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AUSTRALIAN MEDICAL ASSOCIATION

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EXECUTIVE SUMMARY

- The strength of the Australian Health System is that it delivers a large number of high quality medical services at a reasonable cost to the Australian people. On the other hand, health services to the Indigenous community and to the mentally ill are standout weaknesses of the system. Health workforce shortages are emerging as a big issue and the dysfunction between Commonwealth and State Governments reduce leadership and accountability.
- The AMA does not have faith that major change to the level of government responsibility for health programs will be achievable or successful and believes that this should no longer be used as an excuse for inactivity in health reform.
- Reform proposals should be developed from the point of view of the patient and their GP and not from the point of view of the Government. The predominant government interest is in cost control whereas a patient will be interested in access, outcomes and quality of care.
- Both levels of government should locate examples of excellence in health care delivery which have transcended Commonwealth/State boundaries and health financing complexities and examine the reasons why these have been successful and attempt to replicate them in other locations in Australia. This is particularly important for services to the elderly which cross many boundaries between acute, sub acute, transitional, community and residential care.
- Australia needs national standards for our public hospital system which would bring national focus to the differences which exist in relation to access, efficiency and quality in the public hospital system and also bring a focus on the decline in the public hospital performance in relation to teaching and training for the next generation of the medical workforce.
- The Government must continue to involve and encourage the private health sector in the delivery of health services to Australians and ensure that the policy settings are stable and well understood so that there will be confidence to invest in the future of the private health system.
- The Federal Government needs to ensure that the level of regulation around private health insurance is minimal. The key areas to protect by regulation are Lifetime Community Rating, prudential requirements and clear and succinct product information supported by an effective complaints mechanism. The Government needs to ensure effective competition between the funds by ensuring that portability of health insurance entitlements is not stifled by artificial barriers.
- There are a number of measures which the Federal Government can take off its own bat which would improve the payment systems in health for patients and reduce the level of red tape for doctors
- There are also a large number of dead end reforms such as an Australian Health Reform Commission , capitation and US style managed care which will not lead to improvements in the availability of high quality health care to Australians.

1 INTRODUCTION

The Australian Medical Association (AMA) is pleased to have the opportunity to make this submission to the ***Inquiry into Health Funding*** by the House of Representatives Standing Committee on Health and Ageing.

The Committee's broad task is to inquire into and report on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

While this task is very broad indeed, the AMA suggests that there are useful ways to make the task a manageable one. A good foundation is:

- a strong understanding of the strengths of the current system so that we can build on them; and
- an equally strong understanding of the weaknesses of the current system so that we can remedy them.

The latter requires an open, honest assessment of those areas where we are not doing as well as we could.

A candid assessment of the weaknesses will, in turn, open the door to a constructive assessment of the opportunities for strong national leadership to make a difference. Top down remedies are not the answer in every case. There are some issues that will be solved from the bottom up, when patients and health professionals accept that better outcomes are in their hands and do whatever is needed to bring change.

In this submission, the AMA has sought to identify the areas where it believes strong national leadership can make a material difference to the quality of outcomes.

The terms of reference for this inquiry list items of particularity, primarily issues of an inter-governmental and inter-sectoral nature. Each issue is addressed in this submission. The AMA does emphasise, however, that the opportunities for strong national leadership are by no means limited to inter-governmental and inter-sectoral issues. There is much that the Commonwealth government can, and should, address in its own back yard.

1.1 Strengths

Australians experience a high quality health system with, overall, very good health outcomes. The significant strengths of the system are:

- a large number of high quality health services at a very modest cost compared with other wealthy countries;
- a high quality medical workforce which owes a great deal to excellent systems for initial training and ongoing medical education;
- high quality nursing and allied health workforces;
- generally good health infrastructure (facilities and equipment), in some areas excellent; and
- a mix of public and private service delivery which achieves excellence in both sectors and provides patients with choice.

1.2 Weaknesses

The Australian health system also has some significant failures:

- in terms of the health priorities set by governments, not nearly enough attention has been given to mental health and Indigenous health. The *Senate Select Committee on Mental Health* is, of course, addressing the first of these issues currently;
- in terms of health prevention, Australian has not made nearly enough progress with tobacco control, with control of illicit drugs or in addressing obesity and, as a result, many Australians in future will experience poor health outcomes including cancers, mental illnesses and diabetes;
- in terms of financing issues, the stand-out weakness is the deep dysfunction in Commonwealth/State arrangements for health financing; and
- in terms of the delivery of health services, public hospitals have been run down to a perilous level while primary care continues to suffer from workforce shortages. Health workforce is one area where the Commonwealth Government's efforts to provide national leadership have fallen short of what is required.

The responsibility for these weaknesses does not rest at one door only. Governments at all levels, public and private health institutions, health professionals and Australian citizens all bear some shared responsibility for the weaknesses and for their resolution.

Box 1: Mental Health

Mental health is a "weak link" in the Australian health care system.

- Mental health services get an inappropriately low funding priority having regard to the high burden of disability;
- Workforce shortages in mental health are increasingly apparent and problematical;
- While, the National Mental Health Strategy was a worthwhile initiative, policy directions were not always appropriate and there have been failures in the implementation of the policy;
- Access and equity has not yet been achieved for sub-groups within the community;
- Stigma and discrimination remain as major obstacles to improving outcomes;
- Existing resources are not being used as well as they could or should;
- Access to hospital services is increasingly problematical for public mental health patients.

There is much that can be done to "get it right" within the framework of affordable and cost-effective solutions. This will require some new money, complementary workforce initiatives, a proper analysis of need to better inform mental health spending priorities, attention to the dysfunction in mental health financing and delivery systems, a commitment to build on the strengths of the current system, a well trained and highly motivated psychiatrist workforce, proper attention to mental health prevention and a willingness to more effectively engage the Australian community in regard to mental health care (including full accountability for the way that public funds are spent and the patient outcomes achieved).

These issues are addressed in detail in the AMA's submission to the *Senate Select Committee on Mental Health*.

Box 2: Health of Aboriginal Peoples and Torres Strait Islanders

Health outcomes for Aboriginal Peoples and Torres Strait Islanders are a national disgrace. The reasons for these outcomes are many, including:

- a level of resourcing (meaning funding and workforce provision) that is inappropriately low given the very poor health status of the peoples;
- the failure to properly address environmental health with some communities continuing to bear the adverse health outcomes from unsafe water and sanitary infrastructure, the poor quality of housing, etc (all things which other Australians take for granted); and
- the wider web of socio-economic disadvantage confronting the peoples, including poverty and lack of access to education.

Other wealthy countries have made far more progress than Australia in improving the health status of their own Indigenous populations. Australia is no less capable. The issue is one of priority. We can choose to materially improve the health care of Aboriginal Peoples and Torres Strait Islanders.

The AMA has issued a series of reports on Indigenous health issues, pointing to both the problems and the opportunities. As an exercise practical reconciliation, it is hard to think of a better starting point than health and education.

This year, the AMA will be drawing attention to the opportunities to address one of the key causes of poor outcomes—low birth weight and premature babies. There is strong scientific evidence that low birth weight babies do not get a good start in life and suffer many problems later in life if their survive their higher probability of infant mortality. The AMA contends that interventions to improve the quality of maternal and child health care will bring a very large return in terms of quality of life gained and health cost saved. Much revolves around the health of mothers. Action to combat tobacco consumption. genitourinary infections and alcohol abuse during pregnancy and to improve maternal nutrition before and after birth will mean many more full-weight, full-term, healthy babies.

1.3 Workforce issues

In the next decade, the AMA expects health workforce issues to be a significant constraint on the capacity of the health system to meet the health needs of the people. Funding and workforce are two sides of a coin:

- Money without a workforce is money that cannot be spent effectively.
- A workforce without funding is a workforce that cannot be employed effectively.

Planning of funding and workforce have been disconnected for far too long. Although the terms of reference for this inquiry do not explicitly mention workforce issues, the AMA urges the Committee to engage these issues with full knowledge of and a strong interest in complementary work such as the current Productivity Commission research study[1].

