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Senator John Quirke	ALP, South Australia
Senator John Tierney	LP, New South Wales
Senator John Watson	LP, Tasmania
Senator Sue West	ALP, New South Wales

LIST OF ACRONYMS

AAPTC	Australian Association of Paediatric Teaching Centres
ABS	Australian Bureau of Statistics
ACA	Australian Consumers' Association
ACHSE	Australian College of Health Service Executives
AHA	Australian Healthcare Association
AHCA	Australian Health Care Agreement
AHIA	Australian Health Insurance Association
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANF	Australian Nursing Federation
APHA	Australian Private Hospitals Association
ATO	Australian Taxation Office
CHERE	Centre for Health Economics Research and Evaluation
CHF	Consumers' Health Forum
CHPE	Centre for Health Program Evaluation
DHAC	Commonwealth Department of Health and Aged Care
DRG	Diagnosis Related Group
FAG	Financial Assistance Grants
FBT	Fringe Benefits Tax
GDP	Gross Domestic Product
GP	General Practitioner
GST	Goods and Services Tax
HCC	Health Consumers Council WA
HIC	Health Insurance Commission
HOCI	Hospital Output Cost Index
MBS	Medicare Benefits Schedule
NATSEM	National Centre for Social and Economic Modelling
NRHA	National Rural Health Alliance
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
RACP	Royal Australasian College of Physicians
RHA	Regional Health Agency
RRMA	Rural Remote and Metropolitan Areas classification
SASMOA	South Australian Salaried Medical Officers Association
SLA	Statistical Local Area
VMO	Visiting Medical Officer
WCI 1	Wage Cost Index 1
WHA	Women's Hospitals Australia

PREFACE

During this inquiry, the Committee has received a considerable volume of information in relation to the terms of reference and the Australian health system in general. The inquiry process has provided an opportunity for participants to discuss their perceptions of the problems facing public hospitals in Australia. While much of the evidence was critical, comparatively few participants in the inquiry acknowledged the attempts by Commonwealth, State and Territory Governments to address at least some of these problems.

The evidence has demonstrated clearly that the community values its public hospitals very highly. Public hospitals are treasured because of the care and treatment which is provided by their dedicated but increasingly stressed staff, and also because they are an essential element of Australia's social fabric. A strong message has been expressed by various interest groups that the community is sick and tired of the game playing and blame shifting by governments. The community expects its public hospitals to be adequately resourced and is growing increasingly impatient with the unwillingness of governments to put aside their jurisdictional squabbles over public hospital funding.

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. It is clear also that public hospitals are seriously underfunded and that they have been forced to resort to cost shifting as a measure to overcome funding shortfalls. As a result, it is claimed that patients are encouraged to use particular services on the basis of who pays for those services rather than what may be the most effective services to meet their needs.

The report of the New South Wales Health Council emphasised the importance of honesty and openness with regard to the resources available for public hospitals. The Committee has been encouraged by this approach. The current funding arrangements for public hospitals are anything but open, honest and transparent. Often, data relating to the funding arrangements of the Commonwealth, States and Territories is not readily comparable. Accordingly, it has been an easy task for governments to blame each other for perceived shortcomings in public hospital funding. Bedevilled by politics, this process has to move on.

This First Report represents the Committee's initial response to its terms of reference relating primarily to funding within the Australian health system. In this Report, the Committee presents an overview of the public hospital sector, identifies the major problems and issues which the sector faces, examines the adequacy of funding, and canvasses the range of options for reform raised by participants in the inquiry.

The Committee emphasises that in issuing this First Report it has not yet reached any conclusions or made recommendations; nor has it endorsed any of the options for reform. The summary presentation of the evidence received to date reflects the views

of the participants and does not imply any acceptance by the Committee as to the merits of their claims. In this First Report, the Committee is not judgemental but rather seeks to make a genuine contribution to stimulating debate on the issues facing public hospitals in Australia.

The Committee intends to convene a Roundtable Discussion/Forum in August at which expert participants will consider the options presented in this Report. Generally speaking, many submissions that proposed particular options did not specify mechanisms by which the options might be adopted. It is the Committee's intention that the Roundtable Discussion/Forum will create an opportunity to provide focussed consideration of the options and enable further development of mechanisms for their introduction. This process will assist the Committee in its deliberations during the preparation of its final report. The Committee has not yet taken a position on any options presented in this report, but rather, presents the various possible courses of action for consideration and debate.

Background to the inquiry

In July 1999 the State and Territory Premiers and Chief Ministers called on the Federal Government to establish an independent inquiry into the health system, preferably through the Productivity Commission. The Prime Minister declined to establish such an inquiry. The Senate subsequently agreed to establish an inquiry and on 11 August 1999 referred the following matter to the Community Affairs References Committee for inquiry and report

How, within the legislated principles of Medicare, hospital services may be improved, with particular reference to:

(a) the adequacy of current funding levels to meet future demand for public hospital services in both metropolitan and rural Australia;

(b) current practices in cost shifting between levels of government for medical services, including the MBS, pharmaceutical costs, outpatient clinics, aged and community care, therapeutic goods and the use of hospital emergency services for primary care;

(c) the impact on consumers of cost shifting practices, including charges, timeliness and quality of services;

(d) options for re-organising State and Commonwealth funding and service delivery responsibilities to remove duplication and the incentives for cost shifting to promote greater efficiency and better health care;

(e) how to better coordinate funding and services provided by different levels of government to ensure the appropriate care is provided through the whole episode of care, both in hospitals and the community;

(f) the impact of the private health insurance rebate on demand for public hospital services;

(g) the interface between public and private hospitals, including the impact of privatisation of public hospitals and the scope for private hospitals to provide services for public patients;

(h) the adequacy of current procedures for the collection and analysis of data relating to public hospital services, including allied health services, standards of care, waiting times for elective surgery, quality of care and health outcomes; and

(i) the effectiveness of quality improvement programs to reduce the frequency of adverse events.

Conduct of the inquiry

The Committee received over 90 submissions and is continuing to receive submissions throughout the course of the inquiry. The Committee has received submissions and evidence from Federal, State and Territory Governments; health sector and related professional organisations; and academic, consumer, welfare and other interested groups and individuals.

