SUBMISSION – ASMOF ACT

22 February 2018

Inquiry into the future sustainability of health funding in the ACT

- Health expenditure in the ACT for the 2017-8 budget is $1.52 billion, 27% of total ACT Government expenditure, and $3880 per capita. This contrasts with NSW Health expenditure of $20.6 billion or $2730 per capita. This level of expenditure relative to other Australian states is long-standing and does not come with demonstrably superior infrastructure or health outcomes.
- We show in this submission that ACT Health does not optimise hospital revenue from the Commonwealth or private health insurers in line with other states. The shortfall in external funding costs the ACT budget $287 million per annum.
- Despite having the healthiest population in Australia with an enviable standard of living, ACT Public hospitals have the worst financial performance in Australia and the highest administration costs
- Nurse and doctor salary expenditure is in line with other jurisdictions.
- This level of fiscal and budgetary underperformance is not sustainable in the health sector where Commonwealth reforms have prioritized equitable funding for all Australians.

Submission – ASMOF ACT

INQUIRY INTO THE FUTURE SUSTAINABILITY OF HEALTH FUNDING IN THE ACT

1 ACTIVITY-BASED FUNDING OF ACT HOSPITALS

Activity-Based Funding (ABF) is the pricing framework for the Commonwealth funding of Australian public hospitals and was established by the National Health Reform Act 2011. The Independent Hospital Pricing Authority (IHPA) determines the National Efficient Price (NEP) and the National Efficient Cost (NEC) in its annual determinations. The Commonwealth will fund admitted and non-admitted hospital activity up to a cap of 45% of the NEP. The remaining activity is funded by the States through own-source revenue. The minimum State funding is therefore 55%, where that State's hospitals operate at or below the NEP.

This framework is under considerable Federal ministerial oversight. For example, in February 2017 the Minister for Health directed that funding be proportionally reduced for episodes of care involving a hospital-acquired complication or avoidable readmission [1].

In the ACT, ABF funding came into effect in July 2012. ABF is paid from the State Pool Account to a Local Hospital Network (LHN) comprising The Canberra Hospital, Calvary Public Hospital, Clare Holland House and the Queen Elizabeth II Family Centre [2].

The current National Health Reform Agreement expires in 2020. There are current COAG discussions pointing to the funding scenario after 2020. ASMOF-ACT had believed that the ACT Government should prepare for the scenario where the Commonwealth would fund public hospitals at historical ABF levels (2020) adjusted for the consumer price index (cpi). This would reward jurisdictions (such as NSW and Victoria) that operate public hospitals at well under the NEP. It would also cap funding growth to the cpi. In that context, the current Commonwealth offer of 6.5% annual growth in funding is laudable.

Currently, growth in the Commonwealth funding component of ABF is capped at the same 6.5% per annum, allowing the state jurisdictions to bring more of its hospital services in-scope for ABF where this provides a better funding outcome. For example, services that now attract Medicare funding, including diagnostic radiology, pathology and all bulk-billed outpatient clinics, attended by salaried medical staff exercising rights of private practice, are not in-scope for ABF.

When a patient holding private health insurance 'elects' at admission to be treated as a private patient in a public hospital, Medicare pays 75% of the Medicare Benefits Schedule (MBS) fee of the medical services provided during the hospital stay, (plus up to the schedule fee depending on fund coverage) and for medicines through the Pharmaceutical Benefits Scheme. Medicare does not pay for other costs of the admission such as hospital accommodation or theatre fees. The private insurer's payment for this service does not figure in ABF accounting data.

How does the ACT perform in the ABF setting?

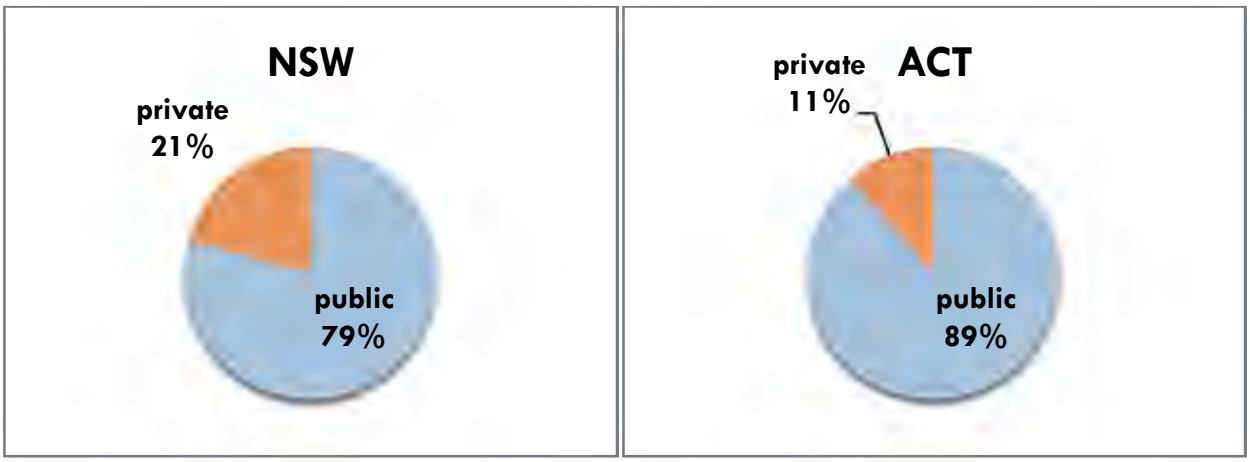
The Diagnosis Related Groups (DRG) system classifies all diseases into approximately 700 groups having similar patients and treatment costs are similar. There is one DRG for every inpatient episode, which

determines total funding for the episode. Every DRG has been assigned a 'cost weight', which is the relative cost of one or more DRG's to another or one bundle of DRGs to another. In ACT Public Hospitals, the overall cost weight across all admitted activity is 0.99. In NSW it is 1.0 [3]. ACT patients are not sicker than in NSW and do not suffer more complications.

There has been growth in public hospital inpatients by 2.6% per annum since 2011 (Acute admitted, Non-admitted, Emergency department, Sub-acute, and Admitted mental health service categories) in the ACT [3]; lower than in NSW, at 2.9% per annum. Over the same period, population growth was 2.2% per annum [4] in the ACT and 1.1% *total* in NSW. Growth in demand in the ACT is highly predictable and does not deviate significantly from year to year.

