



## **Pre-Budget Submission to Treasury 2015-16**

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# Australian Healthcare & Hospitals Association

## Pre-Budget Submission 2015-16

### INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission in advance of the 2015-16 Australian Government Budget.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Medicare Locals and primary healthcare providers, aged care providers, universities, and individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

Much of the recent focus for health policy discourse in Australia has been on economics and funding, and the importance of building sustainability into the Australian healthcare system. The economics of healthcare and a healthy population contributing to the economy underpinned the establishment of Medicare over 30 years ago, and it is timely that the Australian community should refocus on ensuring Medicare retains the capacity to support accessible universal healthcare for all Australians into the future.

While the AHHA agrees that it is incumbent on the Government to ensure that tax payers are getting value out of the money invested into healthcare, it is also essential that reform of the health system is evidence-based, developed in consultation with consumers, clinicians and service representatives, considers the implications and impacts across the whole health system and is implemented and evaluated through a structured and considered approach. While the AHHA recognises the Government's commitment to fiscal repair, it is also imperative that short-term measures do not have long reaching adverse consequences for the health of Australians. It is vital that health policy not be merely viewed through the prism of budgetary cycles.

AHHA is also supportive of the Government's determination to set long term goals and policies for health care financing and would encourage this approach to development of all health policies. The pending release of the fourth Intergenerational Report will once again highlight the importance of maintaining a steadfast commitment to investment in health in the present, informed by evidence to contribute to sustainable long-term health and fiscal outcomes.

The Government's recent approach to health funding reform has been to propose cuts to expenditure and the establishment of price signals by shifting costs to patients and clinicians. This approach has been driven by the perception that health funding is out of control and unsustainable.

Despite these claims, Australia's health expenditure as a proportion of GDP is close to the OECD average. In 2012-13, funding on health by the Commonwealth Government declined by 2.4% in real terms, with the Commonwealth Government's share of total government spending on health falling by 1.0 per cent over the year<sup>1</sup>.

While health expenditure has increased as a proportion of total government tax revenue, this is a reflection of reduced tax revenue as much as increased expenditure. The AHHA maintains that concerns over the level of health expenditure must not be viewed in the context of cyclical variations in the economy. Just as the Government asks the Australian public to accept their fiscal strategy over

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<sup>1</sup> AIHW 2014. Health expenditure Australia 2012-13. Health and welfare expenditure series no. 52. Cat. no. HWE 61. Canberra: AIHW.

the long term, so too must the Australian health system be funded with a view to the long term benefits of a well-functioning and funded healthcare system.

The recommended budget measures and policy directions that we present below do not seek new or additional funding, but rather to more sensibly target and organise the existing health infrastructure Australia already has in place. It is in this context that the AHHA provides its budget submission which focusses on the identification of measures to support the sustainability of Medicare and the broader health system in Australia through mechanisms that focus on patient equity, system efficiency and quality of patient care.

## Choosing Wisely in Australia

The Choosing Wisely campaign was launched in the US in 2012 to encourage physicians and patients to work together in making better health care choices. The US has estimated the top 5 overused clinical activities in just three primary care specialities (paediatrics, internal medicine and family medicine) cost the health sector well in excess of \$US5 billion<sup>2</sup>. In Australia this program holds potential to lower expenses through the MBS and offer considerable savings to the health system. The Choosing Wisely campaign will encourage a much needed 'fundamental shift of medical practice to maximising high-value care'<sup>3</sup>. The AHHA notes that the Department of Health has also identified the potential of a Choosing Wisely approach to minimise no- and low-value interventions<sup>4</sup> and that the Productivity Commission has also favourably cited this approach to improving productivity within the health sector<sup>5</sup>. Key components of this program are:

- Medical colleges and professional associations lead the identification of low-value or no-value investigations and treatments to free up resources for the provision of more effective and timely care for those who will benefit most;
- The program encourages clinicians to identify care options that are based on comparative cost-effectiveness, which would better support health professionals to make a care choice based on the 'less is more' principle, maintaining delivery of high quality care but in a cost-effective way; and
- Patients benefit by avoiding unnecessary tests and interventions with the associated costs, inconvenience, loss of time and productivity (note that this work has already commenced in Australia, led by NPS Medicine Wise in collaboration with professional colleges and others).

NPS Medicine Wise is funded by the Commonwealth Government through the Department of Health, and should be encouraged to continue applying its resources to the roll-out of Choosing Wisely in 2015. Support by the Federal Government for the program will add significant impetus for action and will complement the Minister for Health's stated intent to engage clinicians in policy and reform discussions. The Government would also be seen to be providing support and coordination for an evidence-based efficiency and quality improvement program, while the main responsibility for implementation and success rests with clinicians.

