovernment Relations

University of Adelaide

Professor Nigel Stocks, Head of the Discipline of General Practice

Health Consumers' Alliance of South Australia

Mr Michael Cousins, Chief Executive

Ms Ellen Kerrins, Manager, Advocacy and Policy

Cancer Voices SA

Ms Julie Marker, Chair

Ms Chris Christensen, Deputy Chair

Mental Health Coalition of South Australia

Ms Sandra Arlidge, Acting Executive Director

Friday, 10 July 2015 – Sydney**Australian Hearing and National Acoustic Laboratories**

Mr Bill Davidson, Managing Director

Ms Gina Mavrias, Operations Director

Aussie Deaf Kids

Mrs Ann Porter AM, Chief Executive Officer

Deafness Forum of Australia

Mr Stephen Williamson, Chief Executive Officer

Ms Margaret Dewberry, Adviser

Parents of Deaf Children

Ms Anna Messariti, President

Ms Kate Kennedy, Coordinator

Mr Mark Wyburn, Ordinary Committee Member and Regional Representative

Royal Institute for Deaf and Blind Children

Mr Christopher Rehn, Chief Executive Officer

Deaf Australia Inc.

Mr Kyle Miers, Chief Executive Officer, through Vanessa Sweeney and Kerrie Lakeman, sign language interpreters

The HEARing Cooperative Research Centre Limited

Professor Robert Cowan, Chief Executive Officer

Independent Audiologists Australia

Dr Louise Collingridge, Executive Officer

Deaf Society of NSW

Ms Leonie Jackson, Chief Executive Officer, through Vanessa Sweeney and Kerrie Lakeman, sign language interpreters

The Shepherd Centre

Dr Jim Hungerford, Chief Executive Officer

Better Hearing Australia

Ms Sara Duncan, National President

Department of Health

Ms Catherine Rule, First Assistant Secretary, Medical Benefits Division

Ms Tracey Duffy, National Manager, Office of Hearing Services

Department of Finance

Mr Robin Renwick, Acting First Assistant Secretary, Commercial and Claims Division

Ms Sharon Ong, Assistant Secretary, Commercial and Claims Division

Department of Human Services

Mr Jonathan Hutson, Acting Deputy Secretary, Enabling Services

Ms Rosemary Deininger, General Manager, Whole of Government Coordination Division

Wednesday, 26 August 2015 – Canberra

National Mental Health Commission

Mr David Butt, Chief Executive Officer and Commissioner

Ms Jacqueline Crowe, Commissioner

Professor Allan Fels, Chair

Ms Sally Goodspeed, Executive Director

Professor Ian Hickie, Commissioner

Roundtable One – mental health groups and service providers

Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare

Professor Malcolm Hopwood, President, Royal Australian and New Zealand College of Psychiatrists

Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia

Mr Andrew Peters, Chief Executive Officer, Royal Australian and New Zealand College of Psychiatrists

Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia

Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney

Ms Pamela Rutledge, Chief Executive Officer, RichmondPRA

Roundtable Two – mental health groups and service providers

Ms Tracy Adams, Chief Executive Officer, BoysTown

Mr Peter Bewert, Executive Manager Care Services, Salvation Army Aged Care Plus

Mr John Dalgleish, Manager, Strategy and Research, BoysTown

Mrs Narelle Hand, Program Manager, Anglicare

Mr Jack Heath, Chief Executive Officer, SANE Australia

Mr Christopher John, Chief Executive Officer, United Synergies

Ms Susan King, Director, Advocacy and Research, Anglicare Sydney

Professor Mike Kyrios, President, Australian Psychological Society

Professor Lyn Littlefield, Executive Director, Australian Psychological Society

Mrs Karen Phillips, Manager, National Standby Response Service, United Synergies

Associate Professor Judith Proudfoot, Head of eHealth, Black Dog Institute

Mrs Nicola Rosenthal, Business Development Manager, Salvation Army Aged Care Plus

Roundtable Three – federal government departments

Department of Health

Ms Janet Anderson, First Assistant Secretary, Health Services Division

Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation

Ms Colleen Krestensen, Assistant Secretary, Mental Health Policy Branch

Ms Fiona Nicholls, Assistant Secretary, Mental Health Services Branch

Department of Social Services

Dr Russell Ayres, Branch Manager, Mental Health

Mr James Christian, Group Manager, Disability, Employment and Carers

Dr Nick Hartland, Group Manager, National Disability Insurance Scheme

Mr Eddie Bartnik, Strategic Adviser, National Disability Insurance Agency

Friday, 28 August 2015 – Sydney**Roundtable One – mental health consumers and carers**

Ms Lyn Anderson, private capacity

Mrs Pauline Ferkula, private capacity

Mr Sunny Hemraj, private capacity

Miss Rachael Laidler, private capacity

Ms Kerin O'Halloran, private capacity

Mr David Peters, private capacity

Mr Robert Wellman, private capacity

Roundtable Two – mental health groups and service providers

Ms Victoria Blake, Research Coordinator, ReachOut Australia

Mr Malcolm East, Deputy Principal, St Philips Christian College, Gosford

Ms Christine Morgan, Chief Executive Officer, Butterfly Foundation

Ms Sue Murray, Chief Executive, Suicide Prevention Australia

Ms Ka Ki Ng, Senior Policy Officer, Mental Health and Wellbeing Consumer Advisory Group

Ms Hayley Purdon, Deputy Chair, Lived Experience Network Leadership Group, Suicide Prevention

Ms Deepika Ratnaik, Director of Research and Policy, ReachOut Australia

Mr Matthew Tukaki, Board Member, Suicide Prevention Australia; Chairman, National Coalition for Suicide Prevention

Mr Alan Woodward, Executive Director, Lifeline Research Foundation, Lifeline Australia

Roundtable Three – mental health groups and service providers

Mr Jonathan Harms, CEO, Mental Health Carers Arafmi NSW Inc.

Ms Jane Henty, Executive Officer, Mental Health Carers Arafmi Australia

Mr Brendan Maher, General Manager, R U OK?

Dr Gerard Naughtin, Chief Executive, Mind Australia

Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance

Ms Jaelea Skehan, Director, Hunter Institute of Mental Health

Rural Health Research, Centre for Rural and Remote Mental Health

Professor David Perkins, Director and Professor

Professor Philip Mitchell, Private capacity

Friday, 18 September 2015 – Brisbane**Brisbane North Primary Health Network**

Mr Jeffery Cheverton, Deputy Chief Executive Officer

Ms Pauline Coffey, Executive Manager, Commissioned Services

Ms Nicola Bristed, Private capacity; and Consumer Evaluator, Partners in Recovery Program

Primary Health Care Advisory Group

Dr Steven Hambleton, Chairman

Queensland Mental Health Commission

Dr Lesley van Schoubroeck, Queensland Mental Health Commissioner

Mental Health Commission of New South Wales

Mr John Feneley, Commissioner

Roundtable One – mental health consumers and carers

Mr Gregory Cutts, private capacity

Mrs Lesley McDonald, Carer, Consumer and Carer Engagement Group

Ms Nicole Sutherland, Consumer Engagement Committee, Metropolitan North

Roundtable Two – mental health groups and service providers

Dr Michelle Blanchard, Head, Projects and Partnerships, Young and Well Cooperative Research Centre

Ms Marj Bloor, Mental Health Carers Arafmi Queensland Inc.

Dr Greta Galloway, Independent Researcher; Consultant, Alan Webster Consultancy/Centacare

Mr Gary Hubble, Manager Far North Queensland Partners In Recovery, Centacare Cairns

Mr Majid Khan, Senior Project Officer, Mental Health in Multicultural Australia

Ms Monica O'Neill, Director, Metro North Mental Health

Ms Sharon Orapeleng, Senior Project Officer, Mental Health in Multicultural Australia

Mr Hamza Vayani, National Project Manager, Mental Health in Multicultural Australia

Ms Jody Wright, Executive Officer, Mental Health Association Queensland

Thursday, 8 October 2015 – Canberra**Queensland Health**

Ms Bronwyn Nardi, Acting Deputy Director General, Strategy, Policy and Planning Division

Mrs Diane Maurer, Director, Aboriginal and Torres Strait Islander Health Branch, Strategy, Policy and Planning Division

Northern Territory Department of Health

Mr Mike Melino, Executive Director Strategy and Reform

Mr Michael Kalimnios, Chief Operating Officer, Top End Health Service

Mrs Susan Korner, Chief Operating Officer, Central Australia Health Service

Poche Centre for Indigenous Health

Ms Kylie Gwynne, Director

Royal Australian College of General Practitioners

Dr Brad Murphy, Chair, National Faculty of Aboriginal and Torres Strait Islander Health

Royal Australian College of General Practitioners

Dr Tim Senior, Medical Advisor, National Faculty for Aboriginal and Torres Strait Islander Health

National Aboriginal Community Controlled Health Organisation

Mr Matthew Cooke, Chairperson

Mr Chris O'Connell, Chief Operations Officer

Dr Robert Starling, Chief Information Officer

Ms Sandy Gillies, General Manager, Queensland Aboriginal and Islander Health Council

