CHAPTER 1

PUBLIC HOSPITAL SERVICES AND THE AUSTRALIAN HEALTH SYSTEM

Background

1.1 The Senate has charged the Committee with an investigation of a range of issues regarding public hospital services. The views and evidence received by the Committee through submissions and public hearings have indicated that key issues facing the public hospital sector are adequacy of funding and options for reform.

1.2 The complex and interrelated nature of the Australian health system is such that an assessment of the situation facing public hospitals requires an examination within the context of the broader health system. This chapter provides an overview of the important role played by public hospitals within the Australian health system, together with a discussion of the roles and responsibilities of the key players. Australia's performance is compared to other countries and the chapter also examines the key challenges and problems facing public hospitals and the health system more generally. Chapter 2 examines the adequacy of funding of public hospitals and chapter 3 canvasses the pros and cons of various options for reform.

1.3 The public hospital sector is arguably the centrepiece of the Australian health system. It is a sector which is marked by the dedication of its staff and is a testament to their ingenuity, inventiveness, and adaptability. In addition to the care and treatment of patients, our hospitals teach tomorrow's doctors and nurses, provide an opportunity for crucial work experience for future general practitioners (GPs), and undertake innovative medical research. All this depends on an adequately resourced public hospital sector. Hospitals are expected to treat all who attend and this they do well. However, it appears that in many cases, public hospitals are functioning in spite of, rather than because of, the systems currently used to provide them with funding.

1.4 Most participants in the inquiry argued that the current level of funding for public hospitals is inadequate to meet the demand for their services. However, other than drawing the obvious conclusion that if current funding levels are inadequate then more funds are required, it is a difficult task to identify the level at which funding would be regarded as adequate.

1.5 Evidence received by the Committee portrays a situation that, contrary to the perception which is sometimes portrayed through the media, the public hospital system is neither in, nor faces, a crisis. However, other evidence indicates that public hospitals are, and have been for some time, operating under severe strain. Somewhat ironically, the ability of public hospitals and their dedicated staff to continue to

provide quality services places further pressure upon them. As the Northern Territory Minister for Health commented: 'we are a victim of our own success'.[1]

1.6 The South Australian Salaried Medical Officers' Association (SASMOA) provided cautionary evidence, which indicated that increasing workload pressures were leading to public hospitals 'losing the humanitarian face of medicine'.[2] This is of great concern to the Committee, as it is also to the Australian community, particularly considering the evidence of the Sydney Teaching Hospitals Advocacy Group who argued that '...the public health system is a fundamental of Australian life. It always has been'.[3] The Committee was heartened, however, at the joint submission from the Royal Australasian College of Physicians (RACP), the Australian Consumers' Association (ACA) and the Health Issues Centre which drew on research conducted by the National Centre for Social and Economic Modelling (NATSEM) to indicate that public hospital services were heavily skewed towards lower income people:

> the heavy reliance by the poor on a taxpayer funded system is demonstrated by the findings of NATSEM which found that people in the lowest income quintile receive five times the expenditure received by people in the top quintile.[4]

Community interest in health care issues

1.7 There is little doubt that health-related issues are of significant concern to the Australian community. For example, the results of a *Newspoll* published earlier this year found that 75 per cent of those people surveyed rated health/Medicare as very important. This ranking placed health/Medicare a narrow second to education as the top rated issue, but well above other issues such as taxation, unemployment and welfare/social issues.[5] Similarly, a national survey of 1200 small businesses found that the health system was seen by small business as the top priority facing their State or Territory government.[6]

1.8 Publicly funded health services are also strongly supported by the Australian community. For example, the popularity of Australia's Medicare system is surveyed regularly by the Health Insurance Commission (HIC). In 1999, the HIC reported that 'support for Medicare remains relatively high in the community at 88 per cent and at 81 per cent among medical practitioners'.[7] Such support was exemplified by over

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1 *Committee Hansard*, 24.2.00, p.235 (Northern Territory Minister for Health).

2 *Committee Hansard*, 23.2.00, p.186 (South Australian Medical Officers Association).

3 *Committee Hansard*, 21.3.00, p.398 (Sydney Teaching Hospitals Advocacy Group).

4 Submission No.45, p.7 (RACP, ACA, Health Issues Centre).

5 Henderson, I 'Coalition failing on the big issues', *Australian*, 31 January 2000.

6 Telstra Yellow Pages, 'Small business sees health as top priority for most govts.', *Media Release*, 19 August 1999.

7 Health Insurance Commission, *Annual Report 1998-99*, Canberra, HIC, 1999: p.5.

5000 postcards, letters and emails expressing wholehearted support for Medicare and the public hospital system being received by the Committee.

1.9 In addition to this high level of interest of the community in health-related issues, it is notable that health policy is dominated by vested interests. Governments are self-evident participants, as are groupings of health practitioners, while others include industry groups, academics, commentators, patients and the community generally. Although the community funds the health system, ostensibly for the benefit of the community, much of the debate and commentary often seems to focus on the requirements of funding agencies such as governments and the needs of practitioners. The voice of the patient is often lost among this 'strife of interests' as the participants in health policy debates have been labelled by Dr Sidney Sax.[8]

1.10 This 'strife of interests' is an important factor to be considered in any proposals for health policy change. The interrelated nature of the Australian health system means that changes in one area will inevitably impact on other areas of the health sector. Remedies proposed for a particular problem or set of problems accordingly need to be examined in the light of their impact beyond the particular problem area.

Health sector expenditure

1.11 In excess of $50 billion was spent on health services in Australia in 1998-99, which equates to 8.5 per cent of GDP.[9] A significant proportion of this expenditure is financed through taxation and is spent primarily on two key programs, Medicare and the Pharmaceutical Benefits Scheme (PBS). In general terms, Medicare provides subsidised or free access to out-of-hospital medical services and free access to public hospital services. It also provides payments towards the cost of in-hospital procedures and treatment for private patients. The PBS provides subsidised access to a wide range of pharmaceuticals, with larger subsidies directed to people covered by health concession cards.

1.12 Figure 1 indicates the main sources of recurrent funding for health services in 1997-98, which is the latest year for which data is available. The Commonwealth Government is the major funder, whose key areas of responsibility include payments for medical services, payments to the States and Territories for public hospital services, subsidies under the PBS and subsidies for aged care. The States and Territories make significant payments for public hospital services as well as community health services. The main areas of expenditure for individuals include pharmaceuticals, dental services, medical services, other health professional services and nursing homes.

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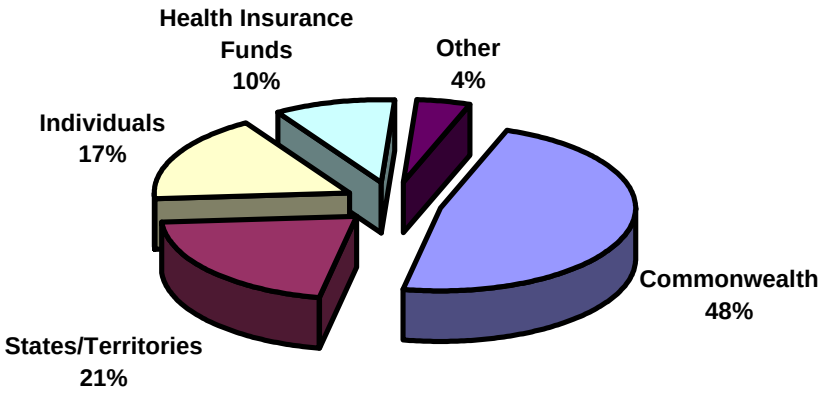
8 Sax, S, *A Strife of Interests: politics and policies in Australian health services,* Sydney, George Allen & Unwin, 1984.

9 Australian Institute of Health and Welfare, *Health Expenditure Bulletin No.16: Australia's health services expenditure to 1998-99*, AIHW, 2000: p.3.