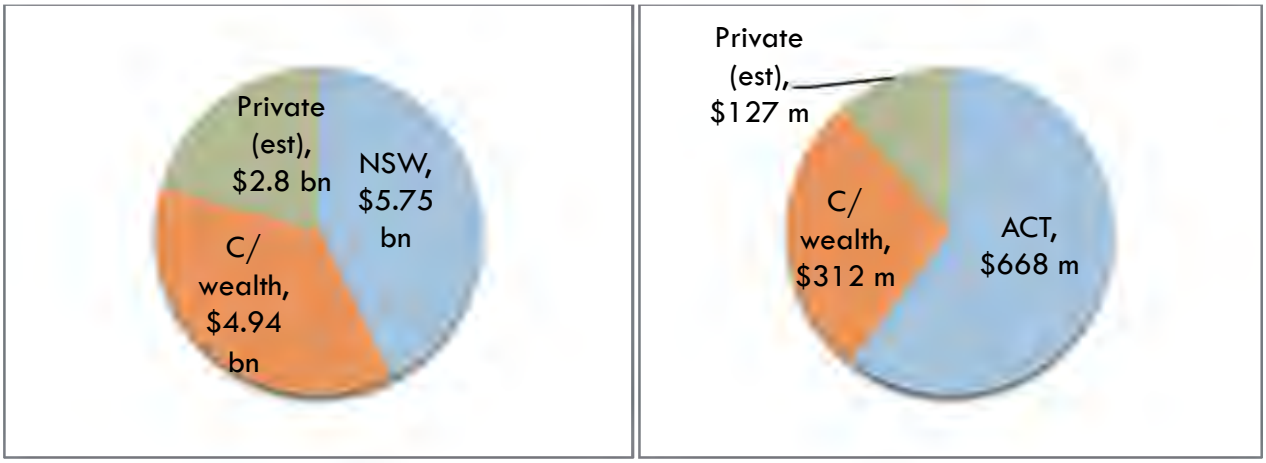
There is minimal PHI funding of public inpatients in the ACT

Currently, 56% of ACT residents hold private health insurance (PHI) covering at least hospital stays. This is the highest rate in Australia. In NSW, the figure is 47% [5]. However, only 11% of Canberra inpatient public hospital stays are funded by PHI, compared to 21% in NSW [3].



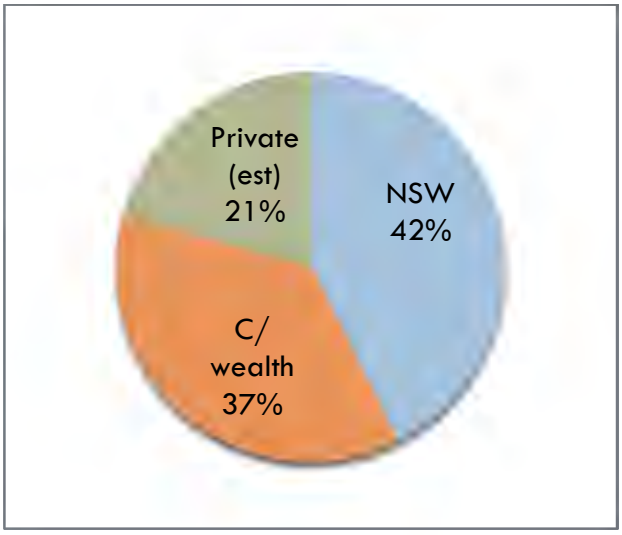
The saving to the ACT budget from PHI funding is approximately $127 million per annum, but could be $184 million per annum if it only just matched NSW performance.

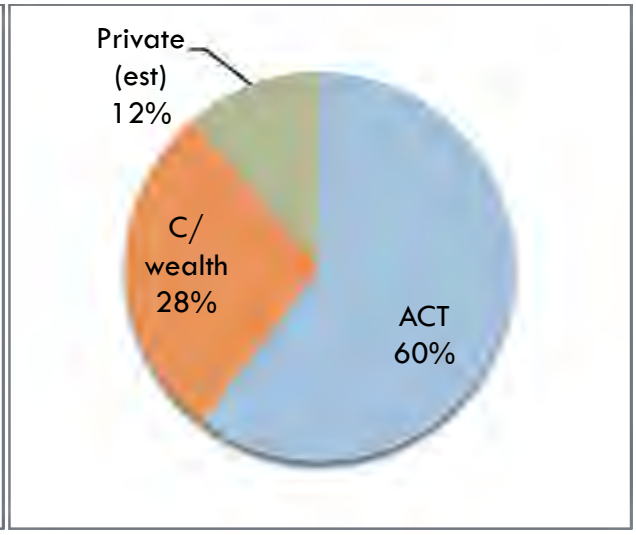
Who pays for Activity-Based Funding?



Details of public hospital funding by state and territory are published monthly [2]. For the 2016-7 financial year, the ACT Local Hospital Network (LHN) received $312 million in ABF funding from the Commonwealth and $668 million from the State. When PHI-funded inpatient services are counted, the contributions to public hospital funding look as above and below (NSW at left, ACT at right). It is clear

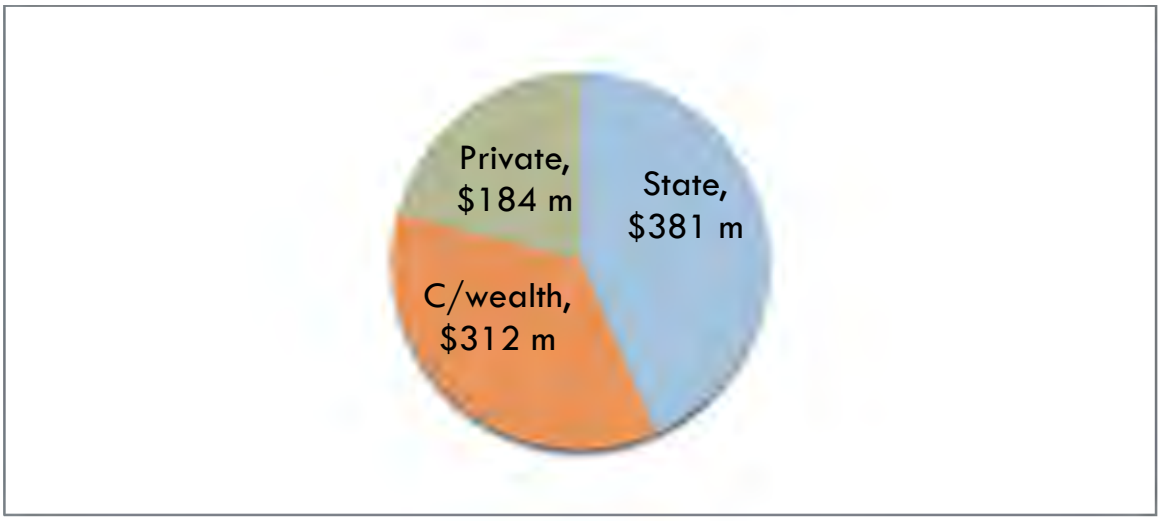
that the ACT Government is over contributing to hospital bed stays. This is because the Commonwealth only funds 45% of the National Efficient Price, and ACT hospitals operate their beds at well over the NEP.





