ROYAL AUSTRALASIAN COLLEGE OF SURGEONS


# SUBMISSION TO ACT LEGISLATIVE ASSEMBLY HEALTH, AGEING AND COMMUNITY SERVICES COMMITTEE

## Inquiry into the future sustainability of health funding in the ACT

**February 2018**

## INTRODUCTION

Established in 1927, the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand and across the Indo-Pacific. The College is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees and international medical graduates.

RACS functions and delivers its services at a bi-national, national and state/territory level. Each region plays a vital role by providing educational opportunities and advocating on behalf of its members and patients.

The ACT Committee was formed nearly 30 years ago in 1989 and now represents around 100 active Fellows, Trainees and International Medical Graduates in the ACT. The Committee has a strong relationship with the ACT Minister for Health, and works closely with ACT Health on a range of issues relevant to surgical practice and patient outcomes.

## KEY POINTS

- The sustainability of health funding in the ACT depends upon a collaborative approach from the government, health services, clinicians and patients.
- Clinicians should be better engaged in funding decisions and service planning, and educated about health economics and wastage.
- Further investigation is needed into the reasons why cost per weighted separation in the ACT is second highest in the country.
- RACS supports the Government's focus on preventative health measures and efforts to reduce unnecessary presentations to emergency departments.

## COMMENTS ON THE INQUIRY TERMS OF REFERENCE

Hospitals and healthcare providers across Australia are facing an increasing demand for services. Overall, funding for health has increased throughout the past decade; however the cost of delivering care has also increased, as have public expectations about acceptable standards and access to health services.

RACS is concerned about this rising cost. We acknowledge that healthcare budgets are finite, and that governments are directing considerable effort to improve the sustainability of Australia's healthcare system. We have welcomed the opportunity to have direct involvement in the MBS Review, Choosing Wisely and other initiatives aimed at improving the efficiency and quality of healthcare at the state and territory level, such as this inquiry.

*Efficiency of current health financing*

The average cost per admitted acute weighted separation in the ACT ($6,347) is significantly higher than the Australian average ($5,199).[1] This is also the case for emergency department presentations where the average cost in the ACT ($1,461) is the highest in Australia.[2]

Although the ACT health system is adequately resourced, these figures indicate service outputs do not reflect efficient use of funding. For example, the ACT has the second lowest proportion of emergency department patients seen within triage category timeframes in Australia (62% compared with the Australian average of 73%).[3]

With the National Efficient Price per National Weighted Activity Unit for 2017-18 set at $4,910,[4] RACS believes further investigation is needed into the efficiency of the ACT health system and areas for improvement.

There is a perception among some that the high proportion of non-clinical staff compared to staff providing direct patient care may be one reason for the inefficiency of the ACT system compared to other jurisdictions. There is a small number of practising clinicians at the executive level of ACT Health, and a disconnect resulting from poor communication between senior administrators and those delivering clinical services.

During the ACT Budget Estimates in June 2017 the Member for Ginninderra made reference to efficiencies and how these could be achieved with a large increase in ACT Health executive staff and salaries.[5] Further investigation of the clinician to administrator ratio in the ACT compared to other jurisdictions may be useful.

Engaging all areas of ACT Health (including surgeons) to be part of the solution will deliver greater efficiencies in health funding. To do this, clinicians need to be educated about health financing, involved in decision making - particularly where administrative decisions may impact workflow - and provided with detailed information about how their costs compare with other hospitals.[6]

RACS recognises that surgeons can actively contribute to the better management of resources and funding by eliminating waste and improving data collection and analysis in their clinical practices.

*Health funding and patient outcomes*

In all states and territories, waiting times for elective surgery continue to be a concern. In the ACT the average wait time for all types of surgery was 45 days for patients at the 50$^{th}$ percentile and 279 at the 90$^{th}$ percentile compared to the national average of 38 and 258 days respectively.[7]

Without efficient use of theatre time and sufficient staffing, surgery gets pushed into the private system as governments strive to meet their elective surgery targets. While the private system provides greater flexibility in terms of working hours, its use may erode the long-term sustainability of the public health system and reduce training opportunities.

Furthermore, emergency surgery and trauma constitute more than 60% of the surgical workload at The Canberra Hospital. The government monitors elective surgery wait times; however resources are rarely reallocated from elective cases to emergency cases. This means treatment is delayed for the most seriously injured patients, leading to increased length of stay, poorer patient outcomes and adding to the inefficiencies and cost of the system.

Inappropriate delays in accessing either elective or emergency treatment can be associated with increased risk of morbidity and mortality. This is particularly true in relation to degenerative diseases and the cumulative effects of an ageing population. In the emergency setting we know that preventable deaths have occurred in the ACT as a result of the current Trauma Service model of care.

Changes need to be made so that resources are focussed on patients' needs rather than statistical targets. The current funding model does not encourage patient-focused service delivery. Keeping patients at the centre of funding decisions will encourage development of more efficient models of care. Giving hospital service units more autonomy will allow them to be more responsive to changes in healthcare requirements, and to engineer efficiencies more quickly and effectively.

RACS supports the public release of outcomes-based data on surgical performance at a team, institutional or national level. It is appropriate that clinicians have access to reports on performance that are valid and reliable, leading to greater uniformity of practice. This information also helps establish trust so that clinicians and their patients can be confident in the quality of medical care being provided. RACS is consulting its Fellows on the status of morbidity audit in the ACT to see if improvements can be made.