## Medical Services Advisory Committee Reviews

Choosing Wisely would efficiently inform the next stage of the Medical Services Advisory Committee (MSAC) reviews of existing MBS item numbers. While the AHHA acknowledges the work that this Committee has completed to date, we also note that:

- The vast majority of the items on the MBS schedule have not been formally assessed against contemporary evidence of safety, effectiveness and cost-effectiveness;

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<sup>2</sup> Minal KS, Bishop T, Federman A & Keyhani S: "Top 5" Lists Top \$5 Billion, JAMA Internal Medicine 2011 Vol 171, No. 20.

<sup>3</sup> Scott, I: Ten clinician-driven strategies for maximising value of Australian health care, Australian Health Review 2014, 38.

<sup>4</sup> Department of Health FOI Request 100-1415, Document 8 (accessed 5 February 2015).

<sup>5</sup> Productivity Commission 2013, An Ageing Australia: Preparing for the Future, Commission Research Paper, Canberra.

- This program needs be re-orientated and streamlined to make more speedy determinations on higher cost MBS items where there is an existing level of awareness of the lack of effectiveness of the treatment; and
- The next stage of MBS reviews could logically and efficiently be informed by those treatments, procedures and tests identified through the Choosing Wisely program.

An ongoing review of MBS items would serve to keep Medicare modern, responsive and providing value for the tax payer without compromising patients' health. Where clinicians agree on a list of low value and ineffective items, there seems minimal justification for public funds to be used through Medicare rebates to support them in practice. Linking the MBS review program to a Commonwealth supported Choosing Wisely campaign would create efficiencies through the common evidentiary review processes, as well as through the disinvestment decisions that would be mutually agreed across Government and clinicians.

## Pharmaceuticals and Pharmacy

Reviewing existing PBS products for their continued appropriateness and efficient cost is equally necessary as research and development in pharmaceutical 'technology' continues to advance. The PBS program needs to reflect developments in the pharmaceutical sector, while at the same time providing value for money on the investment of health dollars being provided. There are opportunities to implement a range of measures to achieve efficiency within the program without impacting on quality of care for patients including:

- Ensuring negotiations on the next Community Pharmacy Agreement (CPA6) aim at ensuring value for money from the significant investment under the CPA, currently around \$15 billion per annum;
- Using the negotiating power of the Commonwealth more effectively to purchase pharmaceuticals at more competitive prices. For example, it has been shown that Western Australia and one other Australian state here able to purchase pharmaceuticals at prices above which the PBS paid an estimated additional \$750 million<sup>6</sup>;
- Reducing inefficient and unnecessary prescribing and dispensing which may lead to gains such as a reduction in anti-microbial resistance and a greater use and acceptability of generic medications by consumers;
- Ensuring that pharmacists are fully utilised, within the constraints of their professional expertise, as providers of community health services; and
- Pursuing further efficiencies through the continuation of price disclosure mechanisms.

## Rationalisation of Unnecessary GP Visits - Referrals and Medical Certificates

There are opportunities to achieve MBS savings through reduction of unnecessary GP presentations, for example through encouraging employers to require medical certificates for sick leave only where there is prolonged use of leave, reducing the requirement for GP referrals to specialists in circumstances such as repeat annual visits and continued case management, and where a referral could be made for defined conditions by allied health professionals such as physiotherapists. Similarly, it should not always be necessary to see a GP where the patient only needs to have a prescription renewed for an ongoing and well-maintained condition. Scope of practice changes could also be made to allow allied health professionals such as physiotherapists to refer a patient directly to a specialist in defined circumstances in place of requiring them to first consult a GP.

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<sup>6</sup> Duckett, S.J. with Breadon, P., Ginnivan, L. and Venkataraman, P., 2013, Australia's bad drug deal: high pharmaceutical prices, Grattan Institute, Melbourne.

## End of Life Planning

Australia needs to formally imbed planning for end of life care needs and intentions into both health and aged care practices. For example, each resident assessed for entering a residential aged care facility should have a care plan prepared as part of their entry requirements. Regardless of an individual's age or health status, this care plan should then be reviewed on a regular basis to reflect the changing needs and wishes of the resident. Benefits and considerations from improved end of life planning include:

- Reduced hospitalisations, a reduction in unnecessary and expensive life prolonging care, and avoidance of unnecessary medications and surgeries.
- End of life planning would benefit from continued research into new strategies to improve this area of care, create new interventions for management of pain and other symptoms, and to develop appropriate health technologies that better support high quality end of life care that is both aligned with the desires of the patient and enables all members of the health and care team to provide the right care.
- An MBS item could be established that supports the central involvement of GPs in end of life planning. This plan could be linked into a patient's ehealth record which would support care being provided that aligns to the wishes and needs of the patient, regardless of what part of the health system they access. Such an MBS item could form part of a set of linked items on chronic disease management and integrated care.
- Requirements for end of life planning should be included in relevant aged care and national health accreditation and quality standards.