Mr Troy Reeves, External Stakeholder Relations Advisor

Department of Health

Dr Wendy Southern, Deputy Secretary

Ms Tania Rishniw, Acting First Assistant Secretary

Ms Meredith Taylor, Assistant Secretary

Ms Alison Killen, Assistant Secretary

Mr Paul McCormack, Assistant Secretary

Ms Nicole Jarvis, Acting Assistant Secretary – Mental Health Early Intervention

Ms Sharon Appleyard, Assistant Secretary, Primary Health Network Establishment

Department of Prime Minister and Cabinet

Mr Robert Ryan, Acting First Assistant Secretary, Community Safety and Policy Division

Mr Gibson Brendan, Assistant Secretary, Health Branch

Mr Matthew James, Assistant Secretary IAG Information and Evaluation Branch

Wednesday, 4 November 2015 – Melbourne**Grattan Institute**

Dr Stephen Duckett, Director, Health Program

Ms Danielle Romanes, Associate

Melbourne Health, the Royal Melbourne Hospital

Dr David Alcorn, Executive Director

Mr George Kapitelli, Executive Director Finance and Logistics

Australian Medical Association (Victoria)

Dr Anthony Bartone, President

Royal Australasian College of Surgeons

Mr Jason Chuen, Chair, Victorian Regional Committee and Fellow of RACS

Department of Health and Human Services, Victorian Government

Ms Kym Peake, Acting Secretary

Ms Frances Diver, Deputy Secretary, Health Service Performance and Programs

Mr Lance Wallace, Deputy Secretary, Corporate Services

Roundtable

Professor Anthony Scott, Melbourne Institute of Applied Economic and Social Research, University of Melbourne

Professor Catherine Bennett, Head, School of Health and Social Development, Deakin University

Ms Alison Verhoeven, Chief Executive Officer, Australian Healthcare and Hospitals Association

Ms Susan Killion, Director, Institute of Health Policy Research, Australian Healthcare and Hospitals Association

Mrs Cathy Ryan, Group Manager Health Funding, St John of God Health Care

Victorian Healthcare Association

Mr Tom Symondson, Chief Executive Officer

Thursday, 5 November 2015 – Melbourne

Independent Hospital Pricing Authority

Mr James Downie, Acting Chief Executive Officer

Mr Shane Solomon, Chair, Pricing Authority

Public Health Association Australia

Mr Michael Moore, Chief Executive Officer

Australian Nursing and Midwifery Federation

Ms Lee Thomas, Federal Secretary

Ms Annie Butler, Assistant Federal Secretary

Australasian College for Emergency Medicine

Dr Anthony Cross, President

Dr Peter White, Chief Executive Officer

National Complex Needs Alliance

Ms Lyn Morgain, Chair

Monday, 16 November 2015 – Cairns

Cairns and Hinterland Hospital and Health Service

Ms Julie Hartley-Jones CBE, Chief Executive

Dr Edward Strivens, Clinical Director, Older Persons Health Services

Torres and Cape Hospital and Health Service

Dr Jill Newland, Chief Executive

Queensland Health

Ms Kathleen Forrester, Deputy Director-General - Strategy, Policy and Planning Division

Mr Paul McGuire, Senior Director, Funding Strategy Unit - Strategy, Policy and Planning Division

Royal Flying Doctors Service - Queensland Section

Dr Oscar Whitehead, Director of Medical Services

Apunipima Cape York Health Council

Mr Cleveland Fagan, Chief Executive Officer

Mrs Paula Arnol, Executive Manager, Primary Health Care

Dr Mark Wenitong, Public Health Medical Advisor

Cape York Partnership

Mr Brian Stacey, Head of Policy

Northern Queensland Primary Health Network

Mr Robin Moore, Chief Executive Officer

Mr Trent Twomey, Chair

Rural Doctors' Association Queensland

Dr Tash Coventry, President

Ms Marg Moss, Executive Officer

Professor Tarun Sen Gupta, Immediate-past President

Tuesday, 17 November 2015 – Rockhampton**Central Queensland, Wide Bay, Sunshine Coast Primary Health Network**

Ms Pattie Hudson, Chief Executive Officer

Roundtable**Breaking down barriers for rural patients in city hospitals**

Ms Justine Christerson, Organiser

Australian Salaried Medical Officers' Federation

Ms Renee Lamont

Queensland Nurses' Union

Mr Grant Burton, Lead Organiser

CQUniversity

Associate Professor Monica Moran, Program Lead for Occupational Therapy,
Program Director HealthFusion Team Challenge

Friday, 27 November 2015 – Sydney**Australian Council on Healthcare Standards**

Dr Christine Dennis, Chief Executive Officer

University of Technology Sydney

Professor Jane Hall, Professor of Health Economics, Centre for Health Economics
Research and Evaluation

Australian Medical Association (NSW)

Professor Bradley Frankum, Vice President

Dr Andrew Pesce, Councillor

Dr Tony Sara, Councillor

National Health Performance Authority

Dr Diane Watson, Chief Executive Officer

Roundtable**University of Newcastle**

Professor Julie Byles, Director, Australian Longitudinal Study on Women's Health and Research Centre for Generational Health and Ageing

Australian Society of Anaesthetists

Dr Antonio Grossi, Chair, Professional Issues Advisory Committee

Dr James Bradley, Specialty Affairs Advisor

Dr Simon Macklin, Chair SA/NT Committee and PIAC Member

New South Wales Nurses and Midwives' Association

Mr Mark Kearin, Manager, Member Organising Team

Friday, 11 December 2015 - Sydney**University of Sydney**

Dr Barbara Mintzes, Senior Lecturer, Faculty of Pharmacy

Roundtable**Centre for Big Data Research in Health, University of New South Wales**

Professor Louisa Jorm, Director

Professor Sallie-Anne Pearson, Head, Medicines Policy Research Unit

Dr Julian Elliott, Senior Research Fellow, Australasian Cochrane Centre

National Health Performance Authority

Dr Diane Watson, Chief Executive Officer

Population Health Research Network

Dr Merran Smith, Chief Executive

Professor Brendon Kearney, Chair

Centre for Data Linkage

Associate Professor James Boyd, Director

Associate Professor Anna Ferrante, Deputy Director

The Sax Institute

Professor Sally Redman AO, Chief Executive Officer

Mr Robert Wells, Deputy Chief Executive Officer

Roundtable**Council of Public Health Institutions Australia**

Professor David Preen, Director, Centre for Health Services Research, University of Western Australia

Australian e-Health Research Centre

Dr David Hansen, Chief Executive Officer

Australian Health Economics Society

Professor Philip Clarke, Professor of Health Economics, University of Melbourne

University of New South Wales

Dr Heather Gidding, Senior Lecturer and NHMRC Early Career Research Fellow, School of Public Health and Community Medicine

National Rural Health Alliance

Mr Gordon Gregory, Chief Executive Officer

Mr Andrew Phillips, Policy Adviser

Ms Fiona Brooke, Policy Adviser

National Aboriginal Community Controlled Health Organisation

Dr Robert Starling, Chief Information Officer

Royal Australian College of General Practitioners

Dr Nathan Pinskiar, Chair of the RACGP Expert Committee – eHealth and Practice Systems

Government panel**Department of Health**

Ms Alanna Foster, First Assistant Secretary, Strategic Policy and Innovation Division

Mr Ian Crettenden, Assistant Secretary, Strategic Policy and Innovation Division

Dr Nicky Antonius, Acting Assistant Secretary, Information Knowledge Management Branch

Australian Institute of Health and Welfare

Mr Warren Richter, Chief Information Officer

Dr Nick von Sanden, Unit Head, Statistical and Analytical Support Unit

Department of Human Services

Ms Michelle Wilson, General Manager, Strategic Information Division

Tuesday, 2 February 2016 – Canberra

Roundtable

Northern Territory Government

Dr Steven Guthridge, Director, Health Gains Planning

SA NT DataLink

Mr Andrew Stanley, Director

Mr Christopher Radbone, Associate Director

Office of the Australian Information Commissioner

Mr Timothy Pilgrim PSM, Acting Australian Information Commissioner

Ms Angelene Falk, Assistant Commissioner, Regulation and Strategy

University of Western Australia School of Population Health and Telethon Kids Institute

Ms Anne McKenzie AM, Consumer Advocate and Program Manager

Telethon Kids Institute

Professor Fiona Stanley AC, Patron and former director

Wednesday, 3 February 2016-Canberra

Roundtable

National eHealth Transition Authority

Mr Peter Fleming, Chief Executive Officer

Ms Bettina McMahon, Head of Risk and Assurance

Australian Commission on Safety and Quality in Health Care

Dr Robert Herkes, Clinical Director

Ms Catherine Katz, Director –Safety and Quality Improvement Systems and Inter-governmental Relations

Public Health Information Development Unit

Professor John Glover, Director

Roundtable

Department of the Prime Minister and Cabinet

Ms Helen Owens, Assistant Secretary

Mr Tim Neal, Senior Advisor

Department of Health

Ms Alanna Foster, First Assistant Secretary

Mr Ian Crettenden, Assistant Secretary

Dr Nicky Antonius, Acting Assistant Secretary

Department of Social Services

Mr David Dennis, Branch Manager, Policy Evidence Branch

Department of Human Services

Ms Michelle Wilson, General Manager, Strategic Information Division

Australian Bureau of Statistics

Ms Gemma Van Halderen, General Manager, Strategic Partnerships and Projects Division

