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LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES

Submission by the AMA (ACT) Ltd to the Inquiry into Future Sustainability of Health Funding in the ACT

Introduction

The Australian Medical Association (ACT) Limited is the principal representative body for medical practitioners in the ACT with a membership drawn from across the medical profession. This broad-base gives the AMA (ACT) a unique perspective on the impact of health policy on both patients and the medical profession.

The Australian health system, with its mix of public and private sectors and mix of funding between State, Territory and Federal Governments, insurers, patients and others presents unique challenges. Despite these challenges, we should be proud of the health outcomes Australia has achieved and the relative efficiency with which those outcomes have been produced.

Amongst the Australian States and Territories, we in Canberra should be likewise proud of our local ACT Health system and acknowledge that we lead the way in many national indicators of good health.

In this submission, we will review the current health financing system and locally, focus on the nature of health funding and innovative means of improving health outcomes.

Australia has a mixed healthcare system

In Australia, the public and private sectors work together as a part of a health system that provides patients with universal access to affordable health care. The balance between the private and public systems has delivered a very good standard of care that is recognised internationally. The current system is subsidised by the Australian taxpayer – at both Federal and State and Territory level.

The private health sector is a large contributor to the system. In 2014-15, 42% of all hospital separations were funded by private health insurance (PHI); 50% were public patients and the remainder were self-funded[1]. In 2014-15 there were 4.5 million privately insured hospital separations for approximately $12.3 billion in outlays[2] [3], or around $2,700 per separation, compared to 5.9 million[4] separations in the public sector for a combined government outlay of around $43 billion (or $7,300 per separation)[5]. While the service mix and complexity may differ between the sectors, the sectors and health financing are interdependent.

Health financing system in Australia

The structure of the health system in Australia is complex, with a multi-payer multi-level system, and an ability to shift either costs or services between payers and levels. Demand for health services has increased on average 2.5%[6] over the ten years to 2014-15 and health expenditure has grown on average by 4.5% over the same period. Average health expenditure per person by all sources in 2014-15 was $6,846[7]. Only about 5% of the growth in per capita health expenditure, as a percentage of GDP, from 6.4% in 1989-90 to 9.7% in 2013-14, has been attributable to ageing[8]. The rest relates to changing demands for improved technology, and an increasing demand for services.

Health expenditure by governments has not kept pace with demand

[1] Australian Institute of Health and Welfare: *Australia's Hospitals – at a Glance 2014-15*, page 7
[2] ABS 4390.0 Private Hospitals Australia 2014-15 Table 2
[3] 3 Australian Institute of Health and Welfare: *Australia's Hospitals – at a Glance 2014-15*, page 8
[4] Australian Institute of Health and Welfare: *Admitted patient care 2014-15*, Table 2.22
[5] Australian Institute of Health and Welfare: *Health Expenditure Australia 2014-15*, Table A6
[6] AIHW, Health Expenditure 2014-15, Table 2.5
[7] AIHW, Health Expenditure 2014-15, Figure 2.10
[8] Media Release, University of Wollongong, https://media.uow.edu.au/releases/UOW234253.html

However, the contribution by governments has reached a plateau in recent years, and does not reflect the changing expectations of the community. The ratio for health expenditure to tax revenue from the states, territories and local governments rose from 22.5% in 2009 up to 24.4% in 2011, and then dropped back down to 22.6% in 2014[9]. Federal Government expenditure as a proportion of taxation revenue dropped from a high of 28.8% in 2009, down to 24.9% in 2012, rising to 26.4% in 2014[10].

Public Hospital Funding

Public hospitals are a critical part of our health system, yet public hospitals are facing a funding crisis that is rapidly eroding their capacity to provide essential services to the public. It took almost three years to have the Commonwealth Government's unilateral cuts to public hospital funding reversed and even then, the 2016 'fix' was inadequate and short-term. Now, the Commonwealth's further, interim 'Heads of Agreement" proposes some further short term funding before the real work of negotiating the next set of health care agreements are finalized.

