PREM14D04720

Hon Jay Weatherill MP
Premier of South Australia

Chairperson
Senate Select Committee on Health
60 Parliament House
CANBERRA ACT 2600

Dear Chairperson of the Senate Select Committee on Health

Thank you for the opportunity to present to the Senate Select Committee on Health's Inquiry into Health at the 28 August 2014 public hearing in Canberra.

At this hearing I took a number of questions on notice. I am now providing you with responses to those questions in addition to South Australia's formal written submission to the Inquiry (Attachments 1 and 2).

In addition to this, I would also like to address several issues raised by Commonwealth officials in their evidence given on 28 August 2014 following my evidence to the Committee. These issues relate to the agreed processes within key National Partnership Agreements for agreement review and renewal and reward funding arrangements.

At the Senate Select Committee hearing, Commonwealth officials advised that the National Partnership on Long Stay Older Patients was a time-limited agreement which was due to terminate, and therefore forward projections were never included within the Commonwealth's forward estimates. Commonwealth officials noted that States and Territories had lobbied the Commonwealth government to continue the National Partnership Agreement.

South Australia does not consider it to have been an unrealistic expectation that this agreement should have been continued. Long-stay older patients remaining in hospital longer than is clinically appropriate whilst they wait for a place in a Commonwealth subsidised residential aged care service are of significant cost to State public hospitals. This agreement had acknowledged the Commonwealth's responsibility for long-stay older patients noting the long term nature of the implementation of Commonwealth aged care reforms.

South Australia notes that this National Partnership Agreement did include provision that the agreement would be reviewed to determine progress in achieving the agreed outcomes (see Clause 35). This review was never undertaken. Without having an understanding of ongoing requirements, and without taking into account South Australia's concerns about the impact of Long Stay Older Patients, it is not clear how the Commonwealth determined that there was no ongoing need for further funding to be built into their budget.

Office of the Premier
State Administration Centre 200 Victoria Square Adelaide South Australia 5000 GPO Box 2343 Adelaide SA 5001
Telephone +61 8 8463 3166 Facsimile +61 8 8463 3168 www.premier.sa.gov.au

In relation to the National Partnership Agreement on Improving Public Hospital Services, Commonwealth officials stated to the Select Committee that all of the facilitation funding under this Agreement has now been paid to States and Territories, and that only the remaining two years of reward funding has been ceased.

The decision by the Commonwealth to not renew the facilitation funding under this agreement is of significant concern. The National Health Reform Agreement set out clear guidelines for a review of the National Partnership Agreement on Improving Public Hospital Services by December 2013. In particular, if this review found evidence of increased activity levels attributable to the National Partnership Agreement the Commonwealth had agreed in principle to making an appropriate baseline adjustment to the National Health Reform Agreement to reflect the share of the ongoing costs of those additional services (Clause 87). Despite all jurisdictions providing evidence to the Commonwealth through the review process of ongoing additional activity and heightened service level expectations from the community, this was disregarded in the Federal Budget.

Further concerns relate to the withdrawal of reward funding under this National Partnership Agreement. The Commonwealth has committed to a question on notice on this issue. At the hearing, Commonwealth officials stated that reward funding under the agreement was contingent on States and Territories achieving the targets set out in the Agreement. Commonwealth officials advised that the cessation of the reward funding may not impact States and Territories if they were not likely to meet the targets. Any failure by States and Territories to meet the targets was further implied by the Commonwealth to represent a breaking of the agreement.

The Emergency Department and Elective Surgery targets in this agreement were set as stretch targets aimed at creating a national commitment to reform in these areas. Due to the nature of these targets, the National Partnership Agreement rewarded proportional performance against these targets. South Australia expected to continue to receive reward funding acknowledging its significant efforts against these ambitious targets for the remaining two years.

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. South Australia seeks a collaborative approach with the Commonwealth to improving the health system and health outcomes for the Australian people going forward.

Thank you for taking the time to consider the issues raised by the South Australian Government.

Yours sincerely

Jay Weatherill
PREMIER

encl.

Senate Select Committee on Health — Inquiry into Health

Submission from the South Australian Government

September 2014

SOUTH AUSTRALIA

Government of South Australia

Introduction

The South Australian government welcomes the opportunity to make a submission to the Senate Select Committee on Health. The Select Committee into Health has been formed to inquire into and report on health policy, administration and expenditure with particular reference to:

- *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;*
- *the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;*
- *the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;*
- *the interaction between elements of the health system, including between aged care and health care;*
- *improvements in the provision of health services, including Indigenous health and rural health;*
- *the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;*
- *health workforce planning; and*
- *any related matters.*

Key Messages

The recent Federal Budget announced a number of significant changes to Commonwealth funding and policy in health that are of great concern to South Australia. Many of these changes impacted shared commitments and agreements between all jurisdictions that aimed to improve the health outcomes for all Australians and ensure the sustainability of the Australian health system.

The key messages that the SA Government would like the Select Committee into Health to note are:

1. **The Federal Budget has led to significant and sudden funding reductions for health services** in South Australia in the order of $655 million over four years with no warning or consultation. This is the equivalent of:
    - Removing 600 hospital beds; or
    - Closing an entire hospital; or
    - The cost of employing 3000 nurses; or
    - Doubling elective surgery waiting times.

2. **The Federal Budget changes represent a significant departure from the shared commitments agreed between the Commonwealth and the States and Territories.** The South Australian government considers that a strong working relationship between the State and Federal governments is essential to a well-functioning Federation where the community has confidence that governments are working together, and services are well coordinated and seamless.

3. **The Federal Budget changes will have longer lasting implications for the State Government.** In particular, the changes leave the State bearing the risks associated with growing public hospital costs but without the resources required to meet the expected growth, and with limited ability to influence the full range of policy levers across the health service spectrum that drive demand for public hospital services. That is, policy changes in areas of Commonwealth responsibility such as Medicare, aged care and Private Health Insurance have a direct impact on demand for State public hospital services.

4. **The Federal Budget changes will disproportionally disadvantage already vulnerable and marginalised members of the community.** They undermine the important principle of universal access for health care services and will result in many people not accessing health services at all, or not accessing health services until their conditions become chronic and require more expensive acute hospital treatment.

5. **The GP co-payment will only disadvantage the most vulnerable groups of our population when primary care should be considering innovation on how to better manage patient outcomes.** A co-payment arrangement on top of the existing Medicare fee structure will only continue to encourage increased throughput rather than providing genuine rewards for improved patient outcomes.

