CHAPTER 3

OPTIONS FOR REFORM

Introduction

3.1 Discussion in the preceding chapters has adopted the view that a 'crisis' is not evident in either public hospitals or the Australian health system. However, participants who have presented submissions and evidence to this inquiry have been almost unanimous in arguing that significant problems do exist and that the public hospital system is under considerable pressure. Most participants viewed recent Commonwealth Government initiatives on private health insurance with some concern. This was particularly the case with regard to the 30 per cent rebate which most participants believed was unlikely to relieve demand on public hospital services, despite costing in excess of $2 billion per annum. Arguably, the 30 per cent rebate can be seen to run counter to the Medicare principles of universality, equity and access. Little evidence was presented showing benefits for public hospitals from the rebate. However, the Commonwealth Department of Health and Aged Care (DHAC) submitted that the full impact of the 30 per cent rebate on public hospitals 'will only be able to be assessed in the long term'.[1]

3.2 More than half of the submissions to the inquiry proposed minor options for reform to address the problems facing public hospitals, while around 25 per cent proposed major changes to the current system. While the available options for reform are virtually limitless, the one option which no-one appears to favour is standing still and opting for the status quo. This view was summed up by the Australian Nurses Federation (ANF) who told the Committee that 'we are not interested in maintaining the status quo, rather we are advocating for change'.[2] Accordingly, the status quo is not considered in this chapter as a serious option for dealing with the challenges facing Australia's public hospitals. A rationale for reform of the existing arrangements can be found also in the following comment from Professor Scotton:

> it is now almost a quarter of a century since the introduction of Medibank marked the start of a new era in the financing of Australian health services. Since then, or rather since its reintroduction under the name of Medicare in 1984, a structure designed to meet the needs of the mid-1960s has remained remarkably stable.[3]

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1 Submission No 38, p.32 (DHAC).

2 *Committee Hansard*, 23.2.00, p.174 (Australian Nurses Federation).

3 Scotton, R, *Managed Competition: the policy context*, (Melbourne Institute Working Paper No. 15/99), Melbourne, Melbourne Institute of Applied Economic and Social Research, University of Melbourne, 1999, p.1.

3.3 Prior to proposing and discussing options for change, the following questions need to be asked:

- what are the problems which the options are required to address? and
- what are the components of the current system which are not open to change?

3.4 It is clear from evidence presented to the inquiry that the key problem which needs to be addressed as a priority is the fragmented nature of the roles and responsibilities of the Commonwealth and the State and Territory governments and the associated cost shifting, in the funding and delivery of public hospital services and in the health system more generally. It is clear also that this is no easy task with several previous attempts at reform having foundered.

3.5 While there is general agreement that problems do exist, consensus virtually ends there. As was argued in chapter 1, different players, particularly the two levels of government, discern different problems and therefore may be more disposed to certain options than others. Some participants in the inquiry as well as commentators maintain that while problems and challenges exist, only minor, marginal or incremental change is required. Others see that major change may be desirable but is not likely to be achieved and believe therefore that change at the margin is preferable to no change at all. Still others argue that in order to address the current problems in a sustainable manner, major change is required. A selection of different perspectives on reform is presented below:

- the Health Department of New South Wales argued that its position, which it regards as one supported by a wide range of forums and reports, is 'for essentially not a fundamental reform';[4]
- Professor Hindle, by contrast, believes that a one-off, total redesign of the health system is required, which could be financed by the $2 billion cost of the 30 per cent rebate for private health insurance;[5]
- the starting point for discussion of change needs to be redefined, according to Professor Stephen Duckett, who argues that:

> responsiveness to consumers, enhancing equity of access, or equitable financing could all be postulated as ongoing frames for health system reform. The major problem of Commonwealth/state relations in health might thus be that the present systems of financing health distorts how health system issues are considered and inappropriately defines the starting point for health policy discussions.[6]

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4 *Committee Hansard*, 21.3.00, p.343 (Health Department of NSW).

5 *Committee Hansard*, 21.3.00, p.326 (Professor Hindle).

6 Duckett, S, 'Commonwealth/state relations in health', in L Hancock (ed) *Health Policy in the Market State*, St Leonards, Allen & Unwin, 1999: p.86.

- this point was raised also in the joint submission by the Australian Healthcare Association (AHA), Women's Hospitals Australia (WHA), and the Australian Association of Paediatric Teaching Centres (AAPTC) who argued that:

> there needs to be a move away from discussions between governments the nature of which is their relative contributions to health care. These have been no more than blame shifting exercises and have done nothing to enhance the health of the community.[7]

- Monash University's Centre for Health Program Evaluation (CHPE) believes that the answer to the question of how Australia is to finance its health care needs is not known. It argues that while choices will depend on a number of technical/economic relationships (which are not well understood), we need to acknowledge that choices also involve values and ideology.[8]

3.6 At the core of all options for reform are trade-offs between benefits and drawbacks. There are no options which are easy and straightforward to implement. Thus, the question emerges: has the problem(s) become of sufficient concern that action is imperative?

Aspects of the health system *off* the reform agenda

3.7 Prior to examining different options for reform, it is arguably necessary first to discuss the elements of the Australian health system, especially those elements integral to the public hospital system, which are immutable and not open to change. Few participants in this inquiry have proposed that the fundamental basis of the Australian health system, universal public insurance through Medicare, should be targeted for reform. Indeed, although the inquiry's terms of reference did not require it, around 25 per cent of submissions took the opportunity to outline their support for universal access to health care and/or the Medicare system. This action was bolstered by over 5000 postcards, letters and e-mails expressing wholehearted support for Medicare and the public hospital system being received by the Committee.

3.8 In the Committee's view, the following aspects of the Australian health system are off the agenda for reform: universal public health insurance through Medicare, financed by taxation; subsidised out-of-hospital medical and diagnostic services; and public hospital services provided free-of-charge. The Committee is not, in the main, presenting options which will undermine principles fundamental to the Australian health system. However, several options for reform, particularly those relating to funding issues, are quite far-reaching in their impact on governments. The Committee is concerned that some evidence has indicated that the key principles which underpin Medicare - universality, equity and access - are not guaranteed for all Australians with regard to public hospital services and other health services. The Committee considers that these principles are central to the Australian health system

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

8 Submission No.46, Additional Information, attachment 3, p.4 (CHPE).

and the options for reform discussed below are presented as a means of better achieving universality, equity and access in the public hospital sector.

Options for reform

3.9 In a research paper prepared for the Committee, CHERE categorised options for reform into three broad levels (note that there is some overlap between the different levels) as follows:

1. Reform proposals relating to fundamental overhaul of the current funding and delivery arrangements:

- reforms relating to how services are funded and delivered; and
- reforms relating to how health care financing is raised.

2. Incremental reform proposals, proposing changes at the margin or changes to a specific sector (partial reform):

- reforms relating to how services are funded and organised; and
- reforms relating to how health care financing is raised.

3. Specific reform proposals addressing specific problems identified in the public hospital system or related health services.

In addition to this categorisation, CHERE evaluated each proposal in categories one and two against a range of criteria, including how the proposal could be expected to impact on universality, equity and efficiency. The description and evaluation of the options for reform in this chapter are largely drawn from CHERE's research paper. Where appropriate, evidence from the inquiry has also been included.

Funding and delivery of services: proposals relating to fundamental overhaul

3.10 Most of the proposals involving major reform of funding and delivery of health services related to rationalisation of Commonwealth and State roles. The motivation for these proposals was reducing duplication and overlap between the Commonwealth and States/Territories, reducing the scope for political game playing around funding issues and removing incentives for cost-shifting. Essentially three broad options for reform of Commonwealth/State roles were proposed:

- Commonwealth to take responsibility for funding and delivery of health services;
- States/Territories to take responsibility for funding and delivery of health services; and
- pooling of Commonwealth and States/Territories funds at the regional/population group level.

3.11 While these options for reform are essentially aimed at rationalising Commonwealth/State overlap of responsibility, and removal of incentives to shift

costs between levels of government, they may also address some of the other issues raised in submissions, such as continuity of care and equity of access to services.

The single funder model: evidence

3.12 More than 25 per cent of submissions proposed that a single funder model be adopted. Proposals differed as to the degree of funding responsibility; for example, 14 per cent suggested that the Commonwealth should assume responsibility for funding public hospitals, while others proposed that one level of government should assume responsibility but were indifferent as to which level of government. Some submissions proposed that one level of government should assume responsibility for particular aspects of public hospital services only, such as pharmaceuticals or nursing home type patients in public hospitals. Others proposed that the Commonwealth should take responsibility for funding the entire health system.