The Committee held eight days of public hearings around Australia – in Canberra (2 days), Adelaide, Darwin, Perth, Sydney, Brisbane and Melbourne. Most of these hearings were held in public hospitals enabling members to experience at first hand the facilities of these hospitals. Committee members have also visited a number of other hospitals to inspect facilities and have informal discussions with administrative and clinical staff. Hansard transcripts of the public hearings may be accessed at: www.aph.gov.au/hansard

Assistance with the inquiry

The Committee's terms of reference raised highly complex issues surrounding the current financial arrangements between the Commonwealth, States and hospitals/health services and their impact on service delivery now and in the future. The Committee benefited from the evidence gained through submissions, public hearings and supplementary information provided by many of the inquiry participants. A complete list of submissions and other information authorised for publication by the Committee will be in the final report. The list may be accessed from the Committee's web site at: www.aph.gov.au/senate_ca

In addition to this material, the Committee has been greatly assisted by the Centre for Health Economics Research and Evaluation (CHERE) based at the University of Sydney, which provided specialised research, information and advice addressing the complexities within the terms of reference.

The Committee also received expert staffing and research assistance from the Department of the Parliamentary Library.

CHAPTER 1

PUBLIC HOSPITAL SERVICES AND THE AUSTRALIAN HEALTH SYSTEM

Background

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

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

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

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

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

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

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

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

Community interest in health care issues

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

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

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

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

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

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

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

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

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

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

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

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

Health sector expenditure

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

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

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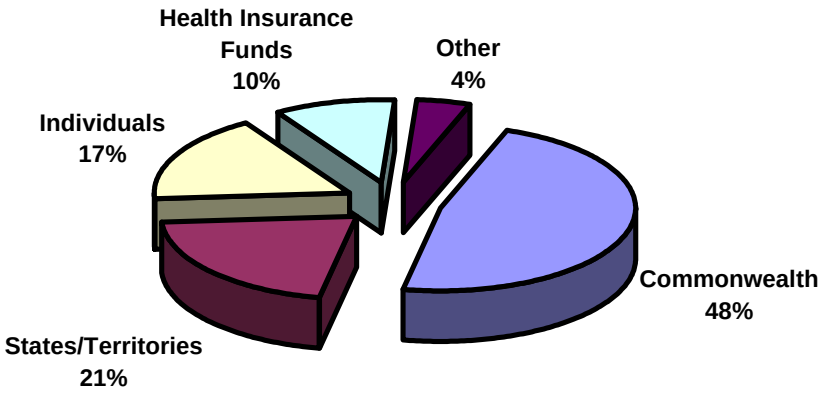
8 Sax, S, *A Strife of Interests: politics and policies in Australian health services,* Sydney, George Allen & Unwin, 1984.

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

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

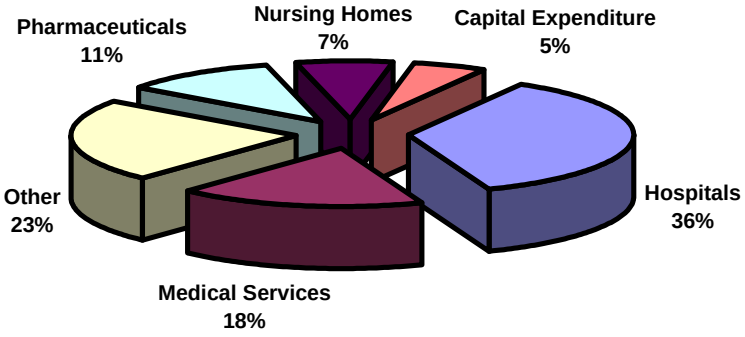
Figure 1: Total Recurrent Health Expenditure 1997-98: Who Pays?



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

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

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



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

International comparisons

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Comparative perceptions of health systems

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Key issues and challenges: public hospital sector

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Indigenous Australians and public hospitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Relationship between the Commonwealth, States and Territories

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

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

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

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

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

1.37 Key problems from the Commonwealth's perspective are:

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

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

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

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

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

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

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

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

Complexity of the health system: patient's perspective

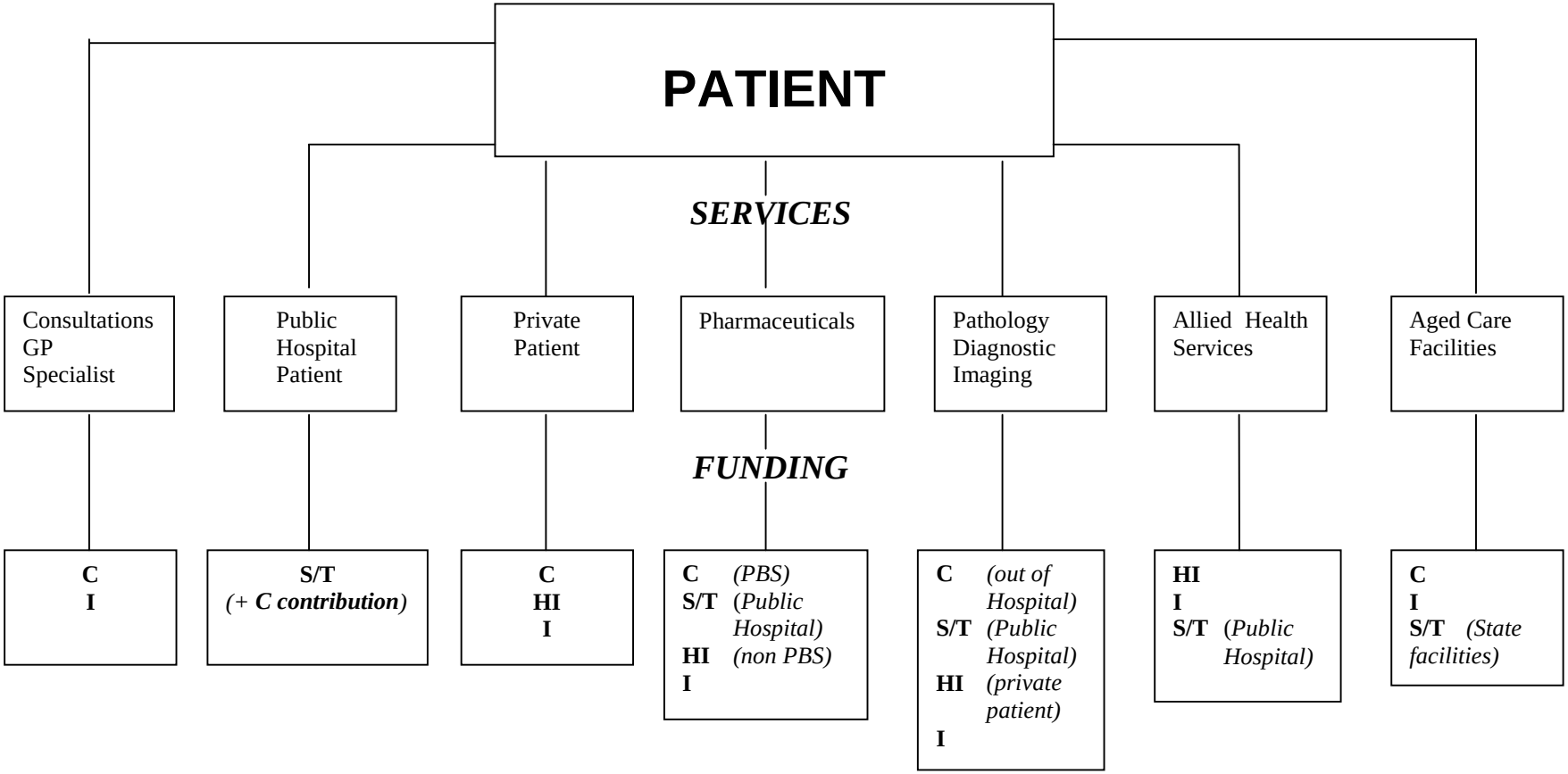
1.41 An indication of the complex nature of the Australian health system is provided by Diagram 1, which presents aspects of the health system from the patient's perspective. Included are some key health services together with an indication of funding arrangements for each group of services.