*Sources and interaction of health financing*

While the Commonwealth supports public private partnerships as vital to the development of infrastructure in Australia,[8] they are not without problems.[9] The partnership may bring about issues with accreditation, employee entitlements, lack of accountability and training.

The ACT operates under a public private partnership arrangement, with government funding provided to Calvary Public Hospital under the Calvary Network Agreement. A 2016 report prepared by the ACT Auditor-General examined the hospital's financial and performance reporting and found inappropriate financial practices and manipulation of data to present a better financial result than was occurring.[10]

There are a growing number of public patients being treated in private settings in the ACT, and while this may be more efficient in the short term, training opportunities are lost which could impact the workforce in the future. Consideration should be given to better integrating the private and public workforce in the ACT, and remuneration options which will incentivise doctors without restricting their trade.

In the private setting, RACS is concerned about rising out of pocket costs for patients and has committed to challenging surgeons who charge manifestly excessive fees. We are collaborating with private health insurers on clinical variation to support surgeons' understanding of their practice in comparison to their peers. The results of this work provide important insights into the way health services are delivered which can be used to inform more efficient patient care.

RACS affirms the rights and necessity for patients to be actively engaged in their own healthcare and to be provided with all relevant information in a manner that they can readily understand. At the national level we are working with the Chief Medical Officer to improve transparency of fees and outcomes for patients.

RACS notes that unpaid patient bills in the ACT, largely owed by patients without a Medicare card or non-citizens, have risen into the millions, and that this must be an ongoing concern for the Government.

*Impact of health financing on population growth and technological advancements*

With rapid increases in medical knowledge, technological advancements and the development of highly individualised packets of care available to meet specific patient requirements, being appropriately informed on these aspects of continuing education is the responsibility of clinicians.

The introduction of new technologies and treatments is dependent on publication of supportive peer-reviewed literature demonstrating efficacy without undue risk, and practitioners ensuring they have acquired the appropriate levels of knowledge and skill. This is most satisfactorily monitored through the robust credentialing of practitioners and their work environment, expected as part of each practitioner's employment or right to access medical facilities.

Other key strategies to ensure continuous quality improvements in healthcare are stricter pre-market scrutiny of devices and equipment, clinical quality registries and post-operative monitoring.

*Hospital financing and primary, secondary and community care*

Health literacy is an important component in improving transparency of health financing, efficiency and outcomes for the public. The role of groups such as the ACT Health Care Consumers' Association and Consumers Health Forum is central to patients' ability to access, understand and use information in ways which promote and maintain good health.

Decisions about hospital financing and patient flow systems and processes must be done in consultation with clinicians. In 2017 changes to the Outpatient Department at The Canberra Hospital led to an increased administrative burden for clinicians which resulted in less time spent with patients.

The Government's efforts to reduce unnecessary presentations to emergency departments by funding walk-in centres is to be commended although we are aware the Royal Australian College of General Practitioners has concerns about this.

We also welcome the Government's cross-portfolio focus on preventative health to help reduce the burden of chronic health conditions such as obesity, heart disease and diabetes.

*Future capital needs*

RACS has offered its input to the Territory-Wide Health Services planning process and we look forward to participating in consultations as the new Surgical Procedures, Interventional Radiology and Emergency Centre is developed.

A general outpatient procedure room would allow minor procedures such as removal of skin lesions to be performed safely and efficiently in the outpatient setting, rather than adding to demand for operating theatres where elective and emergency surgery is performed.

*Relevant learnings from other jurisdictions*

Health sector investment in Australia in 2015-16 represented 10.3% of GDP.[11] According to the Victorian Government public healthcare services generated some 42,000 tonnes of solid waste and the cost of disposing this waste was close to $17 million.[12] They estimate that by 2021-22 Victorian public healthcare services could be generating as much as 52,000 tonnes of solid waste per annum.

Intravenous (IV) bags, face masks and oxygen tubing are all items commonly used in hospitals, which will have a long term impact on the environment and on costs.[13] Over 50 million IV bags are used annually in Australia, yet recycling and landfill diversion is not a common feature of hospital waste management plans. RACS encourages the ACT Government to consider ways to reduce, reuse, recycle and rethink medical waste.

Thank you for the opportunity to provide input to this inquiry. We look forward to the next steps and would be happy to provide further advice as required.

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[1] Productivity Commission. Report on Government Services 2018. Chapter 12 Public Hospitals Table 12A.56. Available from: www.pc.gov.au.
[2] Ibid. Table 12A.58.
[3] Ibid. Table 12.1.
[4] Independent Hospital Pricing Authority. National Efficient Price Determine 2017-18. 2017. Available from: https://www.ihpa.gov.au/sites/g/files/net636/f/nep.pdf.
[5] Legislative Assembly for the Australian Capital Territory. Select Committee on Estimates 2017-18, Transcript of Evidence. Canberra, 27 June 2017. p736. Available from: http://www.hansard.act.gov.au/hansard/2017/comms/estimates08a.pdf.
[6] Duckett SJ, Breadon P, Weidmann B, Nicola I. Controlling costly care: a billion dollar hospital opportunity. Grattan Institute, Melbourne, 2014.
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[9] Duckett S. Public-private hospital partnerships are risky business. The Conversation, 30 July 2013. Available from: https://theconversation.com/public-private-hospital-partnerships-are-risky-business-16421
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