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15 February 2013

Victorian Healthcare Association

Inquiry into the implementation of the National Health Reform Agreement

1. Introduction

This submission outlines the Victorian Healthcare Association's (VHA) response to the *Inquiry into the implementation of the National Health Reform Agreement.*

The VHA agrees to this submission being treated as a public document and the information being cited in the report of the Senate Finance and Public Administration References Committee.

1.1 Contact details

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1.2 The Victorian Healthcare Association

The VHA is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

1.3 Prefacing comments

Victoria is facing a range of health and social challenges including an ageing population, increasing rates of chronic disease, workforce shortage and population growth. Victoria's healthcare system is being placed under stress by these challenges. The expenditure and funding arrangements of health services influence how healthcare is provided and whether the system is capable of adapting to changing community needs.

Unlike other states and territories in Australia, Victoria has a long established model of devolved governance, which is the major strength of the Victorian public healthcare system. The Victorian healthcare governance model provides local leadership across acute health, aged care, community health, social services and sub-acute services. There are 86 government-appointed healthcare boards and a further 38 registered community health boards (registered companies limited by guarantee) across the state. Boards of governance act as employers, are directly responsible for service provision, and set their own strategic priorities in line with the demands arising from their local community.

2. The VHA Response

Of the $1.6 billion the Commonwealth Government will cut to health funding to states and territories over the next four years (2012-13 to 2015-16), Victoria is set to lose $475 million.

The National Health Reform Agreement (NHRA) was signed in August 2011 following recognition of a health funding system that lacked cohesion, consistent policy direction, clear accountabilities, had an inefficient use of resources through service duplication, and had failed to create a truly integrated and seamless health system.

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The intent of the NHRA was to increase transparency and independence of the payment authority in order to reduce the politicisation of health spending. It was formed on the basis of improving partnerships and communication between the Commonwealth and state/territory governments in order to form 'one health system' and reduce the fragmentation that had emerged from different funding sources.

As part of this arrangement, the Independent Hospital Pricing Authority funnels Commonwealth funding to states based on their total activity subject to reimbursement based on price. It is the role of the states, as 'system designers', to distribute these funds across its health services and to ensure they deliver on key performance indicators set by the Commonwealth.

The Commonwealth Government's cut to NHRA funding highlights the need for further clarity on state and Commonwealth funding responsibilities. The pricing methodology within the NHRA has enabled the Commonwealth to interpret its role in a way which appears to support their own budget imperatives and has thus impaired the capacity of the states and territories to give effect to their role as system designers.

a. The impact on patient care and services of the funding shortfalls

The $475 million cut equates to a 3 per cent cut in the Commonwealth's contribution to Victoria's health system and a 1 per cent cut in overall Victorian government appropriations to health spending. In 2012-13 alone, the cut will be $106.7 million (made up of $39.7 million for 2011-12 and $67 million for 2012-13). Because of the higher figure, and the fact that the current financial year is already half over, this will equate to 2% of health service budgets over the second half of this year.

Box 1.1. The likely impact on Victorian services and consumers in 2012-13

The $106.7 million is equivalent to the value associated with:

- Providing 21,340 elective surgery procedures**;**
- Employing 1,400 staff;
- Operationalising 440 hospital beds

For individual health services, these cuts range from a few thousand dollars per month for very small rural health services, up to $2 million per month for the largest metropolitan health services. Overall, the health funding cuts will place an unprecedented demand on an already stretched supply of hospital resources in Victoria. As indicated in Box 1.1 above, the funding reductions have a substantial impact on employment, elective surgery procedures and availability of hospital beds, all impacts which are currently being experienced within Victoria.

Prior to the cuts, Victoria was on target to have a waiting list of 46,000 patients. Due to the short timeframe for implementing these funding reductions, many Victorian health services will not be able to meet the targets prescribed by the Commonwealth under the National Elective Surgery Target. The VHA estimates that the worst case scenario for Victoria is that waiting lists will rise as high as 65,000. A reduction in elective surgery is accompanied by the closure of surgical beds and the closure of operating theatres.

In addition, the reduction of sub-acute, dental and preventative health programs by many Victorian hospitals will place further demand upon a reduced number of beds as there is likely to be an increase in admissions from patients with a chronic illness or functional decline.

Workforce implications include planning that is currently underway for significant reductions in the number of new graduate doctors and nurses employed within Victorian hospitals, thereby curtailing the final part of the qualifying process for new graduates and increasing unemployment.

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b. The timing of the changes as they relate to hospital budgets and planning

The Commonwealth's reductions were implemented on 17 December 2012, half way through the 2012-13 financial year and after health service budgets had been set, resources have already been allocated and activities already planned.

To be financially sustainable, public hospitals must be able to meet current and future expenditure when it falls due. The decentralised nature of governance in Victoria means that boards of health services set their budget for each upcoming financial year on the basis of the estimated flow of revenue and expenses. Like any business, should revenue fall below expectations, other revenue raising avenues are explored or expenses are cut in order to maintain an ideal budgetary position. However, if there is an insufficient period of warning, it becomes more difficult for businesses to plan and find innovative ways to maintain productivity and efficiency.

Thus, the funding cuts to health services mid-way through a financial year is of a considerable concern to VHA, particularly as health service boards and CEOs in Victoria will be placed under significant pressure to manage the reductions at a local level. As public entities, there are limited non-government revenue raising options for Victorian public hospitals to apply to counter such cuts.

The VHA seeks a commitment from the Commonwealth Government that funding determinations will form part of the normal budget process, and will not be adjusted part way through a financial year. This includes avoiding retroactive funding cuts, which have a disproportionate impact on health service delivery.