What if ACT had the same funding efficiency as NSW?

If ACT operated its hospitals at the NEP, and had the same funding PHI contribution as NSW, the chart would look like this (note that PHI revenues would reduce overall activity-based funding):



State ABF payments were $668 million in 2016-2017. **The cost to the ACT budget is $287 million per annum. This amount could fund the light rail project outright in 3 ½ years.** ASMOF-ACT notes the comments made in the Pegasus Report into the 2017-18 ACT Budget:

'The lack of a hard budget constraint on the ACT may explain the relative inefficiency of the ACT Government in relation to the provision of public health and education services that is briefly touched on below [6].'

How can ACT hospitals improve PHI funding of hospital beds?

If ACT hospitals ran PHI funding levels at 23% (40% of the population PHI, less than NSW achieves), it would improve the budget bottom line by $87 million per annum. There would be a commensurate reduction in the 'Activity' part of ABF, of the order of 12,000 occasions of service per year. In theory, there is a risk of a future reduction in the rate of PHI in the ACT and Australia. However, the PHI rate is remarkably constant over time, and has not significantly changed despite average annual growth in premiums of 6% since 2010 [8].

Faced by increasing payments to public hospitals, particularly in NSW, the private insurers' industry group has lobbied the Federal Government to curb PHI funding of public beds. This led to a Commonwealth review and a discussion paper entitled '*Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals*', with submissions from interested parties, including ASMOF [9-10]. Three of the five suggested 'options' would have extinguished any significant revenues from Private Insurers, the fourth called for funding to be denied where there was no meaningful choice of doctors and the fifth called for the NEP calculation to be radically altered. When the Commonwealth announced its reforms there were no changes to the current PHI funding arrangements, although this remains under review [11].

ASMOF-ACT notes the lack of any observable policy on improving PHI funding in ACT public hospitals. We sought this policy directive from ACT Health in order to inform this submission but at the time of writing this has not been provided.

2 ACT HOSPITAL BEDS ARE THE MOST EXPENSIVE IN AUSTRALIA

The National Health Performance Authority released its report on costs of acute admitted patients in public hospitals in 2016 [12], referring to the period 2011-2014. The two hospitals with the highest costs were The Canberra Hospital and Calvary Hospital, 32% above the national average and almost double the costs of some comparable Victorian hospitals. From our data above, the picture has not changed greatly.

There is limited detailed and *public* information on comparable costs of care for Australian Hospitals. There are however highly detailed comparisons of **hospital performance** and **costs of care** available to ACT Health and to individual clinicians, once these data have been submitted to the Commonwealth. These data are available through the **Health Roundtable**. The Health Roundtable is a members-only not-for-profit launched in 1994 as a collaboration between public hospital CEOs who were interested in sharing data to achieve best practice [13]. Roundtable data are able to show relative cost and quality indicators of similar clinical units across Australasia, but also show between-unit comparisons in each member hospital. Absolute and relative indicators of individual de-identified clinical subunits (individual specialists) are also available. These are able to show the most and least efficient units and specialists over time. Not all the news is bad. One large Canberra Hospital unit [14] consistently provides the highest quality services of all Australasian peer organizations at the lowest cost.

The data used for the Roundtable briefings are the same data sent by each jurisdiction to the Commonwealth for its financial reporting. Actual Roundtable data and analysis is not to be disseminated in line with an 'honour code [13].' ASMOF-ACT has requested from ACT Health access to the submitted ACT microdata data [15]), but this request was formally refused 14 February 2018 [38].

The macro data do allow us some general conclusions. The reasons for higher hospital bed costs in Canberra Hospitals have not been adequately explained to ACT Residents. The reasons cited are cross-border payments, economies of scale, higher salaries for clinical staff, and superannuation costs [15, 16]. ASMOF-ACT can prove otherwise.

Economies of scale

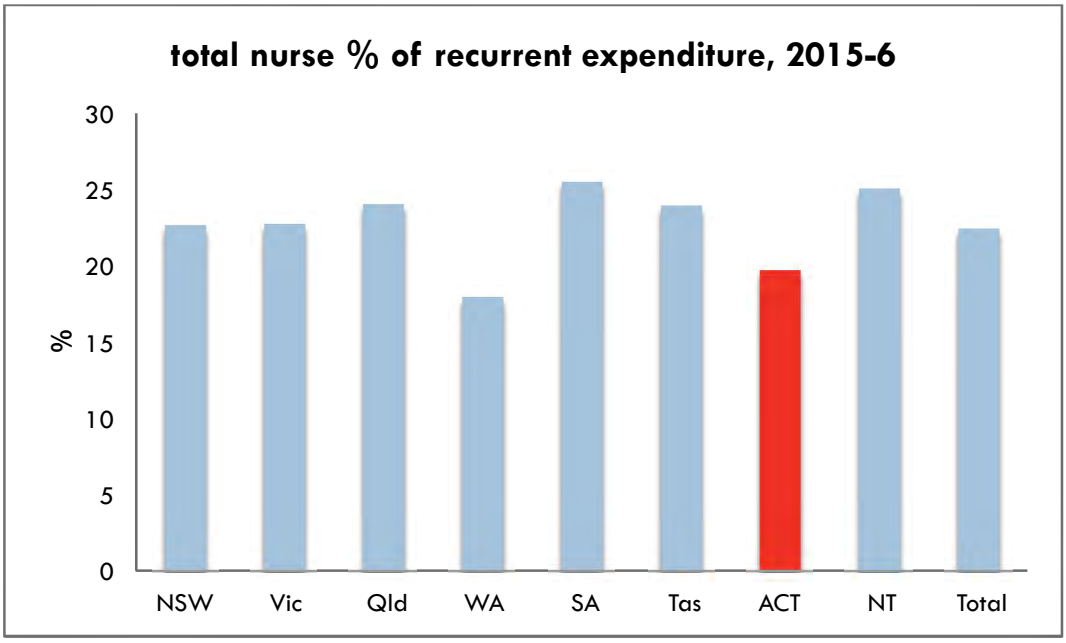
DRGs, case weighting, and the NEP calculations show that 'economies of scale' are mostly illusory. After NHPA figures were released in 2016, ACT Health stated that [16]:

