3

Adherence to clause 6 principles

The primary objective of this Agreement is to secure access for the community to public hospital services on the following principles:

(a) Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals;

(b) Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and

(c) Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.[1]

Clause 6 principles of the AHCAs

3.1 The heart of the AHCAs is clause 6 which sets out the primary objective of the agreements. In essence, the community is to have access to public hospital services, free of charge, within a clinically appropriate time, and regardless of location.

3.2 In applying the principles in clause 6, clause 7(a) commits the Commonwealth and states to agree that the range of services available to public patients will be no less than was available on 1 July 1998. Clause 25 requires the Minister to be satisfied that the states have adhered to the principles set out in clause 6, among other

1 AHCAs, clause 6.

requirements, before they can qualify for full funding. Full funding includes the four per cent compliance payment.

3.3 In its report, the ANAO discussed Health's assessment of the states' adherence to the clause 6 principles and its management of non compliance. This was of particular interest to the committee as it had taken evidence during its inquiry into health funding suggesting a lack of compliance with clause 6 in some states.

3.4 In its audit, firstly, the ANAO considered whether Health identified potential breaches of the clause 6 principles and then whether it obtained sufficient information to assess whether a breach had in fact occurred. Secondly, the ANAO examined whether Health had adequate procedures in place to follow up potential breaches and ensure that they were being addressed. The ANAO also considered how Health assessed state overall compliance with clause 6 and whether the assessments provided sufficient information to the Minister to inform his determination of compliance.[2]

Assumption of adherence

3.5 The AHCAs do not specify how the Commonwealth is to measure the extent to which the states are complying with clause 6.

3.6 The ANAO found that Health assumed that the states were complying with the AHCA principles and did not actively check for compliance. Health was also confident that the states had sufficient incentive to remain compliant:

> Given that there is this penalty clause within the current health care agreements, it really does prompt a whole lot voluntary compliance. Our expectation is that states do not want to lose that four per cent. Four per cent of a large number is still a large amount of dollars.[3]

3.7 Action was only taken by Health when specific complaints or allegations about public hospital services were made to the department or the Minister, or when Health identified potential non-compliance from other sources such as media reports, hospital circulars or state government websites.[4] Health had initiated some

2 ANAO, Audit Report, p 37.

3 Kalisch D, transcript, p 5.

4 ANAO, Audit Report, p 38.

investigations but had to be mostly reactive and dependent upon cases being drawn to its attention.[5]

Complaints and allegations

3.8 Public hospital emergency departments collectively treat just over four million people per year and nearly the same numbers are admitted to hospitals as public patients each year.[6]

3.9 Complaints units, in public hospitals and state health departments or independent bodies, regularly receive complaints from people about their experience as public patients. These complaints are generally about the quality of medical treatment or hospital care that public patients have (or have not) received and are addressed at the state level.

3.10 The Commonwealth, on the other hand, can only receive complaints specifically about non compliance with the AHCAs themselves. For this reason, in the first three years of the AHCAs, a total of only 133 complaints or allegations about public hospital services were received at the Commonwealth level by Health or its Minister.[7]

3.11 Those complaints about clause 6 non compliance that are made to Health or the Minister, tend to come from public hospital staff, medical practitioners or private health insurance companies[8]. This corroborates the committee's experience during its inquiry into health funding and examples of alleged breaches of the AHCAs are listed in *The Blame Game*. Examples of breaches included in public hospitals: billing patients or the Medicare Benefits Schedule (MBS) for services that should have been provided free or charge; pressuring patients to elect to be treated as private patients; and outpatient departments seeking referrals to a named doctor to ensure they can be billed to the MBS.[9]

Health follow up

3.12 When it receives a complaint concerning compliance with the clause 6 principles, Health raises it with the appropriate state health department and relies on their cooperation to confirm whether the

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5 ANAO, Audit Report, pp 38-39.

6 Health, *The state of our public hospitals, June 2007 report*, Commonwealth of Australia, 2007, pp 27, 48; ANAO, Audit Report, p 38.