6. **The Commonwealth Government has reduced funding for preventive health at a time when the increasing rate of adult obesity is one of Australia's most significant national health concerns.** Reduced Commonwealth funding for prevention, health promotion and early intervention will place increased pressure on the primary care system (and hence the sustainability of Medicare), which will in turn put increased demand on the public hospital system.

Addressing the Terms of Reference

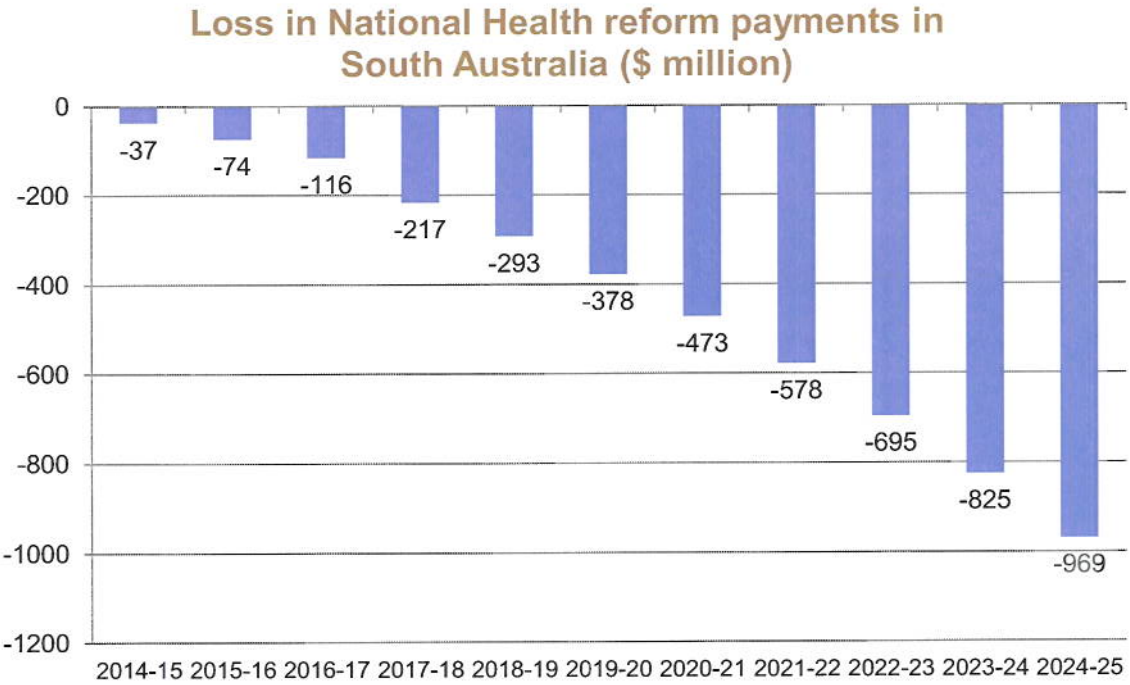
The South Australian government has responded to each of the individual Terms of Reference. The response is based in the context of the National Health Reform Agreement, which has the objective to improve health outcomes for all Australians and the sustainability of the Australian health system.

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;

The Federal Budget detailed significant reductions in Commonwealth funding contributions for the health sector in South Australia in the order of $655 million over the forward estimates. This is the equivalent of:

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

The Federal Budget reductions will mean that South Australia will receive approximately $444 million less in funding over the forward estimates for public hospital services when compared to the 2013-14 Mid-Year Economic and Fiscal Outlook. This equates to a loss of around $4.6 billion over the next 10 years.



The Commonwealth has responded to concerns raised by States and Territories to verify their claim that funding under the NHRA will still grow, by around 9% per annum. These figures are derived from the effective growth in the total national NHRA funding pool from 2013-14 to 2014-15 as presented in the 2014-15 Federal Budget papers.

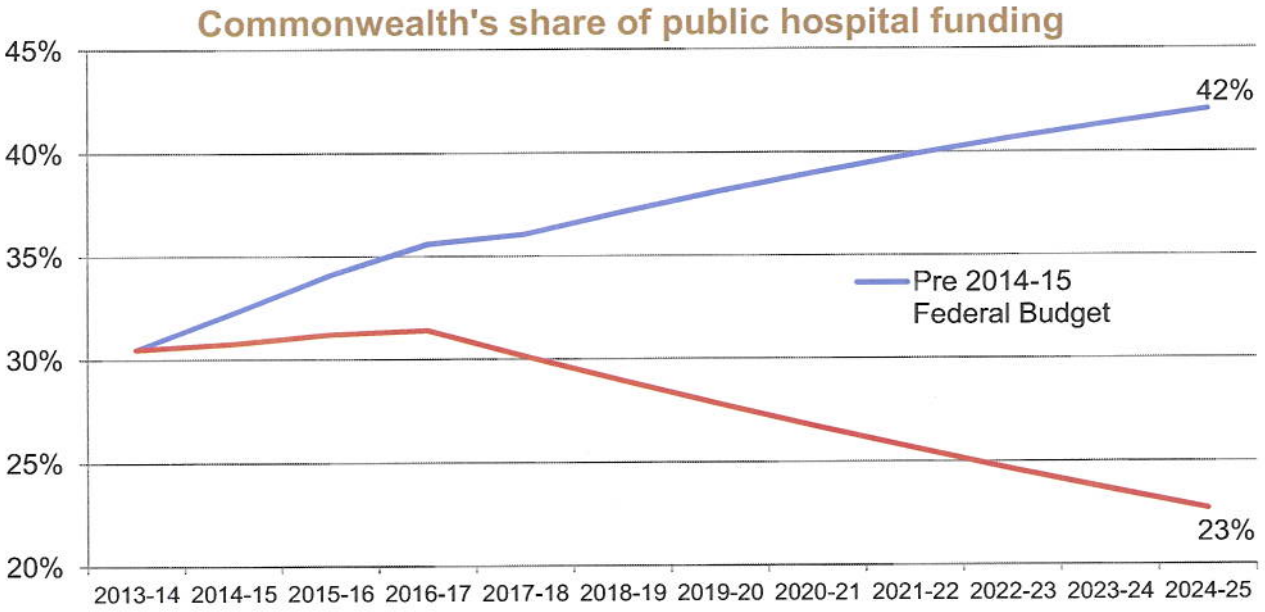
This figure is not reflective of the estimated growth for individual States and Territories. Based on the figures for South Australia in the same table, the estimated level of growth in NHRA funding for South Australia will only be 7.1% in 2014-15. Under the previous NHRA arrangements growth in Commonwealth funding to South Australia for public hospital services was expected to be in the order of 11%. As such, the Commonwealth funding changes have resulted in a fall in total Commonwealth funding growth by 4% for South Australia in 2014-15. This sudden change is difficult to adjust to in a relatively short timeframe. The level of growth in Commonwealth funding also 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.