3.13 A number of participants in the inquiry proposed that a single level of government should assume responsibility for funding public hospital services as a means of overcoming cost shifting and as a way of overcoming the current split of roles and responsibilities between the Commonwealth and State and Territory Governments in health financing. It was argued that adoption of a single funder model would enhance the cost effectiveness of health care services.[9] The ACHSE believed that a single funder 'would remove cost shifting and focus accountability for the use of funds in terms of their health effect'.[10]

3.14 Noting that the New South Wales Minister for Health had argued on several occasions for a single level of funding for the Australian health care system[11], the Director-General of the New South Wales Department of Health expressed his personal preference 'that there be a pool of funding nationally and that the states be the purchasers'.[12] The Queensland Government was more specific, arguing for the adoption of 'a funder/provider model, with the state being the provider of services and the Commonwealth being the funder of services'.[13]

3.15 The Australian Health Insurance Association (AHIA) took this proposal one step further, suggesting that what is required is 'one agency that is paying the bill or negotiating the price' and that 'we should be aiming for a situation where the person who purchases all health services can make some rational decisions about where is the best place to buy'.[14] In other words, it was proposed that the most cost effective service to meet the needs of the patient would be purchased, rather than the patient being directed towards a particular service on the basis of who pays for the service.

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9 *Committee Hansard*, 21.3.00, p.329 (Professor Hindle).

10 Submission No.62, p.4 (ACHSE).

11 *Committee Hansard*, 21.3.00, p.348 (Health Department of NSW).

12 *Committee Hansard*, 21.3.00, p.364 (Director-General, Health Department of NSW).

13 *Committee Hansard*, 22.3.00, p.477 (Queensland Minister for Health).

14 *Committee Hansard*, 11.11.99, p.132 (AHIA).

The AHIA noted that 'the Coordinated Care Trials are already moving in that direction'.[15]

3.16 The HCC supported the use of the Commonwealth as a single funder and proposed that a pilot project be conducted in each of two States to evaluate the proposal. This concept had been supported by Western Australian consumers in an earlier consultation process conducted by the HCC. In these pilot projects, 'the Commonwealth would take responsibility for the funding, management and organisation of outpatient services, discharge planning and care in the community'.[16]

3.17 Professor Richardson advised the Committee that while there was not a simple case for proposing one level of government over the other, the arguments in favour of a single funder were strong. He argued that under a single funder, 'the health system for the population will be improved'[17] and that a single funder overcomes the artificial financial barriers which operate under the current arrangements. In addition, a single funder 'has an incentive to get a better and cheaper system because they cannot cost shift. So it is desirable from both the point of view of allocation and cost control'.[18]

3.18 In addressing the question of which level of government should become the single funder, Professor Richardson and CHPE made the important point that 'it is not sensible to discuss the relative merits of a particular tier of government in abstract from the organisational detail–the particular model–which is envisaged'.[19]

3.19 CHPE discussed the pros and cons of the Commonwealth or the States and Territories being the level of government responsible for public hospital and health funding. The arguments in favour of the Commonwealth as a single funder include: a greater revenue base; the likely economies of scale from a single, larger bureaucracy; and less likelihood of 'single States implementing foolish reforms'. CHPE argued that with the States as the funders that diversity and experimentation will be enhanced and that "dynamic efficiency"–the likelihood of achieving maximum improvement through time–requires the diversity that would be provided through a State-based system'.[20]

3.20 There are also drawbacks in the States and Territories being the responsible level of government. For example, the joint submission from the AHA, WHA and AAPTC argued that their proposal for a basic package of care was made in response to:

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15 *Committee Hansard*, 11.11.99, p.132 (AHIA).

16 Submission No.7, pp.3-4 (HCC).

17 *Committee Hansard*, 23.3.00, p.613 (Professor Richardson).

18 *Committee Hansard*, 22.3.00, p.612 (Professor Richardson).

19 Submission No.46, Additional Information, p.3 (CHPE).

20 Submission No.46, Additional Information, p.3 (CHPE).

> the wide variations in access to the basic healthcare package across State and Territory jurisdictions. These variations are due to differences in policy and funding levels of State/Territory governments.[21]

The AHA, WHA and AAPTC proposed that the Commonwealth should be the single funder for the basic package of health care.

3.21 The New South Wales Government pointed out that awareness of the inadequacies of the current arrangements is not a recent phenomenon and many attempts had been made since the late 1980s 'to initiate processes that might lead to fundamental changes'.[22] Reasons offered by the NSW Government as to why these attempts had generally failed included:

- lack of sponsorship at the Commonwealth level;
- government's acknowledgment of public support of Medicare;
- reluctance of States to become exposed to risks of open-ended programs;
- difficulties in getting genuine reform proposals considered by Ministers; and
- lack of clinical leadership and consensus.[23]

3.22 The joint submission from the Royal Australasian College of Physicians (RACP), the Australian Consumers' Association (ACA) and the Health Issues Centre offered four possible options for reorganising the financing and delivery of public hospital services, including three possible versions of a single level of government assuming full responsibility for funding and organisation of public hospital services or the health system as a whole:

- Commonwealth takes responsibility for funding and organisation of public hospitals and integration with general practice and other health services;
- Commonwealth takes responsibility for all health care delivery; or
- States/Territories take responsibility for all health care delivery.

3.23 However, the groups were not optimistic that any of these options would be acceptable to either the Commonwealth or the States and Territories and felt that 'it is most likely that the current system will remain'.[24] This is a discouraging viewpoint given the range of evidence and views of participants on the importance of addressing the roles and responsibilities of the two levels of government in the public hospital sector and the Australian health system. In the view of the RACP, ACA and the Health Issues Centre:

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21 Submission No.63, p.24 (AHA, WHA, AAPTC).

22 Submission No.79, p.10 (NSW Government).

23 Submission No.79, p.11 (NSW Government).

24 Submission No.45, p.21 (RACP, ACA, Health Issues Centre).

> the best that can be hoped for is a structural reorganisation that articulates and simplifies existing responsibilities; for example, one level of government funding and organising the provision of pharmaceuticals and/or the funding of all non-inpatient care.[25]

3.24 The New South Wales Government proposed a similar model, albeit with a broader focus. It proposed that the Commonwealth assume responsibility for funding all medical and pharmaceutical services in public hospitals through the MBS and the PBS as well as responsibility for the funding arrangements for nursing home type patients in public hospitals.[26] The Commonwealth already funds, via Medicare, rebates for all out-of-hospital medical and diagnostic services as well as similar services for private inpatients. The Commonwealth already subsidises PBS pharmaceuticals outside of public hospitals and also provides considerable subsidies for aged care accommodation. The mechanisms are clearly in place to permit the Commonwealth to assume such wider responsibilities. The States and Territories would obviously need to contribute some funding to these arrangements.

3.25 It may not be desirable, however, to extend the MBS to the remuneration of medical practitioners for their services in public hospitals. Generally speaking, medical practitioners are currently remunerated by public hospitals on the basis of their time rather than what particular procedures or tests are undertaken. The Commonwealth, if it was to fund these services via the MBS, would provide remuneration on the basis of what the practitioner actually did, using the MBS item numbers for the particular procedures and/or tests. Under these arrangements, practitioners would presumably be required to accept the 85 per cent MBS rebate for each procedure/test.

3.26 It should be noted that if the Commonwealth was to assume the role of a single funder, it would not necessarily have to extend the MBS to the payment of doctors in public hospitals. Existing sessional and salaried arrangements could continue to apply or alternative methods of remuneration could be investigated.

Commonwealth as the single funder: assessment

3.27 This model was more commonly suggested as a solution to cost shifting and overlap or roles and responsibilities than other models. This may reflect a number of issues or concerns including:

- the need to ensure national consistency in access to services and the level of services provided;
- the fact that the Commonwealth has greater revenue raising powers;

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25 Submission No.45, p.21 RACP, ACA, Health Issues Centre).

26 Submission No.79, p.4 (NSW Government).

- the fact that the Commonwealth currently has responsibility for open-ended benefit programs (MBS, PBS) which are the most variable in terms of utilisation; and
- the view underlying some submissions that the Commonwealth has been more pro-active in setting national health policy and driving micro-economic reform in health.

3.28 In general, submissions which put forward this proposal as a direction for reform did not suggest mechanisms by which the Commonwealth would take responsibility for or manage services, particularly public hospital services. This is an important issue, because the Commonwealth role in provision of services (across a broad range of services and portfolios of government) is generally one of funding programs, rather than hands-on management. However, some submissions suggested that the Commonwealth could act as a purchaser of public hospital services, using casemix funding (this does not address the broad range of other services such as community health services, which States/Territories provide). Other submissions proposed that the mechanism by which the Commonwealth would assume responsibility for funding and delivery would be through regional budget holding, with the Commonwealth acting as a funder of services which would then be purchased by a regional health authority (which may also be a provider). This is discussed in more detail later in the chapter.