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

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

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

Diagram 1



Legend:

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

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

Complexity of the health system: funding arrangements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cost shifting

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

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

Forms of cost shifting

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

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

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

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

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

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

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

Commonwealth to States and Territories:

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

States and Territories to the Commonwealth:

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

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

Governments to patients:

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

Estimating the monetary value of cost shifting

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

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

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

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

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

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

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

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

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

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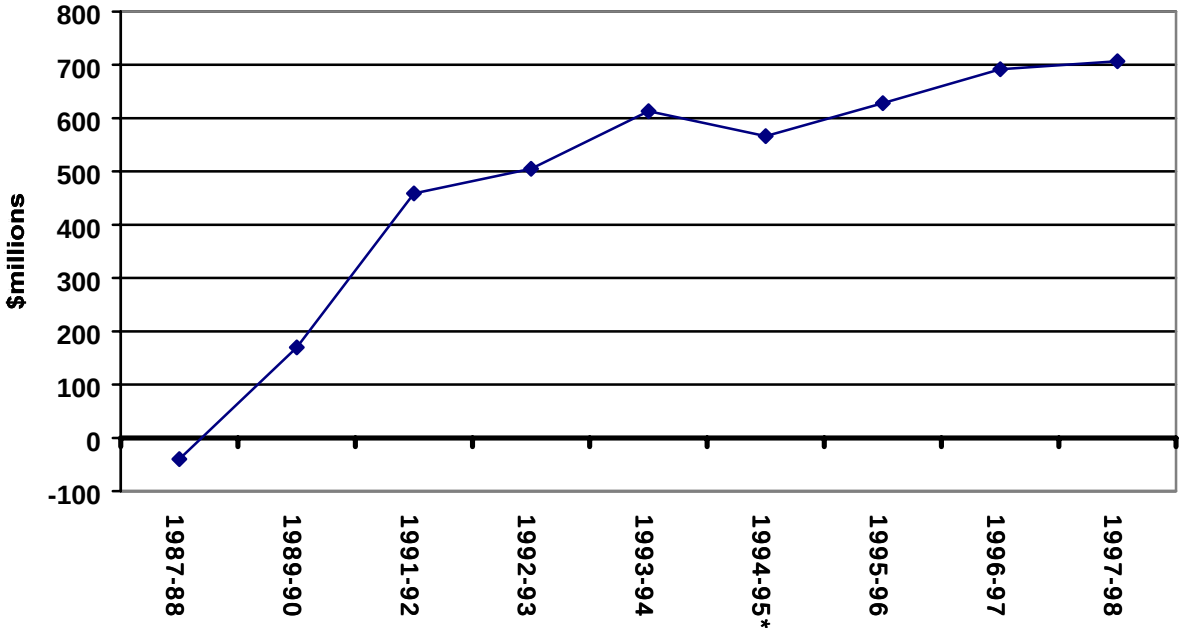
64 Submission No.79, p.12 (NSW Government).

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

Impact of cost shifting on patients

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

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

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

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

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

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

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

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

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

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

Level of concern at cost shifting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Relationship between the public and private sectors

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 2

THE ADEQUACY OF FUNDING FOR PUBLIC HOSPITALS

2.1 This chapter commences with a profile of the public hospital sector. The subsequent discussion provides some contextual background on the intergovernmental arrangements and mechanisms used to fund public hospitals including an overview of the practices adopted in each State and Territory to fund their public hospitals. Given this background, an assessment is then provided of the adequacy of funding for public hospitals now and in the future from several perspectives: the Commonwealth, the States and Territories, and consumers and other participants in the inquiry. Particular issues affecting rural and remote areas are also addressed.

Profile of the public hospital sector

2.2 Table 2 provides an overview of the size, activity and financial details of public hospitals in Australia, including the number of available beds, the number of separations, the proportion of separations which are same day separations, and details of the average length of stay, both in total and excluding same day separations. An indication of the workload of accident and emergency units is provided in the number of non-admitted occasions of service and details of expenditure are included. A breakdown of the activity of public hospitals in terms of public patients and private patients is also provided. The table contains data for both 1993-94 and 1997-98, permitting an analysis of changes over time.