The additional Commonwealth funding agreed in April 2016 of $2.9 billion over three years was welcome, but inadequate. Data published by the independent Parliamentary Budget Office (PBO) shows that funding under the original National Health Reform Agreement would have delivered $7.9 billion in additional public hospital funding to June 2020 compared to funding by CPI indexation and population growth (as announced in the 2014-15 Budget).[11]

The failure of governments to provide sufficient funding for public hospitals is choking their capacity to provide services to the public. Public hospitals provide essential health care services across the community. Funding for public hospitals is an essential investment in the health of the Australian population, and therefore in the capacity of Australians to participate in the workforce and as members of society. Funding public hospitals is not discretionary.

Sustainability

Australian governments have justified health savings measures, including cuts to public hospital funding, on the basis that Australia's health spending is unsustainable. The evidence does not support this.

Backed by national and international data, the AMA has consistently argued that Australia does not have a health spending crisis. The Government's own health expenditure figures (2014-

[9] AIHW, Health Expenditure 2014-15, Figure 2.8
[10] AIHW, Health Expenditure 2014-15, Figure 2.5
[11] PBO Submission to Senate Select Committee on Health, 3 February 2016, pg 5, Table 1

15)[12] show total health expenditure in Australia has seen three years of modest, sustainable growth, with 2.8 per cent growth in 2014-15, 3.2 per cent growth in 2013-14, and 1.1 per cent in 2012-13. For the last three years, growth has been well below the long-term average annual growth of 4.6 per cent over the last decade.[13] While increasing at these modest, sustainable rates, health spending has also faced pressures from an ageing population with increasing levels of chronic disease and the costs of new technologies in health care.

According to the health expenditure report, health spending was 10 per cent of Australia's GDP in 2014-15, which is stable and sustainable when compared with the 10-year average of 9.25 per cent.[14] Australia is below the OECD average, and achieves better health outcomes for its significantly lower proportional spend than the USA (16.4 per cent), and also spends proportionally less than many other countries, including the Netherlands, Switzerland, Sweden, Germany, and France (all around 11 per cent).[15]

The Commonwealth Government's total health expenditure continues to reduce as a percentage of the total Commonwealth Budget. In the 2014-15 Commonwealth Budget, health was 16.13 per cent of the total, down from 18.09 per cent in 2006-07. It reduced to 15.97 per cent in the 2015-16 Budget, and reduced further to 15.85 per cent of the total Commonwealth Budget in 2016-17.[16]

In the ACT, health funding as a percentage of the overall budget has been staying about constant: 2014/15 30.9%, 2015/16 30.9%, 2016/17 30.6%, 2017/18 30.3%.[17] While actual dollar amounts have increased significantly, from $1.39bn in 2014/15 to $1.6bn in 2017/18.[18]

On the basis of these figures, total health spending is not 'out of control'. The health sector is doing more than its share to ensure health expenditure is sustainable.

Within these constraints, and after two years of low growth, Commonwealth recurrent funding for public hospitals in 2014-15 grew 5.4 per cent to $18.170 billion, a sharp increase compared to 2013-14 (0.9 per cent growth), and higher than the 10-year average of 3.4 per cent. At the same time, expenditure by States and Territories grew by just 0.4 per cent to $25.493 billion, a

[12] AIHW, Health Expenditure Australia, 2014-15, pg vii, 6, 40
[13] ibid, pg vii
[14] ibid, pg 7
[15] OECD Statistics, Health Expenditure and Financing, at 19 December 2016
[16] Commonwealth Budget, Budget Overview 2006-07, 2014-15, 2015-16, 2016-17
[17] ACT Budget papers 2014/15 – 2017/18
[18] ibid

sharp drop compared to 2013-14 (3.8 per cent growth). [19]In the ACT, health spending increased by 6.9% or $90m in 2014/15.[20]

Total spending on public hospitals (from Commonwealth, State and Territory, and non-government sources) grew by 2.7 per cent to $48.094 billion in 2014-15 (compared to the 10-year average of 4.4 per cent).

This single year increase in Commonwealth funding, offset by lower State and Territory funding (with the ACT being a notable exception), meant growth in total funding was still well below the long-term average. And, even with this one-off increase, all Australian governments unanimously agreed at COAG in April 2016 that the Commonwealth clearly needed to inject more funding into public hospitals.

Innovation

Innovation in health care delivery has been a constant whether that be in clinical practice or the manner in which healthcare services are organized and delivered. The AMA (ACT) has, over a period of time, identified several initiatives and policy changes that we recommend be implemented in the ACT.