[1] In March 2005, the Australian Government asked the Productivity Commission to undertake a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals and propose solutions to ensure the continued delivery of quality healthcare over the next 10 years.

1.4 Structure of this report

Part 2 addresses terms of reference item (a)—the roles and responsibilities of the different levels of government for health and related services.

Part 3 addresses terms of reference item (b)—the scope for simplifying funding arrangements, and better defining roles and responsibilities, between different levels of government, with a particular emphasis on hospitals.

Part 4 addresses terms of reference item (c)—how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved.

Part 5 addresses terms of reference item (d)—how best to ensure that a strong private health sector can be sustained into the future.

Part 6. addresses terms of reference item (e)—ways to make private health insurance a still more attractive option to Australians who can afford to tale some responsibility for their own health cover.

Part 7 addresses key "back yard" issues for the Commonwealth Government.

Part 8 addresses some of the "dead end" suggestions for changes in the financing and delivery of health care in Australia.

Part 9 provides a compendium of the various recommendations through the body of the submission.

2 ROLES OF DIFFERENT LEVELS OF GOVERNMENT

The terms of reference call for the Committee to give particular consideration to:

> "*a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services*".

Attempts to reform the Australian health system by changing the level of Government responsibility date back to the early 1970s when the Whitlam Government 'bought in' on public hospital funding (prior to that, a State government sole responsibility). The Jamison Royal Commission (1980) inquired into the efficiency and administration of hospitals and, at that stage, was firmly of the view that the States should determine spending priorities in the hospitals.

In more recent times:

- The *National Health Strategy* (1991) canvassed a number of options for reform of Commonwealth/State arrangements without generating any interest;
- There have been a number of Parliamentary inquiries on health policy which have touched on the issues;
- There have been several COAG initiatives (which have not changed anything); and
- Most recently the *Health Review Taskforce* led by Mr Andrew Podger has looked into the issues but the report has not been made public.

Outside government itself, ginger groups have put forward a number of proposals including an overarching Australian Health Commission or Corporation.

Thirty five years ago, governments were actively expanding health spending and seeing the opportunity to enhance the lives of citizens. Commonwealth and State Governments were, to a degree, competing for popularity by pushing the money out. The burgeoning costs have, however, reversed the thrust. The overwhelming mantra is now one of cost containment. Commonwealth and State Governments are now competing to avoid unpopularity by manoeuvres to make it more likely that the other side (or even better, a third party like the private health insurance funds) is landed with the task of pulling the money back.

Health spending is no longer regarded by Government as an investment in the health and well-being of the population. Rather, it is regarded as an unrelenting cost burden which greatly complicates the difficult task of balancing budgets.

2.1 AMA National Conference resolutions, 2004

Against this background and history, AMA National Conference in 2004 passed a number of resolutions, subsequently adopted as policy, which are directly relevant to the thorny question of the roles of different levels of government. These were:

1. *That in the absence of existing policy, this National Conference requests the AMA to ensure that any proposals for reform of the health financing arrangements and health responsibilities between the Commonwealth and the States be evidence based and subject to rigorous impact assessment addressing amongst other things:*
    a. *Access to health and hospital services*
    b. *Integration with related health services*
    c. *Quality of health services*

d. *Levels of bureaucracy associated with the proposals*

e. *Extent to which the proposal will encourage a move to national standards*

f. *Political accountability and responsibility for performance*

g. *Likely acceptance by the public*

h. *Maximising individual choice as to the quantity and location of health services desired*

i. *affordability*

2. *That consistent with AMA policy and recognising the structure of Australian Governments, this National Conference supports a process of incremental change to health service delivery built on funding partnerships between the Commonwealth, the States and Territories.*

3. *That consistent with AMA policy, this National Conference, recognising the current deficiencies in hospital care for older people and those with mental health needs, encourages Federal and State Governments to give priority to funding joint initiatives that address the obstacles to good health care brought about by the interfaces between the hospital, community and residential care sectors.*

4. *That consistent with AMA policy, this National Conference supports the Australasian College for Emergency Medicine's position that the primary cause of overcrowding and access block in Emergency Departments is the restriction of funding to the public hospitals and the consequent shortage of beds and hospital workforce and calls on State and Federal Governments to adopt a mean maximum bed occupancy of 85% as a key performance indicator for public hospitals.*

5. *That in the absence of AMA policy, this National Conference, noting the serious erosion of the teaching environment in public hospitals and noting that the situation will further deteriorate as the number of graduating medical students increases, calls on Federal and State Governments in consultation with training bodies to work with renewed commitment to provide sufficient resources to ensure access to education and training is maintained at levels which will provide for a quality health system into the future.*

6. *That consistent with AMA policy, this National Conference believes the public hospitals should urgently create a sufficiently attractive employment environment to attract and retain Australian medical graduates and set targets for reduced dependence on overseas trained doctors.*

7. *That in the absence of existing policy and recognising that the Australian Government is actively recruiting doctors of widely varying skill base from overseas while restricting the access of Australians to medical training, this National Conference calls on the Australian Government to take financial responsibility for the education of overseas doctors to a level equal to an Australian graduate rather than leaving this to public hospitals and their medical staff.*

2.2 Too many 'fallen inquiries'

The thinking behind these resolutions is that the AMA has witnessed too many 'fallen inquiries' into the roles and responsibilities of the different levels of government to be able to approach this issue with anything other than a jaundiced eye.

It is almost certainly true that anyone starting from a blank sheet would be highly unlikely to design a health financing system like the one we have now. We do not have that luxury. Past attempts to reform the system from the top down have been decidedly unsuccessful. The system is an imbroglio, a huge and tangled mess which imposes needless costs on the Australian community. That said, it is fairly obvious that the political vested interest in retaining a 'cost and blame' shifting system is so powerful, the inertia so large, that the AMA has no expectation of any meaningful reform of Commonwealth/State relations in health care.

Reform would require Commonwealth, State and Local governments to act in the national interest which they will undoubtedly perceive as being against their own interests (at least to an extent). We can think of examples where the various levels of government have acted contrary to both the national interest and their own interests at the same time. Indeed, the very short term horizon which applies to many political decisions ensures that this is the case.

2.3 In the absence of 'big bang' change

In the absence of meaningful 'big bang' change, can anything be done? We believe that there are some positive models which deliver exemplary service delivery within the current funding and responsibility levels.

For example, the integration of acute, sub acute, community and residential aged care services in Ballarat Victoria is a model which has substantially lifted access, quality and outcomes of care for patients in that region. This integration breaches many barriers including those arising from Commonwealth/State divides, program divides, other institutional divides and professional divides. It has come about because of the visionary leadership of certain individuals and the willingness of the institutions in the area to co-operate. While the circumstance in Ballarat do not fully exist in other parts of Australia, it would take the world's biggest pessimist to argue that there is no hope of propagating this successful model in other parts of the nation.

There are examples, also, of brave inter-State co-operation. The Victorian and New South Wales governments have co-operated in the delineation of services in the Albury/Wodonga region in an apparently successful way. These achievements can be replicated in other border areas of Australia where there are large populations.

2.4 Why reform?

The reasons for undertaking reform of the health financing system are critically important. Reform undertaken for the wrong reasons runs a high risk of making the system even less responsive than it is now to the wants and needs of the patient. The political danger in that ought to be self-evident.

The AMA believes that it is extremely important that reform is considered, also, from the viewpoint of a patient and not just that of the government or other funders. The predominant consideration for Governments and large institutions is budget and cost control. Beds and theatres can shut provided the integrity of the budget is maintained. If the work can be transferred to some other setting funded by someone else without disastrous clinical outcomes, that is a good result for government and major public institutions.

From the patient point of view, the predominant considerations are access, quality and outcomes. The problems of the system and the solutions to those problems look completely different when viewed through patients' eyes. We need to consider reform to the system which would improve access, quality, outcomes and affordability from the viewpoint of the

patient and their General Practitioner and we have to equip them to negotiate their way around the system effectively.