2.3 Comparing 1993-94 and 1997-98, it is noteworthy that the number of available beds in public hospitals has declined by 5525. While the cost of hospital beds will vary quite dramatically within and between hospitals (eg intensive care beds will have a higher cost than other hospital beds), as an indication, the Australian Healthcare Association (AHA) calculated that the annual recurrent cost of a 50 bed medium sized rural hospital is $10 million.[1]

2.4 In terms of activity, while the annual number of separations has increased by 452 000, patient days have decreased by 755 000, reflecting, in the main, the decline in the numbers of private patient separations. Same day separations have increased from 34.2 per cent of total separations in 1993-94 to 43.3 per cent of separations in 1997-98. The notable changes over this period with regard to private patients in public hospitals are a decline in the number of private patient separations from 545 000 in 1993-94 to 355 000 in 1997-98 and, allied to this, a decline in patient revenue, from $1.08 billion in 1993-94 to $1.07 billion in 1997-98. This is partly, but not solely, related to the decline in the proportion of the population covered by private health insurance.

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1 Submission No.63, Additional Information, p.6 (AHA, Women's Hospitals Australia, Australian Association of Paediatric Teaching Centres).

Table 2: Profile of the public hospital sector, 1993-94 and 1997-98

Public acute and psychiatric hospitals	1993-94		1997-98	
Establishments				
No of hospitals	746		764	
Available beds	61 260		55 735	
Beds per 1000 population	3.4		3.0	
Activity				
Separations ('000)				
Public acute hospitals	3 296		3 748	
Public patients	2 557		3 222	
Private patients	545		355	
Public psychiatric hospitals	n.a.		23	
Same days separations as % of total				
Public acute hospitals	34.2		43.3	
Public patients	35.0		43.8	
Private patients	33.2		42.7	
Public psychiatric hospitals	n.a.		10.6	
Separations per 1000 population				
Public acute hospitals	185.6		201.2	
Public patients	144.0		173.0	
Private patients	30.7		19.1	
Public psychiatric hospitals	n.a.		1.2	
Patient days ('000)				
Public acute hospitals	15 907		15 152	
Public patients	12 029		12 460	
Private patients	2 529		1 419	
Public psychiatric hospitals	n.a.		1 409	
Average length of stay (days)	A	B	A	B
Public acute hospitals	4.8	6.8	4.0	6.4
Public patients	4.7	6.7	3.9	6.1
Private patients	4.6	6.4	4.0	6.2
Public psychiatric hospitals	n.a.	n.a.	62.4	69.7
Non-admitted occasions of service	n.a.		32 605 248	
Financial data				
Total salary expenditure ($'000)	6 897 956		8 242 305	
Total non-salary expenditure ($'000)	3 690 172		4 783 440	
Total recurrent expenditure ($'000)	10 588 128		13 025 745	
Total revenue ($'000)	1 083 619		1 068 763	

A = all separations B = excluding same day separations

Source: Compiled from Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98,* Canberra, AIHW, 1999, tables 3.1 and 4.1.

Historical overview of the funding arrangements for public hospitals[2]

2.5 The Australian Constitution initially vested responsibility for hospital and health services with State governments. However, the 1946 Constitutional Amendment, which inserted section 51(xxiiiA), gave the Commonwealth power to legislate on:

> the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.[3]

2.6 This change in the Constitution, together with the revenue raising powers of the Commonwealth Government, has made it an important partner to the States and Territories, both in the funding of health services, and in determination of the key features of the Australian health care system. An important implication of this which has been noted in some of the submissions to the inquiry is that although the States and Territories have responsibility for the funding and delivery of health services, the Commonwealth has a major role in determining the level and nature of health services provision in Australia. A short overview of the extent of the Commonwealth's power in the health area is provided in the previous chapter.

2.7 The most important financial relationship between the Commonwealth and State and Territory governments in relation to public hospital services is through the Australian Health Care Agreements (previously Medicare Agreements). The current Health Care Grants (which have also replaced a number of smaller Specific Purpose Payments (SPPs) which have been rolled into the Agreements) were preceded by the Hospital Funding Grants, provided since the introduction of Medicare in 1984, and prior to that by cost-sharing agreements in relation to Medibank in the period since 1975. Before attempting to assess changes in the shares of Commonwealth and State and Territory funding of public hospital and other health services, it is useful to review briefly the arrangements under the different funding Agreements.

Arrangements prior to Medicare

2.8 The arrangements for Medibank, established in 1975, provided one of the first major inputs by the Commonwealth government in policy setting, funding and delivery of public hospital services. Under the funding Agreements (which were effectively ten year agreements, although in practice they were much more short-lived because of changes of government), the States agreed to provide free public hospital services and the Commonwealth agreed to 50-50 cost sharing of the costs of public hospital services. This was an open-ended commitment by the Commonwealth, which significantly increased its financial contribution to public hospital services.

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2 Material in this section is drawn from a research report prepared for the Committee by the Centre for Health Economics Research and Evaluation (CHERE) at the University of Sydney.

3 *The Constitution: as altered to 31 October 1986*, Canberra, AGPS, 1986, p.18.

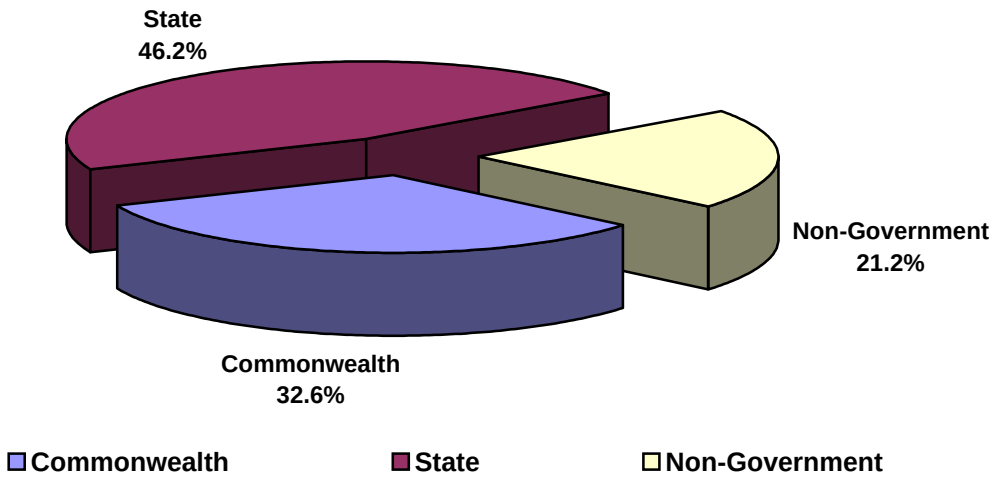
Commonwealth expenditure on public hospitals increased from $222.9 million in 1974-75 to $949.6 million in 1975-76. At the same time as the introduction of Medibank, the Commonwealth increased the use of Specific Purpose Payments (SPPs) to direct policy towards other programs and services, such as community health programs.