Assessment against criteria	**Commonwealth to take responsibility for funding and delivering services**
Universality	Maintained by this proposal
Equity	Impact on equity unclear
Efficiency	May reduce cost-shifting, but impact on overall costs unclear
Consumer participation	No direct impact – depends on how the model is implemented
Consumer choice	No direct impact
Appropriateness of care	Indirect improvement possible because of reduced incentive for cost-shifting
Continuity of care	Indirect improvement possible because of reduced incentive for cost-shifting
Feasibility	Key issue is establishing mechanisms for C/W to manage services
Evidence based	Not applicable

States/Territories as single funders: assessment

3.29 Fewer participants suggested this model as a solution to the Commonwealth/State overlap issues. However, those submissions that did propose it noted the fact that the States/Territories have established infrastructure for managing hospital and community health services. They also argued that this model may be more feasible to implement. The main obstacle to this model is the open-ended nature of the MBS and PBS. This, combined with the large geographical variation in utilisation of Medicare funded medical services (raised by the Queensland and Tasmanian Governments and discussed in the previous chapter) means that the

States/Territories would be reluctant to assume responsibility for funding these programs without either significant change to taxation powers, or significant change to the method of funding these programs.

3.30 With either proposal for one level of government to assume responsibility for the funding and provision of services, it needs to be recognised that incentives for cost-shifting exist wherever there are different pools of funds for different programs. While this becomes a major political issue when the different pools of funds are provided by different levels of government, there will still be cost-shifting incentives if a single level of government provides different pools of funds for programs which it manages. Thus, the most effective options for rationalisation of roles and responsibilities involve major change to the funding of services at the ground level, which could be achieved through pooling of funds.

3.31 The issue is how flexible are funding arrangements. These need to be flexible enough to permit providers to make decisions based on local needs. However, there is currently much variation between States in the way that services are provided and a lot of variation in the per capita utilisation of services, for various reasons.

Assessment against criteria	**States to take responsibility for funding and delivering services**
Universality	Risk that states may provide different level of services – need to maintain national policies and monitoring Impact on equity unclear
Equity	
Efficiency	May reduce cost-shifting, but impact on overall costs unclear
Consumer participation	No direct impact – depends on how the model is implemented
Consumer choice	No direct impact
Appropriateness of care	Indirect improvement possible because of reduced incentive for cost-shifting and improved links between community based and hospital based services
Continuity of care	
Feasibility	Key issue is maldistribution of medical services and fiscal powers of states/territories
Evidence based	Not applicable

Pooling of Commonwealth and States/Territories funds: regional budget holding

Regional budget holding: proposal for Regional Health Agencies

3.32 A developed proposal for regional budget holding was provided in the joint submission by the AHA, WHA, and AAPTC. In essence, this proposal is for the establishment of Regional Health Agencies (RHAs) as statutory authorities at arms length from government. Each RHA would serve a geographically-defined catchment area and would be responsible for planning and purchasing the basic healthcare package for its population. The Commonwealth would allocate funding to the RHAs on the basis of a population-based, needs-adjusted formula. The AHA, WHA and AAPTC propose that funding for the RHAs would be capped, but that each agency

would have 'total flexibility to move funds across existing programs in response to population requirements and availability of providers'.[27]

3.33 Under this proposal, the opportunities for cost shifting would be minimised and the duplication of responsibilities for funding and policy would be overcome. Other key features of the RHA model include:

- in addition to its single funder responsibilities, the Commonwealth Government would also have sole responsibility for national health policy;
- regulation of the RHAs would be the responsibility of one level of government– the AHA, WHA and the AAPTC do not express a preference for which level of government should have this responsibility, although if the RHAs are to be regulated in a 'nationally consistent manner',[28] as they propose, it would seem logical for the Commonwealth to also be the regulator;
- each RHA would negotiate service contracts with a range of providers. These contracts would prescribe quality, price and volume of services. It is envisaged that, where appropriate, provider contracts 'should be specified at the level of the whole episode of care, not the setting' and should 'also specify whole of life healthcare requirements, not just episodes';[29]
- continuity of care and service coordination would be achieved by the RHA as the single purchasing agency being responsible for all funds for its population and the translation of these funds into the service contracts;
- following the allocation of funding by the Commonwealth, all risk associated with the procurement of the basic package of care rests with the RHAs;
- methods of remuneration of providers would be specified by the RHA in the service contracts and could be drawn from block contracts, capitation, case/episode payments and fee for service. The method of payment adopted in the contracts would 'minimise incentives for overservicing and maximise opportunities for coordination of care across settings';[30]
- providers would be able to provide services outside the basic package, with funding provided through optional private health insurance, direct payments by the patient or other arrangements, such as for particular groups such as veterans; and
- explicit and transparent guidelines for the rationing of the basic package would be incorporated into the funding agreement between the Commonwealth and the

27 Submission No.63, p.25 (AHA, WHA, AAPTC).

28 Submission No.63, p.27 (AHA, WHA, AAPTC).

29 Submission No.63, p.25 (AHA, WHA, AAPTC).

30 Submission No.63, p.26 (AHA, WHA, AAPTC).

RHAs which would in turn incorporate this into service agreements with providers.[31]

3.34 The National Rural Health Alliance (NRHA) offered its support for regional budget holding and recommended that the Senate 'take a long term interest in proposals to establish Regional Health Authorities as fundholding agencies of the Commonwealth to purchase and provide health services for their regions'.[32]

3.35 Professor Richardson also supported the regional model, arguing that:

> the regional level is an attractive administrative level because you can take into account the idiosyncrasies of the area, the relative supply or deficit of services, and you can plan more easily.[33]

3.36 Adoption of a regional model would address many of the issues around the roles and responsibilities of the Commonwealth, and the States and Territories, although it would effectively restrict the States and Territories to a role as providers of services through their public hospitals and community health services. However, this would remove the possibility under the current system of variability in service provision in geographically adjacent areas, such as Albury and Wodonga, which are subject to different approaches and priorities by their respective State governments. While regional agencies such as the RHAs may be more responsive to the needs of their local communities than the States and Territories, the proposal for the Commonwealth alone to be responsible for national health policy may be problematic. Some form of mechanism, perhaps the establishment of State-wide consumer forums, as proposed in the report of the NSW Health Council would be necessary to permit local input into national policy formulation.

3.37 Major benefits of this proposal include a more patient-centred approach where the needs of patients are preferred over the requirements of providers and funders. Duplication and cost shifting would be minimised, if not eliminated. The details of exactly which services are included in the basic package of care would be likely to determine its acceptance by the community. The disadvantages of regional budget holding include the difficulty that many special services are only provided at a national or State-wide level and that these would need to be funded by a separate mechanism. Provisions would also be needed to ensure there were no restrictions on access by people temporarily outside of their home region.

Coordinated Care Trials

3.38 An example of budget holding, albeit on a smaller scale than proposed above can be found in the current trials of coordinated care. The trials of co-ordinated care are built around the concept of case management, whereby a care co-ordinator (often a

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31 Submission No.63, pp.24-27 (AHA, WHA, AAPTC).

32 Submission No.66, p.6 (NRHA).

33 *Committee Hansard*, 23.3.00, p.610 (Professor Richardson).

GP) works with the patient to develop a care plan to meet the health care needs of the patient. The care co-ordinator then purchases the full range of required health services using funding which is pooled by the Commonwealth, States and Territories. The trials of co-ordinated care have been primarily directed at people with chronic and/or complex, ongoing illnesses who require a wide range of services and whose needs are not always met in a timely fashion by Australia's health system. The types of services which may be purchased by the care co-ordinator are not restricted to those available under government-funded schemes. The objective is to 'provide the right care at the right time'.[34] The nine general trials which operated in five States and the ACT concluded in December 1999. The four Aboriginal Coordinated Care trials operating in two States and the Northern Territory are continuing in 2000 under transitional funding. The final evaluation of the trials is yet to report.

Regional budget holding: assessment

3.39 This model was proposed in a number of submissions in different forms, and represents an extension of existing models such as coordinated care trials or multi-purpose services. Pooling of funds requires that there is a regional budget holder (for example, a Regional Health Service) which may be responsible for purchasing services, or which may be both a provider and purchaser of services. For this model to operate beyond a trial context would entail significant change to funding, particularly of medical services in the community. One option would be to cash out the region's existing utilisation of Medicare and PBS funds, and combine these with State/Territory funding which may be population based to a region or casemix based funding to hospitals and other health services. However, if this were done on a national basis, it would entrench existing inequities in health care funding and access to services. Therefore, a more realistic alternative would be to fund regions on a needs adjusted population basis, which would, in effect, redistribute medical Medicare and PBS funds.

3.40 A related but separate model of pooling funds is based on arrangements currently being piloted, particularly for Indigenous population groups, involving 'opting out' of Medicare.

3.41 A number of issues arise in considering how either of these models of pooling of funds would be put into operation. To maintain universality, equity of access and national consistency in service provision, the Commonwealth and/or States/Territories would need to establish clear policy guidelines determining the nature of services provided by a region and how services would be funded. This may limit the scope that the regional manager has to achieve efficiencies in service provision. For example, if the model entailed the maintenance of fee-for-service funding of medical services, this would have significant budgetary implications for the regional manager. Alternatively, putting this model into operation may entail fundamental changes to the way medical

34 Department of Health and Aged Care, *Co-ordinated Care: overview*, at http://www.health.gov.au/hsdd/cocare/overview.htm, last updated 12.2.99.

services in the community are funded, particularly for general practice (eg capitation funding), to ensure that it is feasible.