Primary care

General practitioners play a central role in patient care. Almost 85 per cent of Australians will visit a GP at least once each year. General practitioners are usually the first point of contact when Australians become ill, and the vast majority of health problems are managed solely by GPs. When people have a trusted family doctor it is good for their health: those with an ongoing relationship with their GP have been shown to experience better health outcomes.

Walk-in Centres

AMA (ACT) notes the ACT Government's ongoing commitment to and expansion of Walk-in Centres ('WICs') and the stated aims of providing "free" but limited primary care services to certain parts of the ACT and relieve pressure on emergency departments. At same time there is no doubt that the cost of the WICs and use of scarce resources is a cause for serious concern for both the medical profession and the community.

Recurrent costs of $9m per year for Belconnen and Tuggeranong WICs (and likely similar for the planned Gunghalin and Weston Creek WICs) leads us to question of what type of general

[19] AIHW, Health Expenditure Australia, 2014-15, Table A10 pg 70
[20] ACT Budget papers 2013/14 – 2014/15

practice incentives could have been put in place to deal with similar presentations in a more cost effective method with a total of $54m available since the inception of the current WICs?

After Hours Primary Care

We propose that additional nursing resources be made available, via a competitive tender process, to GP practices on the basis that extended after hours primary care services are provided on a "walk-in" basis.

The funding for this proposal should be derived from removing a part of the current and planned WIC budgets. For example, removing 20% of the recurrent budgets from the current and planned WICs would create a fund of $3.6m per annum.

In addition, the AMA (ACT) believes placing nurses in a primary care team setting would be beneficial to patients, GPs and nurses. Enhancing the capacity of general practices to host nurses not only improves quality but will provide a more efficient "walk in model" due to the presence of medical workforce support on site, reducing referrals, enhancing collaborative care for the patient and potentially, permitting Medicare billing.

Review and Triaging of GP Referrals

Ensuring an efficient system of referrals from GPs to specialists would assist medical practitioners in providing high quality patient care. Our experience demonstrates that improvements can be made in the current referral system in terms of triage, clarity and content of referrals.

AMA (ACT) proposes that a position be established at ACT Health for a suitably qualified general practitioner to review and triage, or clarify, referral letters from GPs to specialists at the Canberra Hospital and Calvary Hospital. This position can also be a contact point for urgent referrals.

This proposal is relevant across the various specialities including psychiatry.

Public Health

Alcohol Fuelled Violence Taskforce

Alcohol-fuelled violence is a scourge on our community and evidence-based measures need to be introduced to ensure that the balance between public safety and a vibrant nightlife is restored in Canberra.

The AMA (ACT) proposes that a "3am Last Drinks" policy be introduced immediately and further evidence based measures introduced as needed.

Health Workforce

The health workforce is, of course, key to the delivery of quality, efficient and timely health services across both the public and private healthcare sectors in the ACT. In some areas of the medical workforce, the ACT is relatively 'under doctored' and it is with this in mind the AMA (ACT) proposes a number of initiatives.

Workforce Incentives

The recent announcement by Minister Fitzharris in regard to creating incentives for health professionals to relocate to Canberra is very welcome and we look forward to working with the ACT Government to develop a suitable package.

Of course, it is important to note that retention of experienced clinicians is a key goal too. To this end AMA (ACT) urges the ACT Government to identify and publish workforce planning data and market information that forms the basis for offering and reviewing Attraction and Retention Incentives ('ARIns').

The AMA (ACT) believes that transparency in both offering and reviewing ARIns is a key to developing workforce incentives.

Psychiatric Workforce & Public Mental Health Services

The major issue for AMA (ACT) is the immediate and medium term future of the psychiatric workforce in the ACT. Since mid-2017, the public sector psychiatric workforce remains in a serious staffing crisis which has, on a long-term temporary basis been only partially relieved by the use of locums (soon, the entire staffing of the Adult Mental Health Unit (AMHU) including Director and Consultant Psychiatrists will be by locum staff).

The AMHU has been extremely difficult work environment with high workload and dangerous exposure to assault and aggression for psychiatrists and trainees. In addition, there are now further workforce shortages of trainee psychiatrists, placing further strain on public mental health services.