The funding reductions in the Federal Budget stem from the Commonwealth reneging on several funding commitments under the National Health Reform Agreement which was agreed between all jurisdictions in 2011. The Federal Budget advised that:

- The Commonwealth will not increase its contribution towards efficient growth in public hospital service expenditure to 50 per cent by 2017-18.
- From 2014-15, the Commonwealth funding guarantees under the National Health Reform Agreement will cease.
- From 2017-18, funding for public hospital services will be based on new indexation arrangements made up of a composite of Consumer Price Index (CPI) and population growth.

These changes not only lead to reduced funding to South Australia but will also have longer lasting implications. In particular, the changes leave the State bearing the risks associated with growing public hospital costs but without the resources required to meet the expected growth, and with limited ability to influence the full range of policy levers across the health service spectrum that drive demand for public hospital services. The Commonwealth's decision to renege on its commitments under the National Health Reform Agreement to contribute to efficient growth in public hospital services reduce its skin in the game and creates increased potential for cost-shifting. By the Commonwealth not sharing the risks of growing public hospital costs, this limits the extent to which decision making in areas of Commonwealth responsibility (such as primary health care and aged care) considers the impacts on the hospital system.

The Commonwealth's overall share in public hospital funding will decline compared to that of the States and Territories. As shown in the following graph, the Commonwealth's contribution to public hospital funding will reduce from around 31 per cent in 2014-15 to 23 per cent by 2024-25. The intention of the National Health Reform Agreement was to gradually increase the Commonwealth share of hospital funding to 50 per cent.



The Federal Budget changes represent a significant departure from the shared commitments agreed between the Commonwealth and the States and Territories under the National Health Reform Agreement and the National Healthcare Agreement. These Agreements provided agreed priorities and commitments by all governments across hospital and health care services to improve the health outcomes for all Australians and ensure the sustainability of the Australian health system. The South Australian government considers that a strong working relationship between the State and Federal governments is essential to a well-functioning Federation where the community has confidence that governments are working together, and services are well coordinated and seamless.

The impacts of decisions made in the Federal Budget will be felt at the community level, particularly by the most vulnerable, and will likely have longer term adverse population health outcomes. The Federal Budget decision to introduce a $7 Medicare co-payment highlights the risk of cost-shifting and poorer patient health outcomes. 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 as a result of the introduction of a $7 co-payment.

In addition the $444 million reduction in funding for public hospital services under the National Health Reform Agreement, the Federal Budget included a further $211 million in funding reductions to South Australia related to the termination of several significant health related COAG Agreements. These are:

- $120 million related to the discontinuation of the National Partnership Agreement on Improving Public Hospital Services. This agreement contributed to improved public patient access to elective surgery, emergency department and subacute care services by improving efficiency and capacity in public hospitals. The Federal Budget removes national commitments towards emergency department and elective surgery targets.

- $42 million related to the discontinuation of the National Partnership Agreement on Financial Assistance for Long-stay Older Patients. This agreement provided a Commonwealth funding contribution to recognise that there are some older people in public hospitals who have finished acute and post-acute care and have been assessed as being suitable for Commonwealth aged care but remain in hospital longer than would otherwise be necessary while they secure an appropriate community or residential aged care place.

- $49 million worth of other reductions to health services including the early termination of the National Partnership Agreement on Preventive Health which provides funding for the highly successful Obesity Prevention and Lifestyle (OPAL) program in South Australia.

The South Australian Government does not have the capacity to replace the funding withdrawn by the Commonwealth Government. The South Australian Government has committed to make up for half of the funding gap with the removal of the Emergency Services Levy (ESL) remissions on fixed property and mobile property (including cars and motorcycles). This decision reflects the state government's desire to reduce the impact of the federal funding reductions on the most vulnerable members of the community – including those who do not own property.

Pensioners and self-funded retirees that hold a Commonwealth Seniors Health Card are exempt from the changes for their principal place of residence. (Pensioners include those eligible for a Pensioner Concession Card, Commonwealth Seniors Health Card or other eligible Centrelink benefit.) Mobile property ESL remissions will remain in place for primary production vehicles, trailers and recreational boats.

However, in the absence of any reversal of the Commonwealth decision, it is expected that the remainder of the gap will need to be found in the health system.

The government had also previously announced funding of $184 million for three hospital redevelopment projects: the Queen Elizabeth Hospital stage 3A, Modbury Hospital, and Noarlunga Health Service stage 2A. As a result of the cuts the state needs to re-assess those announcements to ensure the most efficient and appropriate use of health facilities. As a result these three projects have been suspended. The funding for these projects, along with $100 million announced during the election to redevelop the Flinders Medical Centre has been redirected into a Health Capital Reconfiguration Fund.

b. The impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

The three pillars of Medicare are: a universal Medicare rebate for doctors' services, a universal Pharmaceutical Benefits Scheme and universal access to free public hospital care.

The Federal Budget announced significant changes to Medicare that undermine these principles. These include the reduction of Medicare Benefit Schedule (MBS) rebates by $5 from 1 July 2015 in addition to the introduction of a $7 co-payment for standard general practitioner consultations and out-of-hospital pathology and diagnostic imaging services. There is also a related Federal Budget announcement that States and Territories will be provided the ability to charge for GP-type presentations in Emergency Departments. In addition, there are changes to the Pharmaceutical Benefits Scheme (PBS) including increasing co-payments by $5 (from $37.70 to $42.70) and for concessional patients by $0.80 (from $6.10 to $6.90) in 2015. PBS safety net thresholds will also increase by 10 per cent each year.

The South Australian government considers that these announcements will result in many people not accessing health services at all, or not accessing health services until their conditions become chronic and require more expensive acute hospital treatment. The measures would also impose an additional cost burden to States and Territories to administer against minimal revenue that could be collected.