> "Specialist services, such as open-heart surgery, some complex brain surgery, bone marrow transplantation and some high-level care for babies offered in the ACT do not have the same economies of scale possible in larger jurisdictions," he said.

This is misleading. Between 2013-4 and 2015-6, the *average* hospital costs for open-heart valve replacement with cardiac bypass at The Canberra Hospital fell 31% between 2013-4 and 2015-6 despite there being *fewer* occasions of service. Neonatology had almost identical volume of episodes in 2013-4 and 2015-6 while average costs fell by 35%. The improvements were not due to economies of scale but changes in practice and advances in technology.

By way of contrast to ACT Health, NSW Health operates a hospital in Ivanhoe NSW, which is closer to both Adelaide and Melbourne than to Sydney. Ivanhoe hospital emergency department treated 84% urgent patients within the 30-minute benchmark and 90% semi-urgent patients within 60 minutes.

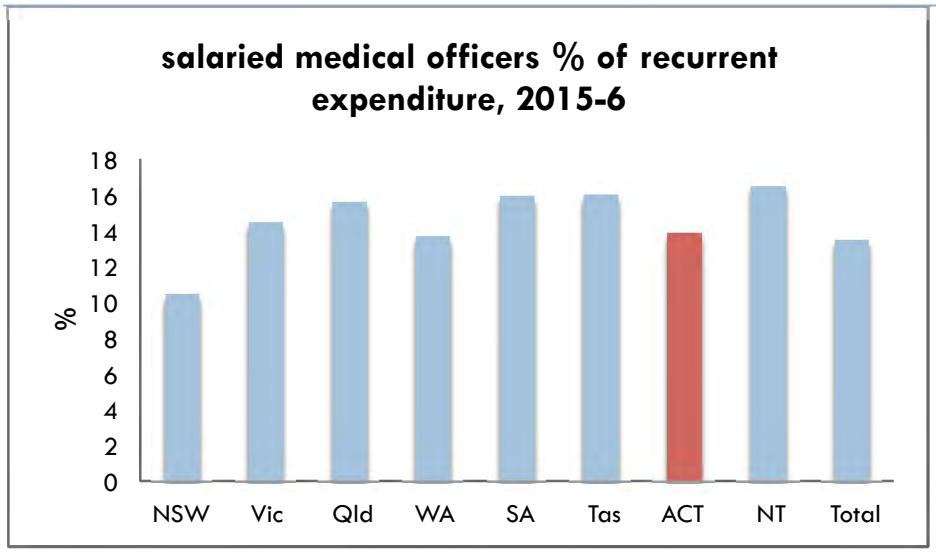
ACT spends 12% <u>below</u> the national average on proportion of nurse salaries



Salary costs are a major proportion of the health budget. The biggest clinical group by total costs is Nursing, at $300 million in 2015-6 or 19.7% of expenditure [17]. This is below the Australian average in relation to recurrent expenditure, and lower than the three most efficient jurisdictions.

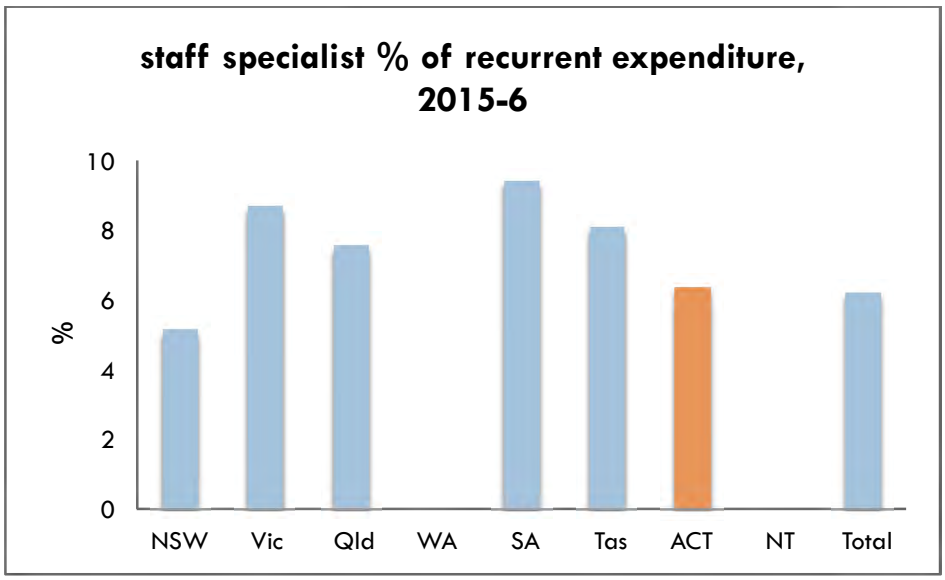
The ACT has <u>average</u> salaried MO costs

Similarly, payments for salaried medical officers (including interns, junior medical officers, registrars and senior medical officers) run at around the national average, as a percentage of expenditure.