VHA Recommendation:

- As part of the normal budget process, the Commonwealth Government must include its determinations on NHRA funding and not adjust the estimates part way through a financial year.

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

The VHA acknowledges the states and territories agreed on the terms of the NHRA. However, the VHA is concerned with the way the Commonwealth Government has chosen to interpret its responsibilities under that agreement. This is despite the intent of national health reform to provide transparency and certainty of funding health services.

The VHA acknowledges that under the NHRA, Commonwealth funding is based on three factors:

- A health specific cost index (a five-year average of the Australian Institute of Health and Welfare (AIHW) health price index growth rate);
- Growth in population estimates weighted for hospital utilisation
- A technology factor (Productivity Commission derived index of technology growth).

The release of the Mid-Year Economic and Fiscal Outlook (MYEFO) on 22 October 2012 indicated that due to the revisions of the Australian Bureau of Statistics (ABS) on the national population arising from the 2011 census and the AIHW measure of growth in health costs, the NHRA funding estimates would be adjusted accordingly.

Based on the latest report by the AIHW covering 2011, the Commonwealth Government has asserted that there has been a reduction in health cost inflation due to the strong Australian dollar and the resulting reduction in costs of medical equipment purchased from overseas. The VHA is concerned with the use of this index, as the vast majority of expenses in healthcare are not subject to currency fluctuation. For example, staffing costs typically

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account for 70% of overall expenditure. To illustrate this point, the recent decision by the Commonwealth Government to approve an average increase in private health insurance policies of 5.6% demonstrates an inconsistency in the current system.

However, the major point of disagreement and confusion surrounding these cuts relates to the use of population data. Since the Agreement was signed in August 2011, the ABS has amended the method used to measure population. This method, first used in the 2011 census, has shown lower than anticipated growth in population between 2006 and 2011. While the VHA does not dispute the ABS figures, we do not believe that they have been correctly applied by the Treasury in determining NHRA funding to the states.

In determining the population change between 2010 and 2011, Treasury has used the unadjusted (and overestimated) 2010 population based on the 2006 census and the adjusted 2011 population based on the 2011 census. This has the effect of showing a negative population change for Victoria of 11,111, reducing the state's funding entitlement by $107 million for the 2012-13 financial year. This is opposed to the actual population growth of 75,400 (according the ABS).

Of particular concern is the precedent set by the 2012-13 determination of federal funding to councils under the Local Government (Financial Assistance) Act 1995. The Act stipulates that the formula which determines changes in grants to councils must take account of population growth figures. In the June 2012 funding determination under the Act, the Federal Treasurer chose to use the adjusted population figures. In practice, this means that population data was applied inconsistently, with the result that healthcare budgets were cut, but not local government.

The lack of detail presented in the NHRA on specific datasets has enabled the Commonwealth to interpret its responsibilities and the determinants of funding under this agreement in such a way as to rationalise the health funding reductions without consultation with the state and territory governments. This is inconsistent with the intention of the NHRA, which was supposed to place transparency at the heart of decisions on funding. It is also inconsistent with approaches taken to other funding decisions.

The VHA believes that it is imperative that the current process is made more transparent and accountable. The NHRA must be revised in order to clarify a specific ABS, or alternative, dataset that can be used as the reference point for population and also a single measure for health inflation which recognises the real burden of inflation on health budgets. These measures must be agreed to by all parties.

VHA Recommendation:

- The datasets used to determine funding estimates must be agreed in advance by all parties to the agreement.

d. Other matters pertaining to the reduction by the Commonwealth of National Health Reform funding and the NHRA

Prior to 2014-15, NHRA is based on the previous mechanism used by the Commonwealth Government to fund state/territory health systems, the National Health Specific Purpose Payment (SPP). Although the SPP determination was governed by the three factors outlined above (health inflation, population and a technology factor) it enables the Federal Treasurer significant leeway in deciding how to interpret the data used to apply those factors. From 2014-15, the Federal Treasurer will lose this ability as the amount of federal health funding will be based on the level of growth in health spending in each state.

The VHA is concerned that as federal health funding over the next four years will be lower than originally anticipated as a result of the changes identified in the MYEFO, growth in health

spending from 2014-15 onwards will be measured from a lower baseline. This means funding growth will effectively be reduced in perpetuity.

The reduction in growth funding will continue to make it difficult for health services to maintain an appropriate level of service provision to meet targets set by the Commonwealth and administrative resources necessary to maintain accreditation.

3. Conclusion

Underpinning the NHRA is the principle that *governments agree that an effective health system that meets the health needs of the community requires coordination between hospitals, GPs and primary health care and aged care to minimise service duplication and fragmentation*. What has emerged is a flawed funding model that has encouraged further fragmentation, reduced the health service provision and augmented the blame game between the Commonwealth and state/territory levels of government.

The recent experience highlights the vulnerable position of hospitals under the Agreement. The current structure of governance means that Victorian hospitals are under enormous pressure to sustain future budget reductions, let alone unexpected mid-year reductions. Devolved governance is a key tenet of the NHRA and the VHA believes that both levels of government must overtly support the principle of board-led governance of healthcare, and not place unnecessary constraints on the ability of boards to carry out their responsibilities.

National health reform was intended to provide transparency and certainty of funding for health services, concepts which the VHA strongly support. While the justification for the cuts has been understood, this move seems to fly in the face of those principles, and of the spirit of the NHRA.

To further discuss this submission, please contact:

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