7 Kalisch D, transcript, p 6.

8 ANAO, Audit Report, p 38. See also Kalisch D, transcript, p 3.

9 Health, *The Blame Game*, Box 7.2. See also ANAO, Audit Report, p 43.

complaints have merit.[10] However, only some half of the 133 complaints could be pursued by Health, mainly because complainants were reluctant to have their identity revealed to state health departments during investigations.[11]

3.13 Health told the committee that, of those complaints it could investigate, only a relatively small number had turned out to be breaches and that some of these were technical breaches.[12] In the cases where the state health department agreed that a breach had occurred in a hospital, Health considered the matter closed once remedial action was taken by the state. Health told the committee it was confident that:

> …if there was rampant non-compliance, we are assuming that we would receive far more than 133 complaints, given that there are over four million admissions a year.[13]

3.14 On this basis, Health advised the ANAO that it would need evidence of 'systemic' and 'on going' breaches rather than isolated cases before deeming a state non compliant with its AHCA.[14]

3.15 Health does not have access to state health departments' data to determine whether complaints about the AHCAs are being dealt with at the state level without being brought to the Commonwealth's attention. Health's access to complaints data generated at the state level is via public information:

> It is still a state system; we do not get access to their internal working documents or internal information…
>
> We get access to the public documents, but there is no further requirement.[15]

3.16 The committee suspects that many complaints that potentially involve breaches of the AHCAs are being dealt with at the state level without coming to the notice of the Commonwealth. To ensure that the Commonwealth is at least aware of the true volume and scope of complaints about AHCA breaches, the committee recommends that the Commonwealth seek greater access to state health departments' complaints data for public hospitals.[16]

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10 ANAO, Audit Report, pp 38-39.

11 ANAO, Audit Report, p 40.

12 Kalisch D, transcript, p 4. See also ANAO, Audit Report, p 42.

13 Kalisch D, transcript, p 6.

14 ANAO, Audit Report, p 47.

15 Kalisch D, transcript, p 3.

16 Schedule D of the AHCAs requires the states to maintain independent complaints bodies to resolve complaints about the provision of public hospital services.

Recommendation 1

3.17 **That in negotiating the 2008-2013 Australian Health Care Agreements (AHCAs), the Australian Government require a reporting framework that provides the Commonwealth with regular and compatible data from the states and territories on the number and nature of complaints and allegations they receive about non compliance with the AHCAs.**

Hospital services as of 1 July 1998

3.18 As mentioned, clause 7(a) of the AHCAs requires the states to provide no less than the range of services available to public patients on 1 July 1998. Health had difficulty confirming exactly what were the full range of services available to public patients on 1 July 1998. This, in turn, made it difficult to test compliance by the states with clause 6(a) – the public's entitlement to services that 'are currently, or were historically, provided by hospitals'.[17]

3.19 Health told the committee that the problem was compounded because in 1998 there was a lack of consistency in the range of services offered within states, let alone between states:

> …it is important to recognise here that this is not a blanket statewide approach that we are often talking about here. Often what the pre-1998 services referred to are the practices in an individual hospital that took place before 1998 and the services that were offered at that time. It is not as if there is a standard statewide coverage that everyone is aware of, that this hospital might offer this service, another hospital may have offered it in a different way that is now consistent and does not breach that principle.[18]

3.20 According to the ANAO, this required Health to accept the states' assertions about when they had implemented particular services, with little, if any, supporting evidence.[19]

3.21 The difficulty facing Health in defining the services available in the states on 1 July 1998 is parallelled by the difficulty Health faced in determining the states' base levels of expenditure on health services at

17 See ANAO, Audit Report, p 46.

18 Kalisch D, transcript, p 8. See also ANAO, Audit Report, p 46.

19 ANAO, Audit Report, p 46.

the commencement of the AHCAs – an issue explored in greater detail in the next chapter.

3.22 Clearly, Health has not been in a position to be too pedantic about the states' compliance with clause 6(a) given the uncertainty inherent in Health's baseline data. The lesson drawn by the committee is that the 2008-2013 AHCAs will need to be drafted with the limitations of the current agreements in mind and define far more clearly and precisely the baseline public hospital services that the states are to provide.

Treatment in a clinically appropriate time

3.23 Clause 6(b) of the AHCAs requires that public patients receive access to services 'on the basis of clinical need and within a clinically appropriate time'. Schedule C of the Agreements specifies three of the performance measures to measure compliance with clause 6(b). They are: waiting times for elective surgery, waiting times for emergency departments by triage category and admission from waiting lists by clinical category.