2.5 Commonwealth/State disconnects

We observed previously that the system is an imbroglio, a huge and tangled mess which imposes needless costs on the Australian community. It is important to note, however, that the disconnects in Commonwealth/State relationships do not affect each area of the health care system equally. The disconnects are largest in terms of:

- **Public hospitals:** Squabbling over funding and arm wrestling over priorities;
- **Aged care:** Bed blockers in public hospitals are there because of insufficient long term high care residential beds;
- **Boundary issues:** The continuum of care is impaired by the boundary issues and the cost shifting that attends them.

Box 3 shows illustrates a solution to one element, that of the public hospital bed blocker.

Box 3: Bed blockers – the solution

The bed blocker problem is a classic example of the Commonwealth/State imbroglio imposing needless costs and inferior health outcomes on the community. The solution is to remove the incentive for cost shifting:

- Patients should be assessed independently by health professionals trusted by both sides before being classified as bed-blockers (or 'nursing home type patients');
- The Commonwealth Government should have to meet the full cost of these patients from their day of classification until their day of discharge;
- This will give the State Governments more revenue to fund extra beds if the bed blockers remain in the public hospitals; however
- More likely, it will give the Commonwealth government the incentive to find more appropriate and cost-effective ways of caring for these patients.

2.6 Who pays for what now?

Table 1 is drawn from more detailed AIHW health expenditure data. It illustrates, in broad terms, the significant variations in the shares of expenditure over the different areas of health spending.

Table 1: Shares of expenditure

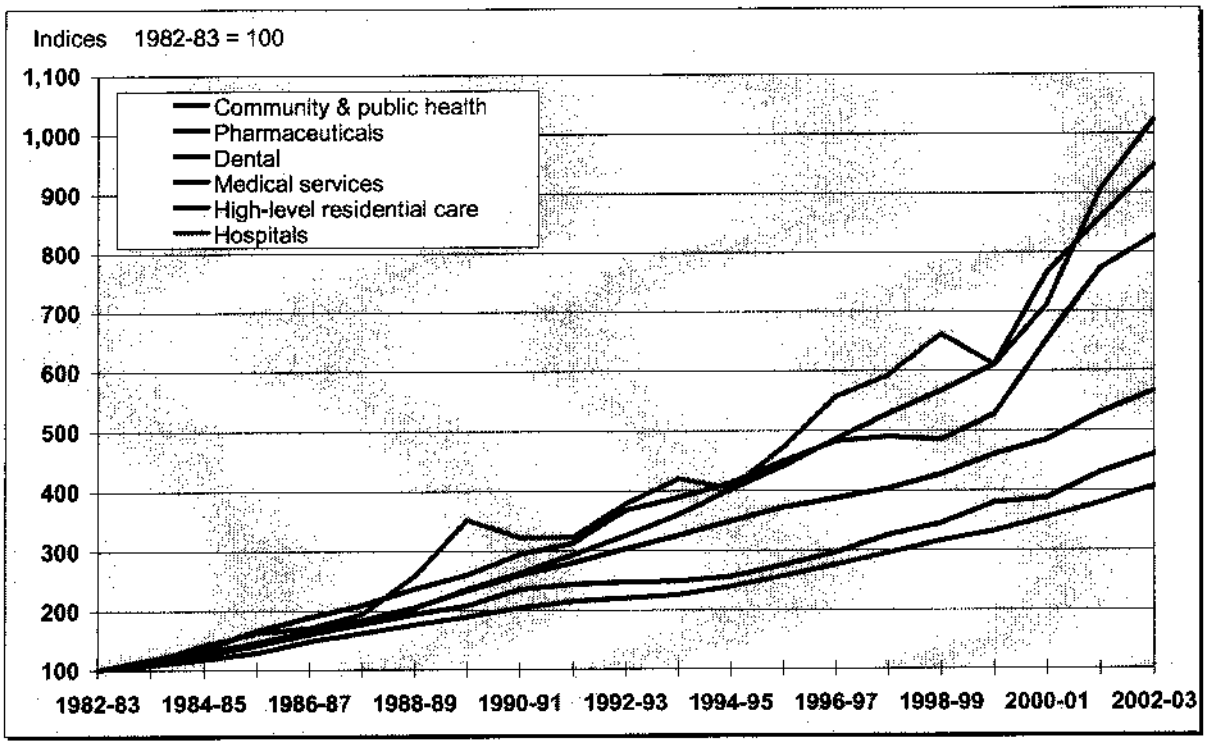
	C'wealth govt	State & local govt	PHI funds	Individuals	Other	Total
Public (non-psych) hospitals	49%	43%	2%	2%	4%	100%
Private hospitals	35%	0%	47%	7%	11%	100%
High-level residential care	74%	9%	0%	17%	0%	100%
Medical services	78%	0%	4%	12%	6%	100%
Benefit-paid pharmaceuticals	83%	0%	0%	17%	0%	100%
All other pharmaceuticals	2%	0%	1%	95%	2%	100%
Total pharmaceuticals	51%	0%	1%	47%	1%	100%
Aids and appliances	8%	1%	9%	80%	2%	100%
Public health	56%	44%	0%	0%	0%	100%
Dental services	9%	8%	16%	68%	0%	100%
Administration	56%	12%	29%	0%	4%	100%
Research	57%	15%	0%	0%	29%	100%
Total health expenditure	**46%**	**22%**	**7%**	**20%**	**5%**	**100%**

Source: AIHW 2004

Chart 1 provides indices of the growth of national health spending in the six major areas, each of which involved national health spending of over $4b in 2002-03. We note that:

- Despite the great focus on the growth of expenditure on pharmaceuticals, it is in fact community and public health spending which has grown fastest;
- Dental expenditure has also grown very strongly, outstripping growth in medical expenditure by a substantial margin;
- Despite the ageing of the population, the growth in national expenditure on high-level residential aged care has been modest, possibly reflecting some improvement in the health status of older Australians but more likely reflecting the cost-saving impact of community care packages; and
- Hospital expenditure is the slowest growing, to be expected given the very large reductions in average length of stay over this period.

Chart 1: Indices of growth in expenditure of the major health programs



Source: Derived from AIHW 2003 (and earlier years).

2.7 Conclusions re roles of the different levels of Government

The AMA concludes that:

- 'Big bang' change in Commonwealth/State arrangements is highly unlikely to gain any traction given the inertia across levels of government and should not be further pursued by the House of Representatives *Inquiry into Health Funding*.
- There is potential for carefully thought through incremental change but questions remain as to whether this will be more effective if 'top down' or 'bottom up'.
- Any proposals for reform of the health financing arrangements and health responsibilities between the Commonwealth and the States must be evidence-based, subject to rigorous impact assessment and viewed from the perspective of the patient, not just the perspective of the funder.
- Incremental change to health service delivery will be more effective if built on genuine funding partnerships between the Commonwealth, the States and Territories.
- There are positive role models for better arrangements, sometimes achieved despite Commonwealth/State arrangements and other times achieved within them—these models should be transplanted wherever possible.

3 SIMPLIFYING FUNDING ARRANGEMENTS

The terms of reference call for the Committee to give particular consideration to:

> "*b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals*".

Our health system and the health financing arrangements which support it have evolved into a web of complexity. That it works as well as it does despite this complexity is a tribute to the health professionals who populate it.

3.1 Many purchasers

Australia has a proliferation of purchasers of health care:

- Federal Government purchases health and hospital services from the States and directly with other providers as well as funding hundreds of programs reaching into every part of the health care system.
- State Governments purchase health services from Area Health Boards.
- Area Health Boards purchase health services from public hospitals and public hospitals purchase health services from private providers.
- Private health funds contract with private hospitals and other providers as well as being part funders of public hospital services;
- Compensation insurers purchase a wide range of services throughout the health care system;
- Patients purchase health goods and services independently of government or other third party payers in some cases and in others, with the assistance of cash benefits or income tax relief.

In the case of a private patient in a public hospital, the payers can comprise: the patient (own out-of-pocket cost), the PHI fund and the Commonwealth and State governments. The Commonwealth is subsidising PHI fund benefits, providing Medicare benefits and sharing responsibility for part of the per diem cost with State governments. In summary, four payers and seven money channels. Obviously not all of these different purchasers can or should be eliminated but we need to always make sure that they make sense from a patient perspective and that obvious blockages are removed.