Australian Institute of Health and Welfare

Mr Geoff Neideck, Group Head, Chief Information Officer Group

Dr Nick von Sanden, Unit Head, Statistical and Analytical Support Unit

Monday, 7 March 2016 – Brisbane

Mr Percy Verrall, Private capacity

Mrs Daphne Verrall, Private capacity

Mr Ian Hiscock, Private capacity

Thoracic Society of Australia and New Zealand

Associate Professor Deborah Yates, Occupational and Environmental Special Interest Group Convener

Dr Ryan Hoy, Convenor, Occupational Lung Disease, Special Interest Group

Royal Australian and New Zealand College of Radiologists

Dr Richard Slaughter, Representative

Mr Mark Nevin, Senior Executive Officer

Mining panel**Vale Australia**

Mr Andrew Vella, General Manager, Operations and SSE Carborough Downs

Dr Edward Foley, Nominated Medical Advisor - Carborough Downs

Anglo American Coal

Mr Mike Oswell, Head of Safety and Sustainability

Dr Rob McCartney, Resile Occupational and Environmental Physician, Coal
Australia Chief Medical Officer

Ms Liz Sanderson, Occupational Health Specialist

Mr Dan Proffitt, Mine Operations Manager, Grasstree Mine

CFMEU Mining and Energy Division

Mr Andrew Vickers, General Secretary

Mr Steve Smyth, District President

Mr Jason Hill, Industry safety and health Representative

Queensland Resources Council

Mr Michael Roche, Chief Executive

Ms Judy Bertram, Director, Community, Skills and Safety Policy

Ms Liz Sanderson, Technical Expert – Industry

Mr Nev McAlary, Technical Expert – Industry

Review of Coal Miners' Health Scheme

Professor David Cliff, Independent Chair

Monash University

Professor Malcolm Sim, Director, Centre for Occupational and Environmental Health

Associate Professor Deborah Glass

Department of Natural Resources and Mines

Mr James Purtill, Director-General

Queensland Health

Dr Jeannette Young, Chief Health Officer and Deputy Director-General, Prevention
Division

Ms Sophie Dwyer, Executive Director, Health Protection Branch, Prevention Division

Tuesday, 8 March 2016 – Mackay

Mr Keith Stoddart, Private capacity

Mrs Danielle Stoddart, Private capacity

Coal Services

Ms Lucy Flemming, Managing Director/Chief Executive Officer

Mr Mark O'Neill, General Manager, Coal Services Health

Mr Matthew Fellowes, General Manager, Mines Rescue and Regulation and Compliance

Mackay Hospital and Health Service

Adjunct Associate Professor David Farlow

Mr Chris Carter, Private capacity

Review of Coal Miners' Health Scheme

Professor Robert Cohen, Review Team Expertise

Wednesday, 23 March 2016 – Campbelltown**Nurses and Midwives Association NSW**

Ms Alison Chapman

University of Western Sydney

Professor Rhonda Griffiths, Dean, School of Nursing and Midwifery

Professor Deborah Parker, Director, Centre for Applied Nursing Research

Mr Evan Alexandrou, Senior Lecturer, School of Nursing and Midwifery

Campbelltown City Council

Mr Jeff Lawrence, Director Strategy

Ms Caroline Puntillo, Executive Planner

Mr Bruce McAlister, Community Development Manager

Dr Andrew McDonald, Private capacity

Dr Karuna Keat, Private capacity

University of Wollongong

Dr Brian Plush, Particulate Matter Scientist

Dr Ting Ren, Associate Professor in Mining Engineering

Department of Natural Resources and Mines

Ms Rachel Cronin, Deputy Director-General Minerals and Energy Resources

Mr Russell Albury, Acting Chief Inspector of Coal Mines

Wednesday, 27 April 2016 – Gladstone

Ms Robin Saunders, Private capacity

Central Queensland Medical Imaging

Mr Keri Kamau, Regional Manager

Queensland, I-MED Radiology Network

Ms Bronwyn Nicholson, General Manager

Australian Medical Association of Queensland

Dr Bill Boyd, Vice President,

Friday, 29 April 2016 – Devonport

Australian Medical Association Tasmania

Professor Tim Greenaway, President

Royal Australian College of General Practitioners

Dr Emil Djakic, Member

Health and Community Services Union Tasmania

Mr Robbie Moore, Assistant Branch Secretary

Mr Stephen Hayes, Social Worker, Tasmanian Health Service

Australian Nursing and Midwifery Federation (Tasmanian Branch)

Mrs Neroli Ellis, Branch Secretary

Mr Shane Rickerby, State, North and North-West Organiser Coordinator

Australian Dental Association Inc

Dr Rick Olive AM, President

Ms Eithne Irving, Acting CEO

Appendix 2

Submissions received by the committee¹

- 1 National Health Performance Authority
- 2 Dr Catherine Pye
- 3 Cootharinga North Queensland – Ability First
- 4 Mr Cliff Weder
- 5 Mr David Gorell
- 6 HealthChange Australia
- 7 Exercise & Sports Science Australia
- 8 Australian Rural Health Education Network
- 9 Palliative Care Australia
- 10 Services for Australian Rural and Remote Allied Health
- 11 Australian Dental Association Inc
- 12 Australasian Podiatry Council
- 13 Cancer Drugs Alliance
- 14 Rural Health Workforce Australia
- 15 Public Hospitals Health and Medicare Alliance of Queensland
- 16 Family Planning NSW
- 17 College of Medicine and Dentistry, James Cook University
- 18 Positive Ageing Taskforce Southern Fleurieu and Kangaroo Island
- 19 Alzheimer's Australia
- 20 The Royal Australian and New Zealand College of Psychiatrists
- 21 The Dental Hygienists' Association of Australia Inc
- 22 St Vincent de Paul Society National Council of Australia
- 23 NSW Consumer Advisory Group – Mental Health Inc
- 24 South Australian Government
- 25 Wellspect HealthCare

1 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Submissions.

- 26 Australian Association for Academic Primary Care Inc
- 27 Mr Gil Wilson
- 28 Carers NSW
- 29 Grattan Institute
- 30 Rural Doctors Association of Australia
- 31 Australian Society of Anaesthetists
- 32 MS Australia
- 33 Mr Chris Hamill
- 34 Health Care Consumers Association of the ACT Inc
- 35 Aged and Community Services Australia
- 36 General Practice NSW
- 37 The Royal Australasian College of Physicians
- 38 Youth Affairs Council of South Australia
- 39 Australian Nursing and Midwifery Federation
- 40 Stryker South Pacific
- 41 Social Determinants of Health Advocacy Network
- 42 Benetas
- 43 Australian Healthcare & Hospitals Association
- 44 Queensland Nurses' Union
- 45 The George Institute for Global Health and the Menzies Centre for Health Policy
- 46 Health Consumers' Council of WA
- 47 Allied Health Professions Australia
- 48 Australian Medical Association
- 49 Australian Diabetes Educators Association
- 50 Audiology Australia Ltd
- 51 Speech Pathology Australia
- 52 National Stroke Foundation
- 53 Women's Centre for Health Matters
- 54 Diabetes Australia
- 55 NSW Nurses and Midwives' Association
- 56 Australian College of Nursing
- 57 Leading Age Services Australia Ltd

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- 58 Kidney Health Australia
 - 59 Dietitians Association of Australia
 - 60 Australian Psychological Society
 - 61 Chiropractors' Association of Australia (National) Ltd
 - 62 National Disability Services
 - 63 Aboriginal Health Council of Western Australia
 - 64 Consumer Reference Group Blue Mountains GP Network
 - 65 Dr Jane Barker
 - 66 Name Withheld
 - 67 Australian Council of Social Service
 - 68 Australian Capital Territory Government
 - 69 Queensland Government
 - 70 Medical Technology Association of Australia
 - 71 National Seniors Australia
 - 72 St Vincent's Health Australia
 - 73 Wakool Indigenous Corporation
 - 74 Consumers Health Forum of Australia
 - 75 GMiA
 - 76 Public Health Association of Australia
 - 77 Illawarra Public Health Society
 - 78 Australian Clinical Trials Alliance
 - 79 Mr John Stafford
 - 80 Victorian Health Promotion Foundation (VicHealth)
 - 81 Australian Women's Health Network
 - 82 AML Alliance (in liquidation)
 - 83 Dr Rachel Mascord
 - 84 Australian Health Promotion Association
 - 85 Doctors Reform Society
 - 86 National Aboriginal Community Controlled Health Organisation
 - 87 Australian meals on Wheels (SA)
 - 88 National LGBTI Health Alliance
 - 89 Australian Catholic University

- 90 Australian Healthcare Reform Alliance
- 91 Dr Ajeet Singh
- 92 Health Consumers Alliance of South Australia Inc
- 93 Northern Adelaide Medicare Local
- 94 NPS MEDICINEWISE
- 95 Heart Foundation
- 96 HSU National
- 97 Australian Indigenous Doctors' Association Ltd
- 98 Macular Disease Foundation Australia
- 99 Lowitja Institute
- 100 Medicines Australia
- 101 Councils on the Ageing Australia
- 102 Pfizer
- 103 Hepatitis Australia
- 104 City of Marion
- 105 Health Workers Union
- 106 Australian Dental Industry Association
- 107 Elizabeth Dolan, Jennifer Smith, Joahne Brown, Matthew Brown, Sharon Gavioli, Narelle Kelly, Felicity Latchford, Francesca Leaton, Fiona Lotherington, Lee Poole, Kate Robson, Paula Steffensen
- 108 Australian Federation of AIDS Organisations
- 109 Optometry Australia
- 110 Mr Martyn Goddard
- 111 Aboriginal Health Council of South Australia Inc
- 112 TasCOSS
- 113 Rural Doctors Association of Tasmania
- 114 Mental Health Council of Tasmania
- 115 Royal Australian College Of General Practitioners
- 116 Australian College of Rural and Remote Medicine
- 117 Association of Nursing Recruitment Agencies
- 118 Mental Health Professionals Network Ltd
- 119 AIDS Council of NSW