Better end of life planning has the potential to improve patient outcomes while also providing savings to the health system. With an ageing population, this proposal is a sensible approach towards the dignified treatment of elderly Australians and for the health and aged care systems.

## Hospital in the Home

The Commonwealth should support the States and Territories to implement and fund a range of Hospital in the Home (HITH) or community based acute and sub-acute care programs by removing current perverse funding disincentives. HITH programs contribute savings to the health system in a number of ways including:

- Providing care in a lower cost setting;
- Avoiding treatment costs that may otherwise be incurred in an in-patient setting, such as for hospital acquired infections;
- Avoiding patient transfer, delayed discharge and emergency department presentations;
- Delaying entry into residential aged care facilities through provision of care in the home and support to age at home;
- Reducing surgery wait times; and
- Financial savings to both patients and their carers.

A number of studies have established the cost savings associated with HITH programs:

- In 2011, the Hospital in the Home Society commissioned Deloitte Access Economics to investigate the effectiveness of HITH care relative to hospital in-patient care. This investigation looked at six common causes of hospitalisation and on average HITH was shown to cost 22 per cent less than hospital care per separation.
- In 2011 Price Waterhouse Coopers was commissioned to quantify the savings attributable to HITH programs offered by just one provider and concluded that a conservative estimate would be between \$232.5- \$291.9 million over 20 years in 2011 value terms.

- A systematic review of the costs of home dialysis versus hospital dialysis for end stage renal failure in the US showed that, despite initially higher set up costs, home dialysis is overwhelmingly lower in total cost than hospital and satellite treatment<sup>7</sup>.
- In Australia, it has been estimated that increasing the use of home dialysis over ten years could result in savings of between \$378 and \$430 million<sup>8</sup>.
- The Productivity Commission has recently suggested that in the long run a 5 per cent improvement in health sector productivity could be associated with reducing the projected fiscal deficit by 0.5 per cent of GDP<sup>9</sup>.

Other considerations with HITH programs include:

- A range of qualitative values including higher staff morale through reduced stress and patient numbers, and greater satisfaction for patients and carers who receive care at home through better access to health care staff and increased levels of information.
- Circumstances where care at home may be the only feasible option such as with people who live in rural and remote areas. For example, the provision of home dialysis or home chemotherapy treatment would enable these patients to stay at home, thereby avoiding the need to travel and enable family members to provide care and support.
- When looking at a long term funding policy for hospital and out-patient services, such policies need to reflect on programs like HITH as a way of reducing costs and burden to the health system and improving qualitative outcomes for patients and carers. Any disincentives to developing and expanding these programs therefore need to be removed. Hospitals and health services running programs such as HITH should not be disadvantaged for managing care in this way.
- HITH programs could be further supported by the Commonwealth through expansion of nationally consistent telehealth and ehealth initiatives further contributing to efficiencies in providing care in low cost environments.
- Proposals to address the challenge of end of life planning discussion by switching from potentially negative terminology of 'do not resuscitate' to the more neutral 'allow natural death' should also be considered. Requirements for end of life planning should also be included in relevant aged care and national health accreditation and quality standards.

## Oral Health

Oral conditions are the second most expensive disease group to treat in Australia. Unlike other health services, the cost of oral health largely falls on the individual. In 2011-2012 individuals were responsible for 57 per cent of the total cost of dental care compared to only 12 per cent of the cost of all other health services.

The previous Labor Government introduced a series of oral health reforms and programs. In its 2013 election health policy, the Coalition was critical of the delayed commencement of aspects these programs highlighting the impact on access for "hundreds of thousands of Australians, 80 per cent of whom are concession card holders".

Despite committing to "honour the arrangements under the National Partnership Agreement for Adult Public Dental Services" prior to the 2013 election, this NPA was deferred by 12 months in the May 2014 Budget. There has been little indication to date of any preparatory discussion with stakeholders in preparation for implementation of the NPA and further delay or cancellation of the NPA will result

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<sup>7</sup> Mowatt, G et al. Systematic review of the effectiveness and cost-effectiveness, and economic evaluation, of home versus hospital or satellite unit haemodialysis for people with end-stage renal failure, *Health Technology Assess* 2003;7(2)

<sup>8</sup> Medical Technology Association of Australia, accessed online 27/01/15: <http://www.mtaa.org.au/about-the-industry/value-of-technology/home-dialysis/cost-effectiveness>.

<sup>9</sup> Productivity Commission 2013, *An Ageing Australia: Preparing for the Future*, Commission Research Paper, Canberra.

in reduced access for the hundreds of thousands of Australian the Government sought to defend prior to the election.

Oral disease is predominantly preventable and the previous Government supported the development of a National Oral Health Promotion Plan. Despite being received in mid-2013, this plan is yet to be publicly released and the implementation funding was cut in the 2014-15 MYEFO.