3.2 Many ways of buying

Australia also has a proliferation in the ways in which health care can be purchased and funded. Just looking at medical and hospital services:

- **Patient initiated service provision for medical services provided in the community:** The Federal Government provides a universal insurance rebate for the 200 million services provided under this heading each year. This works reasonably well under the Medicare arrangements for the most part despite the endeavours to shift costs to patients and PHI funds. The new Safety Net has, of course, had a rocky introduction. The areas where this system falls down the most are in the management of chronic disease and in any condition which requires a range of health practitioners working together in the management of a patient. Mental illnesses is a prime example of an area where the Medicare arrangements contribute to poor outcomes. While some progress has been made, we have no mechanism to ensure equity of access to

services for chronic disease. Many of the services cut across Commonwealth/State divides where they are provided in the public sector.

- **Private inpatients:** These are financed through the private health insurance sector and by patients direct with the Federal Government providing a tax rebate on private health insurance premiums. Private inpatient medical services are subject to strict and onerous regulatory control and, as noted above, can involve up to four payers on every service.
- **Public hospital services:** These are delivered through State Governments with the Commonwealth providing around 50% of the funding through the Australian Health Care Agreements. State Governments can fund hospitals directly or through Area Health Boards or similar structures. Hospitals are funded either by historical funding methods or in some instances through casemix funding which was supposed to change the world but hasn't and has added a lot of bureaucracy.

Under that broad framework, there is quite of lot of cost shifting activity going on. Outpatient Services have almost entirely been cost shifted to the Commonwealth and the services are now offered in a Specialist's rooms. This has reduced the capacity to link in related health services which are only available at the public hospital and more seriously, it erodes the scope for teaching and training the next generation of medical practitioners.

Turning to other health services:

- The PBS is a benefit entitled scheme but is engineered in the reverse to Medicare. Front-end payments (patient co-payments) are mandatory under the PBS while in Medicare, governments have tried to maximise bulk-billing of GP services on the grounds that front-end payments are undesirable.
- The Commonwealth meets the giant's share of high-level residential care services while home and community care services for the aged are jointly funded by the Commonwealth and State governments and delivered by State Governments and NGOs.
- There is a range of services which are in no mans land and which can be funded by the State or the Federal Government depending on how they are set up. These are Outpatient, sub acute and transitional care services for people moving between acute, community and residential settings.

A key feature of the arrangements is that there are no national standards for service delivery. There are big differences between States as to the level of services provided in the public sector, the way the services are funded and the quality of services provided. There are big differences in the access to services, beds per population, quality of care and quality of infrastructure.

Although the Commonwealth puts forward a large chunk of the funding for all health services and particularly public hospital services, it is unable to ensure there is anything like national consistency. Reporting in these areas is in its infancy.

3.2 Incremental change

Whether it is possible to undo some of the complexity of the health in isolation from broader institutional change is open to question. Health care is complex by nature. As we have said in Part 2, the AMA does not believe that any form of 'big bang' change is achievable or desirable. What we do need, however, is to agree on some priorities for change which are manageable in size and go forward with these with the energy, focus and priority we give to other national emergencies.

There are practical steps which can be taken which will reduce the transaction costs in the system and make it easier for patients to negotiate the system.

The AMA recommends that:

- General Practitioners are the only highly trained and skilled health professionals who provide general care to patients. In addition, they are the gatekeepers to the health system. Governments need to accept, rather than resist, the central role of the GP in helping the patient navigate their way through the tertiary system. Well-informed patients will suffer fewer problems in navigating complex systems and efforts to ensure that patients are well-informed are important. That said, there will be patients (eg. Dementia, other mental illness) who will be unable to negotiate the systems without help from their carer and GP (or other patient advocate).
- In considering any initiatives to reduce the complexity of the current system, the first priority should be to reduce the complexity of the system as experienced by the patient—that is we should seek to build systems which meet the requirements of the patient and which follow the path required for patients undergoing treatment as they progress through the system.
- Identification of models of excellence in the provision of health services and rolling these out around Australia is essential (bottom up change).
- A national pharmaceutical scheme (trialled in Victoria with some success) should be further assessed and if suitable, rolled out across the whole of Australia.
- The remnant outpatient services provided in public hospitals are often close substitutes for services funded through medical Medicare and it behoves governments to examine whether there is scope for an improved funding framework for both that will preserve the vital teaching and training activities conducted in the public hospitals and remove the opportunities for cost shifting.
- Information systems, electronic records, electronic prescribing etc all need to be based on improving the quality of care and meeting the needs of patient. The overwhelming goal should be to make the system as smooth and functional as we can for patients. Good outcomes will flow from that and it is the right focus.
- The complexity of the current system demands the immediate introduction of electronic claiming at point of service, electronic payment including assignment of benefits to providers without any exception. The high cost and inconvenience of archaic payment systems can no longer be justified.

We emphasise that reform must be approached from the point of view of the patient. A good first step would be to select a range of the most common illnesses/conditions and map the likely service requirements for those conditions and identify the barriers to excellence in service provision. We then need to intervene so as to enable the best possible treatment being available to patients. Examining the issues confronting an elderly patient with chronic conditions would also be useful.

Having the money follow the patient rather than the patient follow the money is the best situation. An obvious issue will be that the Government will not be prepared to pay the full cost of the optimal care to be provided to patients.

4 ACCOUNTABILITY

The terms of reference call for the Committee to give particular consideration to:

> *"c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved".*

4.1 Narrow scope

The terms of reference is restricted in its scope to public hospital and medical services leaving open the implication that accountability issues are more pressing in those two areas of the health care system. There is no evidence for that. Accountability is a universal issue for health care. Indeed, the community demands a level of accountability in health care that far exceeds that applying in many other sectors for the obvious reason that health care can be a life or death issue.

Accountability is often handled as an issue for providers of health care. It is also an issue for funders of health care. It is not limited to the service delivery level but also applies to those who help create the human capital and physical infrastructure that the health system needs.

Governments cannot hope to escape accountability for:

- Health workforce shortages which directly reflect their failure to provide enough training places in universities and teaching hospitals; or
- Health infrastructure inadequacies which reflect the failure to keep pace with changing demographics (both population ageing and population movements).

Notwithstanding the terms of reference, the Committee should address accountability as a system-wide issue.

4.2 Delete "whether"

The terms of reference call for the Committee to consider "*whether accountability ... can be improved*". The short answer is "Yes, of course". But it will not be improved by the generation of even larger volumes of reports full of data that is devoid of meaning for the population at large.

It requires honest appraisal. In the AMA submission to the *Senate Select Committee on Mental Health* we point to two recent State Government reports which deal with critical issues in a more open and honest manner that we have seen before:

- In 2004, the Chief Psychiatrist in Victoria released a ground-breaking report[2] which documents the critical incidents and suicides of people treated in the mental health system in Victoria.
- In NSW two *Tracking Tragedy* reports have been issued, the first in December 2003 and the second in March 2005.[3]

The AMA strongly commends these landmark efforts, urges the Commonwealth Government and other State governments to try to do even better in their own areas of responsibility.

In contrast, the Commonwealth's 2004 report on public hospitals was carefully sanitised and lacking in substance. It failed to give a credible account of the run-down state of the sector.[4]

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2 Office of the Chief Psychiatrist (Victoria, 2004).

3 NSW Mental Health Sentinel Events Review Committee (2003) and (2005)

The AMA does acknowledge that this was a 'first effort'. There is a great deal of room for improvement.

There are many opportunities. To our minds, a stand-out example of poor accountability relates to the reporting of public hospital waiting lists and times:

- For years State and Territory governments have failed to agree on and adhere to a defensible standard of reporting;
- Definitions and categories have been changed repeatedly to "cook the books" and to make it impossible for anyone to get comparable data that would allow a reliable assessment of trends over time;
- The data are issued with a huge time lag;
- The systems for tracking patients are poor; and
- The results are not trusted by anyone who works in the public hospitals as being a true and fair representation.