Assessment against criteria	**Commonwealth and States/Territories to pool funds: regional budget holding**
Universality	Maintained by this proposal if national guidelines on services established
Equity	Impact on equity unclear
Efficiency	May reduce cost-shifting and increase competition but impact on overall costs unclear
Consumer participation	Consumer participation could be enhanced if the model involves regional management with consumer participation
Consumer choice	May indirectly reduce consumer choice because of regional budget holding role
Appropriateness of care	Potential to enhance appropriateness of care
Continuity of care	Potential to enhance continuity of care
Feasibility	Key issue is establishing appropriate population based funding and mechanisms for purchasing medical/pharmaceutical services
Evidence based	Coordinated care trials provide some evidence, but generalisability to broader context unclear

Funding and delivery of services: incremental/partial reform proposals

3.42 Incremental or partial reform proposals were also largely focussed on rationalisation of Commonwealth/State roles. Here the principal concern was addressing incentives for cost-shifting, with less direct emphasis on the issues of removal of duplication, or on the other potential outcomes such as increasing access to services or ensuring continuity of care. Many of these proposals represented the extension of existing reforms such as ‘measure and share’ initiatives, coordinated care trials, and the arrangements within the current AHCAs for rationalisation of pharmaceutical funding arrangements.

Commonwealth to fund all pharmaceutical services

3.43 This proposal involves the Commonwealth assuming responsibility for funding pharmaceutical services in public hospitals. A number of alternatives were proposed in submissions, including:

- Commonwealth to fund inpatient and non-inpatient pharmaceuticals for public hospital patients;
- Commonwealth to fund only non-inpatient pharmaceuticals in public hospitals;
- Commonwealth to provide block funding for public hospital pharmaceutical services;
- Commonwealth to fund public hospital pharmaceutical services through the PBS;
- use of casemix based funding for pharmaceutical services; and

- extension of the s100 Scheme[35].

3.44 The primary motivation for the proposal for the Commonwealth to assume responsibility for funding of all pharmaceutical services is the removal of incentives for cost-shifting. In particular, it is seen as a way of addressing the concern that patients discharged from hospital are issued with small starter packs of medication which therefore requires them to visit their general practitioner for a PBS prescription. Evidence from the Commonwealth suggests that this would involve significant cost-savings. However, a number of issues need to be considered in relation to this proposal:

- there is a risk that such a proposal, if implemented on its own, would simply shift the boundary for cost-shifting within hospitals. This is particularly the case if there are different arrangements for inpatient and non-inpatient pharmaceuticals;
- if hospital pharmaceutical services are funded from a different pool from the global budget for other hospital services, there are reduced incentives for hospital managers to monitor efficiency in pharmaceutical provision. Hospital pharmacists have noted that the incentives to manage the provision of s100 pharmaceuticals are much lower than for other components of their service provision;
- if hospital-based pharmaceutical services are funded on an open-ended basis (eg through the PBS) there are few incentives for ensuring efficiency in their provision; and
- the different purchasing arrangements which exist for hospital based and community based pharmaceutical services are relevant to the overall efficiency of service provision.

It should be noted that a proposal for the Commonwealth to assume responsibility for non-inpatient pharmaceuticals is already built into the current AHCAs, and negotiations are underway between the Commonwealth and individual States/Territories for its implementation. The differences between jurisdictions in their view of the merits of this proposal are canvassed below.

35 s100 refers to section 100 of the *National Health Act 1953*. This section permits the Minister for Health to make special arrangements for access to pharmaceuticals. It can apply to people living in isolated areas or people requiring pharmaceuticals which may not be supplied under other arrangements such as the PBS. For example, the Commonwealth provides funding for high cost drugs such as interferon for certain limited types of patients under the s100 arrangements. Access to drugs under the s100 arrangements is provided at public hospitals rather than community pharmacies.

Commonwealth's offer to the States and Territories on hospital pharmaceuticals

3.45 Under the 'measure and share' provisions of the AHCAs,[36] the Commonwealth is negotiating with the States and Territories over a proposal for the Commonwealth to assume the responsibility for the funding of pharmaceuticals dispensed in public hospitals. This is an attempt to overcome cost shifting in this area. Under the current arrangements, the Commonwealth subsidises pharmaceuticals dispensed in community pharmacies and private hospitals. Pharmaceuticals dispensed to public patients in hospital are funded by State and Territory governments. The Commonwealth's proposal is to 'allow the States to dispense against the Pharmaceutical Benefits Scheme the full course of treatment. We see that as an all-round win'.[37]

3.46 However, the New South Wales Health Department expressed reservations about the Commonwealth's proposal 'because it simply transferred the risk to the States' and that it was a 'take it or leave it offer'.[38] The Queensland Government held a similar view, stating that 'we do not think at this stage the proposed risk sharing arrangements are acceptable'.[39] The Society of Hospital Pharmacists of Australia and the Therapeutic Assessment Group were concerned that the proposal 'actually makes the system more complex than it needs to be and has administrative issues involved with it'.[40] However, the Northern Territory Government was more optimistic, with the Territory's Minister for Health arguing that 'I think it is an appropriate move. It is early days, so I guess there will be problems along the way, but as a first move I think it is good'.[41]

3.47 These differences of opinion about this proposal indicate the problems inherent in any proposals to reorganise or reform the roles and responsibilities of the different levels of government in health care.

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36 'Measure and share' is a provision of the AHCAs and illustrates, arguably, their flexibility. Essentially, this provision permits the movement of funding across Commonwealth and State programs. The AHCAs provide that the Commonwealth and States may consider proposals that move funding for specific services between Commonwealth and State funded programs provided that each proposal meets certain criteria which are detailed in the AHCA (Clauses 27-28).

37 *Committee Hansard*, 11.11.99, p.21 (DHAC).

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

39 *Committee Hansard*, 22.3.00, p.484 (Queensland Minister for Health).

40 *Committee Hansard*, 21.3.00, p.293 (Society of Hospital Pharmacists and the Therapeutic Assessment Group).

41 *Committee Hansard*, 24.2.00, p.236 (NT Minister for Health).

Assessment against criteria	Commonwealth to fund all pharmaceutical services
Universality	Maintained
Equity	May increase access to pharmaceuticals for some groups
Efficiency	Likely to reduce costs; Reduces incentive for cost-shifting btw levels of government but may create new boundaries for cost-shifting; May reduce incentive to manage services; Overall impact unclear
Consumer participation	No impact
Consumer choice	No impact
Appropriateness of care	Reduces need for additional visits to doctors
Continuity of care	Could indirectly reduce continuity of care
Feasibility	Feasible, and currently being implemented
Evidence based	Not applicable

Commonwealth to fund all medical services

3.48 This option for reform was proposed less often than proposals relating to pharmaceutical services. While the proposal for the Commonwealth to have responsibility for funding all medical services largely relates to addressing cost-shifting, it would also address issues of overlap between public and private services, and the perverse incentives which can arise when medical practitioners are funded from two different programs. Essentially two models can be identified:

- Commonwealth to fund all non-inpatient medical services through the MBS;
- Commonwealth to assume all responsibility for paying for medical services (inpatient and non-inpatient).

3.49 The first model represents a relatively straightforward extension of MBS and existing arrangements to hospital outpatient clinics and to emergency departments, and could be seen as an extension of arrangements which are already occurring on an ad hoc basis. The primary motivation is removal of incentives for cost shifting, but it may also improve access to services by removing some financial barriers and by reducing incentives for outpatient services to be closed. However, it should be noted that if such an arrangement applied in emergency departments, perverse incentives for patients not to be admitted would exist. In addition, as with the proposals for pharmaceutical services, such an arrangement could be seen as shifting the boundary of cost shifting, rather than removing cost shifting per se.

3.50 The second model is more complex to implement, because the extension of the MBS to all inpatient care would, in effect, involve a change in the definition of a private patient, and have significant implications for funding of public hospital services. This model was proposed as one option by the former National Health Strategy. An alternative arrangement would be for the Commonwealth to fund the

medical component of casemix based funding. However, either of these arrangements introduce a new complexity in funding of public hospital services which is likely to create perverse incentives.

Assessment against criteria	**Commonwealth to fund all medical services**
Universality	Maintained
Equity	No direct impact
Efficiency	Reduces cost-shifting and incentives for gaming; Overall impact depends on the funding model implemented
Consumer participation	No impact
Consumer choice	Depends on the model implemented
Appropriateness of care	Impact unclear
Continuity of care	Impact unclear
Feasibility	Depends on the model implemented.
Evidence based	Not applicable

Extension of Coordinated Care Trials/trial of regional budget holding

3.51 A number of submissions proposed that the coordinated care model be further trialed, with extension to broader population groups. In particular, several submissions proposed that the next step in trialing *budget holding* and *coordinated care* would be to pool funds for a region. This requires consideration of who would hold the budget. One option would be to establish regional health authorities with responsibility for purchasing services for their population. Alternatively, general practitioners could act as budget holders for their patients. This would, in effect, involve capitation funding to the general practitioner, with the general practitioner taking on a purchasing role.