1.13 The total recurrent health expenditure excludes capital expenditure. The data in Figure 1 has been presented in this way because it is not possible to allocate capital outlays for the non-government sector by source of funds. If capital expenditure is included, the Commonwealth share drops to 44.8 per cent and the State/Territory share increases to 23.4 per cent.

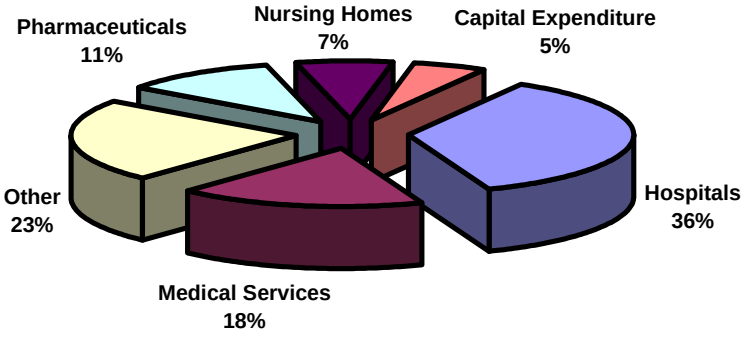
Figure 1: Total Recurrent Health Expenditure 1997-98: Who Pays?



Source: Calculated from AIHW, *Health Expenditure Bulletin No.16*, Canberra, 2000, p.15.

1.14 Figure 2 indicates the main areas of Australia's health expenditure in 1997-98. Public hospitals account for approximately 27 per cent of total health expenditure.

Figure 2: Total Health Expenditure 1997-98: Where are Funds Spent?



Source: Calculated from AIHW, *Health Expenditure Bulletin No.16*, p.15.

International comparisons

1.15 Pressures on health expenditure are increasing in industrialised countries due to ageing populations, advances in technology and the expectations of consumers and health providers. By contrast, the ability of governments to continue increasing health financing to meet demand is limited by finite budgets. Writing about the United Kingdom, Professor Chris Ham has observed that growth in technology, together with ageing of the population, leads to 'an increasing gap between what it possible to do as a result of medical advances and what it is possible to fund with the available budget'.[10]

1.16 Australia, at 8.5 per cent of GDP, spends around the average of OECD countries on health. The United Kingdom spends less, at 6.8 per cent of GDP, while Canada spends more at 9.2 per cent of GDP. The United States spends a much greater proportion of its GDP on health (13.9 per cent) than any other OECD country.[11] Although Australia does finance a significant proportion of its health expenditure from the public sector (70 per cent) this is actually a lower proportion than most other OECD countries.

1.17 Of interest here is that the exact link between the level of health expenditure in Australia and the health status of the population is not known.[12] In other words, while Australia spends around the average of OECD countries on health, there is insufficient knowledge to indicate whether this is too much, too little or about right. The Doctors' Reform Society argued in evidence that Australia may be spending about the right amount on health but that 'the community is not getting full value for its spending and considerable waste and duplication occurs within the health system'.[13] The Australian Medical Association (AMA) has recently advocated an increase in expenditure to 9.5-10 per cent of GDP.[14] However, Professor Richardson, from Monash University's Centre for Health Program Evaluation (CHPE), pointed out that the amount spent on health is largely a matter of choice and that 'the size of the health sector is extraordinarily flexible'.[15]

1.18 Australians appear to be hospitalised at a higher rate than some other comparable countries. For example, OECD data indicates that Australia's acute hospital admission rate was 159 per 1000 of the population in 1996-97, which was well above Canada at 114 admissions per 1000 population (in 1992) and 116 per 1000 population in the United States (1996). Australia was, however, well behind the

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10 Ham C, 'Priority setting in the health services', in *Rationing of Health and Social Care*, edited by I Allen, London, Policy Studies Institute, 1993, p.1.

11 Australian Institute of Health and Welfare, *Australia's Health 2000*, AIHW, 2000: p.408.

12 Australian Institute of Health and Welfare, *Australia's Health 1998*, p.169.

13 *Committee Hansard*, 22.3.00, p.402 (Doctors Reform Society).

14 Dr Kerryn Phelps, Federal President AMA, National Press Club Address, 5 July 2000.

15 *Committee Hansard*, 23.3.00, p.586 (Professor Richardson).

United Kingdom which had a rate of 214 acute admissions per 1000 of the population. These figures exclude same-day admissions.[16]

1.19 Knowledge is lacking on the reasons behind this difference in admission rates. Dr John Deeble, one of the architects of Medicare, submitted that:

> …the extraordinary growth in hospital usage over the last 13 years (but largely from 1992) **cannot continue**. If it did, Australian admission rates would have doubled in twenty five years and we would be the laughing stock of the hospital world. We should discover the reasons why it happened then and what factors are driving it now.[17]

1.20 The Australian Health Insurance Association (AHIA) pointed to differences in the perception of hospitalisation in different countries, arguing that in the United States and the United Kingdom, to some extent, hospitalisation 'is seen as a failure of your health care system'. In Australia, by contrast, the AHIA believes that 'we have an attitude which says that hospitalisation is the line of first resort'.[18] A possible historical reason for Australia's relatively high rate of admission to hospitals was offered by Professor Richardson:

> I have speculated that years before universal insurance we had very good hospital coverage for patients and we had fairly poor medical. From the patient's point of view, and the doctor knew this, to put the patient into hospital was cheaper for the patient and better for the doctor.[19]

It is interesting that, despite the introduction of Medicare's universal public health insurance and its attendant subsidisation of general practice (ie it is now cheaper to keep a patient out-of-hospital), the culture and practice of hospitalisation continues.

Comparative perceptions of health systems

1.21 Evidence was received by the Committee from the New South Wales Government that the Australian health system generally worked well, albeit with some problems.[20] The RACP stated that 'in general terms the Australian health system is of high standard'.[21] Most Australians enjoy very high standards of health and health care. These views were supported by a wide range of participants in the inquiry and tend to indicate that there is not an imminent 'crisis' facing the Australian health system. For

16 de Looper, M and K Bhatia, *International Health–how Australia compares*, Canberra, Australian Institute of Health and Welfare, 1998: p.129

17 Submission No.50, p.18 (Dr Deeble).

18 *Committee Hansard*, 11.11.99, p.132 (Australian Health Insurance Association).

19 *Committee Hansard*, 23.3.00, p.602 (Professor Richardson).

20 *Committee Hansard*, 21.3.00, p.338 (New South Wales Government).

21 *Committee Hansard*, 21.3.00, p.369 (RACP, ACA, Health Issues Centre).

example, in their joint submission, the RACP, the ACA and the Health Issues Centre concluded that 'Australia's health system is not in crisis'.[22]

1.22 Although the AMA discussed its concerns about several aspects of the health system and the public hospital sector, it also stated that 'it is a good system, but it could be made a lot better'.[23] The Sydney Teaching Hospitals Advocacy Group concluded that:

> …the public health system is a fundamental of Australian life. It always has been. It has been attacked on a lot of sides but we have to give decent quality health care to people who turn up, no matter where they come from and how much money they have. As for our health system, which is probably extremely good compared with those in other countries of the world even though it is under great stress, the one thing that has been good about it is that if you get in you will be pretty well treated. We want to continue that but we want to improve the access and not decrease the expertise.[24]

1.23 The view that Australia is neither in, nor faces, a crisis in its public hospitals or the health system more generally, is also supported by commentators. The US health economist Professor Uwe Reinhardt, in a visit to Australia last year concluded that: 'the few problems you have could be fixed with only a few minor changes'.[25]

1.24 Contrasting with these views are findings from the US-based Commonwealth Fund 1998 International Health Policy Survey.[26] Analysis of the results of this survey provide some pause for thought on how well Australia's health system is perceived as meeting the needs of its citizens and, in particular, people with lower incomes. [27] Key findings of the survey include:

- countries with universal coverage that require patient user fees and allow a substantial role for private health insurance also experience inequities in access to care;
- a pattern of inequitable access to care for lower income groups in Australia, New Zealand and the United States. No significant differences in access to care between income groups were found in Canada and the United Kingdom. In

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22 Submission No.45, p.6 (RACP, ACA, Health Issues Centre).