South Australia is concerned that the co-payments will have a significant impact on health outcomes for South Australians. The MBS co-payment will reduce access to GP services and will result in increased pressure on public hospital emergency departments for potentially avoidable GP-type presentations, particularly relating to the management of chronic conditions. SA Health modelling shows the average emergency department wait times in SA are likely to increase to at least 66 minutes - up from the average current 20-minute waiting time.

Moreover, South Australia is significantly concerned about the disproportionate detrimental impact the co-payments will have for the most vulnerable people in the community, particularly Aboriginal and Torres Strait Islanders, older people, those with a lower socio-economic status, and those with chronic conditions needing primary care management in order to avoid hospital. It is concerning that these at-risk patients may see the co-payment as a prohibitive barrier and be discouraged to see their doctor or fill their prescriptions. In turn their conditions could worsen, placing increased pressure on hospitals but also impacting their quality of life and health outcomes.

South Australia considers that reducing the level of Medicare rebates in addition to implementing a co-payment in order to sustain the cost of Medicare, is a counter-productive policy. It may result in some short term savings to the Commonwealth Government, however, in the longer term the costs to provide public hospital services, the costs to patients to be able to afford access to high quality health care, and the costs to the population in terms of outcomes will be deeply affected and outweigh the short term financial benefits to the Commonwealth.

c. The impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

The increasing rate of adult obesity is one of Australia's most significant national health concerns. Reduced Commonwealth funding for prevention, health promotion and early intervention will place increased pressure on the primary care system (and hence the sustainability of Medicare), which will in turn put increased demand on the public hospital system.

These reductions come at a time when the evidence suggests that preventable risk factors (such as obesity) and chronic conditions (such as type 2 diabetes) are of rising concern. The COAG Reform Council has reported that nationally there has been no progress to achieving the benchmark of increasing the proportion of Australians at a healthy body weight by 5 percentage points, with no significant change in the proportion of adults or children at a healthy body weight between 2007-08 and 2011-12. In fact, the COAG Reform Council has reported that nationally in 2011-12, 62.7% of adults were overweight or obese, (27.2% of adults were obese in 2011–12, with another 35.5% being overweight), up significantly from 61.1% in 2007-08.

Obesity is associated with a range of poor health outcomes and the rising levels of obesity, if left unaddressed, will likely result in primary care and public hospitals being flooded with avoidable obesity-related conditions such as type 2 diabetes and cardiovascular disease. There is strong evidence that managing lifestyle factors reduces preventable hospital admissions. Moss and Larg in *The cost of overweight and obesity to South Australia: Public acute inpatients* projected that by 2032-33, obesity related conditions will require $239m of additional public hospital expenditure per year. The longer term cost implications of these types of conditions requires the coordinated response of all governments, and could be avoided with continued joint attention and investment now.

Through the 2014-15 Federal Budget, the Commonwealth has made a decision that States and Territories are responsible for preventive health with no consultation or consideration of the Commonwealth's broader responsibilities. The immediate cessation of the National Partnership Agreement on Preventive Health four years prior to its expected expiry in 2017-18 will have significant consequences for the highly successful Obesity Prevention and Lifestyle (OPAL) program in South Australia. The immediate cessation of Commonwealth funding across the healthy children and healthy workers initiatives places a direct cost pressure on the South Australian Government which has contractual commitments to 2017-18 with a range of local councils, peak bodies and employer organisations.

In South Australia, the OPAL program is the flagship strategy for reducing childhood obesity, influencing children who will be the adults of 2032-33. OPAL has demonstrated clear indicators of success and is regarded internationally as a leader in the field. In South Australia, there is evidence that childhood obesity levels are stabilising, while South Australian adult overweight and obesity levels continue to climb. Data from the 2011-12 Australian Health Survey and 2007-08 National Health Survey shows that South Australia had the highest proportion of adults being overweight or obese (combined) at 66.1%. It is encouraging to note the downward trend in the proportion of South Australian children who are overweight or obese (from 25.7% in 2007-08 to 24.2% in 2011-12) which is also lower than the national average of 25.3%. The levelling out of childhood obesity can be partly attributed to OPAL. Data collected by SA Health also shows some encouraging signs in the behaviours that are the precursors of healthy weight particularly for children, including increased consumption of fruit and vegetables, and increased physical activity for children.

One of the key successes of the OPAL program was the long-term commitment involving coordinated efforts of governments at the Federal, State and Local Government levels. This approach recognised the importance of governments working together to systematically address matters that are of significant national concern. Given the clear evidence of increases in preventable risk factors and chronic conditions, short term savings through decreased investment in preventative activities is likely to result in increased costs in the longer term in other parts of the health system.

d. The interaction between elements of the health system, including between aged care and health care;

Health services are provided across a continuum, and future consideration of roles and responsibilities within the Federation should consider the interdependencies across the full continuum of care. This includes careful consideration of the impacts of primary health care services, preventive health and high quality aged care and disability services can make on the demand for public hospital services.

A key interface exists between the hospital and aged care sector. Whilst States are responsible for the delivery of public hospital services, responsibility for aged care policy, planning and funding sits with the Commonwealth. The Commonwealth's decision to renege on its commitments under the National Health Reform Agreement to contribute to efficient growth in public hospital services reduce its skin in the game and may limit the extent to which its decision making on reforms to aged care will consider the important interface with the hospital system.

Of particular concern, is ensuring that patients who have received hospital treatment and who are eligible to receive Commonwealth subsidised aged care services are able to move seamlessly without waiting for an extended period of time in a public hospital bed. Remaining in a hospital longer than is clinically necessary is not in the best interests of patient well-being and safety and is extremely resource intensive.

In South Australia there are a large number of state-funded Nursing Home Type Places (NHTPs) in country hospitals. Whilst State funded and counted as a hospital bed, these places effectively provide nursing home type care for older people. Whilst aged care remains a Commonwealth responsibility, South Australia has continued to work with the Commonwealth over a number of years in transitioning to multi-purpose services and residential aged care services in rural areas. It should be noted that in many of these rural locations that there is no other aged care option for these patients. Recognising the Commonwealth's responsibility for aged care service provision, the conversion of these places to Commonwealth funding remains a high priority for South Australia.

There are also a number of patients, predominantly in the metropolitan area who wait in hospital longer than is clinically required for placement into Commonwealth funded aged care services. In South Australia, SA Health has implemented over the last few years a range of strategies to reduce the need for older people to access residential aged care through a variety of rehabilitation and restorative care strategies. There has also been much work to reduce the time for those who are waiting in hospital for residential aged care longer than clinically required. These local strategies must work in partnership with Commonwealth reforms in order to be effective.