In addition to confirming its commitment to the allocation of full funding for the National Partnership Agreement for Adult Public Dental Services from 1 July 2015, the AHHA calls on the Government to use the Budget to recommit to the allocation of funding to support the implementation of the National Oral Health Promotion Plan, and to ensure continuation of the Child Dental Benefits Schedule beyond 30 June 2015.

## Commonwealth Leadership on System Integration

The AHHA acknowledges the Commonwealth Government's continued support for the national implementation of ehealth tools and resources as holding immense potential to support high quality and consistent care, as well as supporting a number of efficiencies and reduction of waste.

The benefit and value of the use of standardised use of electronic health records are well documented: better information sharing and communication between healthcare providers and between patient and provider; reduced duplication or over-servicing; more efficient and more appropriate treatment; responds to needs of both clinicians and consumers by being portable and transferrable. Electronic health resources also stand to better support prescribing and referrals for tests and other procedures and would align with other efforts to reduce inappropriate or unnecessary testing and medication prescription.

Greater use and entrenchment of personal electronic health records would:

- Further integrate and support appropriate care regardless of the point of access in the system.
- Provide a greater focus on a digital healthcare system would also support better performance reporting
- Enhance the capability to allow for performance reporting in real time and across a community through linked data collected and analysis to support quality service provision, achievement of health outcomes and responsiveness in delivery programs and services that meet identified needs.
- Allow for information sharing across health services, both public and private, enabling governments and other funders to identify better utilisation of resources for health.

The establishment of Primary Health Networks provides the opportunity for strong Commonwealth leadership to establish primary health care as the cornerstone of a responsive and strong health system. It is vitally important that Primary Health Networks are provided with adequate long-term funding and supports to establish themselves and adapt to the needs of their communities.

Insufficient and uncoordinated primary care services inevitably lead to increased demand on acute hospitals through outpatient clinics, emergency departments and hospital admissions. Funding arrangements should reflect the nature of community needs and should allow for facilitating the right care in the most appropriate environment and supporting unnecessary hospital admissions and presentations.

## Prevention

While investing in preventive health measures generates a short term cost, it will also create savings in reduced health care costs down the track. With the soon to be released fourth Intergenerational Report set to highlight the pressure that health costs will place on the Commonwealth budget, it is

vital that preventive health strategies be encouraged to lessen the individual, intergenerational and health system burden which will otherwise emerge in the future.

Through participation in the WHO, Australia has committed to reducing premature mortality from the four major non-communicable diseases by 2025. These include cardiovascular disease, cancer, chronic lung diseases and diabetes.

Hospital services accounts for around 40 per cent of health expenditure in Australia. Investment in effective prevention efforts and primary health care programs aimed at addressing these four disease groups will support reduction in hospitalisations, leading to lower hospital expenditure.

Health policy today will have a tangible impact on the problems faced by the health system in the future. Investing in preventive health measures is a low cost way of reducing this future fiscal pressure while also improving the wellbeing of all Australians.

## **Other Opportunities for Efficiency through Commonwealth Leadership**

Better utilisation of the health workforce, and appropriate support for upskilling and training will ensure Australia's future workforce is capable and flexible, and that the whole health professional sector is being used to the full potential of their capability. Full utilisation of skill and capability will ensure that health costs for services and interventions can be pushed to the lowest cost of health provider for delivery. An initiative supporting skill diversification and maximisation would also serve to deliver quality and timely care in areas of workforce insufficiency.

The commitment to overcoming the inequitable health outcomes for Aboriginal and Torres Strait Islander peoples must also be maintained. Support for programs that encourage effective collaboration between Aboriginal community-controlled services and mainstream services and which develop the capacity and resilience of individuals and communities should be a priority. There is a particular opportunity through the establishment of Primary Health Networks to entrench better connectedness with non-Indigenous health services at the primary level, but also better planning for the healthcare needs and challenges facing Aboriginal and Torres Strait Islander people. Planning and delivering more appropriate care as treatment and prevention will serve to lower the disease burden amongst Aboriginal and Torres Strait Islander people to lower costs associated with their healthcare and contribute to a healthy and economically productive population overall.

## **Conclusion**

Leadership in the field of health needs to represent more than just financial cuts over a four year planning horizon. The 2015-16 Budget must instead present effective solutions that compromise neither the short term nor long term health of Australians or our health system. By implementing sensible changes in health policy, more can be achieved with our existing health system without having to commit additional resources.

The proposals presented in this submission all represent the more effective and efficient use of existing resources and health infrastructure, not simply a call for additional public funding. Fiscal sustainability within the health sector requires a more nuanced approach with a holistic view across both the sector and over generations. As the nation's income increases with a rising gross domestic product, the opportunity is to spend this wisely on services vital to us all, both as individuals and collectively.