Elective surgery waiting times

3.24 Public patients requiring elective surgery are assigned to one of three categories of urgency. The categories set admission to hospital as being desirable within 30 days, 90 days and 12 months respectively.

3.25 Nationally, in 2005-06, 83 per cent of category one patients were admitted within 30 days, 74 per cent of category two patients within 90 days and 88 per cent of category three patients within one year. Overall national performance has decreased steadily from 1998-99 when 90 per cent of patients were admitted within the recommended times for their elective surgery category.[20] These figures also hide significant variations between states. Nationally, 81 per cent of elective surgery admissions in all categories were seen within the recommended time in 2005-06. Queensland recorded the highest percentage (86%) while Tasmania recorded the lowest (68%).

Emergency department waiting times

3.26 On presentation to hospital emergency departments, patients are assigned to one of five triage categories. A maximum time in which patients should be seen is set for each category. Category one patients

20 Health, *The state of our public hospitals, June 2007 report*, p 40.

are critically ill and require immediate attention. Patients in categories two to four should be seen within 10, 30, 60 and 120 minutes respectively.

3.27 Nationally, in 2005-06, 69 per cent of all patients were seen within the time recommended for their triage category. Victoria performed the best with 77 per cent of all patients seen within the recommend times. The Australian Capital Territory (ACT) at 52 per cent was the poorest performer. Fortunately, very nearly all patients in category one were seen immediately with little variation in performance between the states. Nationally, 64 per cent of patients in triage category three were seen within the recommended time of 30 minutes, although this dropped to 44 per cent in the ACT. Nationally 65 per cent of patients in category four were seen within the recommended 60 minutes. Again the ACT was the worst performer with only 47 per cent of patients being seen within the recommended time. [21]

Committee assessment of waiting times

3.28 The figures for 2004-05 on which the ANAO reported are broadly consistent with the more recent data reported above.[22] It is clear to the committee that not all patients are being seen within clinically appropriate periods – a requirement of clause 6(b) – and that some states are performing worse than others.

3.29 Health was reported to state in its annual advice to the Minister that it believed it would be difficult to propose sanctioning any state for its performance against clause 6(b). The reasons being that the AHCAs did not set benchmarks for waiting times and because there were difficulties with the consistency and accuracy of state waiting time data. [23]

3.30 On the latter issue, Health told the committee:

> We have a minimum data set that we use to measure waiting times, but underneath that there are different processes that occur within hospitals, within emergency departments and in primary care. An example is when the clock starts ticking on your waiting time at the moment we do not have an agreed business rule on when the clock starts.[24]

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21 Health, *The state of our public hospitals, June 2007 report*, pp 49-51.

22 See Health, *The state of our public hospitals, June 2006, report*.

23 ANAO, Audit Report, p 47.

24 Gibson B, transcript, p 15.

3.31 The ANAO recommended that Health work with the states to improve the consistency and accuracy of emergency department performance data and inpatient waiting times.[25] While agreeing with the ANAO recommendation, Health noted that the states managed waiting lists in different ways as described above. Health told the committee that it was working with the states to improve the consistency of the data collected on elective surgery waiting lists and emergency department performance.[26]

3.32 The committee accepts the difficulty Health faces in collecting consistent and meaningful data across the states on elective surgery and emergency department waiting times. The committee also acknowledges that the priority function of state public hospitals is to treat patients rather than collect statistics for the Commonwealth.

3.33 However, in its 2006 health funding inquiry the committee received considerable evidence that the community places a high priority on receiving timely health care, particularly for elective surgery and emergency department care.[27] The complaints to the committee, while anecdotal, back up the official statistics that many patients face lengthy waits on elective public surgery lists or in emergency departments.

3.34 The committee fully endorses the ANAO recommendation that the data on emergency department performance be improved. Even on the presently available data, it seems clear that not all public patients are receiving clinical care 'within a clinically appropriate period' and that this is significantly worse in some states than others. To the committee, this seems a breach of the AHCAs in principle, even if not the lack of performance benchmarks makes it difficult to sanction the worst performing states. Importantly, the data is also necessary in order to hold state governments accountable for the performance of their hospitals. The need for performance benchmarks in the AHCAs and greater public accountability are returned to later.