The Commonwealth recognises that some older people in public hospitals who have finished acute and post-acute care, and have been assessed as being suitable for Commonwealth residential aged care, remain in hospital longer than would otherwise be necessary while they secure an appropriate community or residential aged care place. The Federal Budget announced the cessation of funding from the Commonwealth to South Australia through the National Partnership Agreement on Financial Assistance for Long Stay Older Patients. This agreement had provided funding in the order of $42 million over three years from 2011-12 in recognition of the costs incurred by State and Territory governments in caring for long stay older patients. Commonwealth aged care reforms aimed at improving the flexibility and meeting the increased demand for aged care places, are long term in nature, and the decision to immediately cease the National Partnership Agreement represents a direct cost-shift to the States and Territories.

It is integral to the success of the Commonwealth's aged care reforms, that the Commonwealth considers the important interface with State and Territory services and commits to clear and ongoing dialogue with States and Territories on policy and planning decisions.

e. Improvements in the provision of health services, including Indigenous health and rural health;

Indigenous Health Services

There is significant room for improvement in the provision of services for Indigenous people. In particular, consideration should be given to the way governance and funding structures can better address the long-term generational health inequities faced by the Aboriginal and Torres Strait Islander populations. Commitment should be made to ensuring longer-term funding arrangements can be delivered, to avoid the detrimental impacts to Aboriginal and Torres Strait Islander health services that occur as a result of short-term funding uncertainty. Short term funding does not provide for important relationships to be developed and trust maintained within communities, and culturally appropriate services maintained on an ongoing basis. Further, consideration should be given to having a coordinated national policy approach to avoid duplication and overlap of services. The previous national policy and funding commitments under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes have not been renewed by the Commonwealth through a further COAG agreement. Despite this, South Australia will maintain its commitments to key projects previously funded through this agreement with a State budget allocation of $32 million over three years from 2013-14.

South Australia is particularly concerned that measures on health in the Federal Budget will put at risk efforts to close the gap in health outcomes for Aboriginal and Torres Strait Islanders. The reduction in funding from mainstream health and hospital programs, in addition to measures such as the Medicare co-payments, is likely to have a compounding effect on vulnerable groups such as Aboriginal and Torres Strait Islander people who already encounter barriers such as poor access to primary health care and prevention, cost, and poor health literacy.

The changes to Medicare will disproportionately affect the Aboriginal population and will affect Aboriginal people's ability to access much needed health care services. This single change will impact both the Public Health system and Aboriginal Health Services within South Australia. Aboriginal Health Services are already considering how a co-payment will affect their ability to provide effective targeted services. In addition, changes to the Pharmaceutical Benefits Scheme (PBS) will negatively affect the Aboriginal population's ability to obtain prescription medicines, and it remains unclear how the PBS changes will affect the Federal Government's Closing the Gap: Tackling Indigenous Chronic Disease Practice Incentives Program, which provides free or low cost PBS medicines to Aboriginal patients at risk of chronic disease.

South Australia considers that the impact of the reduction in Commonwealth funding announced in the Federal Budget on the Aboriginal population will set back the gains made to date in achieving the COAG targets to close the gap in Indigenous life expectancy, and the health the gap in mortality rates for Indigenous children under five within a decade. The COAG Reform Council's assessment of the National Indigenous Reform Agreement benchmark to 'halve the gap in mortality rates for Indigenous children under five years of age within a decade' indicates that nationally, governments are on track to halve the gap in child deaths by 2018. The gap in child death rates fell from 111.9 to 87.5 per 100,000 between 2008 and 2012.

Further, South Australia considers that the National Indigenous Reform Agreement benchmark to 'close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation' may not be met due to the impact of the changes. The COAG Reform Council's assessment of this benchmark is that larger gains are needed in future years to meet the target to close the gap by 2031. In 2010–2012, Indigenous life expectancy at birth was 69.1 years for men and 73.7 years for women. This was a gap to non-Indigenous life expectancy of 10.6 years for men and 9.5 years for women. Over five years, the national gap to non-Indigenous life expectancy narrowed by 0.7 years for men and 0.1 years for women. It should be noted that life expectancy rates take a long time to respond to interventions and increased effort may not show for some years. South Australia considers the impact of the Federal Budget will set back or even reverse efforts towards the objective of closing the gap.

Rural Health Services

The GP co-payment will have a particular impact on rural and regional communities and health services in South Australia. As in other jurisdictions, country GPs tend to also provide rostered services at the local hospital. The introduction of the co-payment may lead to patients seeking services at the local hospital, potentially placing challenges on already stretched after-hours services. The administrative costs for small or solo-practices in claiming the co-payment will disproportionally affect doctors working in rural and regional areas and, from many anecdotal reports, may be the 'final straw' that leads to doctors deciding to leave rural practice.
The co-payment is also likely to impose a barrier to people from regional communities accessing vital primary health care services, placing increased pressure on public hospital services as conditions worsen, and resulting in poorer health outcomes for rural and remote people. The COAG Reform Council has noted the relatively poorer health outcomes for people living in regional areas. In particular, the COAG Reform Council noted that people outside major cities reported more unacceptable waiting times for GPs, and had lower rates of mental health service use and mental health plans. People outside major cities also have higher rates of a range of preventable diseases (these may include heart disease, diabetes and chronic lung disease), had lower rates of cancer survival, and were more likely to have babies born with a low birth weight. Many of these conditions relate to a difficulty accessing primary care, which is likely to be worsened by the introduction of a co-payment. Overall, the increased barrier imposed by the co-payment to people in regional areas accessing services for a range of health issues will likely exacerbate the disparity in access and outcomes, and is of considerable concern.

South Australia also has significant concerns about the Commonwealth's decision to cease funding for the Prevocational General Practice Placements Scheme on 31 December 2014.

Funding under the Prevocational General Practice Placements Scheme currently enables junior doctors (mainly Post Graduate Year 1 and Year 2 doctors) to experience General Practice at a time when they are making critical decisions about their career. The program in South Australia has particularly been used to support country general practice rotations and has helped ensure there is a training pathway for rural General Practitioners. The Commonwealth's decision to cease funding under the Prevocational General Practice Placements Scheme will reduce the number of junior doctors who are exposed to rural General Practice as a career and may have flow on effects for future recruitment to rural areas. This comes at a time when there are already difficulties recruiting Australian-trained rural General Practitioners. Many experienced senior rural General Practitioners were able to contribute to the education of junior doctors through the Prevocational General Practice Placements Scheme, and their knowledge base will be a significant loss to the health system.