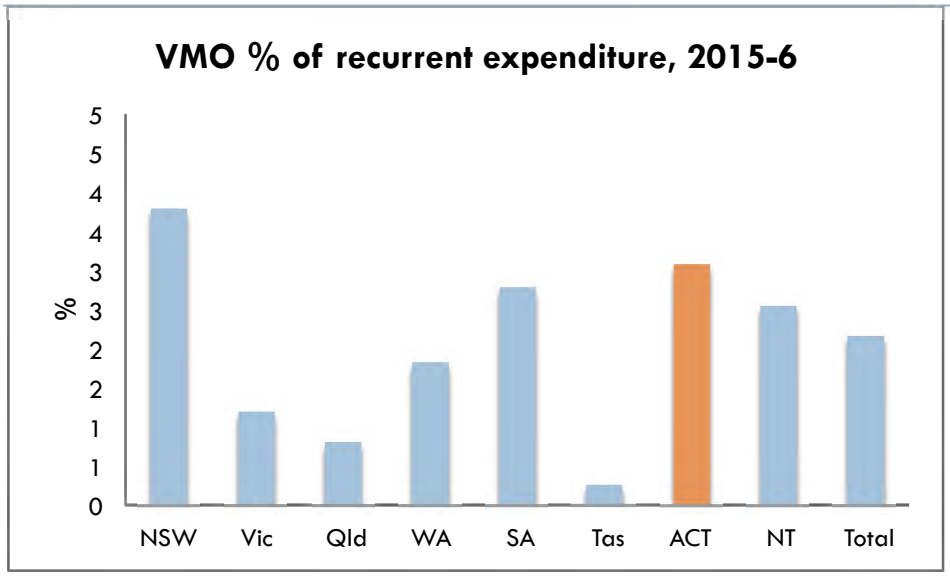
ACT has <u>average</u> salaried specialist costs

Salaried staff specialists comprise the majority of the permanent medical officer workforce in the ACT and in Australia. In the ACT, the salary costs of staff specialists are 6.3% of recurrent health expenditure, in line with the national average (no data are available for West Australia and the Northern Territory).



ACT has <u>above average</u> VMO costs

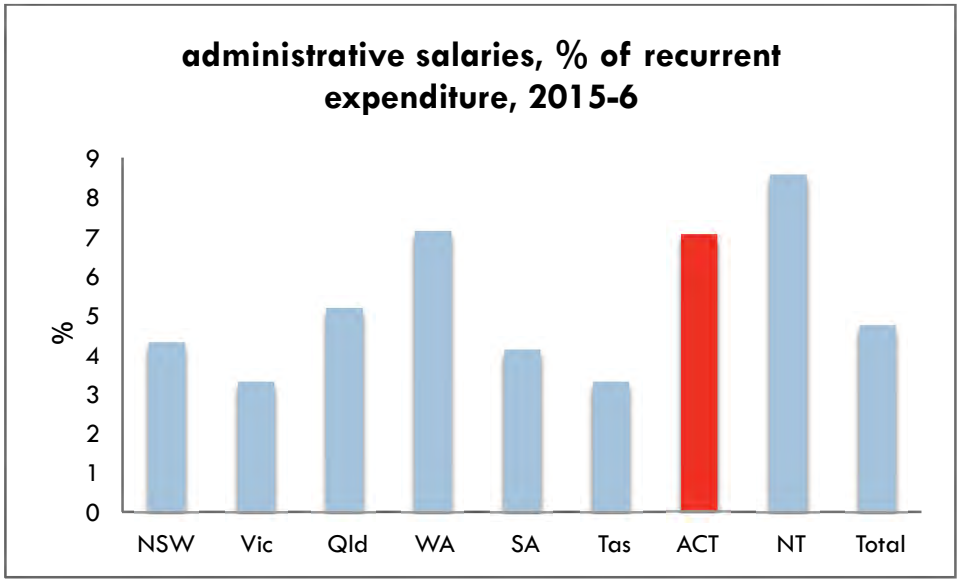
Visiting Medical Officers (VMOs) are engaged as independent contractors in the public health system while typically spending most of their working time in private practice. VMOs may participate in on-call rosters and tend to work in procedural specialties. Some have senior management responsibilities. Metropolitan hospitals typically employ specialist VMOs while rural and regional hospitals typically engage GP VMOs who may comprise the majority of medical staffing [18].

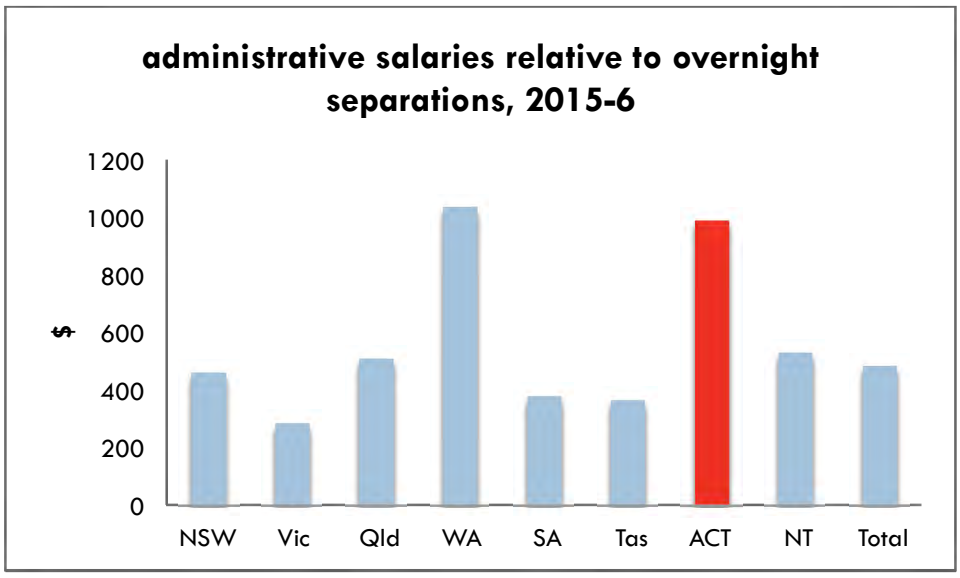


The make-up of the senior medical workforce differs widely across jurisdictions. Seen above, VMO payments in the ACT are above the national average, at 3.1% of recurrent expenditure, although ACT hospitals are exclusively metropolitan. ASMOF notes that there is no association between overall VMO payments and hospital costs by state.