3.52 Related to this, the issue of how services would be paid for needs to be considered. If general practitioners or some other case manager at the local level are to take on the purchasing role, there would be a clear role for government in establishing and prescribing funding arrangements for hospital and other services (for example, defining DRG prices for hospital services and fee schedules for specialist medical services). Further, the effectiveness of such a model is highly dependent on how any cost-savings are distributed. It is important to establish appropriate incentives for the budget holder to manage resources appropriately, but also to ensure that access to appropriate services is guaranteed.

Assessment against criteria	Extension of coordinated care trials/trial of regional budget holding
Universality	Maintained, given clearly established national policies and monitoring
Equity	
Efficiency	Likely to reduce cost-shifting and increase potential for cost savings, however, evidence from CCTs suggests impact on efficiency unclear
Consumer participation	May increase consumer participation at the local level
Consumer choice	Impact unclear
Appropriateness of care	Potential to enhance appropriateness of care and continuity of care
Continuity of care	
Feasibility	Key issue is establishing population funding and addressing variation in medical services utilisation
Evidence based	CCTs provide some evidence but generalisability unclear.

Health care financing: proposals relating to fundamental overhaul

3.53 Although a number of submissions did propose significant overhaul of health care financing in Australia, a consistent theme through most submissions was that there was little reason to change the fundamentals of Medicare or private health insurance. For example, many submissions argued that the level of health care expenditure in Australia is appropriate, and most submissions supported the universal nature of a tax funded health financing scheme, and private health insurance as complementing this (although there was considerable debate about the role private health insurance should play).

3.54 Further, there is strong support for Medicare from consumers. In general most submissions favoured incremental reform rather than fundamental reform, and focussed on funding and delivery arrangements rather than the issue of health care funding as such. To the extent that funding of public hospitals was seen as a problem it was related much more to Commonwealth/State issues and political debate about the relative shares of funding rather than an issue of the nature of the health insurance scheme.

3.55 It should be noted that reforms proposed to how health care funding is raised also involve significant changes to how services are organised and paid for.

Single national insurer

3.56 Some submissions argued for a single national taxation funded insurance scheme for all health care services – that is, extension of Medicare to cover all health care services, with no role for private health insurance. The main argument for this was the relative efficiency of taxation as a means of raising funds and a single insurer as a means of paying for services. However, such an arrangement would significantly reduce choice to consumers.

3.57 An alternative model would be to limit the role of private health insurance to funding of treatment in the private hospital sector, with private health insurance to cover all the costs of this treatment including medical services. This model would provide a much more limited role for private health insurance than currently exists and would considerably reduce access to private health care for consumers. It raises the issue whether private health insurance would continue to be community rated or not.

Assessment against criteria	**Single national insurer**
Universality	Maintained
Equity	May be enhanced
Efficiency	May reduce administrative costs of insurance
Consumer participation	Reduces choice available to consumers
Consumer choice	
Appropriateness of care	Impact unclear
Continuity of care	Impact unclear
Feasibility	May not be feasible because of impact on consumer choice and implications for funding of medical practitioners
Evidence based	Some indirect evidence from other countries to support impact on costs – may not be generalisable

Transferable Medicare entitlements

3.58 Several submissions discussed the model which has been proposed by the Australian Private Hospitals Association (APHA), which involves transferable Medicare entitlements. This model proposes that individuals would be able to opt whether to be insured by the single national insurer (Medicare) or by a private insurer. An individual who does not opt out of Medicare would be entitled to free treatment in a public hospital and to subsidised access to medical services and pharmaceutical services.

3.59 However, individuals who wanted to access private health care could opt to be insured by a private insurer. In this case, the private insurer would receive a risk rated premium from the (Commonwealth) government equivalent to the consumer's 'Medicare entitlement', which would then be supplemented by premium payments by the consumer, depending on the level of coverage. In this model, opting out of Medicare would mean that the individual was no longer entitled to free treatment in public hospitals–they would only be entitled to care in facilities and from providers who had contracts with their private insurer (as in managed competition).

3.60 As well as being risk rated (age and sex adjusted, with some possibility of other adjustments based on factors such as chronic health conditions), premiums could be adjusted for income, with higher income individuals receiving a lower subsidy from government.

3.61 The main rationale for transferable Medicare entitlements is its potential to increase efficiency (through competition), reduce scope for and incentives for cost-shifting, while maintaining universality and consumer choice. However, while some analysis of the financial viability of this proposal has been undertaken by the APHA, it is not clear what the final impact on health care costs would be.

Assessment against criteria	**Transferable Medicare entitlements**
Universality	Key issue is ensuring that all insurers are required to provide a reasonable minimum level of services – may be difficult to monitor
Equity	Depends on the model implemented, but may reduce access to private care and lead to a "two tiered" system
Efficiency	Potential to increase cost control through competition. However, administrative costs likely to be higher. Overall impact unclear
Consumer participation	Potential to enhance choice available to consumers and consumer participation (eg specific population groups could establish their own fund)
Consumer choice	
Appropriateness of care	May enhance appropriateness of care and continuity of care because a single purchaser is responsible for all care
Continuity of care	
Feasibility	Data requirements for establishing appropriate arrangements are substantial
Evidence based	Indirect evidence available from other countries

Health Savings Accounts

3.62 One submission proposed a variant of the Singapore health system model, whereby each individual would have a 'health account' held (and underwritten) by the Commonwealth government. The government would pay an annual amount into each individual's health account, which would accrue over time. Individuals would be entitled to withdraw from their account to purchase services (in the model proposed, the government would define a list of approved health services and establish a fee schedule for these) regardless of whether their account had a positive or negative balance. Individuals who had a positive balance at the end of the year would be entitled to a health dividend. Medical services would be funded on a fee-for-service basis, and pharmaceuticals would be funded on the basis of negotiated prices (as with the current PBS). Hospital services would be funded on a case payment basis, with the government determining the DRG price. Private health insurance could be allowed in the model, to cover services not included in the approved health services, or to cover charges above the schedule fee.

3.63 There are a number of issues with this model. It is likely to increase health care costs, because it places more services on an open-ended fee-for-service basis, and reduces incentives for health services managers to manage the provision of services. Private health insurers would have little scope to manage funds, because their role would essentially be that of a third party payer. Further, while it would be possible to risk-adjust the amount paid into an individual's health account, it is likely that the model would reinforce inequities in health status, because individuals are, in effect, rewarded for not using health services.

Assessment against criteria	Health Savings Accounts
Universality	Risk that universality of access and equity of access to services could be compromised
Equity	
Efficiency	Increases open-ended funding arrangements therefore likely to increase costs
Consumer participation	Potential to enhance choice available to consumers and consumer participation, but this depends on consumers having equitable access
Consumer choice	
Appropriateness of care	Impact unclear – may increase fragmentation in the system
Continuity of care	
Feasibility	Data requirements for establishing appropriate arrangements are substantial
Evidence based	No evidence available

Health care financing: incremental/partial reform proposals

3.64 Although a number of submissions proposed incremental or partial changes to how health care finances are raised, it is difficult to separate these reforms from the broader debate about current health insurance arrangements and the effectiveness of the new measures to increase private health insurance uptake. Thus, proposals often related to either removing or extending some of the existing or proposed measures. In relation to any proposed changes to health insurance arrangements, several points should be noted:

- submissions which addressed these issues tended to be divided between those which argued for less support for private health insurance (for example, submissions which argued that the rebate should be abolished and funds diverted to public hospital funding) and those which argued for greater support for private health insurance (for example, those which suggested measures to eliminate co-payments);
- it is difficult to separate out the rationale for any changes to health insurance arrangements from the underlying position of the stakeholders proposing it. Thus reform proposals in this area often appeared to be driven by ideology or politics rather than evidence;
- as noted in a number of submissions, it is too early to assess accurately the impact of existing and proposed measures including the 30 per cent rebate and the introduction of lifetime health cover; and
- the effectiveness of health insurance arrangements needs to be assessed against their proposed objective. The objective of increasing private health insurance uptake, or making private health insurance more affordable and available to consumers per se needs to be separated from the objective of financing health care, particularly public hospital care. A number of submissions have provided reasonable assessments which suggest that mechanisms to increase private health insurance uptake are a relatively inefficient way of reducing pressure on public hospital services.

Reform proposals addressing specifically identified issues

3.65 Many submissions identified specific reforms to components of the health system. These proposals tended to relate to the funding and delivery of specific services and are briefly outlined below. The issues involved with a number of these proposals will be discussed in more detail in the Committee's final report, which will address the remaining terms of reference.

