Chapter 3

The impact of Commonwealth funding cuts on patient care and services

3.1 The cuts to Commonwealth Government funding for public hospitals in some states have had significant adverse effects on hospital services and patient care. The cuts have had an immediate impact in Victoria while in other states the funding cuts will take effect later this financial year.

3.2 In New South Wales, the Director General of the Department of Health, Dr Mary Foley, explained that the State Government was forced to reallocate funding from within State resources in order to cover the effect of the Commonwealth cuts:

> Senator McEWEN: Dr Foley, I want to go back to your earlier evidence. The New South Wales government was able to absorb the reduction in funding arising from the implementation of MYEFO?
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> Dr Foley: Yes, it has done that.
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> Senator McEWEN: From within the Health budget or across–
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> Dr Foley: No, it is not from within the Health budget. It is from Treasury and out of the whole of government.[1]

3.3 In Queensland, as explained in chapter two, the Commonwealth cuts will be effective in the February 2013 budgets and provided Hospitals and Health Services no more than five months to plan for and implement the budget reductions.

3.4 In the case of Victoria, the decentralised Local Hospital Network (LHN) structure resulted in the Commonwealth's funding cuts impacting hospitals sooner and more directly than other states.[2]

3.5 The Victorian Health Minister, the Hon. David Davis MLC, informed the committee that each health service was asked to work through, with its board, its clinicians and its staff, how it would manage this Commonwealth cut in its funding.[3]

3.6 The committee also heard that the Victorian governance arrangements are being used as the model for future national governance arrangements under the NHR

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1 Dr Mary Foley, Director General, Department of Health, New South Wales, *Committee Hansard*, 21 February 2013, p. 14.

2 Mr Andrew McAuliffe, Australian Health and Hospitals Association, *Committee Hansard,* 21 February 2013, p. 34; see also Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard,* 21 February 2013, p. 32.

3 The Hon. David Davis MLC, Minister for Health, Victoria, *Committee Hansard,* 21 February 2013, p. 50.

and as a result, hospitals in other states will also feel the impact of funding cuts more directly and quickly in the future, as Victorian hospitals felt today.[4]

3.7 Thus, the immediate impact of the Commonwealth cuts on the Victorian public hospital sector provided the committee with direct evidence of the effects these cuts will have on other jurisdictions over the longer term.

Direct and immediate impacts on the availability of services

3.8 The Australian Health and Hospitals Association described the impacts of Commonwealth cuts on health services:

> These impacts are both direct, in the form of bed closures, cancelled surgery, service reductions and ongoing suffering for patients; and indirect in the form of the stress of the uncertainty of access for potential clients anticipating a need to access services in the future and the flow on effects of staffing reductions on workforce and community morale.[5]

3.9 The committee received specific examples from state governments and healthcare providers:

- *Bed closures*
  - up to 559 bed closures (both rural and metropolitan) announced in Victoria since the Commonwealth funding adjustment;[6]
  - 50 bed closures in Catholic Health Australia hospitals; [7]
- *Elective surgery*
  - reduction in elective surgery in Victoria (800 cases at Austin Health, 1800 cases at Southern Health, 1300 at Western Health, and a 25 per cent reduction at Southwest Healthcare Warrnambool);[8]
  - the Victorian Healthcare Association estimated that the worst case scenario for Victoria is that waiting lists to rise as high as 65,000, far higher than those prescribed by the Commonwealth under the National Elective Surgery Target;[9]

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4 Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard,* 21 February 2013, p. 34.

5 Australian Healthcare and Hospitals Association, *Submission 15,* p. 2.

6 Australian Nursing Federation (Victorian Branch), *Submission 5,* p. 4; see also Australian Medical Association (Victoria) Limited, *Submission 11,* p. 1; Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard,* 21 February 2013, p. 30.

7 Catholic Health Australia, *Submission 21,* p. 3.

8 Australian Nursing Federation (Victorian Branch), *Submission 5,* p. 5.

9 Victorian Healthcare Association, *Submission 20,* p. 2.

- reduction in elective surgery in Queensland;[10]

- *Reduction in services*
    - proposed closure of inpatient services in Moura, Central Queensland;[11]
    - closure of Colac Area Health Urgent Care between 10 pm and 7 am;[12]
    - since December substantial cuts to health services in Victoria include extensions of existing theatre closures, additional theatre closures, and impacts on community in-patient and outpatient mental health services.[13]

3.10 Reduction in staffing levels was a primary concern raised by witnesses with Catholic Health Australia reporting that the Commonwealth cuts would lead to staff level cuts in its hospitals.[14] Catholic Health Australia and other witnesses also pointed to uncertainty of employment for staff as a major factor following the funding cuts:

> Then there are the health professionals within our organisation—their employment arrangements becoming uncertain. That uncertainty exists today. There will be staff arriving in our hospitals today who yesterday thought cuts were coming; today they will be somewhat relieved that cuts are not coming, but then they will realise that in just a few months those cuts will need to be dealt with. This is an uncertain time for healthcare planning and administration. It is not the way in which, ideally, you would be managing your health services.[15]

3.11 Across all health services, the way in which the cuts were imposed midway through the financial year, and the consequent difficulties of incorporating those cuts in already established budgets and plans for services, was raised as a significant concern.[16]

3.12 The Queensland Minister for Health, The Hon. Lawrence Springborg, described the impact as 'brutal' and 'dramatic' because adjusting for something

10 The Hon. Lawrence Springborg MP, Minster for Health, Queensland, *Committee Hansard,* 21 February 2013, p. 23.

11 Central Queensland Rural Division of General Practice Assn. Inc., *Submission 6*, p. 1.

12 Colac Area Health, *Submission 12,* p. 4.

13 Mr Paul Gilbert, Australian Nursing Federation (Victorian Branch), *Committee Hansard,* 21 February 2013, p. 6.

14 Catholic Health Australia, *Submission 21,* p. 2.

15 Mr Martin Laverty, Catholic Health Australia, *Committee Hansard,* 21 February 2013, p. 19.

16 Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard,* 21 February 2013, p. 31; Professor Stephen Duckett, *Committee Hansard,* 21 February 2013, p. 4; Services for Australian Rural and Remote Allied Health, *Submission 7,* p. 3.

midway through the financial year with such a retrospective impact is 'very difficult to do'.[17]

Impacts on rural hospitals

3.13 Evidence received by the committee suggested that funding cuts could have more severe impacts on smaller rural hospitals than on larger metropolitan hospitals as smaller rural and regional hospitals have less capacity to absorb these changes in funding.[18] The impact on rural communities will be severe with the Central Queensland Rural Division of General Practice Association commenting:

> The proposed changes will mean people living in rural and remote communities have no access to overnight hospital admissions, ante-natal or post natal care, palliative care, and aged care. Surgical and obstetrics services have previously been removed from these communities, although they have been available in the past. Communities are being told it is the Commonwealth Health reform and shortfalls in Commonwealth funding that are driving the changes in hospital services.[19]

3.14 The Rural Doctors Association of Queensland (RDAQ) stated that the Queensland Treasury has contacted hospital boards advising them of the reduced budgets ($16 million for Central Queensland) as a result of the Commonwealth funding cuts. The RDAQ provided the committee examples of the specific service closures and reductions:

- Service closures and reductions in rural Queensland include outreach clinics and programs which have been assessed as non-core business including women's health clinics, frequency of visiting specialist clinics, reduction in acute bed numbers and in some areas potential closure of whole hospitals. A full review of services with stated threats to overnight admission capacity is under way at a number of sites in Central Queensland and Wide Bay regions.
- There has been a workforce wide call for voluntary redundancies which has resulted in a reduction in the medical, nursing and allied health workforce in rural areas.
- Palliative care services have seen significant reductions in rural Central Queensland.

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17 The Hon. Lawrence Springborg MP, Minster for Health, Queensland, *Committee Hansard,* 21 February 2013, p. 23.

18 Services for Australian Rural and Remote Allied Health, *Submission 7,* p. 3; Rural Doctors Association of NSW Inc., *Submission 9,* p. 1; Colac Area Health, *Submission 12,* p. 8; Rural Doctors Association of Australia, *Submission 18,* p. 1.

19 Central Queensland Rural Division of General Practice Assn Inc., *Submission 6*, p. 2.

- Chronic disease units have been significantly reduced in Mackay and Central Queensland.
- Children's health services have seen significant reduction with about 100 nursing positions abolished state wide. This includes services provided to rural and regional Queensland o Central Queensland has witnessed reduced specialised clinics including childhood immunisation and wound care.[20]

3.15 Witnesses also suggested to the committee that under the reformed funding environment, there are incentives for health and hospital boards to divert activity from smaller rural hospitals to larger metropolitan centres.[21]

Indirect effects in the health system

3.16 During the inquiry the committee received evidence that, in addition to the direct impacts on patients set out above, there were a range of indirect and flow-on impacts across the whole health system as a result of the Commonwealth funding cuts. These included the need for long-term service plans to be reviewed, staff leaving because they are fearful of losing their jobs, skill loss, increased costs of restarting programs, patient churn to alternative service such as emergency departments, and increased costs arising from untreated patients re-presenting with more serious conditions.