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- 120 Central Australian Aboriginal Congress Aboriginal Corporation
- 121 Dr Colin Hughes, Midland Family Practice
- 122 Charlestown Square Medical Centre
- 123 Hunter General Practitioners Association
- 124 National Shelter
- 125 National Aboriginal and Torres Strait Islander Health Worker Association
- 126 Indigenous Allied Health Australia
- 127 Victorian Aboriginal Community Controlled Health Organisation
- 128 Professor Andrew Bonney, Graduate School of Medicine, University of Wollongong
- 129 Dr Graeme Alexander, Claremont Village Medical Centre
- 130 Dr Colin Pearce, Charlestown Square Medical Centre
- 131 Dr Richard Terry, Whitebridge Medical Centre
- 132 Australasian College for Emergency Medicine
- 133 Dr Ian Kamerman
- 134 Aboriginal Medical Services Alliance of the Northern Territory
- 135 National Aboriginal and Torres Strait Islander Leadership in Mental Health
- 136 Dr Mike Moynihan
- 137 Dr Mark Lock
- 138 Lung Foundation Australia
- 139 Name Withheld
- 140 Name Withheld
- 141 Ms Judith Maher, Health Consumers NSW
- 142 Dr Lesley Russell
- 143 Nepean Division of General Practice
- 144 Red Dust Role Models Ltd
- 145 Dr Rajkumar Ramasamy
- 146 Gidgee Healing
- 147 Aboriginal Medical Service Western Sydney
- 148 Northern Territory Government
- 149 Dr Steve Flecknoe-Brown
- 150 Deafness Forum of Australia

- 151 Medecins Sans Frontieres (Doctors Without Borders)
- 152 South Australian Network of Drug and Alcohol Services
- 153 Independent Audiologists Australia Inc
- 154 The Shepherd Centre for deaf children
- 155 Department of Health
- 156 Parents of Deaf Children
- 157 The Deaf Society
- 158 Australian Hearing
- 159 Deaf Australia
- 160 Australian Red Cross
- 161 Poche Centre for Indigenous Health
- 162 Rare Voices Australia
- 163 SANE Australia
- 164 R U OK?
- 165 ReachOut Australia
- 166 Suicide Prevention Australia's Lived Experience Network
- 167 Royal Australasian College of Surgeons
- 168 Volunteering Tasmania
- 169 Suicide Prevention Australia
- 170 Orygen - The National Centre of Excellence in Youth Mental Health
- 171 Curtin University
- 172 Centre for Big Data Research in Health
- 173 Council of Academic Public Health Institutions Australia
- 174 Australian e-Health Research Centre
- 175 National eHealth Transition Authority
- 176 Sax Institute
- 177 Australian Institute of Health and Welfare
- 178 Family Medicine Research Centre, University of Sydney
- 179 Dr Julian Elliott
- 180 Australian Longitudinal Study on Women's Health
- 181 SA NT DataLink
- 182 Research Australia

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- 183 Public Health Information Development Unit
- 184 Australian Health Economics Society
- 185 University of New South Wales
- 186 National Rural Health Alliance
- 187 Australian Commission on Safety and Quality in Health Care
- 188 Population Health Research Network
- 189 The UWA School of Population Health & the Telethon Kids Institute
- 190 Office of the Australian Information Commissioner
- 191 Parliamentary Budget Office
- 192 Australian Bureau of Statistics
- 193 Queensland Nurses' Union
- 194 Thoracic Society of Australia and New Zealand and Lung Foundation Australia
- 195 Queensland Resources Council
- 196 Royal Australian and New Zealand College of Radiologists
- 197 Monash University
- 198 Coal Services
- 199 CFMEU
- 200 Vale
- 201 Dust to Dust: Make Black Lung History campaign standard submissions
- 202 Dust to Dust: Make Black Lung History campaign non-standard submissions
- 203 Australian Institute of Occupational Hygienists Inc.
- 204 Dr Kathryn Antioch
- 205 Committee of Presidents of Medical Colleges

Appendix 3

Tabled documents, additional information, correspondence and answers to questions on notice¹

Tabled Documents

1. Tabled by Department of Health (SA) at a public hearing in Adelaide on 9 October. Excerpt - Health portfolio Budget statement 2014-15
2. Tabled by Population Health Research Network at a public hearing in Adelaide on 9 October - Evidence-based improvement
3. Tabled by the Australian Nursing Federation (SA Branch) at a public hearing in Adelaide on 9 October - Opening comments for the Australian Nursing Federation (SA Branch)
4. Tabled by the Aboriginal Health Council of South Australia INC. at a public hearing in Adelaide on 9 October - Submission to Select Committee on Health
5. Tabled by VicHealth at a public hearing in Melbourne on 7 October
6. Tabled by School of Rural Health, Faculty of Medicine, Nursing and Health Sciences at a public hearing in Melbourne on 7 October 2014
7. Tabled by the School of Rural Health, at a public hearing in Melbourne on 7 October 2014
8. Tabled by Colac Area Health at a public hearing in Geelong on 6 October 2014 - Annual Report 2013-2014. The link to the report [www.swarh2.com.au/cah/documents?Category=Annual Report](http://www.swarh2.com.au/cah/documents?Category=Annual%20Report)
9. Tabled by Colac Area Health at a public hearing in Geelong on 6 October 2014 - Quality of Care Report 2013-2014. The link to the report [www.swarh2.com.au/cah/documents?Category=Quality Reports](http://www.swarh2.com.au/cah/documents?Category=Quality%20Reports)
10. Tabled by Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch at a public hearing in Launceston on 4 November 2014
11. Tabled by Kidney Health Australia at a public hearing in Canberra on 13 February 2015 - Chronic disease care in remote Aboriginal Australia has been transformed
12. Tabled by Dr Sharyn Wilkins, Board Member, South Eastern Sydney Medicare Local at a public hearing in Rockdale on 10 March 2015 - Barbara Starfield article

1 Tabled documents, additional information, correspondence and answers to questions on notice can be accessed at:
www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Additional_Documents

13. Tabled by Ms Lynelle Hales, Chief Executive Officer, South Eastern Sydney Medicare Local at a public hearing in Rockdale on 10 March 2015 - Annual Report 2013/2014
14. Tabled by Professor Anna Shepherd, Chief Executive Officer, Regal Health Services at a public hearing in Rockdale on 10 March 2015
15. Tabled by Dr Michael Moore, Chief Executive Officer, Inner Western Sydney Medicare Local at a public hearing in Rockdale on 10 March 2015
16. Tabled by the Heart Foundation at a public hearing in Rockdale in 10 March 2015
17. Tabled by Central Coast Disability Network at a public hearing in Gosford on 11 March 2015
18. Tabled by Dr Ian Charlton, GP, Tilba Street Family Practice at a public hearing in Gosford on 11 March 2015
19. Tabled by Central Coast Community Women's Health Centre at a public hearing in Gosford on 11 March 2015
20. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015
21. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015 - Community Report on the Blue Mountains Community Forums on Health - 30 August 2012
22. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015 - Community Report on the Hawkesbury Community Forums on Health - 15 October 2012
23. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015 - Community Report on the Nepean Community Forums on Health - 14 November 2012
24. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015 - Community Report on the Lithgow Community Forums on Health - 16 November 2012
25. Tabled by Ms Alison Verhoeven, Chief Executive Officer, Australian Healthcare and Hospitals Association at a public hearing in Canberra on 14 April 2015
26. Tabled by NPS MedicineWise at a public hearing in Canberra on 14 April 2015 - Annual Evaluation Report 2014
27. Tabled by Ms Sally Glass, Chief Executive Officer CHIK Services at a public hearing in Canberra on 15 April 2015
28. Tabled by Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) at a public hearing in Canberra on 15 April 2015
29. Tabled by Dr Marlene Eggert for the Australian College of Nursing at a public hearing in Canberra on 15 April 2015