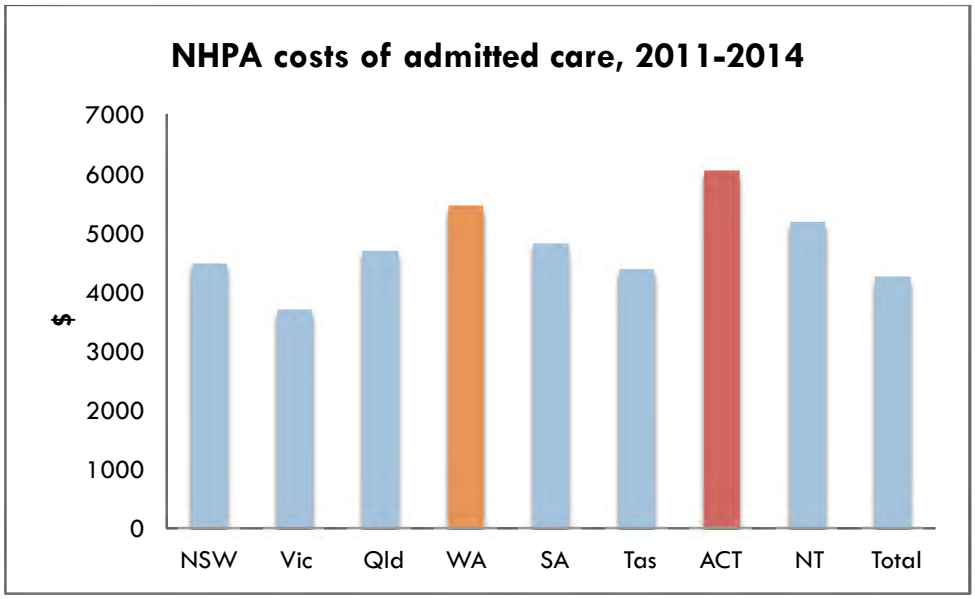
ACT spends more on hospital administrators than on staff specialists

Hospital administrator salary costs are also published in the AIHW reports [17]. They do not ordinarily include costs occurring outside the hospital network, such as in the state health offices or public health operations. ACT public hospital administrative staff salaries were $107 million in the year 2015-6.

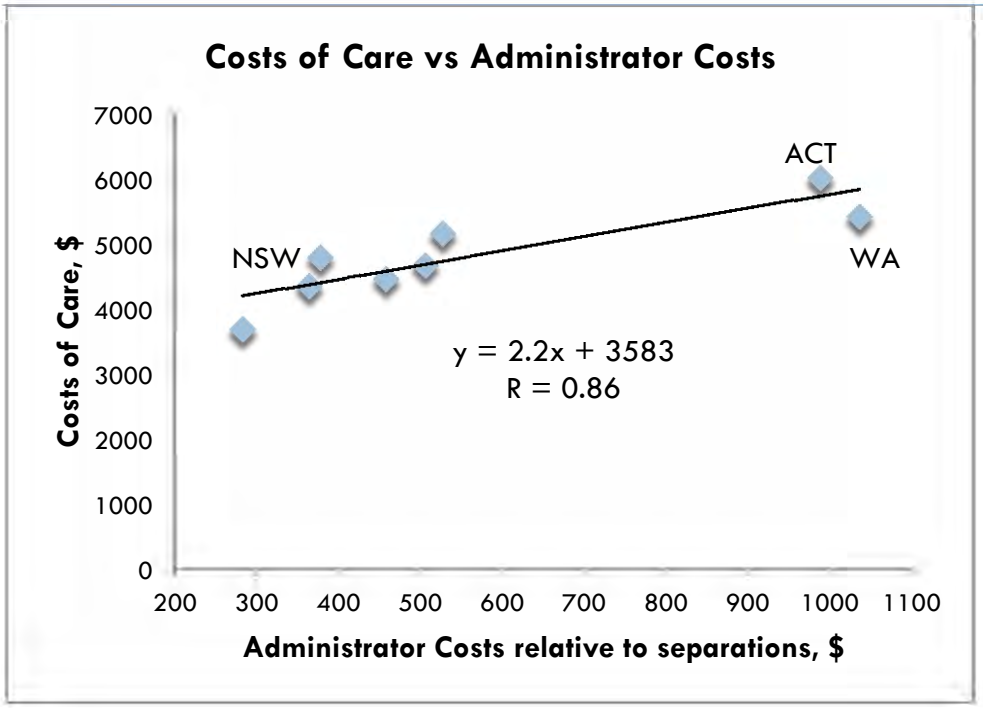




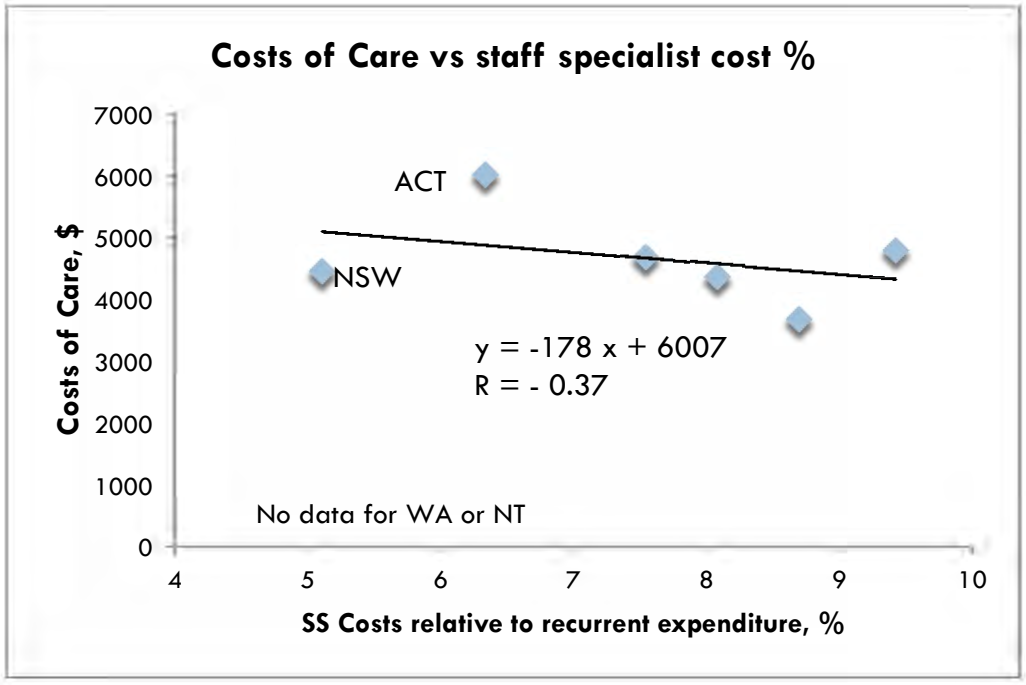
Relative to hospital activity, the ACT spends 205% of the national average on administrative salaries, at **$990 per hospital bed day**, as shown above. The states with the highest relative hospital administrative expenses (lowest administrative efficiency), WA and the ACT, also had the highest costs of hospital care for the period 2011-2015 [19], as shown in the graph below:



There is a strong positive correlation between administrative salary costs and hospital costs. As shown in the following graph, costs rise linearly with administrator salary costs:



In contrast, there is no correlation between nursing salary expenses in Australian states and overall bed costs. For staff specialists, there is a slight **negative correlation**, as shown below. This is because staff specialists are **inherently productive** under ABF while administrators inherently have **negative productivity**. These calculations use costs data for the period 2011-4 and salary data from 2015-6. On the other hand, as we have shown on page 2, ACT hospital efficiency has not improved, so our conclusions from these data are valid.



The AIHW report of 2017 notes [17]:

"At the time of publication, there were no known issues with the Australian Capital Territory data contained in this report. However, the Australian Capital Territory is undergoing a system-wide review of ACT Health data and reporting, that will be finalised 31 March 2018."

As reported in the Canberra Times, executive pay has risen 50% in 4 years [20], with further senior executive appointments announced for the second half of 2017. ASMOF submits that the increase in administrative costs with no demonstrable increase in productivity is unsustainable and is a major area to be reviewed for cost saving.

3 PROPOSED TERRITORY-WIDE HEALTH SERVICES FRAMEWORK

ACT Health is developing The Territory-Wide Health Services framework 2017 – 2027. Amongst other things, this framework promises that [21]:

"We are changing the fundamentals of how we deliver health care and health services across ACT Health"

Leaving this sort of statement aside, ASMOF-ACT sees the core of the 'framework' being service realignment, which will create sixteen 'Centres' each with an additional stratum of management. Similar 'realignments' were trialled or implemented in Western Australia [22] and South Australia [23]. While the details of these realignments may differ in the detail, themes in common with the 'Framework' are:

1. A lack of detail about exactly what is proposed;
2. An absence of a business case for the proposed changes;
3. An abundance of aspirational but meaningless statements;
4. A lack of answers to 'where will the patients go?' - with current and future service levels by specialty omitted from the proposals.

The ACT Health's Framework presents statistics selectively to give the impression of runaway demand. ASMOF-ACT reiterates that demand is both *known* and *modest*. Despite this, there are long waiting lists for elective surgery across a spectrum of services, with an overall median wait time that is the second-worst in Australia [24]. It is a fundamental of business practice that businesses need to align their services with the market. There is no evidence in the 'Framework' that this lesion has been learned.

The death of medical research performed by ACT doctors

The McKeon Review of Health Medical Research [25] recommended governments devote 3 - 4 % of their total health expenditure to medical research. If realised, this would equate to $64 million per annum in the ACT. ACT Health does not provide a dollar value for its total R & D expenditure but it is likely a small fraction of one percent.

Unlike other Australian states, the ACT Government does not operate a significant research funding scheme or any research institute. For many years the only meaningful local medical research fund has been operated by The Canberra Hospital Private Practice Trust Fund (PPF), directed by a voluntary board of staff specialists directed by Management representatives with administrative oversight. The PPF has 'filled the gap' by providing peer reviewed research grants bridging researchers unsuccessful in the

NHMRC and ARC funding rounds with grants of up to $600,000 – $800,000 over three years, as well as seed funding of up to $40,000 for staff with new research ideas.

The PPF operates from marginal revenue above the 'cap' from private practice income earned by staff specialists. These private practice earnings are derived from Medicare billings, comprising 85% of the MBS fee, minus a 20% 'facility fee' withdrawn by the ACT, and capped at a percentage of salary (typically 50% in Private Practice Scheme B and 100% in Scheme C). As salaries rise annually, and the specialist MBS rebate has been frozen since 2013, inflows from specialists to the PPF have slowed and the PPF is no longer able to fund medical research or travel for non-medical staff.

According to the Territory-Wide Health Services Framework [21],

" The ACT Government is committed to the development of a research strategy to drive research and clinical trials in the future."

Medical researchers do not want an organisational view of a research strategy *in the future*. They want infrastructure and a genuine opportunity to compete for research funding.

4 WALK IN CLINICS

The Standing Committee on Health, Ageing and Community Services has called for submissions to explore alternative programs such as nurse-led walk in clinics. ASMOF-ACT has no formal position on existing or future nurse-led walk in clinics, but we do make the following observations.

ACT Health define 'a walk-in centre as a 'non-residential facility operated by the Territory for the treatment and care for people with minor illness or injury.' An objective of the Centre was to reduce demand on the emergency department (ED) at The Canberra Hospital [26]. The first centre opened at the Canberra Hospital and has since closed. Centres are now open in Tuggeranong and Belconnen.

There is a perception, fostered by ACT Health, that too many patients attend the ED for minor problems that would be better managed elsewhere, and that these patients impair the ability of the ED to attend to more urgent patients. There is little evidence that this is the case.

The lowest acuity level for ED presentations is triage category 5, defined as patients who need to have treatment within two hours. Frequently, these patients have minor illnesses or symptoms that may have been present for more than a week, such as rashes or minor aches and pains. However, the triage category 5 is heterogeneous. There is evidence that misclassification often occurs [28].

According to NSW Health data, category 5 patients comprise 20% of patient volume, but spend a median of 1 hour in the Emergency Department, one-quarter of the time required for Category 2 and 3 patients. In addition, 5% require admission to hospital [29]. These data suggest that Category 5 patients are far from being a burden to the ED, but may absolutely need to be there.

Worldwide, existing data are that walk-in clinics do not reduce overall demand, but tend to increase it. Partially, this is because some patients attending the walk-in clinics would not otherwise have sought care at all [26]. However, the data also show that demand on the ED may not be meaningfully reduced [27], and may actually **increase** [26, 30]. Other groups have expressed alarm at the **inefficiency** of care and **overall cost** of the ACT centres [31].