4.3 The focus on service provision

The AMA submission to the *Senate Select Committee on Mental Health* addressed the lack of accountability in the mental health sector and we respectfully draw the attention of the Committee to Part 6 of that submission.

Some of the issues addressed there are not limited to mental health. In particular, we refer to the preoccupation of governments with reporting on the cost and volume of services produced while paying little or no attention to the unmet needs of the patients, the indirect costs of disease, the burdens on families and carers and so forth. It is not acceptable for a Commonwealth Government report to state that:

> *"It is not known how much spending on mental health services is required to meet the priority needs of the Australian population. However, surveys conducted of the extent of mental illness in the community have highlighted a high level of unmet need. Similar findings have been reported in other countries."*[5]

The opening terms of reference for this inquiry call on the Committee to consider "*... how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians*". Given that the demands for health care are high, no community can afford everything it might like to have. Choices have to be made about priorities. If the Federal Health Department can do no better than the statement quoted above, then other stakeholders can have no confidence that informed decisions are being taken about the most pressing needs or the scope for cost-effective initiatives.

4.4 National standards

One way to improve accountability and decrease the differences in health care access and provision provided to Australians is to develop a core set of national standards for public hospital and other health services. These would need to be widely promulgated and reported on by each of the State and Territory Health Governments and the Federal Government as necessary.

The standards would broadly cover access, efficiency and quality of hospital services and would encompass such matters as waiting times, cost of hospital services and outcome

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4 The state of our public hospitals, June 2004 report.

5 National Mental Health Report (2004).

measures from public hospital treatments. The standards would have to be meaningful and well understood by the public and involve some quantitative and qualitative aspects from directly surveying users of the system in the various jurisdictions. AMA believes this would go a long way to putting the "A" back into accountability.

4.5 Medical standards

In contrast to other aspects of the health system, fee for service medicine is the most accountable method of delivering medical services to patients and we should maintain and enhance it. Doctors are directly accountable to their patients for the quality of the service provided and for the fee charged for providing the service. The referral system in Australia ensures that only those conditions which require it will go on to receive more expensive specialist services.Fee for service medicine is a real strength of the Australian health system and we should celebrate it more.

4.6 Conclusions re accountability

As we intimated in Part 2, Commonwealth/State arrangements in health care are difficult to unravel because the cost and blame shifting potential of that system is, regrettably, very appealing to politicians in all jurisdictions and of all persuasions. The inertia against change is immense. While that remains the case, improvements in accountability by government will remain elusive. Were it possible to resolve some of the areas of shared responsibility so that one level of government was fully accountable for outcomes, that would be a significant step forward. However, we are not holding our collective breath.

Even though the probability of reform of that nature is low, there is still ample scope for governments to lift their game. We point to:

- The Commonwealth Government should become a leader, not a reluctant follower, in the open and honest reporting of the problems in the health system, following the good examples set by NSW and Victoria.
- Far more attention should be paid to understanding and reporting on needs (including unmet needs) and health system and community costs of ill health so that future choices can be better informed.
- The AHCAs (National Mental Health Agreement) should mandate reporting by State and Territory jurisdictions of the number of people with mental illnesses who are treated and whether those people are treated face-to-face or by telephone. The public sector should follow the lead of the private sector in this area.
- Resources for outcome measurement in the public mental health system must be increased significantly.
- We need to develop national standards for the public hospital system in Australia against which we can measure the performance of the public hospitals in terms of access, efficiency and quality. We need to encourage and protect fee for service medicine in Australia because it provides direct and immediate accountability to the patient, not through third parties.

5 THE PRIVATE HEALTH SECTOR

The terms of reference call for the Committee to give particular consideration to:

> "*d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government*".

In responding to this element of the terms of reference, we must say that it is natural for there to be some tension between funders and providers and that this tension can be creative. The central outcome we all seek is good patient outcomes. If good patient outcomes require some friction between funders and providers, then so be it. Processes and outcomes are two different things. It is quite possible to have processes that are comfortable but lead to outcomes well short of what could be achieved.

A role model for a good, productive process is the **Strategic Planning Group for Private Psychiatric Services** (SPGPPS). SPGPPS builds capacity into the system and establishes a really effective dialogue between consumers, providers and funders. One very useful outcome of SPGPPS has been data collection in relation to private psychiatric services. That is addressed further in the AMA's submission to the *Senate Select Committee on Mental Health*. A description of SPGPPS is included at Appendix A. The AMA urges the Committee to take a closer look at SPGPPS.

5.1 Sustaining the private sector into the future

Much of the debate about sustainability of the health sector has been driven by the 2002 Intergenerational Report (IGR 2002). That report addressed the issues in a very partial way. It placed its focus on the sustainability of budget-funded health spending. There is, however, a prior question which was not adequately addressed in IGR 2002—that of how we reconcile the growing demand for high quality health services (given an ageing population and rising expectations) with the capacity of the community to pay.

The subsidiary question is how we share the sustainable costs through public insurance (taxpayer-funded), private insurance or direct out-of-pocket costs.

The capacity of the community to pay is not in question. Australia is a wealthy country and real per capita income per head will be a great deal higher by the year 2040, the time horizon of IGR 2002. The prior question is ultimately a question of choice for the community. Or rather, it is a series of choices, some made collectively and others made individually. We will have the sort of health care system we are prepared to pay for. If the health care system can produce high quality outcomes in future, those outcomes will have a value to the community and will influence the community's propensity to spend on health care as opposed to food, shelter, transportation, entertainment, and so forth.

From the viewpoint of the AMA, those questions will work themselves out. We do recognise, of course, that:

- politicians will have an uncomfortable time straddling the barb wire fence comprised of community resistance to tax increases and the relentless growth in health care costs; and
- the widening gap between 'haves' and 'have nots' in the Australian community will also work to tighten the wire and politicians seek to reconcile the interests of those who are dependent on Government support and those who are net payers.

The issues, will, however, be resolved by the electorate in the normal course of events and the challenge for politicians is to listen carefully to what the community wants.

The challenge for the private health sector is to produce the high quality health outcomes that patients want. If it does that, it will be sustainable. If it fails to do that, its future is uncertain.

5.2 Private financing of health care

The term "private health sector" is often used loosely. What we actually have is private and public health funders who both purchase or subsidise the purchase of health goods and services from public and private providers. There is often a failure to recognise that private providers play a relatively much larger role in the health system than private funders.

We first examine the private health financing sector. This comprises the private health funds (as the major players) and the compensation insurers (as the minor players).

One possible outcome from the intergenerational pressures discussed in part 5.1 above is that private financing of health care plays a larger role in future due to taxpayer resistance. For too many years, the private insurance sector was regarded by Government as a necessary inconvenience that sat around the edges of Medicare.

If the community chooses a larger role for private financing in future, then it is imperative that we start taking steps to ensure that the private health insurance sector is better equipped for its role.

That said, given the intergenerational pressures there is more reason than ever to examine the potential for health savings accounts to complement private health insurance. This topic is addressed in Part 6.3.

Private health insurance is addressed in Part 6.

5.3 Private provision of health care

The private health sector plays a major role in the provision of health care goods and services. Private providers include:

- Doctors in private practice (Medicare rebates help patients to access their services while VMO contracts engage their services in the public hospital sector);
- Retail pharmacists;
- Other paramedical health care professionals in private practice (dentists, physiotherapists);
- Private hospitals;
- Pharmaceutical companies;
- Aids and appliance manufacturers; and
- A host of businesses providing goods and services to health providers spanning areas such as construction, transportation, communications, energy, financial services, and so forth.

Given that the Commonwealth Government funds approximately half of national health spending and that the three tiers of government fund two thirds, it will be readily apparent that the largest source of funding for private providers is the public sector.

This public/private sector partnership is one the keys to the successes that are achieved in the Australian health care system (including a large number of high quality health services at a very modest cost compared with other wealthy countries).

Another key is the high quality of the health workforce, the prime asset in the health care system.

There are parts within the private health sector that are not working as well as they should. In some cases (pharmacy), there is excessive mollycoddling. In other areas, there is excessive and inappropriate regulation which adds to costs without improving quality.