2.9 A number of factors, including the need to control expenditure, led to the cost-sharing arrangement being amended from May 1976. The Commonwealth contribution was then limited to 50 per cent of approved hospital operating costs. This gave the Commonwealth the capacity to implement changes in the level of funding it provided. In addition, the new Coalition Government amended the scheme, allowing for individuals to opt for private health insurance or to make voluntary contributions to the public system. Charges for public hospital services were also re-introduced, although they were heavily subsidised for pensioners and those on low incomes.

2.10 Cost-sharing agreements between the Commonwealth and the States persisted in some States until 1980, and in South Australia and Tasmania until 1983. However, these additional outlays were offset by their inclusion in the Commonwealth Grants Commission (CGC) equalisation process. From 1981, based on recommendations of the Jamison inquiry, cost-sharing arrangements were replaced by Identified Health Grants.

2.11 Figure 4 indicates the proportion of public hospital funding contributed by the Commonwealth government, the State and Territory governments and the non-government sector (mainly individuals and private health insurance funds) in 1982-83, the year prior to the introduction of Medicare.

Figure 4: Commonwealth and State/Territory Governments and Non-Government Contributions towards Public Hospital Funding – 1982-83



Source: Calculated from data supplied by CHERE sourced to AIHW data.

Medicare Agreements 1984-1988

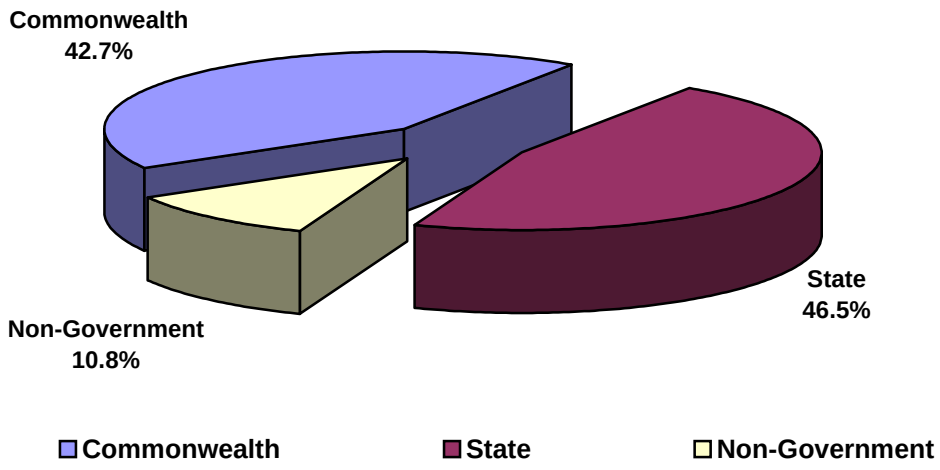
2.12 Medicare was introduced in February 1984, reinstating Agreements between the Commonwealth and the States which aimed to ensure universal access to free public hospital services. Commonwealth payments to the States consisted of Identified Health Grants and a Medicare Compensation Grant. The aim of the Medicare Compensation Grant was to compensate States for the loss of private patient revenue, resulting from a shift of patients from private to public status following the reintroduction of free public hospital services. The Commonwealth paid the States a per diem amount for each bed-day which shifted from private status to public status, and a contribution of $50 per bed-day for increased utilisation as a result of public hospital services being free.[4] In addition, the grant provided for compensation in relation to the elimination of charges for outpatient services, the additional cost of providing medical services to public patients, and new arrangements for nursing home type patients.

2.13 The Agreement between the Commonwealth and the States and Territories also provided for funding for new community health services. During the period of the 1984-1988 Agreements, there were a number of other changes to Commonwealth health policy which impacted upon public hospital services, including removal of the bed-day subsidy to private hospitals, and removal of the after-hours medical fee loading for GPs.

4 It is worth noting, however, that the impact of the utilisation factor was not as anticipated because of issues such as declining length of stay and industrial action by doctors. In later Agreements and negotiations separations rather than bed-days have been used as a measure of utilisation.

2.14 Figure 5 indicates the proportion of funding for public hospitals contributed by the Commonwealth government, the State and Territory governments and the non-government sector during the term of the first Medicare Agreement, 1984-1988.

Figure 5: Commonwealth, State/Territory Governments and Non-Government Contributions towards Public Hospital Funding – 1983-84 to 1987-88



Source: Calculated from data supplied by CHERE sourced to AIHW data.

Medicare Agreements 1988-1993

2.15 The second round of Medicare Agreements between the States, Territories and the Commonwealth replaced the Medicare Compensation Grants and the Identified Health Grants with the base funding grants included in the new Hospital Funding Grants. However, it has been argued that for a number of reasons, the growth in the previous Grants had been low, leading to a lower initial funding base for the second round Grants. This point was made by Dr Deeble, who argued in his submission to the inquiry that 'unrealistically low rates of growth [had been] built into the Commonwealth's hospital contribution. The deficiency was greatest in the first 8 years of its life'.[5]