Evidence from the review of ACT Health's walk in clinic was that patients were satisfied with their treatment, but not their wait times. Nurses expressed satisfaction with their professional standing and autonomy, but dissatisfaction with organisational policies [26]. A third walk in clinic will open in Gungahlin in 2018. It would seem that the ACT Government is committed to the concept.

5 ACT RESIDENTS ARE THE HEALTHIEST IN AUSTRALIA

The residents of ACT are intrinsically healthier than fellow Australians, with less risky health behaviours such as smoking and excess alcohol, less diabetes, more exercise and higher rates of health insurance. Canberrans also have higher literacy and numeracy and are the most tech-savvy. Most importantly, Canberrans have by far the highest health literacy in Australia [32]. Surprisingly, forecast health expenditure in 2017-8 budget is $1.52 billion [6], 27% of total ACT Government expenditure, and $3880 per capita. This contrasts with NSW Health expenditure of $20.6 billion or $2730 per capita. As the Pegasus report [6] states, and ASMOF-ACT concur:

"The available evidence suggests in the case of both health and education that high levels of public expenditure by the ACT Government do not necessarily equate with quality service provision."

The reward for ACT residents having by far the healthiest behaviours and by far the highest public and private investment is sagging infrastructure, middling healthcare outcomes and moribund research. While ACT health expenditure is a major contributor to the state budget deficit, the ACT Government points the finger instead at the GFC, Mr. Fluffy and Commonwealth job cuts [33].

Condition	NSW	Qld	Vic	SA	WA	TAS	NT	ACT (rank)
Diabetes, prevalence %[34]	5.2	4.6	5.1	6.0	4.4	5.4	5.7	**4.1 (8)**
% current daily smokers[35]	14.2	16.1	13.7	13.1	14.3	17.9	20.9	**12.4 (8)**
% Obesity[35]	63.2	63.6	63.3	65.8	60.3	67.5	60.3	**63.5 (4)**
% Excess alcohol[35]	17.6	18.0	15.6	16.8	20.8	18.6	19.3	**15.7 (7)**
% Meet guidelines exercise[35]	47.9	43.9	49.4	45.6	50.3	43.4	48.3	**55.5 (1)**
Total insurance coverage[36]	57.4%	49.8%	50.6%	59.5%	68.2%	51.4%	44.5%	**68.4% (1)**
Hospital only coverage[36]	47.6%	43.9%	43.9%	45.9%	58.7%	44.5%	40.9%	**57.7% (2)**
Literacy Level 3 or above	54.3	56.0	51.6	51.0	52.0	49.8	53.5	**67.2 (1)**
Numeracy Level 3 or above	48.6	50.4	48.1	45.1	51.1	46.4	48.3	**60.9 (1)**
PSTRE score 2/3	27.4	28.0	27.9	25.2	25.5	22.2	25.9	**42.0 (1)**
Health literacy≥3[26]	41.4	38.9	38.9	41.4	43.3	36.6	37.4	**56.0 (1)**

6 WHERE ARE THE DATA?

It stands to reason that tackling efficiency and cost of care would best proceed with collaboration between administrators and providers. Regrettably, ACT Health does not engage medical specialists on such essential elements as relative cost index, length of stay, or activity-based funding.

During enterprise bargaining in July 2017 ASMOF-ACT proposed that comparisons be made with bargaining on a productivity basis, with activity-based funding being compared as a relevant outcome measure of productivity. ACT Health declined this offer, stating that their own expert 'would meet with individual craft groups to detail ABF.' However this has not occurred.

To better inform our submission to The Standing Committee, ASMOF-ACT sought verification of the data presented here, and access to the compiled costs of care data that are submitted to the Commonwealth. Specifically, we sought data that would better explain why apparent costs of in-hospital care are out of range relative to other jurisdictions. The simplest hypothesis is that the ACT costs of care include a **high proportion of indirect costs compared to those jurisdictions.**

On 14 February, ACT Health denied this request [37]. We note that the decision contravenes the ACT Government's Proactive Release of Data Policy [38].

The Productivity Commission recently highlighted the missed opportunities where better uses of data could benefit the community. With respect to Health, The Commission stated [39]

"Australia's health sector exemplifies many of these opportunities, to date largely foregone, due to impediments and distrust around data use"

At ASMOF-ACT, we think we can assist ACT health to make better sense of its data.

7 ASOMF-ACT SUGGESTIONS TOWARDS SUSTAINABLE HEALTH FUNDING

1. Enhance the Business Intelligence Unit with specific briefs to examine PHI inpatient funding and to examine organizational choke points;
2. Review the organizational chart on an accounting basis to identify divisions with strongly negative productivity;
3. Commit to overall reduction in senior executive salary expenditure, particularly in areas of strongly negative productivity;
4. Curtail the outsourcing of activity and revenue-generating services such as elective surgery;
5. Curtail the practice of awarding contracts for targeted reviews by 'single select tender' to external consultancies;
6. Address the obvious bottlenecks in service delivery and capacity that underlie the elective surgery waiting list;
7. Commit to a percentage of 4% health expenditure on ACT medical research by 2020, with at least 50% of this commitment to be dedicated to competitive ACT investigator-initiated and peer-reviewed research programs;
8. Provide a comprehensive business case for the Territory Wide Services Framework;
9. Provide ASMOF-ACT with open access to costs and activity data and performance data prior to submission to the Commonwealth, and access to data analytics.

We have focused here on hospital services as the most significant health cost. Public health services, and block funded hospital services (such as mental health) are not covered in our submission but are important to our members.

ACKNOWLEDGEMENTS:

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ACT Government
Health

Dr Stephen Crook
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Dear Dr Crook

Access to data in the Business Intelligence Unit

Thank you for your letter of 25 January 2018, seeking data from ACT Health.

Unfortunately I am unable to provide you with this information, however ACT Health publishes data on a wide range of issues and these reports are readily available on our website.

Should you require further clarification, please contact Ms Janine Hammat, Janine.hammat@act.gov.au, Executive Director, People and Culture, ACT Health

Yours sincerely

Jane Murkin
Deputy Director-General
Quality, Governance and Risk

14th February 2018