23 *Committee Hansard*, 11.11.99, p.93 (Australian Medical Association).

24 *Committee Hansard*, 21.3.00, p.398 (Sydney Teaching Hospitals Advocacy Group).

25 Ragg, M 'Wait watching', *Sydney Morning Herald*, 14.8.99, p.36.

26 Schoen, C et al, *Equity in Health Care Across Five Nations: summary findings from an international health policy survey*, The Commonwealth Fund International Programs, Issue Brief, May 2000. http://www.cmwf.org/programs/international/schoen_5nat_ib_388.asp

27 This survey canvassed the views of 1000 people in each of Australia, Canada, New Zealand, the United Kingdom, and the United States in order to assess disparities in access to health care, the financial burden of care and perceptions of quality between people with above-average incomes and below-average incomes.

Australia, adults with below-average incomes were about twice as likely to say they had difficulty getting care than those with above-average incomes, while the difference for those not getting needed care was 2.5 times greater for respondents with lower incomes. Waiting times and scarcity of doctors were the main reasons for access problems;

- respondents with below-average incomes in Australia, Canada and New Zealand were two to three times more likely to report not filling a prescription due to cost than those respondents with above-average incomes. Some 14 per cent of Australian respondents with below-average incomes reported difficulty in paying medical bills in the past year. This compares with 4 per cent of low income Britons, and 10 per cent of low income Canadians, but is well behind New Zealand (24 per cent) and the United States (30 per cent); and
- the levels of dissatisfaction in Australia and New Zealand are now closer to US levels. Just one-fifth of people in Australia, Canada, and the United States and only one of 10 New Zealanders, think the system works well and only needs minor changes.

1.25 These findings reveal a certain disquiet within the Australian community in its perception of the health system. Some of this concern can be undoubtedly attributed to the widespread use of the media by the many and varied vested interest groups ('strife of interests') presenting their views on the shortcomings of the system from their particular perspectives. The degree of dissatisfaction with the health system noted in the findings of this survey has not generally been reflected in the views presented to the Committee in submissions and public hearings.

1.26 However, it is important to note that there is no perfect health system, no 'gold standard' to which other countries aspire.[28] Countries with central funding tend to perform well on efficiency or cost control measures while those with universal access score well in terms of fairness and equity. In their joint submission, the RACP, the ACA and the Health Issues Centre argued that the Australian health system generally performs well in comparison to other countries and that it is equitable and efficient, although that did not mean that reform was unnecessary.[29]

1.27 The challenge for Australia, as for other countries, is to retain those elements of its health system which give it strength and seek to change those which contribute to its shortcomings. In order to achieve desirable and sustainable change it is necessary to identify what the community expects from the health system and where the key problems lie.

1.28 Most participants in the inquiry were of the view that some problems and challenges did exist for the public hospital sector and the health system. For example,

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28 Submission No.45, p.4 (RACP, ACA, Health Issues Centre).

29 Submission No.45, p.4 (RACP, ACA, Health Issues Centre).

Professor Hindle argued that the emphasis of the system was geared towards containing costs, rather than value for money and the provision of high quality care.[30]

Key issues and challenges: public hospital sector

1.29 This section identifies a range of issues and challenges currently faced by the public hospital sector. Following this, some key, interrelated problem areas for the health system are identified, each of which have been argued as causing substantial difficulties for public hospitals. The following issues have been presented as contributing in a major way to the problems faced by the public hospital sector:

- rationing of hospital services without any transparent priorities;[31]
- increasing level of expectations on what services public hospitals can and should provide, particularly by and for older patients.[32] For example, 'routine' hip and knee replacements for patients aged over 80 years;
- increasing availability of and consumer demand for new technologies;[33]
- high number of nursing home type patients in acute hospital beds, especially in rural areas, but also in some metropolitan hospitals;[34]
- allied to the previous point, in some public hospitals a large number of acute admissions are older patients.[35] There is also a view that patients today tend to be much sicker than in the past[36] (the degree to which these points apply will obviously vary between different hospitals);
- in some public hospitals, 'capital equipment has been allowed to run down to the point where it is creating serious clinical problems;[37]
- concern was expressed that current funding arrangements have 'undermined the capacity of the public system to support effective teaching, training and research';[38]
- there is a lack of information technology (IT) infrastructure to collect and analyse information on patient outcomes;[39]

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30 *Committee Hansard*, 21.3.00, p.321 (Professor Hindle).

31 Submission No.63, p.15 (Australian Healthcare Association, Women's Hospitals Australia, Australian Association of Paediatric Teaching Centres).

32 *Committee Hansard*, 21.3.00, p.389 (Sydney Teaching Hospitals Advocacy Group).

33 Submission No.45, p.14 (RACP, ACA, Health Issues Centre).

34 *Committee Hansard*, 21.3.00, p.344 (Health Department of NSW).

35 *Committee Hansard*, 23.3.00, p.495 (Committee of Presidents of Medical Colleges).

36 *Committee Hansard*, 24.2.00, p.207 (Australian Nursing Federation, NT Branch).

37 *Committee Hansard*, 21.3.00, p.372 (RACP, ACA, Health Issues Centre).

38 Submission No.45, p.9 (RACP, ACA, Health Issues Centre).

- the average age of hospital doctors is now around 50 years of age[40] and is over 40 years of age for nurses;[41]
- workload pressures are leading to public hospitals 'losing the humanitarian face of medicine';[42]
- issues of stress and burnout are of major importance for nurses;[43] and
- there is an exodus of nurses from the workplace, at least in Victoria.[44]

The important role of and modern challenges faced by public hospitals were emphasised by the Sydney Teaching Hospitals Advocacy Group which stated that:

> the public hospital has become the final common pathway to just about any problem. If you have a person who is psychotic, the police bring them up to the casualty department. If you have a person who is depressed, they bring them up there. If you have a person who is unconscious or they do not know what to do with them, they bring them up to casualty department because that is the only place to bring them.[45]

1.30 There are also a large number of issues and problems that relate directly to the funding of public hospitals. These are identified and discussed in the following chapter which deals with the adequacy of funding for public hospitals. Those issues above which arise from funding problems will also be drawn into the discussion in the following chapter.

Indigenous Australians and public hospitals

1.31 The health disadvantage suffered by Indigenous Australians is well documented. As a joint report released in 1999 by the Australian Institute of Health and Welfare and the Australian Bureau of Statistics conclusively states: 'Indigenous Australians continue to suffer a much greater burden of ill-health than do other Australians'.[46] During the course of the inquiry, several specific issues were identified which relate to the health status of Indigenous people and its impact on public hospitals, particularly in the Northern Territory. These include:

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39 *Committee Hansard*, 23.3.00, p.573 (National Allied Health Casemix Committee), *Committee Hansard*, 22.3.00, p.439 (Queensland Nurses Union).

40 *Committee Hansard*, 23.2.00, p.193 (South Australian Salaried Medical Officers Association).

41 *Committee Hansard*, 22.3.00, p.437 (Queensland Nurses Union).

42 *Committee Hansard*, 23.2.00, p.186 (South Australian Salaried Medical Officers Association).

43 *Committee Hansard*, 23.2.00, p.175 (Australian Nursing Federation).

44 *Committee Hansard*, 23.3.00, p.526 (Australian Nursing Federation, Victorian Branch).

45 *Committee Hansard*, 21.3.00, p.393 (Sydney Teaching Hospitals Advocacy group).

46 Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Canberra, Ausinfo, 1999, p.4.