3.17 Witnesses commented that implementing the Commonwealth cuts has led to increased pressure on other parts of the hospital system, such as emergency departments:

> When you have people waiting longer for surgery, things go wrong and you get more emergency department presentations. Hospitals were operating substantially fewer beds last year than they were the year before. Consequently, it is difficult to have patients come in to an emergency departments who require admission and there is no bed for them. That obviously impacts on things. In order to create bed space, people are being discharged earlier than they would prefer and not necessarily with the support that they need.[22]

3.18 In addition, it was suggested to the committee that there may be incentives for public hospitals to treat more private patients to bolster their budgets. Catholic Health Australia commented that the 'targeting of additional private patients by public hospitals, particularly if it is at the expense of the treatment of public patients, will

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20 Rural Doctors Association of Queensland, *Submission 16,* p. 2.

21 Dr Ewen McPhee, *Submission 1,* p. 2; Central Queensland Rural Division of General Practice Assn. Inc., *Submission 6*, p. 1.

22 Mr Paul Gilbert, Australian Nursing Federation (Victorian Branch), *Committee Hansard,* 21 February 2013, p. 8.

further exacerbate public patient waiting times and further undermine the Medicare principle of universal access to treatment at the time of need, regardless of financial circumstance'.[23]

Palliative and sub-acute care

3.19 Evidence was received by the committee relating to palliative and sub-acute care and the impact on services arising from both the current funding cuts and transition arrangements for the NHRA.

Impact of funding cuts on palliative care

3.20 Submitters argued that palliative care would be hard hit by the Commonwealth's funding cuts. The Health Services Association of New South Wales for example, stated that one large regional hospital expects to have a shortfall of $790,000 in palliative care funding. This shortfall will mean patients and their families will be denied important and valuable medical services at an extremely critical time.

3.21 Flow-on effects of the Commonwealth's cuts and the impact on palliative care were also explored. Patients will either die in acute care beds, meaning other non-palliative care patients needing these acute care beds will be denied access to them, or, the palliative care patient will die at home where their family without any medical support will be forced to care for them.[24]

3.22 Palliative Care Australia stated that many service providers are ceasing services immediately, or ceasing to admit new persons into their service. They commented that this rationing of services will mean patients will not be able to access the palliative care services they need and assessed as requiring. It will also significantly compromise the palliative care workforce.[25]

Funding gap for palliative and other sub-acute services

3.23 As well as experiencing Commonwealth funding cuts arising from December 2012, submitters pointed to the impact of the withdrawal of funding when the National Partnership Agreement on the Health and Hospitals Workforce (NPA) ceases in 2013. Under the NPA the Commonwealth provided additional funding for the implementation of a national system of activity based funding, improving the efficiency of Emergency Departments and approximately $500 million in funding for sub-acute services. This NPA includes palliative care services.

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23 Catholic Health Australia, *Submission 21,* p. 2.

24 Health Service Association of NSW, *Submission 4,* p. 1.

25 Palliative Care Australia, *Submission 24,* p. 3.

3.24 The NSW Government commented that the NPAs have provided critical funding for important health services which are core to national health service reforms.[26] Hammondcare Health and Hospitals pointed to the benefits of the additional funding:

> This NPA is highly significant because it was arguably the first real injection of new funds into the rehabilitation and palliative care sectors for decades, and allowed the opportunity to develop and implement many new and 'best practice' models of care delivery. The NPA rightly focussed on subacute care because of emerging evidence that an efficient subacute care sector was vital to the health of the acute healthcare sector, especially in terms of patient flow from acute care into subacute and community care, but also for best patient outcomes for people with life-limiting or complex illnesses, and ongoing disability.[27]

3.25 However, the NPA will cease on 30 June 2013 and submitters raised concerns about the transition from the NPA to the Activity Based Funding (ABF) model for funding for palliative care. Catholic Health Australia, which provides a large proportion – approximately half – of the nation's palliative care services, stated that there were questions about the transition to ABF and continuation of funding:

> At present the transitional arrangements to activity based funding commence in 2014–15 leave some questions about the transition from the existing national partnership agreement to the activity based funding arrangements when they commence. At risk in the coming financial year: in the state of New South Wales, 54 full-time equivalent positions in palliative care, employed state-wide, some of which are employed within Catholic facilities; in South Australia, some 30 full-time equivalent positions involved in palliative care, employed state-wide, some of which are employed in Catholic organisations. With the contracts about to end 30 June we are already starting to see within our services individual health professional choosing to leave employment because of the uncertainty about their ongoing contracts.[28]