5.4 Conclusions re sustaining the private health sector

Looking towards the future, what can we do to sustain the private health sector?

- First and foremost, we must sustain and build on the quality of the health workforce. This is vitally important to both the public and private health sectors. The role of the public hospitals in training is mission critical. Given the pressures on public hospitals, there is scope to consider a potential role for private hospitals in the teaching and training of our future doctors.
- As things stand, funding mechanisms create all sorts of artificial barriers which constrain the contribution the private sector can make to the provision of health care. Significant markets are not contestable. There are barriers and incentives which skew the provision of care away from the most appropriate environment or away from the most affordable setting.
- Although the efficiency gains from reform based on competition policy are oversold in relation to the health sector, the Commonwealth Government must now move to open up retail pharmacy to the same level of competition as applies to other health professions.
- We need stable policy settings so investment can take place in the private sector with confidence that the demand for private hospital services will be there.

6 PRIVATE HEALTH INSURANCE

The terms of reference call for the Committee to give particular consideration to:

> *"e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover".*

6.1 Community demand for private health insurance

The AMA firmly believes that many people in the community are prepared to accept some financial responsibility for their own health care if, as a reasonable quid pro quo, they are allowed more choice over the care they can access, the setting, the health professional and the timing.

Time and again, the community had also made clear its wish to have a mechanism to share the risk of major health problems. Given that no government of any persuasion has been prepared to fund Medicare at a level that would make it workable and a truly universal, single system of insurance, private health insurance (PHI) is here to stay.

The current "carrots and sticks" structure (PHI tax rebates, Lifetime Health Cover and the Medicare levy surcharge) have largely stabilised PHI coverage. The calls from some vested interests for those arrangements to be changed (in particular, the trenchant calls for the tax rebates to be removed) should be ignored and the wishes of the wider community should be respected.

What's missing now is strong bi-partisan political support for the current arrangements. That is sorely needed to impart some further stability.

The suggestion that the introduction of the rebate was not a factor in the resurgence in PHI participation is also widely held but does not hold up under scrutiny.

6.2 Lifetime Health Cover

The AMA perceived that the old system of community rating was failing and was a leader among stakeholders in urging the adoption of lifetime community rating (known in Australia as Lifetime Health Cover). The AMA was, and remains, a strong supporter of this policy.

We do believe, however, that there could be some fine tuning of the incentive, in particular the effectiveness of the surcharge for those joining after the age of 30 (currently 2% for each year) should be kept under review.

6.3 Health savings accounts

The IGR suggested that current intergenerational transfers cannot be sustained into the future. Some people have interpreted this to mean that Australia will not be able to afford a high quality health care system in the future. Were that true, then private health insurance will not be sustainable either and policies to encourage more Australians to take responsibility for their health cover will inevitably fail.

The AMA considers such a proposition to be the wrong take-home message. As we noted in Part 5.2, it is not plausible for anyone to argue that a wealthy country like Australia will not be

able to afford to give all its citizens access to high quality health care. That said, intergenerational pressures are growing and cannot be ignored.

Health insurance (whether public or private) meets the preferences of the community for a mechanism to share risk.

Whatever the system of health insurance (public or private, social insurance, etc), there will be a call on patients to meet a share of health costs out-of-pocket. These out-of-pocket costs vary from country to country but every system has them. Therefore, every patient has a lifetime health out-of-pocket cost.

Highest health costs are experienced in the senior years. The lifetime health out-of-pocket cost is concentrated in those years when assets may be substantial but not easily accessible and cash incomes may be low. By the time people reach their senior years, many have paid off their home so shelter is provided.

The two great needs in retirement are for retirement income and access to health care. It is timely for Australia to consider whether health savings accounts may be of positive assistance in helping patients meet their lifetime health out-of-pocket costs. The obvious solution is to "plug in" to the superannuation system and to turn occupational superannuation accounts into superannuation and health savings accounts.

The AMA does not see health savings accounts as being in competition with private health insurance. Rather they would complement public and private health insurance and would usefully address issues of sustainability of access to high quality health care and address in some way the growing intergenerational tensions.

6.4 Over-regulation of PHI

The PHI funds have, over the years, been too highly regulated and the regulation deters new entrants and new ideas. If the Committee is interested in innovative ways to make PHI even more attractive, then its first priority must be to identify and analyse the many roadblocks to innovation. The private health insurance industry has been complicit in allowing creeping regulation of the industry as a lever for seeking political favours in other areas. The case for maintaining regulation of premiums, waiting times, reinsurance and gap cover is weak. The important elements of the regulatory framework to keep are Lifetime Community Rating, prudential requirements and for clear and succinct information about the products supported by an effective complaints mechanism. Measures to protect portability of private health insurance and to prevent discrimination against the mentally ill may also be necessary.

Every consumer should have the option of being able to purchase comprehensive health insurance covering the full range of medical services. Increasing the control of private health insurers over the medical profession will increase costs, decrease quality and lead to more litigation against private health insurers.

The Commonwealth Government has undertaken some tentative steps to deregulate PHI. In future, it will need to be a little less timid. It needs to start from the position that there is no regulation unless a clear case can be made out for there to be regulation.

6.5 Competition in PHI

The over-regulation of PHI (addressed in Part 6.4) has stifled competition between the funds.

In some cases, the regulation stands in the way of competition and conflicts with national competition policy. For example, the arrangements which were supposed to enshrine portability of PHI membership between funds has fallen into disrepair, failing to keep pace

with other legislated changes and changes in the way the industry operates. That legislation now needs to be updated to make portability of cover inviolable.

6.6 Incremental change

Given that 'it ain't broke', the focus in this area must be very much on incremental change with an eye towards the future.

- Keep under review the adequacy of lifetime Health Cover arrangements, specifically the 2% a year ramp up in PHI premiums for people who join a private health fund after the age of 30.
- Take a more strategic, long term view of the regulation of PHI with a view to further winding back excessive regulation of the industry.
- Enshrine portability of membership between funds without the imposition of new waiting periods for benefit entitlements.
- Give consideration to the scope for health savings accounts to augment PHI in the future.

7 COMMONWEALTH GOVERNMENT'S "BACK YARD"

The terms of reference call for the Committee to:

> *"inquire into and report on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians".*

In addressing this part of the terms of reference, the AMA urges the Committee that it should not restrict its consideration to intergovernmental and inter-sectoral issues. It must also consider a range of issues that are partly or entirely "own back yard" issues for the Commonwealth Government.

7.1 Two big weaknesses in priorities

As we noted in part 1, the two biggest weaknesses in terms of the health priorities set by governments, are that not nearly enough attention has been given to:

- mental health; and
- Indigenous health.

In both areas we note the poor outcomes, the under-resourcing relative to the needs of the sub-populations and the scope for cost-effective initiatives. The terms of reference specifically refer to "all Australians". Here are two sub-groups who do not get a 'fair go'.

Both areas cry out for strong national leadership. In both cases, the failings do not sit with one government alone. Both areas are dogged by prejudice and stigma. In both cases, the patients are less able to negotiate the complexities of the system without external help.

7.2 Big weaknesses in health prevention

In terms of health prevention, Australian has not made nearly enough progress with:

- tobacco control;
- control of illicit drugs; or
- addressing obesity.

These are areas where there are potentially large returns to the nation in terms of health cost saved and years of life gained from well-targeted strategies.

Again we refer the Committee to the AMA submission to the *Senate Select Committee on Mental Health* where (in Part 7.1) we point to a number of key issues including the inappropriate use of the penal system to deal with people with mental and substance abuse comorbidities and the scope to achieve better outcomes through holistic treatment of these patients. This will require mental health and alcohol and other drugs (AOD) services to be brought together as part of a national chronic disease strategy.

7.3 Improving the structure of benefit programs

Not all the complexity in the health system can be attributed to intergovernmental and inter-sectoral issues. On the contrary, the Commonwealth Government has made it own contributions through the multiplicity of its health spending programs and multiple payments systems.

The structure of benefit entitlement systems can be improved in many small ways. The AMA suggests that an entirely logical next step would be to introduce a single safety net covering both Medicare and the PBS. Initiatives of this nature are vital to help an ageing population negotiate a needlessly complex payments system.