- the high incidence of renal disease among Indigenous Australians as a driver of costs in the Northern Territory. In evidence, the President of the Northern Territory branch of the AMA stated that this is also an issue in North Queensland and Western Australia.[47] Dialysis accounts for 32 per cent of hospital admissions in the Northern Territory;[48]
- many Indigenous people presenting to hospitals in the Northern Territory have 'complex co-morbidity conditions, including renal disease, heart disease and scabies';[49]
- a link was drawn between the failure to treat ear infections, suffered by a large proportion of Indigenous children, leading to hearing problems which cause subsequent problems for them in the education system and health system;[50] and
- the impact on health costs of the lack of an adequately funded interpreter service for Indigenous patients because Australia fails to recognise that English is a second language for many Indigenous people. An inability to communicate causes problems for health workers in arriving at a correct diagnosis as well difficulties for the patient in understanding and complying with medication and follow-up care.[51]

1.32 The Australian Health Care Agreements (AHCAs), like the earlier Medicare Agreements, do not relate specifically to Indigenous health matters. DHAC advised that the Commonwealth and each State and Territory Government have signed bilateral Aboriginal Health Framework Agreements which provide for a partnership approach to Indigenous health issues.[52] It was also acknowledged in evidence that the Commonwealth has funded specific initiatives directed towards improving Indigenous health. However, in respect of the Northern Territory, the view was expressed that the expenditure on these initiatives was not being reflected in presentations to the Territory's acute hospitals.[53]

1.33 The House of Representatives Standing Committee on Family and Community Affairs recently released its report into Indigenous health, entitled *Health is Life*. That Committee found that 'the planning and delivery of health and related services for Indigenous Australians is broadly characterised by a general lack of direction and poor coordination' and that:

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47 *Committee Hansard*, 24.2.00, p.223 (AMA, NT Branch).

48 *Committee Hansard*, 24.2.00, p.244 (NT Shadow Minister for Health).

49 *Committee Hansard*, 24.2.00, p.244 (NT Shadow Minister for Health).

50 *Committee Hansard*, 24.2.00, p.226 (Deafness Association of the Northern Territory Inc.).

51 *Committee Hansard*, 24.2.00, p.245 (NT Shadow Minister for Health).

52 Submission No. 38, p.26 (DHAC).

53 *Committee Hansard*, 24.2.00, pp.208-9 (Senator Knowles; ANF (NT Branch)).

> the biggest barrier to progress has been the lack of any real efforts to integrate indigenous community involvement into the planning and delivery of health and related services.[54]

Problems identified in the report, such as the poor coordination of health services for Indigenous Australians, have also emerged in evidence to this inquiry, both in regard to hospital and health services for Indigenous Australians and the public hospital and health system more generally.

Key issues and problems: public hospitals and the Australian health system

1.34 The concluding sections of this chapter discuss three interrelated problem areas of the Australian health system, each of which create considerable difficulties for public hospitals. These are:

- the complex nature of the health system as it relates to public hospitals, including the relationship between the different levels of government;
- cost shifting, including its effects on consumers; and
- the relationship between the public and private sectors.

Complex nature of the health system as it relates to public hospitals

Relationship between the Commonwealth, States and Territories

1.35 The complex nature of the health system is, in part, an outcome of Australia's federal structure. While the provision of health services has traditionally been the responsibility of the States and Territories, the insertion of section 51(xxiiiA) in the Constitution following a referendum in 1946 accorded the Commonwealth power to legislate in the health arena. At the core of the tensions, buck-passing and blame-shifting that occurs between the Commonwealth and the States and Territories in health policy matters is, arguably, the unresolved nature of the exact constitutional boundaries between the two levels of government. John McMillan, in his book *Commonwealth Constitutional Power over Health*, argues that:

> the explicit references made to health matters in the Constitution define a scope of Commonwealth responsibility that is far more limited than what it has carved out for itself. By creative adaptation of the limited powers available there has been a gradual expansion of Commonwealth responsibility. Even so, there has been reticence, and Commonwealth regulation still falls far short of the most optimistic constitutional boundary.[55]

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54 House of Representatives, *Debates*, 5.6.00, p.15927.

55 McMillan, J *Commonwealth Constitutional Power over Health*, Canberra, Consumers' Health Forum, 1992, p.1.

1.36 The outcome of the mixture of roles and responsibilities of the two levels of government[56] in the funding and delivery of public hospital services has inevitably led to problems. One of the problems is that the parties have differing perceptions of where the problems lie and consequently may disagree on the possible solutions or options for reform. A former health bureaucrat at both state and national levels, Professor Stephen Duckett, has usefully summarised the key problems of Commonwealth-State relations in health from the viewpoints of the Commonwealth, the States and Territories, and the community. Similar perspectives have been offered in submissions and evidence to the inquiry.

1.37 Key problems from the Commonwealth's perspective are:

- increasing government health care expenditure;
- cost shifting; and
- difficulty of policy implementation, because Commonwealth policies often require implementation by the States which requires negotiations between the parties.

1.38 From the State and Territory perspective, key problems include:

- vertical-fiscal imbalance: the Commonwealth raises most of the funds via its taxation powers while the States have much of the responsibilities for service delivery;
- cost shifting;
- restrictive conditions of 'tied' grants from the Commonwealth; and
- the existing division of responsibilities between the States and the Commonwealth leads to duplication, waste and administrative burdens.

1.39 From the community's perspective, the main problems caused by Commonwealth/State relations in health include:

- the results of the lack of coordination between the two levels of government, particularly the impact on costs, quality of care and access to treatment;
- problems of the political process and accountability (so-called 'blame game');
- the overlap in multiple programs which address the same need can lead to irrational outcomes;
- cost shifting; and
- gaps in government funded service provision.[57]

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56 While local government does have a role in the funding and delivery of some health services (particularly in rural areas), it does not generally play a significant role in the funding and delivery of public hospital services.

57 Duckett, S, 'Commonwealth/state relations in health', in *Health Policy in the Market State*, edited by L Hancock, St Leonards, NSW, Allen & Unwin, 1999, pp.73-79.

1.40 Nearly all of these systemic problems summarised by Professor Duckett affect public hospitals and are key contributors to the situation currently facing the sector.