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30. Tabled by Ms Sarah Stewart for the Australian College of Midwives at a public hearing in Canberra on 15 April 2015
 31. Tabled by Dr Lesley Russell at a public hearing in Canberra on 15 April 2015
 32. Tabled by Professor Kirsty Douglas, Professor of General Practice at the Australian National University, Practicing GP and executive member of the Australasian Association for Academic Primary Care at a hearing in Canberra on 15 April 2015
 33. Tabled by Consumer Health Forum of Australia at a public hearing in Canberra on 15 April 2015
 34. Tabled by Dr Andrew Bell (Chair) and Ms Judy Davis (Deputy CEO) of Northern Territory Medicare Local at a public hearing in Darwin on 27 April 2015
 35. Tabled by Mr Graham Castine, Chief Executive Officer for Sunrise Health Service Aboriginal Corporation at a public hearing in Katherine on 29 April 2015 - Annual Report 2013-2014
 36. Tabled by Mr Graham Castine, Chief Executive Officer, Sunrise Health Service Aboriginal Corporation at a public hearing in Katherine on 29 April 2015
 37. Tabled by Mr Peter Gazey, Binjari Health Service at a public hearing in Katherine on 29 April 2015
 38. Tabled by Mr Peter Gazey, Binjari Health Service at a public hearing in Katherine on 29 April 2015
 39. Tabled by Mr Peter Gazey, Binjari Health Service at a public hearing in Katherine on 29 April 2015
 40. Tabled by Mr Peter Gazey, Binjari Health Service at a public hearing in Katherine on 29 April 2015
 41. Tabled by Ms Carol Dowling, Treasurer for Kalano Community Association at a public hearing in Katherine on 29 April 2015
 42. Tabled by Mr Eddie Mulholland, Chief Executive Officer, Miwatj Health Aboriginal Corporation at a public hearing in Galiwin'ku, Elcho Island NT on 30 April 2015
 43. Tabled by Dr Stephen Parnis, Vice President, Australian Medical Association at a public hearing in Melbourne on 9 June 2015
 44. Tabled by Dr Morton Rawlin, Vice President and Victorian Faculty Chair for the Royal Australian College of General Practitioners at a public hearing in Melbourne on 9 June 2015.
 45. Tabled by Ms Melanie Walker, Acting Chief Executive Officer, Public Health Association of Australia at a public hearing in Melbourne on 9 June 2015
 46. Tabled by Mr Bob Davis, Chief Executive Officer, Maari Ma Health Aboriginal Corporation at a public hearing on 10 June 2015 in Broken Hill

47. Tabled by Mr Stuart Gordon, Chief Executive Officer, Far West NSW Medicare Local at a public hearing in Broken Hill on 10 June 2015 - Annual Report 2013-2014. Also tabled Preliminary Needs Assessment 2013
48. Tabled by Ms Amanda Mitchell, Acting Deputy Chief Executive Officer, Aboriginal Health Council of South Australia, at a public hearing in Adelaide on 11 June 2015 - Annual Report 2013-2014
49. Tabled by Mr Steve Archer, Deputy Chief Executive Finance and Corporate Services, SA Health at a public hearing in Adelaide on 11 June 2015
50. Tabled by Ms Alison Verhoeven, Chief Executive Officer, Australian Healthcare and Hospitals Association at a public hearing in Melbourne on 9 June 2015. (Opening statement via teleconference)
51. Tabled by Mr Michael Cousins, Chief Executive Officer, Health Consumer Alliance of SA at a public hearing in Adelaide on 11 June 2015 - Response to the Transforming Health Discussion Paper
52. Tabled by Mr Michael Cousins, Chief Executive Officer, Health Consumer Alliance of SA at a public hearing in Adelaide on 11 June 2015 - Report on the Community Workshop held to establish the Peak Consumer and Community Engagement Forum and Strategy for Transforming Health - May 2015
53. Tabled by Deafness Forum of Australia at a public hearing in Sydney on Friday, 10 July 2015 - NDIS Interface Information Sessions
54. Tabled by Deafness Forum of Australia at a public hearing in Sydney on 10 July 2015 - What the National Disability Insurance Scheme means for hearing services
55. Tabled by Sara Duncan from Better Hearing Australia at a public hearing in Sydney on 10 July 2015 - A Fairer Hearing
56. Tabled by Ms Anna Messariti, President, Parents of Deaf Children, opening statement at public hearing in Sydney, 10 July 2015
57. Tabled by Professor Allan Fels, Chair of National Mental Health Commission at a public hearing in Canberra on 26 August 2015
58. Tabled by Mr Frank Quinlan, Chief Executive Officer of Mental Health Australia at a public hearing in Canberra on 26 August 2015 - Opening Statement
59. Tabled by Mr Peter Bewert, Executive Manager Care Services, Salvation Army at a public hearing in Canberra on 26 August 2015 - Opening Statement
60. Tabled by Mr Christopher John, Chief Executive Officer, United Synergies (Standby Response) at a public hearing in Canberra on 26 August 2015 - Cost Effectiveness of a Community-Based Crisis Intervention Program for People Bereaved by Suicide

61. Tabled by Mr Christopher John, Chief Executive Officer, United Synergies (Standby Response) at a public hearing in Canberra on 26 August 2015 - Press clip from Weekend Australian 22 March 2014
62. Tabled by A/Professor Judith Proudfoot, Head of eHealth, Black Dog Institute at a public hearing in Canberra on 26 August 2015 - Proposed Suicide Prevention Framework for NSW
63. Tabled by A/Professor Judith Proudfoot, Head of eHealth, Black Dog Institute at a public hearing in Canberra on 26 August 2015 - The Digital Dog (Improving mental health through technology)
64. Tabled by A/Professor Judith Proudfoot, Head of eHealth, Black Dog Institute at a public hearing in Canberra on 26 August 2015 - The Black Dog Institute Stepped Care pathway
65. Tabled by A/Professor Judith Proudfoot, Head of eHealth, Black Dog Institute at a public hearing in Canberra on 26 August 2015 - A World - Class Integrated Approach to Suicide Prevention. Also tabled was the 2014 Black Dog Institute Annual Report (Available online)
66. Tabled by Hunter Institute at a public hearing in Sydney on 28 August 2015 - Prevention First - A Prevention and Promotion Framework for Mental Health
67. Tabled by Hunter Institute at a public hearing in Sydney on 28 August 2015 - Background Document
68. Tabled by Professor David Perkins, Director and Professor of Rural Health Research, Centre for Rural and Remote Mental Health at a public hearing in Sydney on 28 August 2015 - Key Issues in Rural and Remote Mental Health. Also tabled were Gove Box Guide to Mental Health, Volume 3 - linking rural people to the help they need and research-based solutions for rural communities
69. Tabled by the Butterfly Foundation at a public hearing in Sydney on 28 August 2015 - Paying the Price - The economic and social impact of eating disorders in Australia
70. Tabled by Butterfly Foundation at a public hearing in Sydney on 28 August 2015 - Executive Summary - Cost-effective interventions for eating disorders
71. Tabled by The Butterfly Foundation at a public hearing in Sydney on 28 August 2015 - Paying the Price - Executive Summary
72. Tabled by Mr Malcolm East, Deputy Principal, St Philip's Christian College, Gosford at public hearing in Sydney on 28 August 2015
73. Tabled by Mr John Feneley, Commissioner, NSW Mental Health Commission at the committee's hearing on 18 September 2015, Brisbane. The documents include Mr Feneley's opening statement, proposed suicide prevention framework, and paper on Keeping the Body in Mind Program - smoking and mental illness

74. Tabled by National Aboriginal Community Controlled Health Organisation (NACCHO) at a public hearing on 8 October 2015, Canberra. Document title: 'Checklist of Topics from NACCHO for the Senate Select Committee on Health'
75. Tabled by National Aboriginal Community Controlled Health Organisation (NACCHO) at a public hearing on 8 October 2015, Canberra. Document title: 'Analysis and Comparison - Commonwealth Department of Health Standard Terms and Conditions and Supplementary Conditions 2015/16 - Indigenous Australians Health Programme (IAHP)'
76. Tabled by National Aboriginal Community Controlled Health Organisation (NACCHO) at a public hearing on 8 October 2015, Canberra. Document title: 'First Grants Report: Medicare Locals and Primary Health Networks - An analysis of the Accountability Deficiencies for Closing the Gap in the Web Based Reporting of Aboriginal and Torres Strait Islander Health Grants'
77. Tabled by National Aboriginal Community Controlled Health Organisation (NACCHO) at a public hearing on 8 October 2015, Canberra. Document title: 'NACCHO Submission - Primary Health Care Advisory Group September, 2015'
78. Tabled by National Aboriginal Community Controlled Health Organisation (NACCHO) at a public hearing on 8 October 2015, Canberra. Document description: Geo-Coded Map Based Decision Support Tool
79. Tabled by Dr Stephen Duckett, Grattan Institute at a public hearing in Melbourne on 4 November 2015. Dr Duckett's opening statement
80. Tabled by Ms Kym Peake, Acting Secretary, Department of Health and Human Services, Victorian Government at a public hearing in Melbourne on 4 November 2015. Opening statement
81. Tabled by the Australian Medical Association (Victoria) at a public hearing in Melbourne on 4 November 2015 - Opening statement of Dr Anthony Bartone, President
82. Tabled by Dr David Alcorn for Melbourne Health (Royal Melbourne Hospital) at a public hearing in Melbourne on 4 November 2015. The documents include Totally and generally available inpatient POC and Block funded services
83. Tabled by the Royal Australasian College of Surgeons (RACS) at a public hearing in Melbourne on 4 November 2015 - Opening statement by Mr Jason Chuen, Chair Regional Victorian Committee and Fellow of RACS
84. Tabled by Mr James Downie, Acting Chief Executive Officer, Independent Hospital Pricing Authority at a public hearing in Melbourne on 5 November 2015 - Significant Slowdown in Costs
85. Tabled by the Chair at a public hearing in Melbourne on 5 November 2015 - Information provided during site visit to Royal Melbourne Hospital by Mr Peter Kelly