A further significant area of concern, revealed in a recent survey of public sector psychiatrists, was that over 50% endorsed that they had experienced bullying or harassment in the workplace (anecdotally reported to be from other medical and allied health staff interacting with psychiatrists and trainees mental health services), adding to the concerns about dangerous, unsustainable working conditions that will impair ability to recruit and retain medical staff.

It has taken the considerable goodwill and dedication of local consultant psychiatrists and psychiatric trainees to prevent the collapse of services, but consequent increasing workloads to

cover for insufficient staffing and resources are unsustainable and will necessarily lead to dangerous working conditions.

Action is needed on recruitment and retention of psychiatric workforce, as well as planning and resourcing of public sector mental health services.

The use of locums and 'Area of Need' appointments continues to be the primary means of dealing with the shorter and medium term issues in public sector psychiatric staff recruitment – a situation we would like to see rectified.

The overall private sector workforce, while not in a similar short-term crisis, has an ongoing shortage of consultant psychiatrists in general adult and all subspecialty areas of psychiatry. The lack of local private sector workforce is likely in part to arise from the workforce issues, and consequent impacts on the public sector, as, in all states private and public sectors tend to function in a complementary fashion.

While there seems to be little alternative to the public sector's use of Area of Need appointments and locums in the short term, in our view, an urgent priority is to begin the process of drafting a comprehensive workforce plan for the combined public and private sector psychiatric workforce, both specialist and trainee. The emphasis of such a workforce plan should be on recruitment and retention specifically considering safety, working conditions and broadly considered incentives to work and remain in the ACT.

The Royal Australian and New Zealand College of Psychiatrists ('RANZCP') has undertaken somewhat similar and extensive work for the Victorian Government (Victorian Psychiatry Attraction, Recruitment and Retention Needs Analysis Project Report, 2017), at least in relation to the public sector workforce. Consequently, we believe there is considerable value to be obtained from examining the Victorian work and propose that the RANZCP be invited to present their views on a way forward.

Systematic planning and coordination of the provision of public sector mental health services, predicated on adequate resourcing and staffing, is needed in the ACT. Such strategic planning will need to include advice from psychiatrists, GPs, allied health as well as patients and the community, but especially needs expert advice from psychiatrists and GPs. Such expert advice can be provided through AMA (ACT) and the ACT Branch of the RANZCP. For example, the ACT Branch of RANZCP is contributing to a psychiatry workforce and acute beds benchmarking project coordinated by the RANZCP across Australia and New Zealand.

<u>Area of Need Policy</u>

ACT Health's 'Area of Need' Policy was to be reviewed over the course of 2017 and AMA (ACT) raised the issue with ACT Health on several occasions as it affected general practice, including GP registrars and their need to secure GP training positions.

The creation of AON position allows a practitioner who would not otherwise be registerable in Australia to gain conditional registration and be engaged to provide patient services in a practice.

At present, the AON policy deals only with the approval of AON positions and does not take into account the issue of appropriate supervision or the progress of the practitioner in obtaining the minimum Australian standard.

Supervision is a matter between AHPRA, the engaging practice and the AON position holder. We wish to see a more comprehensive policy that includes all the relevant parties in not only approving the creation of an AON position but monitoring the progress of AON position holders and record of supervisors.

Australian Government Funding and Performance of Public Hospitals[21]

In its 2014-15 Budget, the Commonwealth Government made savings of $1.8 billion over four years from 2014-15 by abandoning the funding guarantees made under the National Health Reform Agreement 2011, and revising Commonwealth Public Hospital funding arrangements from 1 July 2017.