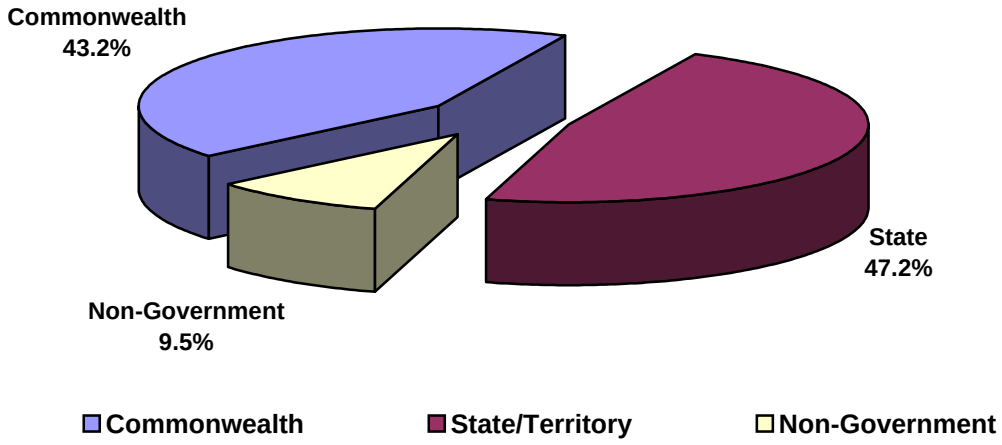
2.16 The base grant during the period of the Agreements was adjusted for inflation (based on 75 per cent of the Award Rates of Pay Index and 25 per cent of the Consumer Price Index (CPI)) and for growth in the population (based on age and sex weighted hospital utilisation). The base grant was to be adjusted if a State's or Territory's proportion of private bed-days exceeded the national average, or if the State per capita level of in-hospital Medicare benefit payments exceeded the national average by more than 5 per cent.

5 Submission No.50, p.14 (Dr Deeble).

2.17 In addition to the base grant, the Commonwealth also provided funding for the treatment of HIV/AIDS patients (adjusted for population growth and increases in the number of AIDS patients) and grants for the development of incentives programs. These amounts were quarantined for adjustment under the Commonwealth Grants Commission (CGC) processes (unlike the base grant). The funding for incentives programs reflected an increased involvement by the Commonwealth in hospital policy development, because it provided the opportunity for the Commonwealth to encourage service innovation. Incentive funding was provided for palliative care, day surgery and early discharge programs, and for development and implementation of casemix information systems and management in public hospitals.

2.18 Figure 6 indicates the proportion of funding for public hospitals contributed by the Commonwealth government, the State and Territory governments and the non-government sector during the term of the second Medicare Agreements 1988-1993.

Figure 6: Commonwealth, State/Territory Governments and Non-Government Contributions towards Public Hospital Funding – 1988-89 to 1992-93



Source: Calculated from data supplied by CHERE sourced to AIHW data.

Medicare Agreements 1993-1998

2.19 The third round of Medicare Agreements between the Commonwealth and the States and Territories commenced from 1 July 1993, and, as with the previous Agreements, there was little change to the basic arrangements whereby the States and Territories provided free public hospital services to eligible persons, and the Commonwealth provided funding. From 1992, the Medicare Principles and Commitments as well as the new funding arrangements were established under Commonwealth legislation (the *Medicare Agreements Act 1992*). As noted earlier, these principles related to choice to be treated as a public patient, universality of access and equity in service provision.

2.20 However, there were some changes to the funding arrangements between the Commonwealth and the States and Territories. The base grant continued to be calculated in the same way (although $400 million was removed from the base grant and included in bonus pools, and quarantined from the CGC processes), that is, adjusted for inflation (based on 75 per cent of the Award Rates of Pay Index and 25 per cent of the Consumer Price Index) and for weighted population growth. As well as the base grant, two bonus payment pools were introduced to encourage improved public access.

2.21 Bonus Pool A was to be distributed to States and Territories for additional public bed-days above a benchmark proportion of 51.5 per cent of total bed-days, and included penalties for a State or Territory if the share of public bed-days was below 51.5 per cent. That is, if a State or Territory treated more public patients, resulting in a greater proportion of its bed-days being public bed-days, then it would receive funds from Bonus Pool A. However, if the proportion of public bed-days fell below the minimum of 51.5 per cent in a State or Territory then financial penalties would apply.

2.22 Bonus Pool B was to be distributed to States and Territories that increased their share of public bed-days over the public share in 1990-91. That is, if a State's or Territory's share of public bed-days was, say, 53.5 per cent in 1990-91 and the jurisdiction treated a greater proportion of public patients in 1993-94, resulting in the share of public bed-days increasing to 54.0 per cent, then it would receive funds from Bonus Pool B.

2.23 In addition, there were penalty clauses in relation to the base grant if a State's or Territory's level of per capita expenditure on the Medicare Benefits Schedule (MBS) exceeded the national average by more than 1.11 per cent. The Agreement also included funding (in the form of incentives packages) for other reforms relating to improvements in quality and management of services. This again reflected increasing Commonwealth involvement in policy development in relation to hospital services.

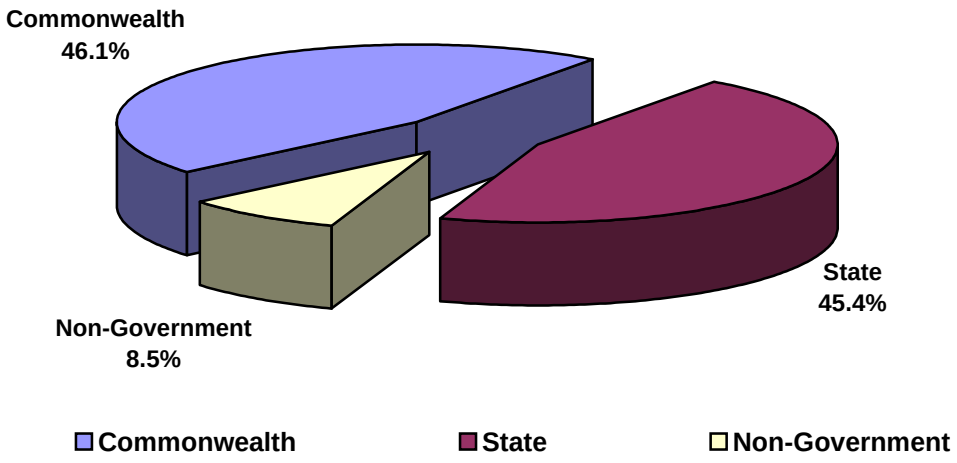
2.24 Finally, an important addition to the 1993-1998 Agreements was the provision that the amount of funding provided by the Commonwealth would be reviewed if the proportion of the population covered by supplementary hospital insurance (as opposed to basic table insurance) fell by at least 2 percentage points from the June 1993 level (the so-called '2 per cent reviews'). This reinstated as an explicit part of the Agreements recognition of the relationship between the level of private health insurance coverage and the demand for public hospital services. However, it is notable that when the reviews did take place as a result of continued decline in private health insurance coverage, the Commonwealth and the States and Territories could not reach agreement about the financial impact or the level of compensation which was appropriate.