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86. Tabled by Ms Pattie Hudson, Chief Executive Officer, Central Queensland, Wide Bay, Sunshine Coast PHN at a public hearing in Rockhampton on 17 November 2015
 87. Tabled by Australian Medical Association (NSW) at a public hearing in Sydney on 27 November 2015
 88. Tabled by Professor Julie Byles, Director, Australian Longitudinal Study on Women's Health and Research Centre for Generational Health and Ageing at the University of Newcastle at a public hearing in Sydney on 27 November 2015 - Health Service Use and Costs for Australian Women
 89. Tabled by Dr Barbara Mintzes, Senior Lecturer, Faculty of Pharmacy, University of Sydney at a public hearing in Sydney on 11 December 2015
 90. Tabled by Professor Louisa Jorm, Director, Centre for Big Data Research in Health, UNSW at a public hearing in Sydney on 11 December 2015
 91. Tabled by Professor Sally Redman AO, Chief Executive Officer, The Sax Institute at a public hearing in Sydney on 11 December 2015 - SURE: safe sharing of sensitive data
 92. Tabled by Professor Philip Clarke, Professor of Health Economics, University of Melbourne at a public hearing in Sydney on 11 December 2015 - Long-term Disability Associated With War-related Experience Among Vietnam Veterans
 93. Tabled by Gordon Gregory, Chief Executive Officer, National Rural Health Alliance at a public hearing in Sydney on 11 December 2015
 94. Tabled by Professor Glover, Director, Public Health Information Development Unit at a public hearing in Canberra on Wednesday, 3 February 2016 - SA3 Level data - Table
 95. Tabled by SA NT DataLink at a public hearing in Canberra on 2 February 2016
 96. Provided by Ms Anne Mckenzie AM, Consumer Advocate and Program Manager, Telethon Kids Institute, University of Western Australia School of Population Health and tabled by Chair on 3 February 2016
 97. Provided by Ms Anne Mckenzie AM, Consumer Advocate and Program Manager, Telethon Kids Institute, University of Western Australia School of Population Health and tabled by Chair on 3 February 2016
 98. Provided by Ms Anne Mckenzie AM, Consumer Advocate and Program Manager, Telethon Kids Institute, University of Western Australia School of Population Health and tabled by Chair on 3 February 2016
 99. Provided by Ms Anne Mckenzie AM, Consumer Advocate and Program Manager, Telethon Kids Institute, University of Western Australia School of Population Health and tabled by Chair on 3 February 2016

100. Tabled by Ms Bettina McMahon, Head of Risk and Assurance, National E-Health Transition Authority Ltd at a public hearing in Canberra on 3 February 2016 - Opening Statement by Bettina McMahon
101. Tabled by Mr Michael Roche, Chief Executive, Queensland Resources Council at a public hearing in Brisbane on 7 March 2016 - Media release by Minister for State Development and Minister for Natural Resources and Mines, The Honourable Anthony Lynham
102. Tabled by Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian branch) at public hearing in Devonport on 29 April 2016

Answers to Questions on Notice

1. Answers to questions on notice - public hearing 28 August 2014, Canberra - Department of Treasury
2. Answers to questions on notice and in writing - public hearing 4 September, Canberra - Organ and Tissue Authority
3. Answers to questions on notice - public hearing 25 September, Canberra - National Blood Authority
4. Answers to questions on notice - public hearing 2 October 2014, Canberra, Department of Health
5. Answers to questions on notice - public hearing 8 October 2014, Melbourne, Department of Health
6. Answer to question on notice - public hearing 16 September 2014, Moruya, NSW - Southern NSW Medicare Local
7. Answers to questions on notice - public hearing 8 October 2014, Melbourne - Allied Health Professions Australia
8. Answers to questions on notice - public hearing 8 October 2014, Melbourne - Royal Australasian College of Physicians
9. Answers to questions on notice - public hearing 9 October 2014, Adelaide - South Australian Department of Health and Ageing
10. Answers to questions on notice - public hearing 3 November 2014, Hobart - Social Determinants of Health Advocacy Network (Tasmania)
11. Answer to questions on notice - public hearing 9 October 2014, Adelaide - Population Health Research Network
12. Answer to question on notice - public hearing 5 February 2015, Canberra - The Royal Australian College of General Practitioners
13. Answers to questions on notice - public hearing 13 February 2015, Canberra - Department of Prime Minister and Cabinet
14. Answer to question on notice - public hearing 13 February 2015, Canberra - Australian Indigenous Doctors' Association

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15. Answers to questions on notice - public hearing 5 February 2015, Canberra - Department of Health
 16. Answer to question on notice - public hearing 19 February 2015, Strathfield - BEING
 17. Answers to questions on notice - public hearing 13 February 2015, Canberra - Department of Health
 18. Answers to questions on notice - public hearing 15 April 2015, Canberra – Dr Katrina Alford
 19. Answers to questions on notice - public hearing 27 April 2015, Darwin - CEO Danila Dilba Health Service
 20. Answer to question on notice - public hearing 14 April 2015, Canberra – Ms Carolyn Gullery, General Manager, Planning, Funding and Decision Support - Canterbury District Health Board
 21. Answer to question on notice - public hearing 16 April 2015, Colac – Ms Marg White, Acting CEO, Colac Area Health
 22. Answer to question on notice - public hearing 17 April 2015, Burnie – Mrs Anita Dow, Mayor of Burnie
 23. Answers to questions on notice - public hearing 5 February 2015, Canberra - Department of Finance
 24. Answer to question on notice - public hearing 5 February 2015, Canberra - Department of Finance
 25. Answers to questions on notice - public hearing 9 June 2015, Melbourne - Royal Australian College of General Practitioners Dr Morton Rawlin, Vice President
 26. Answers to questions on notice - public hearing 9 June 2015, Melbourne - Australian Medical Association Dr Parnis, Vice President
 27. Answers to questions on notice - public hearing 9 June 2015, Melbourne - General Practice Registrars Australia Ms Sally Kincaid, CEO
 28. Answers to questions on notice - public hearing 9 June 2015, Melbourne - Public Health Association of Australia Ms Melanie Walker, Deputy CEO
 29. Answers to questions on notice - public hearing 10 June 2015, Broken Hill - Maari Ma Health Aboriginal Corporation, Mr Bob Davis, Chief Executive Officer
 30. Answer to question on notice - public hearing 10 July 2015, Sydney - Department of Health
 31. Answer to question on notice - public hearing 10 July 2015, Sydney - Department of Health
 32. Answers to questions on notice - public hearing 10 July 2015, Sydney - Australian Hearing, Department of Human Services

33. Documents supplied in answer to question on notice - public hearing 10 July 2015, Sydney - Parents of Deaf Children
34. Answers to questions on notice - public hearing 10 July 2015, Sydney - Independent Audiologists Australia
35. Answers to questions on notice - public hearing 26 August 2015, Canberra - Department of Social Services
36. Answers to questions on notice - public hearing 10 July 2015, Sydney - Department of Finance
37. Answer to question on notice - public hearing 26 August 2015, Canberra - Royal Australian and New Zealand College of Psychiatrists
38. Answer to question on notice - public hearing 26 August 2015, Canberra - National Mental Health Commission
39. Answer to question on notice - public hearing 26 August 2015, Canberra - Mental Illness Fellowship of Australia
40. Answers to questions on notice - public hearing 26 August 2015, Canberra - Department of Health
41. Answers to questions on notice - public hearing 8 October 2015, Canberra - Northern Territory Department of Health
42. Answers to questions on notice - public hearing 4 November 2015, Melbourne - Professor Catherine Bennett, Deakin University
43. Answers to question on notice from Robin Moore Chief Executive Officer, Northern Queensland PHN at a public hearing on 16 November 2015 - Cairns
44. Answers to question on notice from Julie Hartley-Jones CBE, Chief Executive and Dr Edward Strivens, Clinical Director at a public hearing on 16 November 2015 - Cairns
45. Answer to question on notice - public hearing 17 November 2015, Rockhampton - Ms Pattie Hudson, Chief Executive Officer, Central Queensland, Wide Bay, Sunshine Coast Primary Health Network
46. Answer to question on notice - public hearing 27 November 2015, Sydney - Dr Christine Dennis, Chief Executive Officer, Australian Council on Healthcare Standards
47. Answer to question on notice - public hearing 27 November 2015, Sydney - Dr Christine Dennis, Chief Executive Officer, Australian Council on Healthcare Standards
48. Answers to questions on notice - public hearing 4 November 2015, Canberra, Ms Cathy Ryan, Group Manager, Health Funds, St John of God Health Care
49. Answer to question on notice - public hearing 5 November 2015, Melbourne - Australasian College for Emergency Medicine