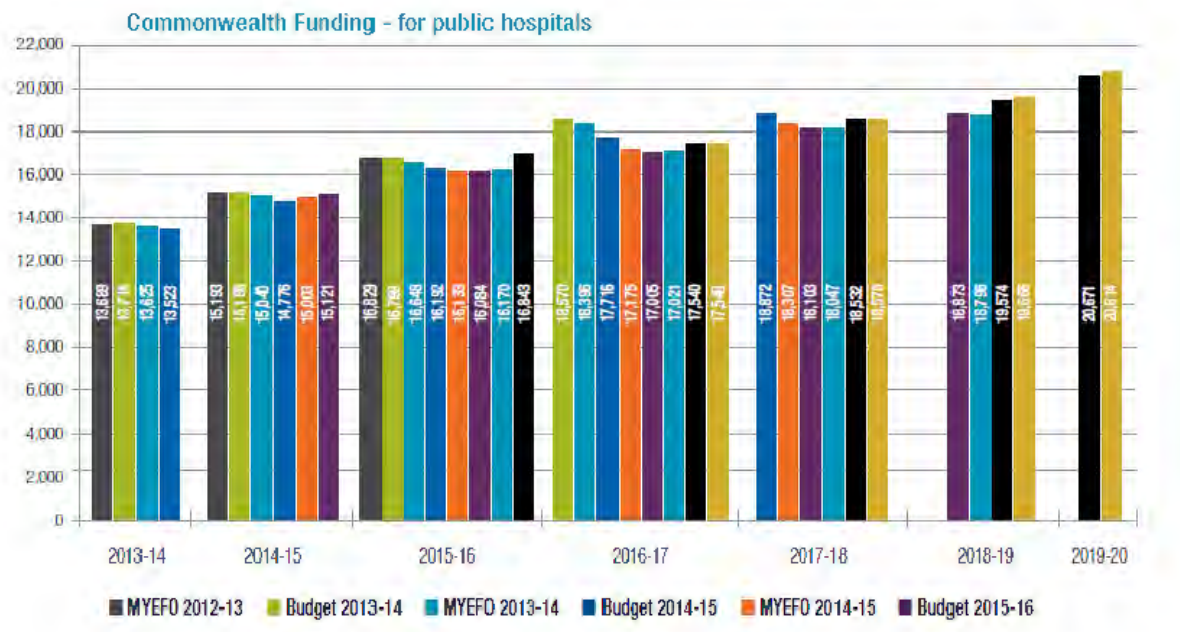
In April 2016, COAG signed an interim Heads of Agreement on Public Hospital Funding setting out arrangements for public hospital funding up to June 2020. The Agreement included additional funding from the Commonwealth of $2.9 billion over this period, and provision for the Commonwealth to meet 45 per cent of efficient growth in public hospital services, subject to a cap on growth of 6.5 per cent.

The additional Commonwealth funding was included in the 2016-17 Budget and MYEFO papers (with some forward year adjustments included in MYEFO reflecting updated activity forecasts). Details of the funding approach were agreed at COAG's December 2016 meeting. Consideration of longer-term hospital funding arrangements began in 2017 and hopefully will be agreed by COAG this year.

[21] AMA Public Hospital Report Card 2017

Graph 1 tracks Commonwealth funding for public hospitals as reported in the Commonwealth Budget and MYEFO papers.

Graph 1: Commonwealth Funding for Public Hospitals



Source: Commonwealth Budget and MYEFO papers, Commonwealth funding for public hospitals

The COAG Heads of Agreement marks a change from the Commonwealth's policy announced in its 2014-15 Budget to move to public hospital funding by indexation and population growth. At least until June 2020, Commonwealth funding will continue on an activity based funding approach, although at a lower rate than would have operated under the National Health Reform Agreement, and with a cap on growth.

These funding levels are reflected in the performance of our public hospitals. The AMA Public Hospital Report Card shows that, against key measures, the performance of Australian public hospitals is essentially frozen at the unsatisfactory levels of previous years. This is the direct effect on patient care of reduced growth in hospital funding and capacity.

Although data issues prevented ACT Health from providing the relevant ACT information, we have little reason to believe that performance of the ACT public hospitals has improved from previous years.

Bed number ratios have remained static (although the ACT has the highest ratio of bed numbers to population nationally).

Emergency department (ED) waiting times have deteriorated and, in most cases, remain well below the target set by governments to be achieved by 2012-13. The percentage of ED patients treated in four hours has not changed over the past three years (since 2013-14), and is well below target. Elective surgery waiting times have worsened, while treatment times have only improved marginally.

Without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment.

Services provided by public hospitals are essential, and public hospitals require sufficient and certain funding to deliver these essential services.

There is no reason why governments cannot act together in the interests of the health care of all Australians and there is no reason why governments cannot work out a sensible, practical agreement to ensure public hospitals have sufficient and certain funding over the long term to meet the public's requirements for hospital services.