Overall, the cessation of funding will mean an annual reduction in the number of young doctors that SA Health can train by 39 (23 less doctors in their first year of training and 16 less doctors in their second and subsequent year of training).

States and Territories agreed at COAG in 2006 that they would guarantee to provide clinical placements and intern training for all domestic Commonwealth supported (as opposed to international full fee paying) medical and nursing students. With the funding cessation to the Prevocational General Practice Placements Scheme announced in the Budget, from 2015 SA Health would face a significant cost pressure if it was to employ the number of interns coming through the system and SA Health would have more interns than required for workforce purposes.

As such, SA Health may need to consider reducing the number of medical internships available. Whilst SA would still meet its COAG obligation to guarantee 2015 intern positions for all 2014 South Australian domestic medical graduates, SA Health may not be able to guarantee all domestic Commonwealth-supported graduates an intern position in the future.

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;

The introduction of the Medicare co-payment will only serve to further disadvantage the most vulnerable groups of our population when primary care should be considering innovation on how to better manage patient outcomes. A co-payment arrangement on top of the existing Medicare fee structure will only continue to encourage increased throughput rather than providing genuine rewards for improved patient outcomes.

The current Medicare system is episodic in nature and there are not sufficient incentives for General Practitioners to manage chronic diseases according to appropriate guidelines and access the full continuum of services (i.e. allied health and nursing) required for their patients to achieve optimum health outcomes.

Further, the current Medicare system contains a range of care items that are potentially not clinically required, wasteful or ineffective. Of the 6,000 MBS items (excluding Pharmaceuticals), only 3 per cent have been formally assessed against contemporary evidence of safety, clinical effectiveness and cost-effectiveness (National Commission of Audit report , part 1, pg100)..

Reform of Medicare is required to enable a focus on more modern approaches that provide genuine rewards for improved patient outcomes and address issues for the health system as a whole. The Diabetes Care Project provides an example of how things might be done differently. The Diabetes Care Project is a three-year project of a new model of healthcare delivery designed to improve care for people with diabetes. A consortium, led by global management consultancy McKinsey and Company, has been appointed to deliver the project for the Australian Government. The project will involve up to 150 practices in three states (Queensland, Victoria and South Australia) and will compare results between two intervention groups and a control group of general practices to enable a rigorous evaluation of the outcomes, with participation voluntary for consumers and healthcare providers. The project tested 4 changes to primary care through trialling an integrated information and technology system, a new model of funding, the inclusion of a Care Facilitator in the care team, and an education and training program that builds capabilities related to the project and overall care management. The results and final report are still pending however this project provides a useful indication of the improvements required.

g. Health workforce planning;

The 2014-15 Federal Budget announced the closure of Health Workforce Australia, with essential functions transferring to the Commonwealth Department of Health. Health Workforce Australia was originally established by COAG to provide a national coordinated approach to create a health workforce able to meet the current and future healthcare needs of all communities, recognising that reform needed to be national, large-scale and cut across jurisdictional, sectoral and professional boundaries.

Prior to its closure on 6 August 2014, Health Workforce Australia had an ambitious programme of work, which included national workforce analysis and reporting, provision of tools to assist in use of national datasets, workforce studies of selected pressure points, reform initiatives in key sectors (including Aboriginal and Torres Strait Islander Health, rural and remote health, aged care and mental health) and through the establishment and evaluation of new roles, including both advanced and extended scope and assistant roles. Work undertaken by Health Workforce Australia in the development of an Australian health leadership framework has been widely taken up. It is important that work of this kind is maintained or further built upon across the nation, in order to maximise the significant investment already made and the benefits of greater national coordination.

The Australian healthcare system is undergoing profound change in response to multiple drivers that have considerable impact on workforce and on health workforce planning. The health workforce is critical to delivery of high quality care, and, as the single largest ongoing cost to the system, is critical to provision of affordable care.

Accessibility of services and distribution of the health workforce will continue to be a challenge, with improved workforce integration, including through greater collaboration and team work between disciplines and health care settings, being one of a number of strategies requiring additional work.

Policy changes in other sectors, including reductions in the 2014-15 Federal Budget for the higher education sector, also impact on health workforce planning. For example, changes to university funding arrangements may have significant impacts on health workforce. If, as seems likely, fees in some programs are substantially increased this may impact both on supply of health professionals and on the demographic composition of student cohorts. This is of potential concern as it is important that the health workforce reflect the community it serves. If funding changes also led to an increase in the number of full fee paying international students this would be of concern as it has the potential to place increasing pressure on the public health system to respond to requests from the education sector for assistance with clinical placements and internship and graduate programs.

h. Any related matters.

South Australia notes that there are a range of related reviews that are being undertaken by the Commonwealth Government that the Senate Select Committee on Health should be cognisant of in their report on health policy, administration and expenditure. These reviews are occurring concurrently and any Commonwealth decisions about them will influence the direction of health reform.

Of key significance is the White Paper on the Reform of the Federation to be released in 2015 and the associated health issues paper expected to be released later this year. In addition, a range of other reviews have been undertaken or are currently in process by the Commonwealth Government, such as the review of mental health services and programs, the review of competition policy, and the review of after-hours primary health care services in Australia.

Given the long-term timeframes for this Committee to report, South Australia would welcome further opportunities to comment.

Health
Submission 24

Witness	Question	Hansard reference
1. Premier SA	Senator EDWARDS: Anyway, I will move on. How much is the state government spending on health in the year 2014-15? Mr Weatherill: Our total expenditure? I have not got that. I will take it on notice. I will bring that back to you. Senator EDWARDS: So you do not know? Mr Weatherill: I said I will take it on notice and bring it back to you. Senator EDWARDS: So how much funding will you receive from the federal government in the year 2014-15? Mr Weatherill: I am happy to supply those answers to you. Senator EDWARDS: You do not know? Right. How much is the state government spending on health in the 2017-18 financial year? Mr Weatherill: I am happy to bring back those numbers, if you find them interesting. CHAIR: The committee would appreciate them coming on notice.	pp. 4-5.
Response	***How much is the state government spending on health in the year 2014-15?*** The Department for Health and Ageing is currently budgeted to spend $5.248 billion in 2014-15. ***How much funding will you receive from the federal government in the year 2014-15?*** The South Australian Department for Health and Ageing is currently expected to receive $1.501 billion in Commonwealth funding in 2014-15. $1.07 billion is provided through the National Health Reform Agreement and a further $122.6 million through COAG National Partnership Agreements and Project Agreements. The remaining funding to South Australia is for a variety of purposes but mostly for fee-for service type arrangements where the State provides services on behalf of the Commonwealth such as the Department of Veterans Affairs Agreement which totals $54.9 million. ***How much is the state government spending on health in the 2017-18 financial year?*** The Department for Health and Ageing is currently budgeted to spend $5.539 billion in 2017-18 of which South Australia is forecast to receive $1.316 billion in 2017-18 from the Commonwealth for public hospital funding. This estimated amount is around $217 million less than previous estimated in the December 2013 Commonwealth Mid-Year Economic and Fiscal Outlook.	