2.25 This reflects an important factor that has not been adequately quantified in negotiations over financing public hospital services between the Commonwealth and the States and Territories, and is reflected in some of the submissions to the inquiry. This issue is discussed in a later section of this chapter, which will canvass issues

related to the inquiry's term of reference dealing with the adequacy of current funding levels to meet future demand for public hospital services.

2.26 Figure 7 indicates the proportion of funding for public hospitals contributed by the Commonwealth government, the State and Territory governments and the non-government sector during the term of the third, and final Medicare Agreements, 1993-1998. Unlike the periods covered by the previous agreements, under the third Medicare Agreements, from 1993-94 to 1997-98, the proportion of public hospital funding contributed by the Commonwealth exceeded that contributed by the States and Territories.

Figure 7: Commonwealth, State/Territory Governments and Non-Government Contributions towards Public Hospital Funding – 1993-94 to 1997-98



Source: Calculated from data supplied by CHERE sourced to AIHW data.

Australian Health Care Agreements 1998-2003

2.27 The 1998-2003 Australian Health Care Agreements (AHCAs) represent, in some ways, a significant departure from its two predecessors, the Medicare Agreements. The 1998-2003 AHCAs encompass greater scope for altering funding levels and also enable flexibility in service provision. This section will focus on those changes and highlight some points of contention between the States and Territories and the Commonwealth.

2.28 In the previous Medicare Agreement 1993-98, funding levels were based on the base grant with some scope for variation based on population, age, sex, award rates of pay and CPI. It further included penalties for States with higher than average MBS growth rates and bonus payments for improved public access. In the 1998-2003 AHCAs, variations to the base health care grant can be made on the basis of a weighted population index (based on population growth and ageing), changes in hospital output costs, known as the Hospital Output Cost Index (HOCI), changes in the veteran population and private health insurance coverage.

The Hospital Output Cost Index

2.29 As noted above, under the AHCAs, funding to the States and Territories is partially indexed to a hospital output cost measure (HOCI). State funding increases should the HOCI rise, and decreases if the HOCI goes down. Whilst the Commonwealth and States agreed to this in principle, the formulation of the HOCI has been a point of contention. The AHCAs state that the parties will commit to the development of a suitable index for adjusting the Health Care Grants to reflect changes in hospital output costs. The AHCAs also state that in the case of a dispute, an independent arbiter may be proposed and that the parties will use their best endeavour to reach a settlement. The fall-back position, in case there was disagreement on the HOCI, was that the Commonwealth would use a default 0.5 per cent measure.

2.30 A brief outline of the process leading to the appointment of an independent arbiter was provided by the New South Wales Government in its submission:

> States and Territories commissioned the Australian Bureau of Statistics to develop an index (to be used in conjunction with a productivity dividend) to reflect the change in hospital input costs. This index was estimated to be 4.2% in 1998-99. In another display of disregard for the public hospital system, the Commonwealth refused to consider this index and decided to retain the default indexation arrangements. States and Territories invoked the arbitration provision and an independent arbiter was appointed to resolve the dispute.[6]

2.31 The independent arbiter, Mr Ian Castles, who was appointed by the Commonwealth, recommended that the HOCI should comprise the CPI plus 0.5 per cent and that a review should be held to assess any effect of the GST. In response to a question on notice during the Senate Community Affairs Legislation Committee's scrutiny of the 1999-2000 Additional Estimates, the Commonwealth Department of Health and Aged Care (DHAC) outlined the reasons why the Commonwealth had decided to reject the recommendation of the independent arbiter on the HOCI:

> …the Commonwealth decided not to adopt the arbiter's recommendation because there was no evidence that output costs were increasing at the rate of increase of the Consumer Price Index, far less at that rate plus 0.5%.
>
> Evidence from State budget papers indicated that States collectively expected output costs per separation to increase by 1.2 per cent in 1999-2000, or about the same rate of increase as Wage Cost No.1. This is in line with long term trends in hospital output costs.[7]

6 Submission No.79, p.19 (NSW Government).

7 Senate Community Affairs Legislation Committee, *Examination of Additional Estimates 1999-2000: additional information received*, v. 2, May 2000, p.145.

2.32 The Commonwealth Government's position on the HOCI was contained in a letter dated 23 December 1999 from the Minister for Health and Aged Care, Dr Wooldridge, to his State and Territory counterparts. In this letter, the Minister advised that the Commonwealth Government had decided to index the health care agreements by wage cost index 1 (WCI 1), which is a mix of 75 per cent of the wage index and 25 per cent of the CPI. However, in evidence, the Western Australian Health Department argued that the independent arbiter:

> looked at wage cost index 1 and considered that as a possible indexation and he commented in his report–something with which we all agree–that it does not bear any relationship to the cost of producing outputs in the health sector. He actively rejected that as a possible index, as we do.[8]

2.33 Concerns have been raised by several State governments about the Commonwealth's position on the HOCI and these concerns are discussed later in this chapter. DHAC has advised that the Minister for Health and Aged Care has approved the AHCA funding arrangements for 1999-00 and 2000-01, using WCI 1 as the HOCI.

Casemix-based funding

2.34 Casemix refers to the range and types of patients treated by a hospital.[9] Casemix-based funding has become the dominant form of funding of public hospitals in most jurisdictions. The objective of casemix-based funding is to fund hospitals on the basis of their output, what they actually do, rather than on the basis of the level of funding provided in the previous year. However, casemix-based funding does not fund hospitals on the basis of how much it costs them to care for and treat a particular mix of patients but rather on the basis of how much each jurisdiction is prepared to pay for the care and treatment of the casemix.