3.26 Hammondcare Health and Hospitals stated that the transition is already causing problems for the effective delivery of rehabilitation services:

> Many of these new services will cease from July 1st 2013. Hospital administrations are already reducing the scope and caseload of these services, as staff members begin to leave seeking alternative employment.
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> These rehabilitation services will cease not only because of a lack of ongoing funding, but also because many of the new models of care do not conform to "standard" hospital-based rehabilitation care, and so are not

26 NSW Health, *Submission 53,* p. 8.

27 Hammondcare Health and Hospitals, *Submission 23,* p. 1.

28 Mr Martin Laverty, Catholic Health Australia, *Committee Hansard,* 21 February 2013, p. 18.

> accommodated within the Activity-Based Funding models of rehabilitation care being applied across the country.[29]

3.27 Palliative Care Australia noted the impact of changes to funding on staffing retention with many staff in palliative care services looking at options to guarantee their future. This may result in a loss of many staff to overseas services or to staff leaving palliative care altogether. Palliative Care Australia provided further examples of the impact:

> The impact of such closures will be catastrophic nationally. For example:
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> - In New South Wales, it is estimated that at least 53.95 full time equivalent (FTE) positions will cease on 30 June 2013.
> - In South Australia, indications are that in excess of 30 FTE positions will cease on 30 June 2013.[30]

3.28 Palliative Care Australia also pointed to flow-on impacts including cuts to clinics and education programs conducted with universities planned for 2013–14, compromising training of future palliative care professionals; cessation of rapid response to get patients home or to support them to stay at home, resulting in significant increases in hospitalisations; longer hospitalisations for palliative patients; reduction of social work services which support both patients and their families and carers; and unavailability of other services, such as pharmacists for example, to assist with education and support for nurses and doctors. In addition, palliative care research and trials will be at risk.[31]

3.29 The NSW Government stated that not only would community and hospital based palliative care be effected but also funding for rehabilitation services; funding to older people to leave hospital earlier – freeing up acute care beds; 69 short stay (<48 hour) Medical Assessment Unit beds treating around 17,000 patients per year; 8,300 Hospital in the Home packages and the contribution to salaries for Emergency Physicians.[32]

3.30 The NSW Government also commented that the states had unsuccessfully sought information from the Commonwealth, including through COAG, on how the services provided under the NPA would continue.[33]

3.31 In their joint submission the Treasury and Department of Health and Ageing described the NPA funding which started in 2008–09 as 'one off' funding.[34]

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29 Hammondcare Health and Hospitals, *Submission 23,* p. 1.

30 Palliative Care Australia, *Submission 24,* p. 4.

31 Palliative Care Australia, *Submission 24,* p. 6.

32 NSW Government, *Submission 53,* p. 11.

33 NSW Government, *Submission 53,* p. 11.

Committee comment

3.32 The evidence provided to the committee demonstrates the significant impacts of the Commonwealth funding cuts on public hospitals and the availability of hospital and health services. Any funding cuts of this scale would have a substantial impact, however the timing of the cuts, midway through a financial year, has exacerbated the outcome. Hospitals have had to make immediate and deep cuts in order to work within the reduced budgets over the last seven months of the current financial year.

3.33 The evidence also points to indirect effects of the cuts such as disrupted planning, problems with staff retention, loss of skills, patient churn to alternative services, such as emergency departments, and increased costs arising from untreated patients re-presenting with more serious conditions.

3.34 The committee flags some concern regarding the evidence that it has received about the potentially greater impact of the funding cuts on rural hospitals and the potential incentives to move services away from rural hospitals under the Activity Based Funding model. Due to the very short timeframe of this inquiry, the committee has not been able to investigate these matters in sufficient detail to draw any concrete conclusions. However, they do appear to be issues worthy of some attention and the committee invites the government to provide further information on those issues in its response to this inquiry.

3.35 The committee is also concerned about the uncertainty faced by the palliative and sub-acute care community working under the NPA. As witnesses have indicated to the committee a significant capacity to deliver services has been developed and is delivering services. It would be detrimental to patients if that capacity were to be lost completely or to substantially wither during a period of funding uncertainty.

3.36 While the Commonwealth Government may consider that it has made its position clear by stating that aspects of the NPA were 'one off', the evidence received by the committee demonstrates that both state governments and others in the sub-acute community do not appear to have sufficient information regarding the transitional arrangements.

3.37 The committee considers that the Commonwealth must make clear to providers the funding arrangements during the transition period to ensure that these critically needed services continue to be available to those who require them.

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34 Department of Health and Ageing and Treasury; *Submission 55,* p. 22.