Witness	Question	Hansard reference
2. Premier SA	Senator DI NATALE: Premier, thank you very much for appearing before us today. Senator McLucas asked about any modelling you may have done on the impact of the co-payment on emergency departments. I understand there was some modelling done on the impact of increased utilisation of emergency departments as a result of the co-payment—that is, people who might otherwise have gone to a GP deciding to go and visit their emergency department because they do not face a cost barrier. Do you have some numbers for me? What is the impact in increased utilisation and what is it going to cost the South Australian government? Mr Weatherill: I made reference to an increase in emergency department waiting times. I am sure that other information exists but I do not have it to hand. I am happy to take that on notice.	p. 5
Response	The MBS co-payment will reduce access to GP services and will result in increased pressure on public hospital emergency departments. It is estimated that increased emergency department presentations due to the MBS co-payment will cost the South Australian government about $80 million, or 55% of the total cost with the Commonwealth to meet the balance of 45% as per arrangements under the National Health Reform Agreement up to 2016-17 . The cost estimates are based on a prediction that emergency department presentations for Triage Category 3 and Triage Category 4 patients will double as a result of the co-payment, which equates to about 290,000 extra presentations.	

Health
Submission 24

Health
Submission 24

<table>
<tr><th>Witness</th><th>Question</th><th>Hansard reference</th></tr>
<tr><td>3. Premier SA</td><td>CHAIR: It would be very helpful for the committee if you could provide us with a detailed outline of all the places where that preventative health funding was being enacted and of the impact of the program's cessation.
Mr Weatherill: I will take that on notice.
CHAIR: Thank you.</td><td>p. 6</td></tr>
<tr><td>Response</td><td>The National Partnership Agreement on Preventive Health provided funding for two of South Australia's key prevention programs: Obesity Prevention and Lifestyle (OPAL) and Healthy Workers- Healthy Futures (HW-HF).

The OPAL program is the flagship strategy for reducing childhood obesity, influencing children who will be the adults of 2032-33. OPAL was run in four phases across various councils through five-year agreements during 2009 – 2017. As OPAL is based on a population cohort, some councils have more than one site.

<table>
<tr><th>Phase 1 (2009-14)</th><th>Phase 2 (2010-15)</th><th>Phase 3 (20011-16)</th><th>Phase 4 (2012-17)</th></tr>
<tr><td>City of Marion</td><td>City of Whyalla</td><td>City of West Torrens</td><td>Alexandrina Council</td></tr>
<tr><td>City of Mt Gambier</td><td>District Council of the Copper Coast</td><td>City of Murray Bridge</td><td>The Coorong District Council</td></tr>
<tr><td>City of Onkaparinga</td><td>City of Charles Sturt</td><td>Mid Murray Council</td><td>City of Salisbury - North</td></tr>
<tr><td>City of Playford</td><td>City of Port Adelaide Enfield</td><td>Northern Areas Council</td><td>City of Charles Sturt - Outer</td></tr>
<tr><td>City of Port Augusta</td><td></td><td>City of Playford South</td><td>Campbelltown City Council</td></tr>
<tr><td>City of Salisbury</td><td></td><td>City of Palmerston - NT (COPAL)</td><td></td></tr>
</table>

OPAL has demonstrated clear indicators of success and is regarded internationally as a leader in the field. In South Australia, there is evidence that childhood obesity levels are stabilising, while South Australian adult overweight and</td><td></td></tr>
</table>

Health
Submission 24

obesity levels continue to climb. Data from the 2011-12 Australian Health Survey and 2007-08 National Health Survey shows that South Australia had the highest proportion of adults being overweight or obese (combined) at 66.1%. It is encouraging to note the downward trend in the proportion of South Australian children who are overweight or obese (from 25.7% in 2007-08 to 24.2% in 2011-12) which is also lower than the national average of 25.3%. The levelling out of childhood obesity can be partly attributed to OPAL. Data collected by SA Health also shows some encouraging signs in the behaviours that are the precursors of healthy weight particularly for children, including increased consumption of fruit and vegetables, and increased physical activity for children.

One of the key successes of the OPAL program was the long-term commitment involving coordinated efforts of governments at the Federal, State and Local Government levels. This approach recognised the importance of governments working together to systematically address matters that are of significant national concern. Given the clear evidence of increases in preventable risk factors and chronic conditions, short term savings through decreased investment in preventative activities is likely to result in increased costs in the longer term in other parts of the health system.

Impacts of cessation of Federal funding of the OPAL program: Of the remaining $13.5 million until 2017-18 required to conduct OPAL in 20 sites (reaching one quarter of the State's population of ~400,000), the Federal Government has withdrawn $8.33 million. The State and Local Governments have maintained their commitment with the State Government continuing to fund $6.3 million.

The result of cuts have been: all council contracts have been shortened; staff numbers have been significantly decreased; evaluation has been ceased; operational budgets in communities have been slashed and central agency support has been decreased. The Federal Budget changes has meant that the overall impact of OPAL has been compromised as has the initial plan for sustainability of OPAL in South Australian Councils.

OPAL Communities will be impacted by a significant decrease in local funding. Policy makers will be disadvantaged by the cessation of the OPAL evaluation which would have pointed to the most effective community based childhood obesity prevention strategies.

The Healthy Workers – Healthy Futures (HW-HF) initiative targeted adult obesity and poor health by addressing the key modifiable chronic disease risk factors of smoking, nutrition, alcohol and physical activity. The approach of the initiative is in line with international action to improve workplace health and the World Health Organisation's Healthy Workplace Model.