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50. Answers to questions on notice from Mr Shane Solomon, Chair, Independent Hospital Pricing Authority at a public hearing 5 November 2015, Attachment: A Literature Review on Integrating Quality and Safety into Hospital Pricing Systems
 51. Answers to questions on notice - public hearing 11 December 2015, Sydney - Australian Institute of Health and Welfare
 52. Answers to questions on notice - public hearing 11 December 2015, Sydney - Dr Julian Elliott
 53. Answers to questions on notice - public hearing 11 December 2015, Sydney - Australian Bureau of Statistics
 54. Answers to questions on notice - public hearing 11 December 2015, Sydney - Summary of data collections - Australian Bureau of Statistics
 55. Answers to written questions on notice - public hearing 11 December 2015, Sydney - Department of Social Services
 56. Answer to question on notice - public hearing 11 December 2015, Sydney - Department of Health
 57. Answers to written questions on notice - public hearing 11 December 2014, Sydney - Australian Institute of Health and Welfare.
 58. Answer to question on notice - public hearing 11 December 2015, Sydney - Department of Health
 59. Answer to question on notice - public hearing 11 December 2015, Sydney - Department of Health
 60. Answer to question on notice - public hearing 11 December 2015, Sydney - Australian Institute of Family Studies
 61. Answer to questions on notice - public hearing 11 December 2015, Sydney - Department of Health
 62. Answers to written questions on notice - public hearing 11 December 2015, Sydney - Department of Human Services
 63. Answers to question on notice - public hearing 2 February 2016, Canberra - Office of the Australian Information Commissioner
 64. Answers to questions on notice - public hearing 2 February 2015, Canberra - Mr Andrew Stanley, Director, SA NT DataLink
 65. Answer to question on notice - public hearing 3 February 2016, Canberra - Department of the Prime Minister and Cabinet
 66. Answers to questions on notice - public hearing 3 February 2016, Canberra - Department of Health
 67. Answers to questions on notice - public hearing 7 March 2016, Brisbane - Thoracic Society of Australia & New Zealand

68. Answers to questions on notice - public hearing 7 March 2016, Brisbane - Associate Professor Deborah Glass, Monash University
69. Answers to questions on notice - public hearing 7 March 2016, Brisbane - Mr James Purtill, Director-General, Queensland Department of Natural Resources and Mines
70. Answers to questions on notice - public hearing 7 March 2016, Brisbane - Royal Australian and New Zealand College of Radiologists
71. Answers to questions on notice - public hearing 7 March 2016, Brisbane - Royal Australian and New Zealand College of Radiologists
72. Answers to questions on notice - public hearing 7 March 2016, Brisbane – Vale
73. Answers to questions on notice - public hearing 27 November 2015, Sydney - Professor Jane Hall
74. Answers to questions on notice - public hearing 23 March 2016, Campbelltown - Dr Ting Ren, University of Wollongong
75. Answers to questions on notice - public hearing 7 March 2016, Brisbane - Safe Work Australia
76. Answers to questions on notice - public hearing 23 March 2016, Campbelltown - Campbelltown City Council
77. Answer to question on notice - public hearing 3 February 2016, Canberra - Department of Human Services
78. Answers to questions on notice - public hearing 7 March 2016, Brisbane - Queensland Resources Council
79. Answers to questions on notice - public hearing 7 March 2016, Brisbane - Queensland Department of Natural Resources and Mines
80. Answers to questions on notice - public hearing 7 March 2015, Brisbane - Anglo American Coal
81. Answers to questions in writing - public hearings 7 and 8 March, Brisbane and Mackay, Anglo American Coal
82. Answer to question in writing following public hearing 26 August 2015 - National Disability Insurance Agency

Additional Information

1. Loss of practice revenue example in a 100% bulk billing practice without changing business model or charging co payment when 50% of patients don't have HCC or other exemption DVA <16 etc. supplied to the committee at a public hearing on Thursday, 5 February 2015
2. Report - Evaluation of the Marapai Ngartathati Murri Women's Group and Yurru Ngartathati Men's Group - Indigenous Justice Program for North West Queensland Indigenous Catholic Social Services supplied to the committee at

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- a public hearing on Friday, 1 May 2015, Mount Isa by Father Michael Lowcock
3. Opening statement from Debbie Blumel at a public hearing on Monday, 27 April 2015 Darwin
 4. Additional information from Mrs Sue McTurk, Podiatrist at a public hearing on Friday, 17 April 2015 Burnie
 5. Questions on the future of hearing services for deaf and hard of hearing children supplied to the committee at a public hearing on Friday, 10 July 2015, Sydney by Mrs Ann Porter - Aussie Deaf Kids
 6. Additional Information supplied to the committee at a public hearing on Friday, 10 July 2015, Sydney by Mrs Ann Porter - Aussie Deaf Kids
 7. Opening statement from Mr Chris Rehn at a public hearing on Friday, 10 July 2015 Sydney - Royal Institute for Deaf and Blind Children
 8. Clarification of evidence from a public hearing on Friday, 10 July 2015 by Mr Renwick, A/g First Assistant Secretary, Business, Procurement and Asset Management, Department of Finance
 9. Clarification of response given to the committee at a public hearing on Wednesday, 26 August 2015 by Mr James Christian PSM, Group Manager, Disability Employment and Carers Group, Department of Social Services
 10. Additional information - newspaper article - supplied by Mr Sunny Hemraj and referred to in his evidence at the committee's hearing on 28 August 2015, Sydney
 11. Evaluation and Investigative Study of the Queensland Rural Generalist Program supplied to the committee at a public hearing on Monday, 16 November 2015 in Cairns by Dr Tash Coventry of the Rural Doctors Association of Queensland
 12. Statistics on the Rural Generalist Pathway supplied to the committee at a public hearing on Monday, 16 November 2015 in Cairns by Professor Tarun Sen Gupta of the Rural Doctors Association of Queensland
 13. Additional information - valedictory lecture provided by A/Prof D'Arcy Holman from UWA to assist the committee in preparing for 2 February 2016 public hearing in Canberra

Correspondence

1. Chair's invitation to the Hon Jillian Skinner MP, Minister for Health NSW - public hearing 10 June - Broken Hill - dated 21 May 2015
2. Letter from Ms Deborah Hyland, Director, Strategic Relations & Communications, NSW Health to Chair - re public hearing Broken Hill - dated 4 June 2015

3. Chair's letter to the Hon Jillian Skinner MP, Minister for Health NSW - re NSW Health officials prevented from attending public hearing - dated 11 June 2015
4. Letter from the Hon Tanya Plibersek MP, Deputy Leader of the Opposition regarding inquiry into the effectiveness of Australia's response to the Ebola crisis in West Africa, 9 June 2015
5. Letter from Mr Timothy Pilgrim PSM, Acting Australian Information Commissioner, clarifying evidence from the public hearing 2 February 2016 - Canberra - dated 8 February 2016
6. Letter from Professor Louise Hickson, President, Audiology Australia, right of reply to evidence provided in an answer to question on notice by Independent Audiologists Australia from hearing 10 July 2015

Appendix 4



Parliament of Australia
Parliamentary Budget Office

Submission to the Senate Select Committee on Health regarding Commonwealth funding of public hospitals

3 February 2016

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Introduction

- 1 The Secretary of the Senate Select Committee on Health (the Committee) wrote to the Parliamentary Budget Officer on 16 December 2015 requesting the preparation of a submission to the Committee in relation to Commonwealth funding of public hospitals. A copy of this request is provided at [Attachment A](#).
- 2 In response to this request the PBO has provided the following information:
 - [Table 1](#)
Aggregate and State breakdown of the difference in Commonwealth hospital funding under current Government policy (indexation by Consumer Price Index (CPI) and population growth, see Table B1 at [Attachment B](#)) and the scenario where Commonwealth hospital funding was to be provided in accordance with the *National Health Reform Agreement 2011* (the 2011 Agreement, see Table B2 at Attachment B),¹ over 2014–15 to 2024–25.
 - [Table 2](#)
Aggregate and State breakdown of the difference between Commonwealth hospital funding with and without the funding guarantee specified in clauses A67 to A79 of the 2011 Agreement in place, over 2014–15 to 2017–18.
 - [Table 3](#)
Aggregate and State breakdown of the difference in Commonwealth funding under current Government policy and the scenario where the National Partnerships terminated in the 2014–15 Budget were still in effect, over 2014–15 to 2024–25.

Background

National Health Reform

- 3 On 2 August 2011 the Council of Australian Governments (COAG) agreed to the 2011 Agreement, replacing the former National Healthcare Specific Purpose Payment (SPP).
- 4 Under the 2011 Agreement, from 1 July 2014 Commonwealth funding for public hospitals would use an activity based funding (ABF) approach with a national efficient price for hospital services. The Commonwealth agreed to meet 45 per cent of the efficient growth in activity based funding initially, rising to 50 per cent after 1 July 2017.
- 5 The 2011 Agreement also set out an approach for hospital services and functions where block funding was deemed appropriate (such as those provided in rural/small hospitals). As per the ABF approach, the Commonwealth agreed to meet 45 per cent of the efficient growth in block grant funding based on the national efficient cost initially, rising to 50 per cent after 1 July 2017.

1 Note the 2011 Agreement profile used to derive these amounts did not include the funding guarantees.

- 6 Further, the 2011 Agreement provided a guarantee that the Commonwealth funding under the ABF approach would provide at least an additional \$16.4 billion in growth in funding between 2014–15 and 2019–20. As such, in the event the ABF approach resulted in additional funding of less than \$16.4 billion over the period, the Commonwealth would provide the remainder to States as top-up funding.
 - a Of the \$16.4 billion guarantee up to \$9.5 billion in top-up funding (referred to as the state specific guarantee) was to be provided to states based on an annual reconciliation of what was provided under the ABF approach and what would have been provided under the former National Health Care SPP.
 - b An assessment of the amount of the remaining top-up funding under the national guarantee (\$6.9 billion) was to occur in 2017 at which time decisions regarding the quantum and timing of the remaining guarantee funding would be made (refer to clause A75 of the 2011 Agreement).
- 7 In May 2015 the Government announced that from 1 July 2017 the Commonwealth’s contribution would grow in line with CPI and population growth.
- 8 The 2014–15 Budget included two measures ceasing the National Partnership on Preventive Health and the National Partnership on Improving Public Hospital Services.

