# Is the Tasmanian health system fiscally sustainable; Problems and options

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Panel presentation, 15 minutes

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- The first comment I have to make, is on the premise, we always need to put the patient and community are the forefront of any discussion on health systems and the quality of the services we provide.

- Sustainability is not just measured by financial measures alone, caution is raised or we run the risk of a financially sustainable, low quality service. Cost and Quality have to be considered together.

- We need to engage the community in the debate, and explain the options and this needs to inform purchasing/commissioning priorities

- As a supporter of the Purchaser/Provider (P/P) model based on detailed Price, Volume and Quality purchasing contracts and Activity Based Funding/case mix . it is of note that at LGH/THON we changed our reporting to put Quality first.

Problems

- Who is responsible? Does……. we will end the Blame game ring a bell? Has the Federal rescue package and the $325 million in funding to address, in part, the reported up to 30% extra costs in Tasmania that was intended to give us a pathway to a fiscally sustainable model? Where are the reports from over 20 consultancies, that have never been released or peer reviewed? Maybe this is indicative of the sort of problems we have, noting the current Green and White papers at both a state and federal level

and there associated reforms. Is there a theme that may point to where the problems are, unless of course you are a consultant!

- An example, Dental/Oral health, is included in the Constitution as a Federal responsibility, The *Commonwealth of Australia Constitution Act 1900* s51 (xxiiiA) empowers the Commonwealth to provide for dental services. But as we know this is an area no one taken end of line responsibility, and what are the outcomes we have?

    - Childhood cavities are 55% higher for remote area children than children in major cities, and the number of filled teeth in remote area children is double that of city children.

    - A quarter (23%) of adults in major cities have untreated tooth decay, but this rises to one third (37%) of remote area residents;

    - More than half (57%) of Indigenous Australians have one or more teeth affected by decay;

    - Six in ten (63%) major city adults visited a dentist in a year, compared to little more than four in ten (45%) visiting a dentist in remote areas;

    - One in three (33%) remote area residents had a tooth extraction in a year compared to little more than one in ten (12%) people from major cities;

    - Cities have three times as many working dentists than country areas, with 72 dentists for every 100,000 people in cities compared to only 22 for every 100,000 people in the country.

So who has responsibility for funding dental/oral health? More than half (58%) of the cost of dental services have been met by individuals, 18% by the Commonwealth and 8% by State and Territory Governments. So those that need the service, cannot access it as they can in most cases

for medical care, that is 2/3 thirds Government funded, unless they fund the service themselves.

- Where do we spend our $,
    - illness,
    - wellness or
    - the social determinates of health

“you need to invest in the health of people, as there is no return on investment in investing in there illness” M Pervan A/Secretary DHHS

Are we spending scare $ in the right area? Where is the discussion? Who is making the decisions?

- What are we measuring? For example, what are the KPIs important enough to be in the THS, Service Agreement ?

    - The Tasmanian Health service (THS) budget allocation in 2015/16, as contained in the Service Agreement, is $1,324,946,511, noting this does not include own source revenue. The allocation for Primary Health is $136,918,342. There are only three KPIs or the Primary Health allocation, being the Aged Care Assessment Team assessments being competed on time for category 1, 2 and 3 clients.

    - The allocation to Oral Health Services is $27,053,457, with the there being two KPIs, both activity undertaken, rather than screening or prevention services.

http://www.dhhs.tas.gov.au/tho/service_agreements

This reinforces the RFDS call for the inclusion of more meaningful KPIs to measure the health outcomes for remote and rural areas.

- Demand, reactive responses, capital, short political cycles, are real challenges to problems that are complex
- Who as responsibility, direct or indirect, for leading the change, or is the same faces?

Solutions/options

- P/P can work, LGH was below the NEP and delivered balanced or surplus budgets for 4 years, but there was a down side with reduced access/volume. The question not asked, was why only the LGH?

- Rare and unique opportunity, one THS, PHT, DHHS etc., but there is a risk of monopolies, diseconomies of size, loss of local responsiveness and accountability and other risks like a one size fits all approach we need to avoid.

- Purchasing/commissioning needs to encourage and support the use of providers other than traditional providers, this is occurring in other areas. This includes changing the tender processes used, e.g. why isn't Alliance contracting used? My clear conflict of interest needs to be declared on this point

- We need an integrated health system/continuum of care, and to achieve this the health needs and all services should be mapped. If we did this, for example we could then focus on the top 10 potentially avoidable hospital admissions. A question, what is the top of the list? Dental Conditions, 1607 of them in 13/14

- There needs to be agreed position on how we manage short/medium term demand, while we invest in the wellness and social determinates of health, noting the concerns of the productivity commission

> *The benefits of greater investment in **preventive health** are widely acknowledged. But doing this cost effectively is tricky, especially for complex health problems such as obesity. Moreover, fragmented funding, financing and policy responsibilities for preventive health weaken the incentives to invest in it.*

- It is time we sought a dedicated focus and funding for populations/pubic health initiatives, separate from the vagaries of the political system, ensuring we use the best evidence from work such as ACE in Queensland.