Quality management

- introduction of report cards/performance monitoring for public and private hospitals and other providers;
- trialing of quality improvement programs;
- relating funding to quality improvement and to outcomes, for example, by funding hospitals only if they have established clinical care pathways;
- establish financial incentives for hospital managers to implement quality improvement programs;
- further development of clinical care pathways;
- increased development of evidence based guidelines; and
- support for teaching and research in public hospitals.

Continuity of care

- more comprehensive discharge planning;
- increased role for general practitioners; and
- financial incentives/funding arrangements to encourage general practitioners to link with other providers.

Data collection

- establish unique patient identifiers applicable to all health services; and
- improve data collection in specific areas (eg rehabilitation services).

Access to services

- provision of funding for Aboriginal language interpreters;
- appropriate funding for primary health care for Aboriginal and Torres Strait Islander populations;
- increase the role of nurse practitioners in rural areas; and
- extend the provision of multi-purpose services in rural areas.

Consumer choice

- establishment of a prospective payment for maternity services.

Further options for reform

3.66 In addition to the funding options considered and evaluated by CHERE, several further options for reform were raised by participants during the course of the inquiry. Although these options do not relate primarily to funding issues (other than the discussion of managed competition), a number of them could be considered to underpin or facilitate the adoption of some of the funding proposals. These further options are discussed below although, other than the managed competition proposal, they are not readily assessable against the criteria applied to the funding options earlier in the chapter.

A National Health Policy

3.67 Australia does not currently have a national health policy,[42] although the formulation of such a policy has been on and off the health policy agenda for some time. It could be argued that Medicare is a defacto national health policy but while it articulates several core principles it does not encompass all aspects of health care. In order for all components of the health system to have a similar set of priorities, it may be worth considering the extension of the Medicare principles beyond their present focus.

3.68 A national health policy could be expected to offer an overarching articulation of what the community expects of Australia's health system and its key components, including the public hospital sector. It could be expected to focus on the system as a whole and the linkages between its different elements, constructing pathways which are built around the needs of patients, rather than the priorities of funders and providers.

3.69 Submissions and evidence to the inquiry have indicated that a national health policy underpins many of the other options for reform. For example, the New South Wales Health Department argued that the investigation of options which would overcome problems around the split of roles and responsibilities of governments, such as a single pool of funding, could not be done 'without a national health policy in place'.[43] ACHSE believes that a national health policy is a prerequisite for any reforms aimed at improving information systems and data collection in public hospitals. ACHSE argues that:

> …we strongly believe that there is a need for a national health plan–a national health policy framework–so that if you cascade that down the states have a framework in which they are working and the health care providers

42 The concept of a national health policy is included in Part 4 of the AHCAs, but only as a generalised commitment and no detailed policy parameters are included.

43 *Committee Hansard*, 21.3.00, p.364 (Health Department of NSW).

> also have a local and a broader framework within which they are working. If we had that framework and we had the sorts of outcomes we want clearly identified, then I think we could start designing our systems and data collection to focus on where we are trying to get to.[44]

Other participants, including representatives of nurses, such as the Queensland Nurses Union[45] and consumers, such as Western Australia's Health Consumers' Council (HCC),[46] also offered their support for the formulation of a national health policy.

3.70 The development of a national health policy would necessarily involve players other than governments and would include providers and other interest groups as well as the broader community. The following section discusses the arguments around community consultation and involvement and also canvasses various methods of achieving these ends.

Community debate and transparent priorities

3.71 A number of submissions raised the need for the consultation, involvement and/or education of the community in setting priorities for the health system, including the level of funding and methods of paying for services. For example, Monash University's CHPE stated that 'it is impossible to determine the ideal allocation of resources without knowing what it is that the community wishes'.[47] The HCC informed the Committee of feedback from consumers who argued that 'we had a tax summit in the 1980s, why can't we have a health financing summit at Parliament House?'[48]

3.72 The HCC proposed that the key to an informed community response is education: 'the education of the community about a range of factors that impact on the health system is the best way to get an informed community response–a citizen response, not just a consumer response'.[49] The joint submission from the AHA, WHA and AAPTC argued that community debate is not a static, one-off process but rather 'there should be an ongoing and open public debate as to the nature and level of funding for the health system'.[50] The ACHSE acknowledged the difficulties involved but believe that 'communities and key stakeholders need to have some discussion about the resources that are available and what our expectations, needs and key priorities should be'.[51]

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44 *Committee Hansard*, 23.3.00, p.544 (ACHSE).

45 *Committee Hansard*, 22.3.00, p.438 Queensland Nurses Union).

46 *Committee Hansard*, 25.2.00, p.265 (Health Consumers' Council).

47 Submission No.46, Additional Information, p.7 (CHPE).

48 *Committee Hansard*, 25.2.00, p.265 (HCC).

49 *Committee Hansard*, 25.2.00, p.268 (HCC).

50 Submission No.63, p.7 (AHA, WHA, AAPTC).

51 *Committee Hansard*, 23.3.00, pp.540-1 (ACHSE).

3.73 Professor Hindle argued that cost effectiveness could be improved if the community had a greater degree of involvement in, and understanding of, the health system:

> we would have, overnight, a radical improvement in the cost effectiveness of health services if the community had a real voice, a real understanding and a set of rights about knowing what was going on and had the opportunity to say how it should be changed.[52]

3.74 Several participants expressed the view that the community needed to be engaged in a dialogue or debate about the health system and the public hospital sector to help determine the community's preferences and priorities. For example, the Australian Medical Association (AMA) 'believes that it is time for the Australian community to have a more mature dialogue about the ***provision of a wider range of choices*** when it comes to publicly funded services'.[53] Professor Phelan of the Committee of Presidents of Medical Colleges, offering a personal view, felt that the medical profession was concerned about moving ahead of community expectations with regard to what care could and should be provided, particularly for older patients. He argued that 'what we have failed to do is to stimulate an informed community debate on this issue' and that 'the community needs to set its priorities'.[54]

3.75 Part of this lack of community engagement has been a failure to acknowledge that there are constraints upon the services that can be delivered by the public hospital sector and the Australian health system. It is simply impossible to provide all possible services to all patients all of the time. No health system is capable of doing this because there are limits on health budgets. Certainly, choices can be made and 'the size of the health sector is extraordinarily flexible'[55] as argued by Professor Richardson, but it is a fallacy to pretend that limits do not exist. The Western Australian Health Department acknowledged that:

> we need a much larger community debate on what people actually want from their health system, because it is impossible, certainly under the current funding arrangements, to provide everything that everybody wants.[56]

3.76 In accepting that budgetary limits exist, there is an implication that priorities need to be established. While the issue of limits and priorities is difficult to grapple with, it is one that needs to be addressed. Several levels of the health system and the public hospital sector currently set priorities, but few are transparent. Governments set priorities in a number of ways, but most visibly through the funding provided for services. For example, as was discussed in the previous chapter, all State and Territory

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52 *Committee Hansard*, 21.3.00, p.329 (Professor Hindle).

53 Submission No.47, p.17 (AMA).

54 *Committee Hansard*, 23.3.00, p.497 (Professor Phelan).

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

56 *Committee Hansard*, 25.2.00, p.276 (Health Department of WA).

governments fund their public hospitals via a global capped budget. The response from public hospitals is to establish priorities to enable them to work within their budgets. This response takes the form, for example, of bed/ward closures and waiting lists for elective surgery. Priorities are also set by medical providers whereby a privately insured patient is likely to be treated before a public patient with a similar elective condition.[57]

3.77 The New South Wales Health Department developed the issue of transparency, arguing that governments generally had not been very good about engaging the community in a dialogue of what realistically could be expected of the health system:

> I think we have a way to go in the Australian health care system in terms of having a true dialogue with our community about what our system is good at–and it is a very good system, particularly by comparison with the rest of the world–and also what the limitations are of the $43 billion we expend upon the Australian health care system.[58]

3.78 Finally, the Northern Territory Government warned the Committee that community consultation might require a long time frame, perhaps 10 years, but that 'the debate must be had and must be heard'.[59]

Mechanisms for engendering community debate

3.79 Although several submissions discussed the necessity for community involvement and education, none proposed any means of achieving an engagement with the community. The following section provides an overview of various methods of ascertaining the community's ideas and wishes and/or involving the community in consultations and decision-making on health policy matters. This section includes models which are currently occurring in Australia as well as selected examples of overseas experience.

3.80 In attempting to gauge the preferences and expectations of the community with regard to the public hospital sector, one obvious mechanism is to utilise the existing consumer and health consumer groups, such as the Consumers' Health Forum, the Health Consumers Council (WA) and the Australian Consumers' Association. While these groups would be able to provide useful community feedback, it is difficult to judge whether the feedback would necessarily reflect the preferences of the community as a whole. However, the feedback available through these groups would be important because it is likely to reflect the preferences of users of the health system and the public hospital sector.

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57 *Committee Hansard*, 11.11.99, p.86 (AMA).

58 *Committee Hansard*, 21.3.00, p.364 (Health Department of NSW).