The key component of HW-HF was to fund and support key peak industry bodies, unions and regional business

Health
Submission 24

associations to create workplace environments, policies and cultures that support healthy lifestyle behaviours across the sectors they represent. The focus on prevention of ill health in the workplace provides benefits to businesses and produces returns on investment through cost savings and improved productivity.

A competitive tendering process identified the initial eight Healthy Worker Host Agencies (see table below) within the first of three planned rounds, expected to engage up to 20 peak bodies in total. The industries engaged reach workforces with high chronic disease risk factors and provide reach not only to workplaces and employees state wide but in turn reach disadvantaged families.

Healthy Workers Host Agencies *(commenced December 2012)*	**Sector represented** (*= masculinised)
Construction, Forestry, Mining and Energy Union (CFMEU)	Construction industry*
Primary Producers SA (previously SA Farmers Federation)	Farming industry*
United Trades and Labor Council Building Incorporated (SA Unions)	Logistics and transport industry, specifically the rail and maritime sector*
Cement Concrete and Aggregate (CCAA)	The heavy construction materials sector*
Aged and Community Services (ACS)	The aged and community care sector
Inner West Business Enterprise Centre (IWBEC)	Small and medium enterprise sector
Australian Services Union (ASU) SA & NT Branch	The non–government community sector
South Australian Council of Social Services (SACOSS)	The community and social services sector.

Health
Submission 24

	Impacts of cessation of Federal funding of the HW-HF: The HW-HF initiative was entirely Commonwealth funded and expected to continue until 2018. The early termination of the National Partnership Agreement on Preventive Health on 30 June 2014 resulted in the eight Host Agencies funded under this initiative receiving their final quarterly payment on 1 July 2014, ending HW-HF in the Agencies less than two years into the three year agreement. In addition, no funding or support will be provided to the 12 further sectors planned to host HW-HF, each over a three year period, to create healthy workplaces environments for the thousands of adult workers they represent. In doing so this removes significant opportunities to address the incidence of smoking, unsafe alcohol consumption, poor physical activity levels and eating behaviours across at risk South Australian workforces. Finally, the state's workplace health leadership and capacity building approaches of HW-HF have been cut. This includes leadership forums open to all sectors and workplace leaders to share knowledge and evidence, further development and review of practical online workplace tools, training opportunities and evaluation of the effectiveness of the HW-HF approach. Prior to the Federal funding cessation and in recognition of the merit of the HW-HF approach, the State government made an Election Commitment to utilise the HW-HF approach within male dominated industries to improve men's health by addressing modifiable chronic disease risk factors. This recent State government commitment of $2 million over four years under the Men's Health Strategy provides a limited opportunity to realign the HW-HF approach in two of the existing Host Agencies and potentially to a restricted number of other male dominated industries.	

Health
Submission 24

Witness	Question	Hansard reference
4. Premier SA	Senator DI NATALE: Do you have a quantum of funding that has been withdrawn for that program [preventative health programs]? Mr Weatherill: Yes. For that discrete program it is $3.9 million in each year of the forward estimates, so $3.9 million times four. I do not know quite what the allocation is between OPAL and the others, but we will give you that information.	p. 6
Response	The sudden termination of the National Partnership Agreement on Preventive Health with removal of $15.4 million over the next four years (2014-18) will have a significant and immediate impact on South Australia's prevention programs: Obesity Prevention and Lifestyle (OPAL) and Healthy Workers- Healthy Futures (HW-HF). This places a direct cost pressure on the South Australian Government which has contractual commitments to 2017-18 with a range of local councils, peak bodies and employer organisations. **The OPAL program** has been funded by three tiers of government, with a planned total investment of $41.3m (2008-18), comprising $17.6m Commonwealth; $18.6 million SA Health and $5m from Local Government (half of which was "in kind"). The State anticipated a further $8.33 million from the Commonwealth (2014-2018). **The Healthy Workers- Healthy Futures initiative** was 100% Commonwealth funded. The State anticipated a further $7.12 million from the Commonwealth (2014-2018).	

Health
Submission 24

Witness	Question	Hansard reference
5. Premier SA	Senator McLUCAS: Some of those agreements had been in place for some time. Was your elective surgery waiting time tracking downwards in the previous years? Were we on the right track? Mr Weatherill: I think we had hit the targets for elective surgery waiting times that were employed by the agreement. They were effectively met— Senator McLUCAS: If you would like to take that on notice, that is fine. Mr Weatherill: I might take that on notice, but I can clarify that for you. In regard to reward funding, we were meeting our elective surgery targets. In relation to the emergency department, we were substantially meeting them. So we were getting a percentage of our reward payments for those things. Senator McLUCAS: You might want to take this one on notice as well: You have indicated what the cuts will mean to various elective surgeries. Was it expected, if the original funding that had been committed had been adhered to, that those elective surgery waiting times were still going to continue to track downwards? Mr Weatherill: I will have to take that on notice. That has been an area of substantial achievement but I will take that on notice to find out the exact answer.	p. 7
Response	***Was your elective surgery waiting time tracking downwards in the previous years? Were we on the right track?*** South Australia's waiting time performance as measured under the National Elective Surgery Target improved in 2013 compared to the previous year. South Australia met all targets for NEST Part 2 (Average overdue waiting times in days) in 2013, an improvement compared to the previous year. South Australia was successful in treating all patients with the longest waiting times in 2013 and 2012.	

Health
Submission 24

South Australia's NEST performance

NEST (Schedule A)	2013 Target	2013 Actual Performance	2012 Target	2012 Actual Performance
Part 1 - Timely admissions				
Urgent	100.0%	92.5%	94.0%	91.0%
Semi-urgent	94.0%	92.2%	91.0%	90.7%
Non-urgent	98.0%	97.9%	97.0%	96.3%
Part 2 - Average overdue waiting times in days				
Urgent	0 days	0 days	0 days	23 days
Semi-urgent	15 days	0 days	23 days	38 days
Non-urgent	23 days	0 days	34 days	66 days
Number of very long wait patients at 31 December				
Urgent	0	0	0	0
Semi-urgent	0	0	0	0
Non-urgent	0	0	0	0

Was it expected, if the original funding that had been committed had been adhered to, that those elective surgery waiting times were still going to continue to track downwards?

Given that elective surgery waiting times had reduced, and that there has been a consistent improvement in the percentage of patients that have been treated within the clinically recommended time under the previously agreed funding arrangements, it is reasonable to expect that if Commonwealth funding had continued that further improvements to waiting times could have been made. There was not an expectation that elective surgery waiting times would increase into the future, and 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.