Complexity of the health system: patient's perspective

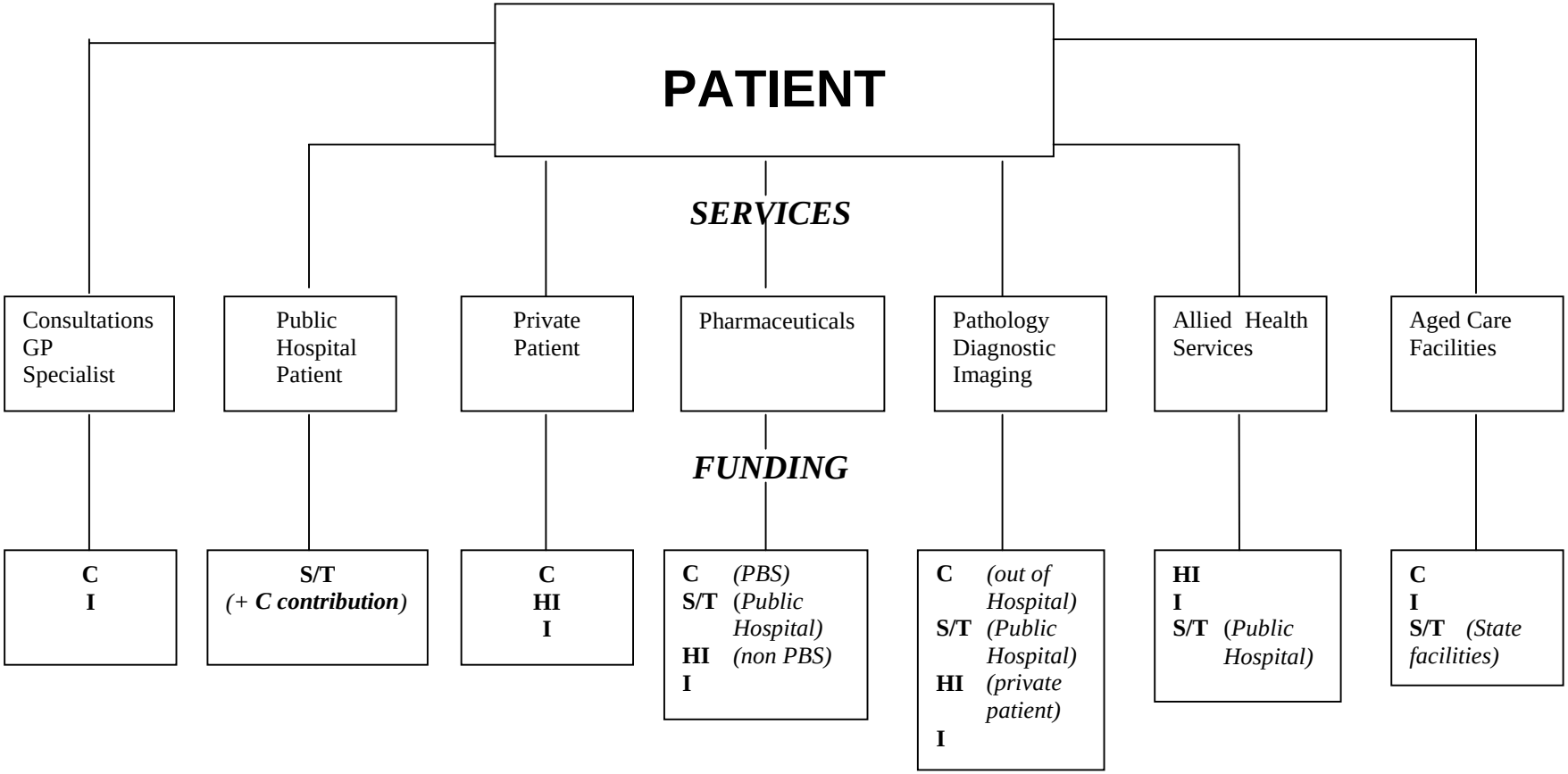
1.41 An indication of the complex nature of the Australian health system is provided by Diagram 1, which presents aspects of the health system from the patient's perspective. Included are some key health services together with an indication of funding arrangements for each group of services.

1.42 The complexity of the health system is an important issue for patients. It can be argued that the system has been designed around the priorities of governments and the requirements of providers, and consequently it may not always work in the best interests of the patient. The poor linkages between GPs, hospitals and aged care facilities mean that it is often the patient who has to try to navigate around the health system, in many cases working with imperfect knowledge. In an efficient, patient-focussed health system, it shouldn't matter which level of government pays for which services but, unfortunately for some patients, 'who pays' can be of central importance in the Australian health system.

1.43 For example, a patient with a foot condition can attend a GP and have the cost fully paid, or at least subsidised, by the Commonwealth Government. Alternatively, the patient can attend a public hospital accident and emergency unit and have the cost fully met by the State or Territory government (which has received substantial funding from the Commonwealth via the AHCAs). Depending on the condition, a podiatrist may be a more appropriate practitioner to assist the patient. However, there is no Medicare rebate for services provided by podiatrists, so the patient will need to meet the full cost of the consultation, (although if the patient has ancillary health insurance, the health insurance fund will make some contribution towards the cost of the consultation).

1.44 While it is undoubtedly the case that not every service required by a particular patient may be able to be subsidised by government, there appears to be little logic in a system which will subsidise services which may be of marginal or no assistance in a particular circumstance (such as the example above), rather than focusing on the optimal outcome for the patient and funding accordingly. The Coordinated Care Trials, discussed briefly in the following chapter, aim to overcome these aspects of the health system.

Diagram 1



Legend:

C Commonwealth Government
S/T State and Territory Government
HI Health Insurance Funds
I Individuals

PBS Pharmaceutical Benefits Scheme
Pharmaceuticals Drugs, medicines, vitamins, herbal preparations
Allied Health Services including dental, physiotherapy, podiatry etc

Complexity of the health system: funding arrangements

1.45 A second perspective from which to examine the complex nature of the Australian health system is through the arrangements for funding. Table 1 indicates the sources of health expenditure and the main areas in which this expenditure is spent. Essentially, it provides a snapshot of who pays for what services. The Table provides details of the components of Australia's total health expenditure and is the source from which the data presented earlier in Figures 1 and 2 is calculated. The Table indicates, for example, that almost $13 billion was spent on public acute hospital services in 1997-98, of which nearly $12 billion was paid by the Commonwealth, State and Territory governments.

1.46 The Table also indicates the interrelated nature of the different elements of the Australian health system. Perhaps the most striking feature of the Table is that none of the key elements of the health system receive all funding from a single source. Public hospitals, for example, receive most of their funding from two levels of government, but also receive revenue from health insurance funds and individuals, as well as from workers' compensation and other insurers.

Complexity of the health system: governments' role in medical practice

1.47 A further illustration of this complexity is the role played by the different levels of government in medical practice. Before a medical practitioner can treat patients s/he must be registered. This is the responsibility of the States and Territories through their medical boards. If the practitioner wishes to prescribe and/or bill patients under the Medicare arrangements, s/he requires a provider number. This is a Commonwealth responsibility, through the Health Insurance Commission (HIC).

1.48 When seeing and/or treating patients in consulting rooms the practitioner will bill Medicare for each consultation. Depending on the practitioner's preference, s/he may elect to accept the bulk-billed rate of 85 per cent of the Medicare Benefits Schedule fee as full payment for the consultation or the patient may be required to pay a proportion of the charge. For each consultation, the Commonwealth Government through the HIC meets a rebate of 85 per cent of the MBS fee.

1.49 If the practitioner has visiting rights at a public hospital s/he may treat both public and private patients. Payment for the practitioner's treatment of public patients is at a rate agreed with the hospital and is paid by the State or Territory government. If the practitioner treats a private patient in the same hospital, Medicare will reimburse 75 per cent of the schedule fee for each procedure (paid by the Commonwealth) while the patient and the health insurance fund (where relevant) meet the remainder of the charge. Accordingly, the practitioner may perform an identical procedure on two patients (one public, one private), in the same hospital, on the same day, and receive a different level of reimbursement for each procedure from two different levels of government as well as from one patient and a health insurance fund.

Table 1: Total health services expenditure, current prices, Australia, by area of expenditure and source of funds[a], 1997–98 ($ million)

Area of expenditure	Government sector			Non-government sector				
	Common-wealth[b]	State and local	Total	Health insurance funds[b]	Individuals	Other[c]	Total	Total expenditure
Total hospitals	6,343	6,437	12,780	2,607	418	1,095	4,120	16,900
Recognised public hospitals	5,771	6,080	11,851	311	79	595	986	12,836
Private hospitals	550	—	550	2,295	321	493	3,109	3,658
Repatriation hospitals	15	—	15	—	—	—	—	15
Public psychiatric hospitals	7	357	365	—	18	7	25	390
Nursing homes	2,575	137	2,712	—	608	—	608	3,320
Ambulance	90	281	370	106	129	38	273	643
Total institutional	*9,007*	*6,855*	*15,862*	*2,712*	*1,155*	*1,133*	*5,000*	*20,863*
Medical services	6,970	—	6,970	217	897	419	1,533	8,503
Other professional services	219	—	219	214	1,046	173	1,434	1,653
Total pharmaceuticals	2,785	16	2,801	34	2,463	37	2,534	5,335
Benefit-paid pharmaceuticals	2,783	—	2,783	—	593	—	593	3,377
All other pharmaceuticals	2	16	18	34	1,869	37	1,941	1,959
Aids and appliances	174	—	174	177	435	38	649	823
Other non-institutional services	1,380	2,086	3,466	1,080	1,611	8	2,699	6,165
Community and public health[d]	775	1,357	2,132	1	—	—	1	2,133
Dental services	76	328	404	568	1,611	8	2,187	2,591
Administration	529	401	930	511	—	—	511	1,441
Research	427	96	523	—	—	129	129	652
Total non-institutional	*11,956*	*2,197*	*14,154*	*1,721*	*6,452*	*805*	*8,978*	*23,132*
Total recurrent expenditure	**20,964**	**9,053**	**30,016**	**4,434**	**7,606**	**1,938**	**13,978**	**43,994**
Capital expenditure	70	1,400	1,470	n.a.	n.a.	n.a.	[e]994	2,464
Capital consumption	34	538	572	..	..	..	[f]..	572
Total health expenditure	**21,068**	**10,990**	**32,058**	**n.a.**	**n.a.**	**n.a.**	**14,972**	**47,030**

(a) This table shows the amounts provided by the Commonwealth Government, State and Territory Governments, local government authorities and the non-government sector to fund expenditure on services. It does not show gross outlays on health services by the different levels of government or by the non-Government sector.