59 *Committee Hansard*, 24.2.00, p.240 (NT Minister for Health).

3.81 Barwon Health informed the Committee of a survey of its local community that is currently underway which could provide a possible model or be used more widely. Barwon Health is conducting:

> a community survey of the community's priorities and expectations about their public health system. I do not believe such a survey has been done before in Australia. We have just completed the focus groups attached to that and we will have a major survey in July. Out of that we are getting a lot of data about what the community feels are the advantages, disadvantages of our organisation and, indeed, the broader health care system.[60]

3.82 The recent report of the NSW Health Council, chaired by Mr John Menadue, made several recommendations on involving communities in health service planning at both the local and State levels. The Council's recommendations included:

> That local community participation structures be enhanced. This includes the appointment of dedicated staff in each Area Health Service, to assist community organisations to participate in planning the role and distribution of health services;
>
> That a new, State-wide consumer forum be established to provide input into State-wide policy development and resource allocation.[61]

In his response to the report of the NSW Health Council, the NSW Minister for Health announced that the Government would establish the recommended State-wide consumer forum.[62]

3.83 The approach adopted by the Commonwealth Department of Health and Aged Care (DHAC) and Queensland Health to involve local communities in the planning and establishment of Regional Health Services (RHS) utilises a technique called rapid needs appraisal. This is described by DHAC as a process:

> where we go and engage members of the community direct and work with local health professionals as well as to provide them with a very broad context of health to give them the capacity to understand their health context in a broader sense.[63]

Research in the United Kingdom indicates that rapid appraisal methods work best in a 'population that can be considered as a community in some sense of the word' and can

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60 *Committee Hansard*, 23.3.00, p.561 (Barwon Health).

61 New South Wales Health Council, *A Better Health System for NSW: the report of the NSW Health Council*, Gladesville, NSW, Better Health Centre, 2000, p.xxiv.

62 NSW Minister for Health, Hon C Knowles, *Working as a team–the way forward*, May 2000, p.4.

63 Senate Community Affairs Legislation Committee, *Estimates Committee Hansard*, 23.5.00, p.241.

be used to 'gain community perspectives of local health and social needs and to translate these findings into action'.[64]

3.84 A report was issued by DHAC in 1997 of a research project which investigated the involvement of consumers in improving hospital care. An underlying premise of the report was that 'hearing the voice of consumers is an effective way for hospitals to get good information about what needs to be done about the quality of their services'.[65] One of the lessons derived by the report was that:

> consumer councils/advisory committees have an important role to play, but they are unlikely to be effective, unless participation processes are in place at service planning and delivery level, and processes are in place to consult with consumers. These high level committees need to have a process of consumer consultation.[66]

3.85 Other countries have adopted a variety of mechanisms to generate community debate and/or attempted to get a sense of the priorities and expectations of the community. For example, Oregon, in the United States, undertook a series of consultations with its community in the 1980s over changes to its Medicaid[67] program, the most controversial of which was to put in place an explicit, transparent system of rationing publicly funded health services. The mechanisms used in Oregon to involve the community in the decision-making process included the formation of a citizen-based project (Oregon Health Decisions) which was intended to increase public awareness of the issues involved in health care provision; a telephone survey of a sample of residents; and community meetings.

3.86 Several studies and polls have been conducted in Canada in an attempt to gauge whether the community wishes to participate in decisions on health-related matters. Writing in the *Canadian Medical Journal* about the findings of a deliberative polling survey of three urban and three rural communities in Ontario, Abelson *et al* concluded that 'there are significant differences among groups in the community in their willingness to be involved, desired roles and representation in devolved decision making on health care and social services in Ontario'.[68] The authors found that as participants understood the complexity of devolved decision making they 'tended to assign authority to traditional decision makers such as elected officials, experts and

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64 Murray, S 'Experiences with "rapid appraisal" in primary care: involving the public in assessing health needs, orienting staff, and educating medical students', *British Medical Journal*, vol. 318, 13.2.99, pp.440-444.

65 Draper, M, *Involving Consumers in Improving Hospital Care: lessons from Australian hospitals*, Canberra, Department of Health and Family Services, 1997, p.ix.

66 Draper, M, p.xi.

67 Medicaid is a publicly funded health insurance program for the poor in the United States. It is jointly funded by the Federal and State governments, with eligibility for the program decided by each State.

68 Abelson, J *et al*, 'Does the community want devolved authority? Results of deliberative polling in Ontario', *Canadian Medical Journal*, 15.8.95, p.403.

the provincial government'. The preferred role for the community was in a consulting role, such as interested citizens attending meetings at town halls.[69]

3.87 In the United Kingdom, trials have been conducted to evaluate a community health advisory forum called citizens' juries. These juries, selected by random sample in local communities, sit for several days during which time they are presented with information by experts and patients to assist them in arriving at health-related decisions. Some juries have considered broad issues such as how priorities should be set for purchasing health care and what (if any) role the community should play, while others have deliberated on more specific issues such as the provision of primary care services in an area with a shortage of GPs. Although citizens' juries appear to be an expensive form of community consultation, costing 13 000-20 000 pounds for each meeting,[70] an initial evaluation indicated that 'given enough time and information, the public is willing and able to contribute to the debate about priority setting in health care'.[71]

Managed Competition

3.88 Budget holding is a central feature also of the managed competition model proposed by Professor Richard Scotton.[72] Managed competition has been proposed in several forms both in Europe (and implemented in the Netherlands) and the United States as a means of overcoming perceived shortcomings in different health systems. Scotton's proposal addresses the Australian situation and aims to eliminate cost shifting through the use of a single funding pool, creates distinct roles for each level of government in the health system and utilises budget holding to promote efficiency. The AHA, WHA and AAPTC argued in their submission that Scotton's model 'offers much promise for the improved organisation of jurisdictional responsibilities of government'.[73] Scotton's model of managed competition utilises elements of the market but does so without compromising the universality and equity of Medicare.[74] The main features of Scotton's proposals are as follows:

- defined and distinct roles for Commonwealth and State authorities;
- a private sector basically operating within the national system–subject to incentives designed to achieve national program objectives–and not (as now) outside it; and

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69 Abelson, p.403.

70 Bryan, J, 'Citizens juries vote to extend nurse roles', *British Medical Journal*, vol. 314, no. 7083, 1997, p.769.

71 Lenaghan, J, B. New, and E. Mitchell, 'Setting priorities: is there a role for citizens' juries?', *British Medical Journal*, vol. 312, no. 7046, 1996, p.1591.

72 A detailed explanation of this model can be found in: Scotton, R 'Managed competition', in *Economics and Australian Health Policy*, edited by G. Mooney and R. Scotton, St Leonards, NSW, Allen & Unwin, 1998, pp.214-231.

73 Submission No.63, p.23 (AHA, WHA, AAPTC).

74 Scotton, p.218.

- efficiency-promoting incentive systems, including:
    - all government subsidies taking the form of risk-related capitation payments to purchasers or budget holders (to inhibit risk selection, or 'cream skimming');
    - all costs incurred in the treatment of any individual being financed out of a single budget (to prevent cost shifting); and
    - the income of all service providers consisting of payments by budget holders for services provided to their enrollees at prices reflecting the full costs of efficient production (to promote internal efficiency).[75]

3.89 Professor Scotton argues that a strong case can be mounted for managed competition, particularly in its ability to deal with some structural features, and therefore the underlying problems, of the Australian health system. Most participants in this inquiry have raised these features, notably the Commonwealth/State jurisdictional issues and their attendant problems. Scotton acknowledges that his model will not solve all problems but argues that 'it provides a framework within which many problems that now seem intractable could be more successfully tackled'.[76]

3.90 Professor Duckett has argued that Scotton's model would require significant issues to be addressed before it could be implemented in Australia. These include the ability of funders to set a fair capitation rate (and the consequent risk of 'cream skimming' in the absence of a fair rate) for coverage and that independent utilisation review is very much in its infancy in Australia.[77] He points also to the likely opposition of the Australian Medical Association (AMA) due to the managed care elements of the model.[78]

75 Scotton, p. 217-8.

76 Scotton, p.230.

77 Duckett, S 'The new market in health care: prospects for managed care in Australia', *Australian Health Review*, vol. 19, no. 2, 1996, p.15.

78 Duckett, S 'Commonwealth/state relations in health', in *Health Policy in the Market State*, edited by L Hancock, St Leonards, NSW, Allen & Unwin, 1999, p.86.