Equitable access

3.35 Clause 6(c) of the AHCAs imposes on the states a requirement to provide 'equitable access to [public hospital services] for all eligible persons, regardless of their geographic location'.

25 ANAO, Audit Report, recommendation 2, p 40.

26 Gibson B, transcript, p 15.

27 HAA, *The Blame Game*, pp 206-09.

3.36 The ANAO assessed that Health had insufficient information to evaluate or measure whether access to services based on geographic location was indeed equitable:

> In particular, Health requires measures and data to enable it to assess whether States and Territories were providing equitable public hospital access to people in rural and remote areas, as well as in the fast-growing areas on the edges of major cities.[28]

3.37 In *The Blame Game* the committee also noted that the AHCAs provide no guidance to the states on the standard of access necessary to qualify as 'equitable access'. Evidence indicated that public hospital services were less accessible to those living in regional and remote areas, particularly if specialist treatment is required.[29] While it is unrealistic to expect every town to have the full range of public hospital services, it is currently left to the states to determine what is an appropriate level of service.

3.38 In *The Blame Game* the committee recommended that in negotiations for future AHCAs, the Commonwealth define the standards that the states must meet to satisfy the principle of equitable access regardless of geographic location.[30] The committee can only reiterate this recommendation here and urge Health and the states to develop the necessary performance data sets.

Benchmarks

3.39 Clause 6 of the AHCAs sets only the broadest of performance standards with which the states need to comply. The Commonwealth can use *The state of our public hospitals* series to highlight variations in the periods patients are forced to wait for various services but the AHCAs themselves do not articulate acceptable waiting times for compliance purposes. Health also struggles to confirm whether people have 'equitable access' to services regardless of location, but again there are no standards for what is acceptable.

3.40 The AHCAs allow Health to determine performance relativities between states and over time in some detail but it is not underpinned by detailed benchmarks or performance expectations. This allows all

28 ANAO, Audit Report, p 48.

29 HAA, *The Blame Game*, pp 154-55. See also: chapter 5.

30 HAA, *The Blame Game*, recommendations 11 and 15, pp 130, 155.

the states to 'comply' with Clause 6 of the AHCAs even while some clearly offer lower standards of performance in their hospitals.

3.41 In evidence to the committee Health noted the variation between the states:

> What is apparent from some of the data collected… is that some state health systems are less well funded than others. Some we would argue are underfunded and others are funded to a more acceptable level. You see that in terms of the services they are providing and the way in which the general public are able to access those services in those states.[31]

3.42 Furthermore:

> …it is clear that some states do much better than others. Whether that is because of extra funding or because they are more efficient and effective, probably both.[32]

3.43 The committee takes a national perspective on health care and does not believe that people should suffer a lesser standard of public hospital care simply because they live in one state and not another. AHCAs are the vehicles to pull up those states providing a lesser service to public patients. The mechanism is to set performance benchmarks that need to be met as part of the AHCA compliance assessment.

3.44 The committee is aware that Health sees the setting of benchmarks for performance as a policy matter and that the current AHCAs do not give the department a mandate to define, negotiate or apply performance benchmarks.[33] The Commonwealth and states are also still grappling with the development of nationally consistent performance indicators – necessary to measure whether the benchmarks have been met.

3.45 However, the committee has already recommended that the Commonwealth define standards associated with the principle of equitable access. Furthermore, the ANAO has also suggested the development of performance benchmarks and noted that 'the absence of such benchmarks causes difficulties in assessing whether the States and Territories are complying with the AHCAs'.[34]

3.46 The committee can only urge the Government to adopt the relevant recommendations in *The Blame Game* and heed the advice of the Audit

31 Kalisch D, transcript, p 11.

32 Yapp G, transcript, p 12.

33 ANAO, Audit Report, p 48.

34 ANAO, Audit Report, p 48.

Office and develop performance benchmarks for application in future AHCAs.

Rewarding good practice

3.47 The ANAO noted that state health authorities were keen to avoid breaching the AHCAs and thus risk receipt of the annual compliance payment of four percent of the Base Health Care Grant.[35] The threat of this sanction seems, at least, a partially effective tool for ensuring compliance with the Agreements. The committee, however, also sees the potential for a system of incentives to be built into the AHCAs to encourage compliance and reward good performance.

