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AMA Submission to Senate Finance and Public Administration References Committee Inquiry into the Implementation of the National Health Reform Agreement

The AMA welcomes the opportunity to make this submission to the Committee's Inquiry into the Implementation of the National Health Reform Agreement.

The AMA has a direct interest in the funding, capacity and performance of the Australian public hospital system. Our members work at the coalface providing medical care to their patients in a public hospital system that is struggling to meet demand.

The AMA notes that the Committee's Terms of Reference focus on the implementation of the National Health Reform Agreement in relation to reductions in Commonwealth funding for public hospital services arising from recent parameter changes. Our members experience first hand the impact funding changes have on patient care.

There should be no reduction in the funding of public hospitals by post hoc adjustment of the health funding agreements. In the current public hospital environment, it is clearly unacceptable for any government to introduce reductions in funding as it can only further reduce capacity in the system, putting patients' health and well-being at risk.

(a) Impact on patient care and services of the funding shortfalls
The AMA is not in a position to attribute specific impacts of the funding shortfalls by the Commonwealth as a result of the population and health index adjustments, particularly as various states have also reduced their annual health budgets at the same time.

However, at the clinical level, reductions in funding, by any government for any reason, directly and inevitably result in bed closures, operating theatre shut downs, closing of outpatient clinics and reductions in emergency services. All of this impacts on patient access to care and treatment and ultimately to the quality of care provided.

At the political level, the complicated and opaque way in which the various Commonwealth-state funding agreements and arrangements describe the basis and conditions of funding, and the start and finish of different agreements, provides a conducive environment for non-productive argument and assertions about which government is responsible for the inevitable clinical impact.

The public hospital 'performance' record is clear evidence that the Australian public hospital system is under-funded i.e. public hospitals do not have the capacity to meet the clinical demands being placed on them, even before the Commonwealth adjustment and state budget reductions were imposed. Performance against key measures has changed very little in recent years:

> While 872 new beds were opened across Australia in 2010-11, these clearly offset previous closures because the number of beds per 1,000 people remained at 2.6.
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> In 2011-12 emergency department Category 3 patients who were seen within 30 minutes was 66% compared to the target of 80%.
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> Under the new National Emergency Access Target, in 2011-12 64% of all emergency department visits were completed in four hours or less, compared to the target of 90% to be achieved by 2015.
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> In 2011-12 elective surgery category 2 patients who were admitted within 90 days was estimated at 81% compared to the target of 100%.

There is very little publicly available information that allows us to monitor 'performance' for other medical services like cancer care and paediatric services. It will be nearly impossible to quantify the impact on patient care and services of adjustments and budget reductions to these services.

In addition, National Partnership Agreements provide an unstable funding stream. For example, the National Partnership Agreement (NPA) on Improving Public Hospital Performance provided $1.6 billion in funding to the states and territories for subacute beds, but ceases in 2013-14. As there is no recurrent funding for the subacute beds, the services that have been funded will likely close, which will mean a return to previous hospital capacity, putting additional pressure on performance.

As with the population and health index funding adjustments, there is a strong argument that the NPA should be revisited and that there should be ongoing funding for any subacute beds that have been established, which will make more existing acute beds available.

(b) Timing of the changes as they relate to hospital budgets and planning

Added to the current under-funding, the adjustments for population estimates and the health cost index are being applied retrospectively, i.e. to services that have already been provided to patients and to money that has already been spent.

This means that in real terms there will be less Commonwealth money for public hospital services in 2013 in addition to the budget reductions to public hospital funding made by some state and territory governments.

Reductions applied retrospectively provide no scope for hospitals to systematically assess and plan how best to apply such reductions to the most sensible cost areas. Such reductions can take little account, if any, of the possible effects on the quality of outcomes.

In the current environment there should be no reduction in the funding of public hospitals by post hoc adjustment of the health funding agreements. Now is not the time for any government to introduce reductions in funding for any reason. Public hospitals are clearly not meeting demand and already have compromised outcomes with current resources. Any reductions will only further reduce capacity in the system.

Both levels of government, Federal and State, have to take full responsibility for providing the necessary and essential funding.

Further, the public hospital system is currently in transition to Activity Based Funding (ABF) and the National Efficient Price (NEP) under the National Health Reform Agreement. The AMA considers that the 2012-13 NEP was based on the 2009-10 cost data for a public hospital system that was already under-funded and significantly under-performing.

It will be nearly impossible to assess whether the ABF and the NEP have a net positive or negative impact compared to the "current" funding, now that the retrospective Commonwealth adjustments and state budget reductions have been made.

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

The AMA does not have the necessary expertise to assess the fairness and appropriateness of the funding model and the parameters set by the Treasury. However, they are clearly part of the Inter-Governmental Agreement on Federal Financial Relations (the Agreement) signed by all governments in July 2011 (we assume based on the advice of their respective Treasuries).

We note that Clause D24 of the Agreement provides for 'growth factors'. These factors are neutral and could operate to increase, maintain or decrease funding depending on the net direction of the movement in the matters they encompass. At the time of the Agreement it appears likely that the indexes were broadly expected to operate so as to increase funding, given their description as 'growth factors'. The use of these 'growth factors' to actually reduce funding retrospectively to states and territories was clearly unexpected. This is consistent with the fact that the Agreement makes no explicit provision for how and when negative growth would be implemented.

(d) Other matters pertaining to the reduction by the Commonwealth of National Health Reform funding and the National Health Reform Agreement

In terms of the broader implementation of the National Health Reform Agreement the AMA is concerned that ABF and the NEP could result in:

- a real reduction in the number of services provided – because the funding amount does not cover the cost of providing timely and effective care;
- a reduction in the quality of care, with poorer patient outcomes, complications and major increases in delays to care; and
- a diminution in the number of training places, and the quality of the training experience for junior doctors – with a focus on higher throughput in order to attract more funding for activity.

At this time the AMA has no certainty that any mechanisms have been or will be put in place to identify and monitor the incidence and effects of these and other (unforeseen) changes so that action can be taken to adjust funding to ensure patients continue to receive clinically appropriate, timely and high quality treatment in Australian public hospitals.

With insufficient funding it may be impossible to assess whether the move to ABF and a NEP for public hospital services will bolster the capacity of our hospital system to improve the volume of services provided and the quality of those services, and provide the training places needed to teach the next generation of medical practitioners and other health care providers.

The National Health Reform Agreement was expected to increase the capacity of the public hospital system and improve the ability of public hospitals to provide safe and timely health care and meet clinical demand. We urge governments to redirect their efforts into making the National Health Reform Agreement achieve these outcomes, and abandon the blame game.

From this point on the focus must be on patients and the quality care and treatment they need.

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