7.4 Improving the payments system

As noted in part 3, there is very considerable scope to improve the efficiency of the payments system. The AMA believes that the health payments system should be entirely electronic with patients able to claim all benefits electronically at point of service and, if they wish, assign all benefits electronically to their health care providers.

This should apply to the entire (public and private) health sector (hospitals, doctors, paramedical health professionals, etc). The current system is hugely wasteful of government and private fund money and patient time.

7.5 Reducing Commonwealth red tape

Outcomes from the GP Red Tape Review have fallen far short of expectations. The AMA remains of the view that the fee-for-service system supported by benefits entitlements is the system which will be most responsive to meeting the needs of patients and the most productive system.

7.6 Improving workforce policy

The Commonwealth Government has been a weak and reactive leader in the area of workforce policy, especially workforce planning for the future. Extraordinary efforts seem to be put into Commonwealth/State issues with not enough in the way of outcomes.

The Commonwealth government has started to become a little more proactive in engaging other stakeholders (professional associations, colleges, universities) in regard to workforce issues. There needs to be a much greater understanding that this is not a simple question of how many health professionals to train. Workforce policy needs to engage both quality and quantity issues in relation to training, pay far more attention to workforce retention and encompass strategies to help lift the productivity of the health workforce.

7.7 The importance of health research

There is much that the Commonwealth Government ca do to support health research. Too often, doctors are relying on limited and out-of-date epidemiological data. The Health Insurance Commission (HIC) has data of potentially great value if it can be unlocked. Researchers should be able to access de-identified unit records from the Medicare, PBS and hospital data sets. Patient privacy must be respected (not negotiable) but current restrictions of access to data go far beyond what is necessary to protect privacy.

7.8 Better ways to set health priorities

Australia needs a much more rational and better informed debate about health priorities and the efficacy of treatments. Some recent debates have been handled at a very immature, emotional level.

Increasingly, health care is moving from the acute to the chronic conditions. No respectable argument can be made that Governments ought not fund treatment for arthritis (eg, access to

pharmaceuticals, joint replacements) or blindness (eg, cataract surgery) on the grounds that the conditions are not immediately life threatening.

The ultimate aim of health care is to deliver more years of disability-free life and, in that framework, there is just as strong a case for treating non-life threatening illnesses as life threatening illnesses. Any lessening in commitment to fund the treatment of chronic disease would be hugely discriminatory against older Australians and would be morally and politically unsustainable.

It is valid for Governments and the health professions to seek to influence the peoples' choices by marshalling the scientific evidence about which interventions:

- are likely to be effective;
- may be potentially damaging; or
- may involve acceptable risks.

This is, however, a task which needs to be completely separated from the adversarial political stage.

7.9 Conclusions re "back yard" issues

The AMA notes the following areas where strong national leadership is required:

- Give a much higher priority to mental health in the allocation of resources.
- Give a much higher priority to Indigenous health in the allocation of resources.
- Provide strong national leadership re meeting the health needs of those who abuse substances.
- In particular, provide strong national leadership on tobacco control.
- Pay far more attention to health promotion to combat obesity.
- Consider a single safety net to cover both Medicare and the PBS.
- Adopt a strategy to achieve a fully electronic payments system in every part of the health care sector within 5 years.
- Redouble efforts to engage stakeholders on health workforce issues with a view to achieving a strong national consensus on policy directions.
- Look at ways of unlocking valuable datasets that would support high quality studies in the area of epidemiology.
- Sponsor the health research that would lead to a much better informed (and depoliticised) basis for setting health priorities, taking account of indirect costs and benefits as well as direct (health system) costs and ensure that the population at large and their GP advisers have access to this information.

8 DEAD ENDS

From the perspective of the AMA, a number of the proposals for change in the way health care is delivered and financed have little or no merit. Such judgments are based on one central issue—whether or not the proposed reform is likely to produce better outcomes for patients.

8.1 An Australian Health Care Commission

A number of stakeholders have seen merit in a joint and over-arching *Australian Health Care Commission* or *Australian Health Corporation* which would manage pooled funds on behalf of Federal and State Governments. There are a number of variations on this theme, including the possibility that the Corporation could also manage funds on behalf of private funders and, on a rather different tack, the concept of a semi-independent body with a separation between it and political government. The Corporation would be the mother of all purchasers and would purchase services on behalf of all Australians. We note that:

- Far from reducing bureaucracy as claimed by proponents, this is likely to add yet another layer on top of existing three layers (Commonwealth, State and Local);
- Previous attempts to distance the health bureaucracy from Ministerial responsibility have ended, inevitably, with the abolition of boards of management. Putting politicians at arms length from key decisions on the expenditure of taxpayer money is a pipe dream;
- There is no viable way to marry the concept of a central purchaser with a benefit entitlements system as per Medicare and the PBS. This reform would take decision making about how often, what and where care will be sought out of the hands of patients and their doctors, and put it into the hands of bureaucrats instead;
- We can see no prospect that this would be acceptable to the Australian people.

8.2 Capitation schemes

Some stakeholders, especially those with a particular interest in managing budgets, seem to think that the answer to the inexorable growth in health expenditure is to cap spending. Capitation schemes are, in essence, schemes to transfer risk from Government to the household sector. Were the funding adequate to meet the needs of the people, the damage they would do might be contained to a poor allocation of health resources. But funding never is adequate. Capitation schemes run counter to the strong wish of the Australian people for a viable system of health insurance, a mechanism which allows the community to share the financial risks of poor health.

8.3 Budget-holding schemes

A variation on capitation schemes is to distribute capped funds to budget holders who would purchase services as agents of Government. The appeal of budget-holding is that it makes some intermediate party the 'bunny' when the inadequate funding inevitably gives rise to crude rationing of access to services. In these circumstances, Governments will claim that the funding is adequate and that the budget-holders have to manage better. In some cases, it is contended that the budget-holding intermediaries will be better placed than the government to determine spending priorities. One of the many problems with budget-holding is the immense difficulty in distributing funds between budget-holders so as to avoid situations where sub-groups are severely disadvantaged on a regional or disease basis.

8.4 A single level of government

Some stakeholders look at the Commonwealth/State arrangements in health care with bemusement and wonder aloud if we should radically change the responsibilities of the various levels of government so that responsibility for health care fell to just one level of government. History is littered with failed attempts to rationalise Commonwealth/State roles. The AMA can see no prospect of success in rationalising health care to a single level of funding given the failures in much less complex sectors like railways.

Countries which once had unitary systems (the UK for example) have headed off down a pathway towards a Federal system with delegation of powers to 'state' governments.

As we read it, the Australian people are no more keen to see everything run from Canberra than they are to see everything run from Sydney, Melbourne, etc. Whether Commonwealth or State seem immaterial as both seem so far removed from the every day reality of long waits to see a GP or even longer waits in Accident & Emergency Departments.

8.5 A salaried medical workforce

Some stakeholders argue that the fee-for-service system is itself a cost-driver and that cost control would be easier if all doctors were salaried. The AMA believes that the fee-for-service system ensures that the medical workforce is responsive to the wants and needs and patients and that it creates the incentives for the medical workforce to be highly productive. In most jurisdictions around the world, fee-for-service plays a strong role in the remuneration of doctors.

8.5 A ban on 'extra-billing'

Some stakeholders argue that doctors should be forced to adhere to a schedule of fees and ought not have any right to set their own fee levels. The health system is beset with administered prices and this contributes quite directly to a sub-optimal allocation of resources. In short, price controls create much bigger problems than the problems they purport to fix.

8.6 US-style managed care

Some stakeholders, particularly some private health funds, seem to retain the point of view that the problems they face would be more easily managed if they had more control over health professionals. US-style managed care has been shown time and again to contribute to poor quality outcomes, to interfere on a grand scale in the doctor-patient relationship and to strip patients of any real say in their treatment. The AMA notes that the best outcomes in terms of cost-effective health care occur when the patient has a strong understanding of the risks, costs and likely prognosis as a result of the treatment. Attempts to remove patients and their GP advisers from the decision-making process will fail.