Assessment against criteria	Managed Competition
Universality	Maintained
Equity	Maintained–dependent on fair capitation rate
Efficiency	Reduces cost-shifting; potential for greater efficiency
Consumer participation	Potential for greater involvement
Consumer choice	Choice of provider likely to be more limited than current system; choice of services may increase
Appropriateness of care	Possibility of enhanced appropriateness of care
Continuity of care	Possibility of increased focus on continuity of care
Feasibility	Key concern on fair capitation rate; likely opposition of AMA although may be more acceptable to GPs; will require education of community to gain acceptance

Redefining the role and services of hospitals

3.91 A number of submissions proposed that a means of ameliorating the pressures on public hospital finances was to reduce the demand for hospital services. Several methods were suggested, including a greater emphasis on preventive services. For example, the Northern Territory Government told the Committee about its Preventable Chronic Diseases Strategy which has as a fundamental objective an increase in the birth weight of Aboriginal babies.[79] Professor Richardson argued that efficiency gains had been made in public hospitals through the use of techniques such as casemix-funding in an attempt to do more with the available resources, an approach which he labelled as technical efficiency. Acknowledging that the data is limited, Richardson believed that the greatest efficiency gains could be made from allocative efficiency, or 'working out where we should be putting our services', offering the example: 'should you be putting so many people in hospital rather than having preventive care?'.[80]

3.92 The Health Department of New South Wales argued that efficiency gains for public hospitals were possible by keeping people out of hospital and that this was particularly evident in the better management of chronic care.[81] The Northern Territory Government warned, however, that the benefits of a greater emphasis on prevention would only be visible in the long term: 'we believe that the benefit will accrue possibly in decades, in generations'.[82] The Committee of Presidents of Medical Colleges supported the argument of the New South Wales Government regarding the likely efficiencies available from a reduction in demand for public hospital services and commented that at least part of the solution lay beyond the public hospital sector:

79 *Committee Hansard*, 24.2.00, p.235 (NT Minister for Health).

80 *Committee Hansard*, 23.3.00, p.589 (Professor Richardson).

81 *Committee Hansard*, 21.3.00, p.359 (Health Department of NSW).

82 *Committee Hansard*, 24.2.00, p.236 (NT Minister for Health).

> many patients are admitted to hospital in Australia because there are no alternative facilities in the community and patients are retained in hospital because they are not able to be discharged, again because of a lack of community facilities and also because of work practices within the hospital environment.[83]

3.93 Other proposals were for a more fundamental reform for public hospitals. Professor Roberton, for example, suggested that it would be preferable to 'remove the word "hospital" totally from our lexicon and say that hospitals are health services and parts of health services'.[84] The NRHA held a similar view, arguing that in non-metropolitan areas 'a hospital does not have to be there to provide a really good health service, because you can have health centres instead'. It acknowledged, however, that the community valued its public hospitals and that hospitals held a special significance in rural and remote areas:

> …we need to get away from that fixed hospital structure which the community look upon. The minute the word "hospital" is mentioned, people say, "They are going to close it. We are going to be left. Nobody is going to come here".[85]

The Australian Health Insurance Association (AHIA) expressed its concern about the community's perception of the public hospital and also indicated that some community education may be required: 'for many people, the big cathedral hospital has a psychological effect way beyond its actual benefit, and it is a psyche that we really have to shake in this community'.[86]

3.94 The NRHA argued in its submission that rural and remote areas were leading the rest of the country in 'the redevelopment of hospitals' contribution to health care' and it believes that 'it is clear that hospitals of the future will have quite a different place in the health care system'.[87] The joint submission of the AHA, WHA and AAPTC offered the Committee a vision of the hospital of the future. This statement was also quoted in the NRHA's submission:

> a number of commentators have suggested that the core of the hospital of the future will consist of emergency and intensive care units and a small number of high level acute care beds. Operating theatres, diagnostic services and other therapeutic services, such as cardiac angiography units will support them. The trend towards day of surgery admissions, shorter length of stay, day only, ambulatory and home care will continue to reduce the traditional emphasis on beds. Subject to commercial viability assessments, which will vary between locations, "medi-hotels" will be able to meet many

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83 *Committee Hansard*, 23.3.00, p.490 (Committee of Presidents of Medical Colleges).

84 *Committee Hansard*, 23.2.00, p.146 (Professor Roberton).

85 *Committee Hansard*, 11.11.99, p 120 (NRHA).

86 *Committee Hansard*, 11.11.99, p.133 (AHIA).

87 Submission No. 66, p.29 (NRHA).

> of the accommodation needs of people requiring treatment but not needing an acute care bed. They will be cheaper to run than an acute ward and not being "core business" could be run by the private sector. Service delivery systems will focus increasingly on the continuum of care with networks of service providers involved in meeting the pre-admission, acute episode and post acute care needs of patients.[88]

3.95 Perhaps the most radical option for reform in this area was proposed by ACHSE (NSW Branch), which believed that 'the term "hospital" should no longer be used and that we should move away from the current concept of a hospital'.[89] The key components of ACHSE's alternative model include:

- hospitals should be redefined as 'Acute Treatment Centres' (ATC), which patients would attend in an emergency or for 'complex, short-term, serious treatments';
- ATCs would consist of accident and emergency, theatre, intensive care units and other intensive treatment services;
- all other care and treatment, where possible, would occur in a person's home, although institutional care will be required for some rehabilitation, convalescence and long term care;
- consumers should be offered a 'one-stop shop' which incorporates all services offered through the many Commonwealth, State and Commonwealth/State funded health programs such as HACC, primary care, allied health and community health. ACHSE proposes the concept of 'Multi Service Provider' (MSP) to fill this role. This would require pooling of funds and 'ideally could be best achieved by having one level of government responsible for all of health care funding'; and
- any such reforms 'must be focused on meeting the needs of the whole Australian community'.[90]

3.96 During the course of the inquiry, the Committee has been informed of several developments currently underway which seek to redefine the role and services of the traditional stand-alone public hospital. Two of these, Barwon Health and Health Direct, are briefly discussed.

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88 Submission No. 63, p.35 (AHA, WHA, AAPTC).

89 Submission No. 62, Attachment, p.1 (ACHSE, NSW Branch).

90 Submission No. 62, Attachment, pp.1-2 (ACHSE, NSW Branch).

Barwon Health: An example of an integrated organisation

3.97 Barwon Health was established in 1998 as a result of a voluntary amalgamation of five formerly separate organisations: Geelong Hospital, the Grace McKellar Centre (a rehabilitation and aged care facility), and Corio, Geelong and Surfcoast Community Health Services. Barwon Health regards itself as:

> a good example of an integrated model of care and one that represents, I think, what the future of health care is going to be–and that is not standalone silos that deliver services independently of each other but rather more integrated services that do not have artificial barriers that individual organisations create.[91]

3.98 Although Barwon Health is attempting to create a patient-focused health service which will enable patients to move through the system without encountering organisational barriers, it still must deal with the funding rigidities and obstacles inherent in the health system. For example, it is required to deal with some 64 different lines of funding just in its community health program.[92]

3.99 Another innovative aspect of Barwon Health's patient focus is a survey it is conducting of the local community to obtain a sense of its priorities and expectations about the public health care system. Barwon Health is also surveying its staff.[93]

Health Direct in Western Australia

3.100 Health Direct is an initiative of the Western Australian Government. It has operated for approximately 12 months and works in the following way:

> that is a telephone service where nurses answer the telephone and take you through the level of your emergency, triage you and let you know about locums, after-hours general practitioners or seeing a GP the next day–so that people have some more choices and there is more consumer information given to the public.[94]

3.101 Thus, Health Direct may save a patient who does not require hospital treatment the time involved in attending an accident and emergency unit by being referred to a more appropriate service. The scheme is strongly supported by Western Australia's main health consumer association, the HCC, which reports a high level of consumer satisfaction with the service. Similar operations are to be introduced in New South Wales[95] and the Australian Capital Territory.

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91 *Committee Hansard*, 23.3.00, p.557 (Barwon Health).

92 *Committee Hansard*, 23.3.00, p.559 (Barwon Health).

93 *Committee Hansard*, 23.3.00, p.561 (Barwon Health).

94 *Committee Hansard*, 25.2.00, p.270 (HCC).

95 *Committee Hansard*, 21.3.00, p.347 (Health Department of NSW).

Concluding comments[96]

3.102 Few of the proposals for reform suggested in submissions are new. However, a persistent problem with assessing proposals for reform is the lack of appropriate data to determine whether reforms are likely to achieve their objectives. In some cases this could be addressed through pilot projects or trials, but it is important to note that trials of some reforms will not necessarily provide appropriate data for full assessment of the reform. In making an assessment of the reform proposals against criteria, in most cases it was only possible to make a broad qualitative judgement of whether reforms would enhance equity and efficiency.

3.103 While there were proposals for reform to the way health care funding is raised, a strong theme that ran through many submissions was that the Australian health system generally performs well by international standards, and that features such as the universality of Medicare and the availability of choice to consumers should be maintained. There is a tension between those commentators who believe that funding arrangements are inherently unstable and the system is heading for a crisis, and those who believe that the fundamentals of a taxpayer funded national health insurance scheme supplemented by private health insurance are sound, and that reform is only needed at the margin to improve the efficiency of how services are funded and organised.

Senator the Hon Rosemary Crowley

Chair

96 These concluding comments are drawn from CHERE's report to the Committee.