Table 1: PBO projections—Aggregate and State breakdown of the difference in Commonwealth hospital funding under current Government policy (indexation by CPI and population growth) and the scenario where Commonwealth hospital funding was to be provided in accordance with the 2011 Agreement, over 2014–15 to 2024–25² (a)(b)(c)(d)(e)(f)

(\$m)	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24	2024–25	Total
New South Wales	-	-	-	-371	-801	-1,265	-1,782	-2,359	-2,988	-3,679	-4,436	-17,681
Victoria	-	-	-	-272	-589	-952	-1,356	-1,806	-2,298	-2,838	-3,430	-13,541
Queensland	-	-	-	-199	-464	-752	-1,074	-1,433	-1,824	-2,254	-2,726	-10,726
Western Australia	-	-	-	-168	-308	-474	-658	-863	-1,087	-1,333	-1,602	-6,493
South Australia	-	-	-	-103	-206	-312	-429	-559	-701	-858	-1,029	-4,197
Tasmania	-	-	-	-20	-53	-83	-117	-154	-195	-240	-289	-1,151
Australian Capital Territory	-	-	-	-84	-113	-145	-180	-218	-260	-306	-356	-1,662
Northern Territory	-	-	-	-30	-46	-63	-82	-103	-125	-150	-178	-777
Total	-	-	-	-1,247	-2,580	-4,046	-5,678	-7,495	-9,478	-11,658	-14,046	-56,228

- a The impacts are on a fiscal balance basis.
- b Figures presented are based on economic and fiscal parameters as at the 2015–16 MYEFO.
- c Note the 2011 Agreement profile used to derive these amounts did not include the funding guarantees (this is addressed in Table 2).
- d Amounts may not sum due to rounding.
- e The aggregate financial implications are considered to be of **medium** reliability. The estimates for hospital funding under the current policy setting (where growth is based on population and CPI) are considered reliable particularly given that population is relatively stable and has predictable growth. The estimates for hospital funding based on the 2011 Agreement are less reliable as they are based on estimated total hospital expenditure (Commonwealth and state governments) which are less predictable as there is limited historical data (particularly for growth in efficient prices).
- f The state breakdowns are of **medium** reliability as the estimates are calculated based on state proportions of the total in the last known year of available data, and the future distribution of the Australian population across states and territories may differ, particularly as the projection period increases.

2 Timeframe as requested by the Committee.

Table 2: PBO projections—Aggregate and State breakdown of the difference between Commonwealth hospital funding with and without the funding guarantee specified in clauses A67 to A79 of the 2011 Agreement in place, over 2014–15 to 2017–18³ (a)(b)(c)(d)(e)

(\$m)	2014–15	2015–16	2016–17	2017–18	Total
New South Wales	-	-	-	-	-
Victoria	-	23	109	3	135
Queensland	17	92	160	87	356
Western Australia	-	43	74	58	174
South Australia	-	-	21	-	21
Tasmania	-	-	7	-	7
Australian Capital Territory	-	1	1	-	2
Northern Territory	-	-	-	-	-
Total	17	158	371	148	695

- a The impacts are on a fiscal balance basis.
- b Figures presented are based on economic and fiscal parameters as at the 2015–16 MYEFO.
- c Amounts may not sum due to rounding.
- d The aggregate financial implications are considered to be of **low** reliability. The estimates for the withdrawal of the funding guarantee were derived using the estimates for Commonwealth hospital funding, based on the 2011 Agreement, and estimates for the National Healthcare SPP, and a state breakdown of the funding guarantee amounts outlined in the 2011 Agreement. The reliability of estimates for funding based on the 2011 Agreement are outlined in notes to Table 1, and the estimates for the National Healthcare SPP are slightly more reliable as they are based on the formula specified in the 2009 *Intergovernmental Agreement on Federal Financial Relations*. As the aggregate implications are dependent on the two series of estimates mentioned, they are rated as low reliability as the margins for error compound.
- e The state breakdowns are of **medium** reliability as the estimates are calculated based on state proportions of the total in the last known year of actual data and may differ particularly as the projection period increases.

3 Timeframe as requested by the Committee.

Table 3: PBO projections—Aggregate and State breakdown of the difference in Commonwealth funding under current Government policy and the scenario where the National Partnerships terminated in the 2014–15 Budget were still in effect, over 2014–15 to 2024–25⁴ (a)(b)(c)(d)

(\$m)	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24	2024–25	Total
New South Wales	17	49	74	42	-	-	-	-	-	-	-	182
Victoria	13	38	56	32	-	-	-	-	-	-	-	139
Queensland	11	32	48	27	-	-	-	-	-	-	-	117
Western Australia	6	16	24	14	-	-	-	-	-	-	-	60
South Australia	4	11	16	9	-	-	-	-	-	-	-	40
Tasmania	1	3	5	3	-	-	-	-	-	-	-	12
Australian Capital Territory	1	2	4	2	-	-	-	-	-	-	-	9
Northern Territory	1	2	3	2	-	-	-	-	-	-	-	6
Total	54	153	230	130	-	-	-	-	-	-	-	567

- a The impacts are on a fiscal balance basis.
- b Figures presented are based on economic and fiscal parameters as at the 2015–16 MYEFO.
- c Amounts may not sum due to rounding.
- d The aggregate financial implications and state breakdowns are considered to be of high reliability as the amounts are as presented in the 2014–15 Budget and the funding that would be provided under the relevant National Partnerships were fixed amounts and not dependent on population or price factors.

4 Timeframe as requested by the Committee.

Data Sources

- 1 The Department of Finance and the Treasury provided 2015–16 MYEFO parameter and population projections.
- 2 Commonwealth Budget, MYEFO and Final Budget Outcome documents.
- 3 Council of Australian Governments National Health Reform Agreement, February 2011:
http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf
- 4 Intergovernmental Agreements on Federal Financial Relations, Schedule D, March 2009:
http://www.federalfinancialrelations.gov.au/content/inter_agreement_and_schedules/superseded/Schedule_D_March_09.pdf
- 5 Australian Institute of Health and Welfare—Health Expenditure Australia annual publications.

Attachment B

Table B1: PBO projections of commonwealth hospital funding under current Government policy (indexation by Consumer Price Index (CPI) and population growth), at an aggregate and state and territory level, over 2014–15 to 2024–25⁵ (a)(b)(c)

(\$m)	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24	2024–25	Total
New South Wales	4,878	5,243	5,523	5,755	5,987	6,236	6,491	6,755	7,028	7,312	7,605	68,813
Victoria	3,851	4,134	4,331	4,533	4,734	4,931	5,132	5,341	5,557	5,781	6,013	54,338
Queensland	3,061	3,284	3,451	3,629	3,778	3,935	4,096	4,263	4,435	4,614	4,799	43,345
Western Australia	1,755	1,831	1,956	2,001	2,095	2,182	2,271	2,364	2,459	2,559	2,661	24,134
South Australia	1,125	1,188	1,238	1,270	1,315	1,370	1,426	1,484	1,544	1,606	1,670	15,236
Tasmania	334	349	359	378	388	404	421	438	455	474	493	4,493
Australian Capital Territory	305	321	343	296	308	321	334	347	362	376	391	3,704
Northern Territory	158	174	193	184	191	199	207	215	224	233	243	2,221
Total	15,466	16,525	17,394	18,047	18,796	19,578	20,378	21,207	22,065	22,955	23,875	216,286

a The impacts are on a fiscal balance basis.

b Figures presented are based on economic and fiscal parameters as at the 2015–16 MYEFO.

c Amounts may not sum due to rounding.

5 Timeframe as requested by the Committee.

Table B2: PBO projections of scenario where Commonwealth hospital funding was to be provided in accordance with the National Health Reform Agreement 2011, over 2014–15 to 2024–25⁶ (a)/(b)/(c)/(d)

(\$m)	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24	2024–25	Total
New South Wales	4,878	5,243	5,523	6,126	6,788	7,501	8,273	9,114	10,016	10,991	12,041	86,494
Victoria	3,851	4,134	4,331	4,805	5,323	5,883	6,488	7,148	7,855	8,619	9,443	67,880
Queensland	3,061	3,284	3,451	3,828	4,242	4,687	5,170	5,695	6,259	6,868	7,525	54,070
Western Australia	1,755	1,831	1,956	2,169	2,403	2,656	2,929	3,227	3,546	3,891	4,263	30,626
South Australia	1,125	1,188	1,238	1,373	1,521	1,681	1,854	2,043	2,245	2,464	2,699	19,431
Tasmania	334	349	359	398	441	487	538	592	651	714	782	5,645
Australian Capital Territory	305	321	343	380	421	466	514	566	622	682	748	5,368
Northern Territory	158	174	193	214	237	262	289	318	350	384	420	2,999
Total	15,466	16,525	17,394	19,294	21,377	23,623	26,055	28,703	31,545	34,613	37,922	272,517

a The impacts are on a fiscal balance basis.

b Figures presented are based on economic and fiscal parameters as at the 2015–16 MYEFO.

c Amounts may not sum due to rounding.

d Note these figures exclude ant state specific of national guarantee funding.

6 Timeframe as requested by the Committee.