Private Health Insurance

The private health sector is a large contributor to the Australian healthcare system generally and funding in particular. If consumers withdraw from the private sector, these services will need to be provided by the public sector. Under current capacity, the public sector will either not meet the additional demand, or will only do so at a higher cost to governments.

Private health insurance is a key element in maintaining the viability of the private healthcare sector.

Out of Pocket Payments

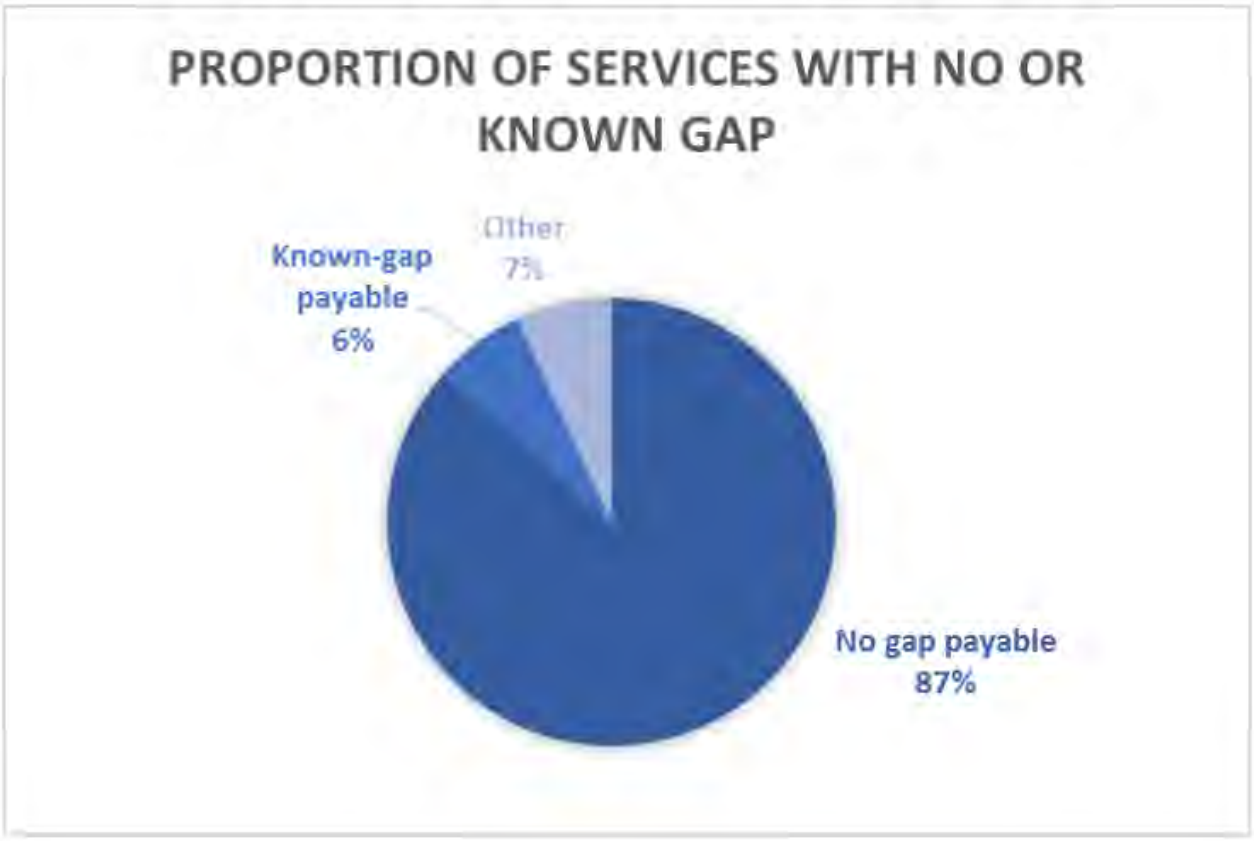
The perception in the Australian community that out-of-pocket costs for health care have increased as a proportion of total health expenditure is not supported by the Government's data. The proportion of health expenditure funded by individuals (i.e. not government or 3rd party/insurance) has remained relatively static at 17% over the decade to 2014-15[22].