(b) PHIIS subsidies of $252 million paid directly to funds are included in the Commonwealth column and are subtracted from the health insurance funds column. PHIIS benefits paid in the form of tax ($207 million) are not designated as Commonwealth funded expenditure in this table but are included as Commonwealth Funded expenditure in Table 5.

(c) 'Other' includes expenditure on health services by providers of Workers' Compensation and Compulsory Motor Vehicle Third Party insurance cover.

(d) Expenditure on 'Community and public health' includes expenditure classified as 'Other non-institutional nec'.

(e) Capital outlays for the non-government sector cannot be allocated according to 'source of funds'.

(f) Private capital consumption (depreciation) expenditure is included as part of recurrent expenditure.

Source: AIHW, *Health Expenditure Bulletin No.16*, p.15.

Cost shifting

1.50 Cost shifting is an inevitable outcome of the current mix of roles and responsibilities of the different levels of government in the Australian health system. As the Queensland Government argued: 'cost shifting' is, and always will be, the outcome of an ill-defined and fragmented funding system'.[58]

1.51 These funding arrangements, whereby the Commonwealth provides grants to each State and Territory for the provision of public hospital services, supplemented by the States and Territories from their own source funding, which includes the general purpose Financial Assistance Grants (FAGs), have led to a lack of transparency in the relative funding efforts of each level of government for public hospital services. Hence, it has been an easy task for governments to simply 'blame shift' to each other the responsibility for perceived shortfalls in the funding available for public hospital services. Bedevilled by politics, this process has achieved little and has 'done nothing to enhance the health of the community', according to the joint submission from the Australian Healthcare Association (AHA), Women's Hospitals Australia (WHA) and the Australian Association of Paediatric Teaching Centres (AAPTC).[59]

Forms of cost shifting

1.52 Determining exactly what constitutes cost shifting has proved a difficult task for the Committee, with a variety of views being presented on cost shifting, its extent and impact on governments and patients. Many different forms of cost shifting were outlined in submissions to the inquiry. Hard evidence on the extent and value of cost-shifting has been elusive, with most comments and views presented in submissions and public hearings being of an anecdotal nature.

1.53 Different parties (especially governments) have different positions on what constitutes cost shifting, and in particular, whether their own practices constitute cost shifting. For example, the Commonwealth Department of Health and Aged Care (DHAC) provided detailed examples of what it regards as cost shifting by the States and Territories and also commented that: 'of course, States claim that the Commonwealth also shifts costs through a variety of mechanisms…'.[60] In other words, the States and Territories may regard these practices as cost shifting but the Commonwealth does not necessarily agree. Similarly, the States' and Territories' view was encapsulated graphically by the Health Department of Western Australia as: 'I believe that cost shifting is occurring but I believe that it is occurring from the Commonwealth to the State and not necessarily vice versa'.[61]

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58 Submission No.41, p.17 (Queensland Government).

59 Submission No.63, p.13 (AHA, WHA, AAPTC).

60 Submission No.38, p.18 (Commonwealth Department of Health and Aged Care).

61 *Committee Hansard*, 25.2.00, p.276 (Health Department of Western Australia).

1.54 Examples of cost shifting provided in evidence are listed below in terms of the effect of the cost shift; ie from the Commonwealth to the States and Territories, from the States and Territories to the Commonwealth and from both levels of government to patients. It is important to note, however, that issues around cost shifting are contested.

Commonwealth to States and Territories:

- capped funding for Commonwealth programs. For example, limits on the funding and therefore the available beds for aged care facilities means that some older nursing home type patients are located inappropriately in acute public hospital beds rather than in aged care facilities;
- failure of medical workforce policy results in fewer GPs in rural and remote areas, with the State-funded public hospitals or community health centres required to address and fund the primary care needs of these communities;
- lack of after hours services by GPs may force patients to attend the (State-funded) accident and emergency units of public hospitals for GP-like services;
- inadequacies in the funding and delivery of health services for Indigenous Australians may mean that the States and Territories are required to provide extra services (and therefore funding) through the public hospital system;
- changes to priorities at the Commonwealth level can force changes at the State and Territory level. For example, increased patient expectations driven by the Commonwealth Dental Health Scheme led to a blow-out in waiting lists for public dental care when the Commonwealth ceased funding for the scheme in 1996. Similarly, changes to fringe benefits tax (FBT) arrangements for public benevolent and charitable institutions will force changes to salary packaging arrangements for employees of public hospitals.

States and Territories to the Commonwealth:

- early discharge of patients may shift costs to the Commonwealth through patients needing to consult (Commonwealth-funded) GPs;
- limitations on and privatisation of outpatient services in public hospitals shifts costs because these services are then billed to (Commonwealth-funded) Medicare;
- small quantities of pharmaceuticals provided to patients on discharge from public hospitals means that the patient will need to consult a GP (Commonwealth-funded) in order to obtain a prescription to be filled at a community pharmacy (also Commonwealth-funded);
- in accident and emergency units of public hospitals, patients who do not require admission may be directed to a (Commonwealth-funded) GP; and

- overuse of taxation exemptions, such as FBT, for salary packaging which results in the Commonwealth Government and Australian taxpayers further subsidising the salaries of public hospital employees.

Governments to patients:

- privatisation of services previously provided free-of-charge in public hospitals (such as outpatient services) may attract a patient payment (State to patient);
- patients discharged from public hospitals with only a small supply of pharmaceuticals will pay a patient payment for each prescription filled at a community pharmacy (currently $3.30 for health card holders and $20.70 for general patients). These same pharmaceuticals would be free-of-charge in the public hospital (State to patient);
- capped funding of programs or non-coverage of certain health services and/or products by governments may require patients to meet some or all the cost of the service/product. For example, Medicare subsidises access to out-of-hospital medical services but not out-of-hospital allied health services (Commonwealth to patient); and
- access by patients to certain aids, dressings and equipment previously provided free-of-charge are being withdrawn by some public hospitals, requiring patients to provide their own supplies (State to patient).

Estimating the monetary value of cost shifting

1.55 Little data appears to be available about the extent of cost shifting so it is a difficult task to estimate the value of cost shifting which occurs at any particular point in time. However, in an initiative introduced in its 1996-97 Budget, the Commonwealth Government did place a monetary value on cost shifting. This initiative, 'Reductions in Hospital Funding Grants to the States to Offset Cost-Shifting of Public Hospital Related Services', was expected to save the Commonwealth Government some $316 million over the four years from 1996-97.[62] In the event, the initiative operated for only 1996-97 and 1997-98, the final two years of the previous Medicare Agreement.