Australians are better educated and wealthier than ever before. Health funders, whether governments or private funders, are going to have to engage the reality of a wealthier and better educated population and find ways to engage them constructively in decisions about what will be funded and what not funded. In addition, the origins, values and financing systems have a completely different history which would cause us to reject US style managed care being grafted on to the Australian health system. Neither do we have the problems in our system which US style managed care was invented to fix.

9 COMPENDIUM OF RECOMMENDATIONS

Roles and responsibilities of the different levels of government

- 'Big bang' change in Commonwealth/State arrangements is highly unlikely to gain any traction given the inertia across levels of government and should not be further pursued by the House of Representatives *Inquiry into Health Funding*.
- There is potential for carefully thought through incremental change but questions remain as to whether this will be more effective if 'top down' or 'bottom up'.
- Any proposals for reform of the health financing arrangements and health responsibilities between the Commonwealth and the States must be evidence-based, subject to rigorous impact assessment and viewed from the perspective of the patient, not just the perspective of the funder.
- Incremental change to health service delivery will be more effective if built on genuine funding partnerships between the Commonwealth, the States and Territories.
- There are positive role models for better arrangements, sometimes achieved despite Commonwealth/State arrangements and other times achieved within these them—these models should be transplanted wherever possible.

Simplifying funding arrangements

- Governments need to accept, rather than resist, the central role of the GP in helping the patient navigate their way through the tertiary system. Well-informed patients will suffer fewer problems in navigating complex systems and efforts to ensure that patients are well-informed are important. That said, there will be patients (eg. Dementia, other mental illness) who will be unable to negotiate the systems without help from their carer and GP (or other patient advocate).
- In considering any initiatives to reduce the complexity of the current system, the first priority should be to reduce the complexity of the system as experienced by the patient—that is we should seek to build systems which meet the requirements of the patient and which follow the path required for patients undergoing treatment as they progress through the system.
- Identification of models of excellence in the provision of health services and rolling these out around Australia is essential (bottom up change).
- A national pharmaceutical scheme (shown by the pilot to be workable and desirable) should be rolled out across the whole of Australia.
- The remnant outpatient services provided in public hospitals are often close substitutes for services funded through medical Medicare and it behoves governments to examine whether there is scope for a single funding framework for both that will preserve the vital teaching and training activities conducted in the public hospitals.
- Information systems, electronic records, electronic prescribing etc all need to be based on improving the quality of care and meeting the needs of patient. The overwhelming goal should be to make the system as smooth and functional as we can for patients. Good outcomes will flow from that and it is the right focus.
- The complexity of the current system demands the immediate introduction of electronic claiming at point of service, electronic payment including assignment of benefits to providers without any exception. The high cost and inconvenience of archaic payment systems can no longer be justified.

Accountability

- The Commonwealth Government should become a leader, not a reluctant follower, in the open and honest reporting of the problems in the health system, following the good examples set by NSW and Victoria.
- Far more attention should be paid to understanding and reporting on needs (including unmet needs) and health system and community costs of ill health so that future choices can be better informed.
- The AHCAs should mandate reporting by State and Territory jurisdictions of the number of people with mental illnesses who are treated and whether those people are treated face-to-face or by telephone. The public sector should follow the lead of the private sector in this area.
- Resources for outcome measurement in the public mental health system must be increased significantly.
- We need to develop national standards for the public hospital system in Australia against which we can measure the performance of the public hospitals in terms of access, efficiency and quality. We need to encourage and protect fee for service medicine in Australia because it provides direct and immediate accountability to the patient, not through third parties.

Sustaining the private health sector

- First and foremost, we must sustain and build on the quality of the health workforce. This is vitally important to both the public and private health sectors. The role of the public hospitals in training is mission critical. Given the pressures on public hospitals, there is scope to consider a potential role for private teaching hospitals.
- As things stand, funding mechanisms create all sorts of artificial barriers which constrain the contribution the private sector can make to the provision of health care. Significant markets are not contestable.
- Although the efficiency gains from reform based on competition policy are oversold in relation to the health sector, the Commonwealth Government must now move to open up retail pharmacy to the same level of competition as applies to other health professions.
- We need stable policy settings so investment can take place in the private sector with confidence that the demand for private hospital services will be there.

Sustaining private health insurance

- Review the adequacy of lifetime Health Cover arrangements, specifically the 2% a year ramp up in PHI premiums for people who join a private health fund after the age of 30.
- Take a more strategic, long term view of the regulation of PHI with a view to further winding back excessive regulation of the industry.
- Enshrine portability of membership between funds without the imposition of new waiting periods for benefit entitlements.
- Give consideration to the scope for health savings accounts to augment PHI in the future.

Back yard issues for the Commonwealth Government

- Give a much higher priority to mental health in the allocation of resources.
- Give a much higher priority to Indigenous health in the allocation of resources.

- Provide strong national leadership re meeting the health needs of those who abuse substances.
- In particular, provide strong national leadership on tobacco control.
- Pay far more attention to health promotion to combat obesity.
- Consider a single safety net to cover both Medicare and the PBS.
- Adopt a strategy to achieve a fully electronic payments system in every part of the health care sector within 5 years.
- Redouble efforts to engage stakeholders on health workforce issues with a view to achieving a strong national consensus on policy directions.
- Look at ways of unlocking valuable datasets that would support high quality studies in the area of epidemiology.
- Sponsor the health research that would lead to a much better informed (and depoliticised) basis for setting health priorities, taking account of indirect costs and benefits as well as direct (health system) costs and ensure that the population at large and their GP advisers have access to this information.

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APPENDIX A: SPGPPS

The **Strategic Planning Group for Private Psychiatric Services** (SPGPPS) is the peak mental health alliance that brings together diverse stakeholders to identify and agree on issues directed at improving mental health services in the Australian private sector. This alliance is a strong partnership between the following stakeholders.

1. Australian Medical Association (AMA);
2. Royal Australian and New Zealand College of Psychiatrists (RANZCP);
3. Royal Australian College of General Practitioners (RACGP);
4. Australian Private Hospitals Association Limited (APHA);
5. Australian Health Insurance Association (AHIA);
6. Australia Government Department of Health and Ageing (DoHA);
7. Australian Government Department of Veterans' Affairs (DVA); and
8. Mental health consumers and their carers.

The alliance seeks to not only better inform each stakeholder's own policy processes, but also to reach agreement on actions that will improve practice and better integrate mental health care across the private and public sectors. The SPGPPS and its Working Groups meet regularly to work toward achieving these goals, particularly in relation to the following key areas that are critical to the provision of high quality private sector mental health services:

- Participation of private sector consumers and carers;
- The funding and uptake of innovative models of service delivery that have been shown to be effective and feasible;
- Flexibility of funding arrangements so that the implementation of appropriate models of care is not inhibited;
- Strong linkages, co-ordination, and continuity of care between GPs, Psychiatrists and private hospitals; and
- The quality, availability and utilisation of information regarding private sector mental health services.

Centralised Data Management Service

In 2001, the SPGPPS established a **Centralised Data Management Service** (CDMS) to improve the quality, availability and utilisation of information regarding private sector mental health services through the implementation of a **National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based, Psychiatric Services**. Participation in the National Model by 43 of the 46 Australian private hospitals with psychiatric beds (hospitals) enables those hospitals and payers to evaluate and monitor the quality and effectiveness of the care provided by those participating hospitals.

National Network of Private Psychiatric Sector Consumers and Carers

In 2003, the **AMA**, **RANZCP**, **APHA**, **AHIA** and **beyondblue** financially supported the establishment of the **National Network of Private Psychiatric Sector Consumers and Carers**, to improve the participation of mental health consumers and their carers in private sector mental health services. The National Network is working to better involve consumers

and their carers in policy decisions around the design, delivery and evaluation of private sector mental health services, and to be an effective advocate of their rights and responsibilities.

The work of the SPGPPS, its CDMS, and National Network is supported through the SPGPPS Secretariat, located at the offices of the Federal AMA in Canberra. The SPGPPS website is located at: www.spgpps.com.au.

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