3.48 As was noted in *The Blame Game,* the committee is generally reluctant to see the AHCAs as a vehicle for large scale health system changes.[36] The AHCAs are interconnected with broader Commonwealth-state financial transfers and, as currently structured, are too blunt a tool to be a successful mechanism for negotiating broad reform.

3.49 However, in *The Blame Game* the committee recommended dividing future AHCAs into separate streams: one stream to provide general revenue assistance; and the other to allow specific purpose payments to be made to the states to support policy objectives in relation to public hospitals and health system reform.[37] These latter payments were to be linked to outcomes and performance standards.

3.50 As indicated, the committee does not know whether the Government will adopt this and other recommendations to restructure the AHCAs. Given this uncertainty, the committee has chosen to make a conservative assumption that the 2008 to 2013 AHCAs will be similar to their 2003 to 2008 predecessors.

3.51 In this more limited context, the 2008-2013 AHCAs could reward states that significantly exceed performance benchmarks associated with the clause 6 (or equivalent) principles and the associated financial and reporting requirements. Potentially the AHCAs could offer additional Commonwealth funds to states that significantly exceed benchmarks set for emergency department or elective surgery waiting times (Clause 6(b)) or for providing better access to services in regional and remote areas (Clause 6(c)). Similarly, incentives could be offered for the early adoption of particular national performance

35 ANAO, Audit Report, p 49.

36 HAA, *The Blame Game*, p 155.

37 HAA, *The Blame Game*, recommendation 16, p 156.

indicators by all states (see chapter 5). Accordingly, the committee makes the following recommendation.

Recommendation 2

3.52 **That in negotiating the 2008-2013 Australian Health Care Agreements (AHCAs), the Australian Government offer a structure of financial incentives to allow it to reward those states and territories that significantly exceed benchmarks associated with meeting AHCA objectives.**

3.53 More ambitiously, financial incentives could be offered by the Commonwealth if the states meet or exceed benchmarks associated with the cooperative reforms outlined in Part 4 of the Agreements. Part 4 commits the Commonwealth and states to work together to, among other things: improve the interface between hospitals and primary and aged care services; explore setting up a single national system for pharmaceuticals across all settings; and support ongoing work in areas of information management and workforce. These are the types of broader reform that the committee thought in *The Blame Game* were best facilitated through significantly restructured AHCAs.

Dispute resolution

3.54 As already indicated, Health is responsible for assuring the Minister that the states are meeting their obligations under the AHCAs in a given grant year. Only after such an assurance will the Minister approve release of the base health care grant, other grants and the four percent compliance payment.[38]

3.55 The compliance payments have been paid to all states in each grant year to date, even though Health recognised that minor breaches of the principles had occurred and been addressed.[39] Mention has already been made of the difficulty of withholding payments due to the lack of performance benchmarks. The ANAO noted that Health was also reluctant to withhold the compliance payments when in doubt because withholding the funds would be a disproportionate penalty and impact adversely on patient care.

38 AHCAs, clause 31.

39 ANAO, Audit Report, p 13.

3.56 State government representatives, on the other hand, told the ANAO that they were concerned that Health's assessment process could result in the full compliance payment being withheld for a one-off breach by a single hospital. States also considered that they had no recourse if they disagreed with an assessment of non compliance by Health that subsequently led the Minister to withhold the compliance payment.[40]

3.57 Clause 29 of the AHCAs does require the Commonwealth to allow a state 28 days to respond to any potential finding that it has not met the AHCA compliance requirements before a final assessment is made by the Minister. However, the AHCAs do not include any formalised dispute resolution procedures to allow such a state to disagree with a potential or final finding of non compliance.

3.58 While they have not been needed to date, good practice suggests that dispute resolution procedures should be included in any form of intergovernmental agreement.[41] The committee recommends accordingly.

Recommendation 3

3.59 **That in negotiating the 2008-2013 Australian Health Care Agreements, the Australian Government include dispute resolution procedures.**

40 ANAO, Audit Report, p 49.

41 See Council of Australian Governments, *Guide to Intergovernmental Agreements*, COAG, December 2005, www.coag.gov.au/guide_agreements.htm, viewed on 16 July 2007.