1.56 According to the New South Wales Government, the end result of this initiative was that the Commonwealth 'unilaterally withheld $153 million from the Hospital Funding Grant payments to states and territories as a penalty for cost shifting practices in any substantial form'.[63] However, this Commonwealth measure does not appear to have been based upon any hard evidence of cost shifting by the States and Territories. The NSW Government claimed that:

62 Health and Family Services Portfolio, *Portfolio Budget Statements 1996-97*, pp.149-50.

63 Submission No.79, p.12 (NSW Government).

> although states and territories have called for evidence to justify the application of penalties, the Commonwealth has been unable to provide empirical evidence that the states and territories have been conducting cost shifting practices.[64]

1.57 During the Senate Community Affairs Legislation Committee's inquiry on the originally titled Health Legislation Amendment (Health Care Agreements) Bill 1998, the then Commonwealth Department of Health and Family Services (DHFS) provided an explanation as to how the cost shifting penalty for 1996-97 had been calculated. The DHFS advised that over the period 1994-95 to 1995-96 'the difference between total actual Medicare benefits paid and total adjusted benefits paid (ie adjusted for high growth States (Victoria and Western Australia))[65], is assumed to be the value of cost shifting'. DHFS conceded that the estimate was 'by no means an accurate calculation' but regarded it as a 'very conservative estimate'.[66]

1.58 Professor Richardson proposed that it was unlikely that an estimate could be calculated that indicated 'an absolute number of dollars are being cost shifted, because you get into a legal wrangle about where that spending should have occurred'.[67] However, it may be possible to analyse the changes over time that may have been expected in expenditure on particular areas.

1.59 Research performed by the Centre for Health Economics Research and Evaluation (CHERE) for the Committee indicates that a relationship may exist between the number of services provided under the Medicare Benefits Schedule (MBS), paid by the Commonwealth and the number of services provided by public hospitals for non-admitted patients. Services provided under the MBS include GP consultations as well as pathology and diagnostic imaging services.

1.60 The data indicates that during the period 1985 to 1998, per capita MBS services increased by 40 per cent, whereas public hospital outpatient services decreased by 26 per cent. If it is assumed that the drop in public hospital outpatient services is substituted onto the MBS, then growth in the MBS and the proportional decline in public hospital expenditure both may be partially explained by the decrease in the number of public hospital outpatient services. Figure 3 illustrates this substitution in monetary terms.

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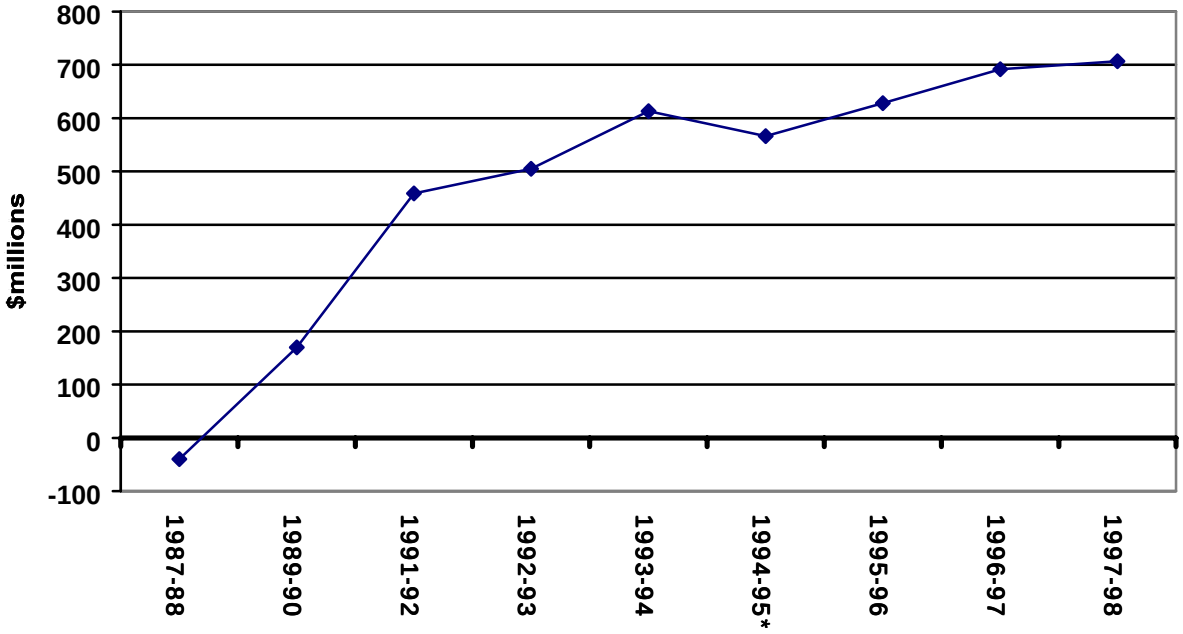
64 Submission No.79, p.12 (NSW Government).

65 This process removed the effect of the high growth in MBS benefits evident in Victoria and WA in 1995-96 in order to calculate the effect of cost shifting.

66 Senate Community Affairs Legislation Committee, *Report on the Health Legislation Amendment (Health Care Agreements) Bill 1998*, May 1998, p.6.

67 *Committee Hansard*, 23.3.00, p.594 (Professor Richardson).

Figure 3: Estimation of Cost Shifting – Additional MBS Expenditure explained through fewer public hospital outpatient services (Constant 96-97 $M)



* No WA data for 1994-95 is available for non-admitted public hospital services. This graph assumes that WA statistics are in line with the national average.

** Total Medicare outlays have been adjusted for services that would have been provided in public hospitals had the 1985-86 proportion been maintained.

Please note that in the 1987-88 financial year, the proportion of non-admitted public hospital patients rose slightly (over 1985-86) and therefore the 'cost-shift' appears as a negative figure.

Source: CHERE, calculated from Butler (1998), AIHW, *Australia's Health 1998*, Medicare Statistics from the HIC's website at www.hic.gov.au.

1.61 It is important to note, however, that the exact relationship between the MBS and public hospital services for non-admitted patients is far from resolved. For example, the Queensland Government has calculated that the Commonwealth Government is underfunding some jurisdictions (and therefore cost shifting) due to the relative under-provision of primary care (eg GP) services in States such as Queensland, which is very decentralised.

1.62 The Queensland Government has calculated that it would receive an extra $31 million per annum if it was to receive the national average per capita benefit for its population from Medicare services. This process would see a redistribution of funding from New South Wales and Victoria to the other States and Territories.[68]

68 Submission No.41, p.18 (Queensland Government).

However, an estimate such as this does not take account of other (Commonwealth-funded) programs such as grants for Indigenous health services which may, at least in part, substitute for the lack of available MBS and PBS services in remote areas and accordingly may disproportionately benefit some jurisdictions.

1.63 The purpose of including these examples of estimating the costs of cost shifting is not to apportion blame to any party. The examples highlight firstly, that it may be pointless to attempt to place a value on cost shifting and secondly that it is the existing roles and responsibilities of the different levels of government which should receive much of the blame. As Monash University's Centre for Health Program Evaluation (CHPE) pointed out:

> as patients are entitled to public outpatient and emergency care (a cost to the State) and also to the services of private doctors (a cost to the Commonwealth) there is no real way of determining whether or not a patient should have received a given service from one provider or another.[69]

1.64 Professor Richardson, from CHPE, also drew the Committee's attention to the fact that 'just documenting the existence of cost shifting and having bureaucrats extremely concerned about their bottom line being jeopardised is not the issue'.[70] Rather than attempting to estimate what may or may not constitute cost shifting, it may be more productive for efforts to be directed to reshaping the existing arrangements between the different levels of government in order to minimise the opportunities for cost shifting.

Impact of cost shifting on patients

1.65 The most visible impact of cost shifting on patients is evident where a previously free service is replaced by one where a patient charge or co-payment is levied. This may occur, for example, as a result of the privatisation or outsourcing of outpatient services, the closure of specialist clinics or the discharge of patients from a public hospital with only a very limited supply of essential medication. As a representative of the Australian Nursing Federation (ANF) pointed out, of most concern here is that:

> the poorer you are the sicker you tend to be. The chronically ill in our society, therefore, may be unable to access services because they have an inability to pay for that service.[71]

1.66 Possibly the most concerning impact of cost shifting occurs where patients are encouraged to use particular services on the basis of who pays for those services rather than what may be the most effective services to meet their needs. The Consumers' Health Forum (CHF) argued that this process tends to make it less likely that the

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69 Submission No.46, Additional Information, p.2 (Centre for Health Program Evaluation).