The bulk billing rate for total MBS services for the March quarter 2017 was 78.7%, up from 78.5%. The average out-of-pocket costs for specialist attendances was $73.8 for the March 2017 quarter22. The proportion of services for hospital treatment with no gap was 86.6% and the proportion of services with known gap was 6.5%. In total, more than 93% of services

[22] AIHW: Health Expenditure 2014-15, Table 2.1

provided in hospital and covered by private health insurance were provided at the no gap or known-gap rate.

Figure 1: Proportion of services provided at no or known gap[23]



The Federal Minister for Health, Greg Hunt, has recently established the Ministerial Advisory Committee on Out-of-Pocket Costs to bring together key individuals with expertise in clinical practice, private health insurance, and consumer issues to work in partnership on the development of best practice models to make information on out-of-pocket costs charged by doctors more transparent and to help consumers with private health insurance better understand out-of-pocket costs.

The role of the Committee is to provide advice to the Minister on possible reforms covering:

- best practice models for the transparency of in-hospital medical out-of-pocket costs, and associated medical services in the community;

[23] APRA: March 2017 quarterly statistics at http://www.apra.gov.au/PHI/Publications/Pages/Quarterly-Statistics.aspx

- legislation and regulatory barriers to consumer transparency of out-of-pocket medical costs;
- the implementation of best practice models; and
- other related issues as directed by the Minister.

The Committee will progressively report over the 2018 and 2019.

In the ACT, the bulk billing rate for attendances at general practices has consistently been below the national average. While, no doubt, factors involving the unique nature of the ACT are relevant, in the view of the AMA (ACT), the percentage of bulk billed GP attendances, by itself, says very little about an individual patient's experience.

In the AMA (ACT)'s experience, while many GPs do not advertise their bulk-billing services, they do bulk-bill many of their patients at their discretion. One practice owner – not untypically - estimates that her practice bulk bills 30% to 40% of patients including the elderly, people on healthcare cards and children. The focus for her practice – and many like it in the ACT - remains on providing high quality, ongoing holistic patient care that leads to better patient outcome in terms of both the health of the community and cost.

In the AMA (ACT)'s view, 100% bulk-billing practices are usually offering a different service: episodic care where the patient is seen quickly and a single issue is dealt with (sometimes referred to as 'six-minute medicine').

The Federal Government's move in last year's budget to progressively lift the Medicare rebate freeze from 1 July 2018 will likely have some impact on bulk-billing rates.

Other Sources

There is a general expectation in the Australian community that health care should be 'free' at the point of service provision. Most Australians oppose paying to see a doctor[24].

This appears to be based upon the argument that an individual's outlay for healthcare is not discretionary.

However, the data suggests that Australians do spend significant amounts of money on discretionary health items, and this expenditure is growing.

Approximately a third of what individuals spend on health – to the tune of $9.3 billion – goes on vitamins, supplements, over-the-counter painkillers and other unsubsidised drugs. It is more

[24] Consumers Health Forum of Australia. Media release *Medicare co-payment plan a massive concern to voters, new poll finds* 11 May 2014

than the combined sum we spend on dental care and hospitals[25]. Australians spend $3.5 billion on complementary medicines and therapies each year – around 13% of individuals' total health expenditure[26]. A considerable proportion of this expenditure is for unproven treatment.

Patients also contribute to their health care for ancillary treatment. For the quarter ending March 2017, 41,080 general treatment services were provided at a cost of $5,600,900. The insurers contributed $3,185,799 in benefits, or only 57%[27].

It is clear that Australians are prepared to purchase some products, but it is not clear why they are not prepared to contribute to the purchasing of high quality health care. The health system would be financially stronger if some of this discretionary expenditure was spent on proven treatments.

Further Information

Representatives of AMA (ACT) are, of course, willing to appear in person before the Standing Committee on Health, Ageing, Community and Social Services to further discuss the matters contained in this submission.

[25] http://www.smh.com.au/money/saving/how-much-australians-spend-on-health-20170222-gujalb.html
[26] Expenditure is sourced from the National Institute of Complementary Medicine website; percentage is derived from comparison with AIHW Health Expenditure Australia 2012-13 Table 3.10 on individuals' funding of health expenditure.
[27] APRA 2017, Private Health Insurance Members Benefits, March 2017