70 *Committee Hansard*, 23.3.00, pp.593-4 (Professor Richardson).

71 *Committee Hansard*, 23.2.00, p.175 (Australian Nursing Federation).

patient will receive an integrated package of care, which may actually be more cost effective for the community, as well as more beneficial for the patient.[72]

1.67 A further impact of cost shifting on patients is the funds foregone for patient care. Funding which may otherwise be spent on patient care is wasted through staff at senior levels in Commonwealth, State and Territory government departments and public hospitals spending time and scarce funds devising new ways to cost shift and/or checking for possible cost shifting. In addition, Professor Richardson noted that health bureaucrats are:

> important people in making the system work well. If their energies are channelled into cost shifting, then that is at a very high cost of long-term planning.[73]

1.68 Finally, while cost shifting may cause increased inconvenience for patients and physicians[74], as was noted by the RACP, ACA and Health Issues Centre, it can also result in the provision of inappropriate care, and/or the provision of care in an inappropriate setting each of which may ultimately compromise the quality of the care provided. The CHF suggested that under the current funding arrangements, analgesics to manage pain are subsidised under the PBS but access to physiotherapy which may minimise the patient's pain (and the need for medication) is very limited in the public system with 'patients needing to pay for private assistance if their need is urgent'.[75]

Level of concern at cost shifting

1.69 In comparison to the views expressed by governments, others did not view cost shifting as such a serious problem. For example, Professor Richardson argued that 'cost shifting is only a problem if it actually results in adverse outcomes for patients' and that 'cost shifting per se, and the size of the cost shifting is not the problem'.[76]

1.70 A key issue in assessing the significance of cost shifting, as with so many aspects of the public hospital sector, is a lack of available information or data. Two possible reasons for this lack of data were raised by Professor Hindle, who told the Committee that:

> very little work is done on the issue of cost shifting. I have tried to understand why, but I suspect there are two obvious answers. The first one is that everybody knows…Secondly, there is a sense in which researchers

72 Submission No.72, p.17 (Consumers' Health Forum).

73 *Committee Hansard*, 23.3.00, p.593 (Professor Richardson).

74 *Committee Hansard*, 21.3.00, p.371 (RACP, ACA, Health Issues Centre).

75 Submission No.72, p.16 (Consumers' Health Forum).

76 *Committee Hansard*, 23.3.00, p.593 (Professor Richardson).

> say, 'If I were to produce the authoritative description of the nature, size and total cost of cost shifting in Australia, who would listen?'[77]

1.71 Salaried medical practitioners and hospital managers provided examples of where individuals felt pressured to engage in cost shifting but no evidence was received about any written or explicit instructions to cost shift by State or Territory governments. The Australian Council of Health Service Executives (ACHSE) stated that 'cost shifting has occurred, I think, from the managers' point of view because they are under financial pressure to run their hospitals'.[78] A representative of SASMOA argued that:

> there is no doubt that hospitals are seeking to have cytotoxic drugs, which I heard you refer to this morning, on the PBS. That is happening. It is deliberate hospital policy and it is happening all over the place. There is no doubt too, that there is a deliberate move to Medicarisation of public outpatients.

1.72 These types of occurrences were attributed to States and Territories reducing funding for public hospitals while expecting them to treat the same (or greater) numbers of patients. However, when asked if any written instructions to that effect were available, the SASMOA's response was 'No. I think our senior colleagues have been reasonably careful about not doing it that way.'[79]

1.73 The New South Wales Health Department offered a different justification on cost shifting by arguing that it may sometimes be clinically appropriate. A practical example of where this might apply was:

> …the continuing care of someone who has suffered a fracture or broken bone. Rather than insisting on that person having to come back to a hospital outpatient clinic, quite appropriately they say, 'Why can't I go and see the orthopaedic surgeon nearby?' It seems to us that that is both clinically appropriate and good customer service.[80]

1.74 Another area of concern with regard to cost shifting is the impact that a reduction in the activity of outpatients clinics and/or their privatisation can have on the teaching and training of specialist trainees. For example, the immediate past Chairman of the Committee of Presidents of Medical Colleges advised that:

> most patients admitted to a public hospital for surgery now are not seen in outpatients before or after, so the surgical trainee simply sees the patient in the operating theatre. That is a major problem.[81]

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77 *Committee Hansard*, 21.3.00, p.325 (Professor Hindle).

78 *Committee Hansard*, 23.3.00, p.543 (Australian College of Health Service Executives).

79 *Committee Hansard*, 23.2.00, p.189 (South Australian Salaried Medical Officers Association).

80 *Committee Hansard*, 21.3.00, p.349 (Health Department of NSW).

81 *Committee Hansard*, 23.3.00, p.491 (Committee of Presidents of Medical Colleges).

1.75 The RACP expressed the view that the main effect of cost shifting on hospital physicians resulted in a misallocation of their time. This means that cost shifting requires physicians to take time away from clinical work and spend it instead on increased administration and management tasks.[82]

1.76 In summary, the New South Wales Health Department argued that whether cost shifting was perceived as good or bad depended on the eye of the beholder: 'there is a terminology of cost shifting which implies an illegality and there is a terminology of cost shifting which implies maximising the benefits'.[83]

Relationship between the public and private sectors

1.77 Australia has significant private sector involvement in the health system. This involvement has several manifestations. The non-government sector contributes around 30 per cent of Australia's total health expenditure[84] and Australia has a large and growing network of private hospitals. For example, in 1997-98, private hospitals accounted for 1.8 million separations[85] and 6 million patient days, compared to 1.3 million separations and 5.1 million patient days in 1993-94.[86] In addition, Australia's health system has always included private medical practice.

1.78 Despite the significance of the non-government sector, the relationship between it and the public sector is hazy and unresolved and contradictions abound. For example:

- Australia's health system is based around the concept of 'choice'. Universal access is provided to medical services (where charges may apply) and public hospital services (where charges do not apply) and patients may elect to pay for private health insurance which will provide access to hospital services as a private patient and doctor of choice. This 'choice' is effectively compulsory for people with taxable incomes above certain levels. If these people are not covered by private health insurance, a one per cent penalty is applied to their Medicare levy;
- however, all private health insurance premiums are subsidised at the rate of 30 per cent by the Commonwealth Government, including premiums for ancillary cover which provides rebates for services provided by a wide range of allied health practitioners. The Commonwealth does not provide any subsidy towards these services for people without private health insurance;

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82 *Committee Hansard*, 21.3.00, p.371 (RACP).

83 *Committee Hansard*, 21.3.00, p.366 (Health Department of NSW).

84 Australian Institute of Health and Welfare, *Health Expenditure Bulletin No. 16: Australia's health services expenditure to 1998-99*, Canberra, AIHW, 2000, p.5.

85 A separation is the term used to describe an episode of care in a hospital.

86 Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98*, Canberra, AIHW, 1999, p.39.

- a patient may be added to a public hospital waiting list for elective surgery but the 'choice' provided by private health insurance may ensure that the procedure is provided in a more timely manner. The procedure may be performed in a co-located private hospital by the same physician who would have eventually performed the procedure on the patient in the public hospital;
- the default bed-day charge for private patients in public hospitals (that is, the maximum charge which a public hospital may levy a private patient for hospital accommodation) is set by the Commonwealth Government at well below the actual cost, which means that public hospitals do not fully recover the costs of accommodating private patients. The actual bed-day cost, however, must be charged by private hospitals in order for costs to be recovered;
- there is no compulsion to actually use private health insurance when hospitalised; and
- access to subsidised pharmaceuticals through privately-owned community pharmacies is means tested[87] while the same pharmaceuticals may be provided on a non-means tested basis to public hospital patients regardless of income.

1.79 The following chapter deals with a key term of reference for this inquiry: gauging the adequacy of funding for public hospital services now and in the future.

87 People covered by a health care concession card presently pay a patient payment of $3.30 per prescription, while general patients pay a patient payment of $20.70 per prescription.