2.35 While casemix-based funding has provided a useful means of requiring hospitals to focus on their costs, it is not entirely clear whether knowledge has actually improved on the reasons why costs for the same procedure vary between different hospitals or precisely how much it should cost to treat a particular patient with a particular condition. The Committee of Presidents of Medical Colleges pointed to these shortcomings when it told the Committee that 'most hospitals do not have real understanding of what it costs to treat an individual patient. Without that, it cannot have a good classification system'.[10]

2.36 The Australian College of Health Service Executives (ACHSE) explained to the Committee the difference between what casemix aims to do and the resource allocation process of government which determines the level of funding that will be provided to public hospitals. ACHSE argued that:

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8 *Committee Hansard*, 25.2.00, p.278 (Health Department of Western Australia).

9 Australian Institute of Health and Welfare, *Australia's Health 2000*, Canberra, AIHW, 2000, p.439.

10 *Committee Hansard*, 23.3.00, p.493 (Committee of Presidents of Medical Colleges).

> it is important to have costing systems that tell us what it costs for units of activity, and casemix does that. Where the difference is, is then allocating on a proportional basis of the total funds available where there is a gap between the price paid for a unit of activity and the cost of delivering that activity. I think that is why a lot of people are saying that therefore casemix does not work.[11]

2.37 Recognition by State and Territory governments that casemix does not provide adequately for a wide range of the functions and responsibilities of different hospitals, such as teaching and staff development, has led to increases in the fixed grants which they provide to hospitals together with variable casemix-based payments. However, other shortcomings have been summarised by Professor George Palmer as: 'some patients do not properly belong in any of the casemix groups' and, 'for the same DRG[12], certain costs, notably for intensive care, may be incurred in treating some patients but not others'. Palmer argues that these costs are high and may together 'represent more than 20% of the aggregate costs of acute-care hospitals'.[13] Other concerns with casemix-based funding include perverse incentives to discharge patients quickly. The Royal Australasian College of Physicians (RACP), the Australian Consumers Association (ACA) and the Health Issues Centre concluded in their joint submission that:

> generally, it is agreed that casemix funding forces hospitals to examine and use their resources more efficiently, and encourages clinicians to consider the economic impact of their clinical decisions. It also clearly encourages throughput.[14]

2.38 Finally, the South Australian Salaried Medical Officers Association (SASMOA) argued that while casemix 'is acknowledged as having changed the focus of health care':

> we believe that the casemix system is now past its use-by date. Outcome and evidence-based measures of performance should now be developed and adopted to underpin the funding model.[15]

However, this is not a universal view, with a representative of ACHSE informing the Committee that: 'I do not think casemix is by its use-by date'.[16]

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11 *Committee Hansard*, 23.3.00, p.549 (ACHSE).

12 DRGs, or diagnosis related groups are used in casemix classification systems. Australian acute hospitals use AN-DRGs to classify patients admitted to hospital into groups with similar conditions and similar use of hospital resources. This then enables comparisons to be made of the activity and performance of hospitals. (Australian Institute of Health and Welfare, *Australia's Health 2000*, p.440).

13 Palmer, G 'Evidence-based health policy-making, hospital funding and health insurance', *Medical Journal of Australia*, vol. 172, 7.2.00, p.131.

14 Submission No.45, p.11 (RACP, ACA, Health Issues Centre).

15 *Committee Hansard*, 23.2.00, p.187 (SASMOA).

16 *Committee Hansard*, 23.3.00, p.549 (ACHSE).

Overview of State and Territory funding arrangements for public hospitals[17]

2.39 It is important to note that in all States and Territories, hospitals and health services receive a capped budget each year, although this budget will generally be based on the anticipated mix of patients and conditions which the hospital is expected to treat and the price which the State or Territory is prepared to pay for each separation. The extent to which casemix information is used to fund ambulatory services and community health services varies considerably across the States and Territories. Similarly, within this broadly dominant model, there continues to be funding on the basis of block grants, often historically determined.

2.40 The fact that hospitals and health services in all jurisdictions are funded via capped budgets is an important feature of the Australian health system. It is only at the margins that public hospitals are able to increase total funding or budget share by undertaking more activity. In addition, once the budget is set, the incentives are for hospitals and health services to manage as efficiently as possible the demand for services, within the given budget and the operating environment.

2.41 A notable difference between the States and Territories is the extent to which the Department of Health in each jurisdiction is seen as a direct purchaser of services from hospitals and health services or as a funder of regional based services for a defined population. This latter model is most fully articulated in NSW which continues to be committed to needs adjusted population based funding to Area Health Services, which are then responsible for managing services. In other jurisdictions the principle of population based management is less explicit. However, to some extent this relates to the size and geographical distribution of the population. The following is an overview of the funding arrangements in each State and Territory.

New South Wales

2.42 In NSW, health services provision is funded, organised and delivered on an Area Health Service basis. Area Health Services are responsible for the management of the health of a geographically defined population. A needs-adjusted population-based funding formula is used as a basis for allocating resources to Area Health Services, although the formula also includes components relating to cross-boundary flows for tertiary services. Area Health Services are then responsible for funding and managing the constituent health services. Hospitals and other health services within an Area Health Service are funded on the basis of a global capped budget. In many Area Health Services, casemix information is used as a basis for determining the budget shares of individual hospitals within the Area Health Service, although some hospitals and health services continue to be funded on a historical basis.

2.43 However, some important changes to these arrangements were announced recently by the New South Wales Minister for Health in his response to the reports of

17 Material in this section of the report has been primarily based on the research report prepared for the Committee by the Centre for Health Economics Research and Evaluation (CHERE).

two recent inquiries in New South Wales, chaired by the Right Hon Ian Sinclair (Ministerial Advisory Committee on Smaller Towns) and Mr John Menadue (NSW Health Council). Key initiatives to be implemented include episode funding[18] for all planned and acute hospital admissions and a three-year recurrent health budget.[19]

Victoria

2.44 Victoria implemented casemix-based funding for hospital services from 1 July 1993. Since the initial introduction of casemix funding, there have been a number of changes to how services are funded and organised. Hospitals now receive a fixed annual grant related to overheads and some other services, and a variable case payment. Variable payments account for approximately 40 per cent of total hospital budgets.

2.45 In practice, the funding model involves determining an individual hospital's share of the State's global capped budget on the basis of casemix weighted volume, that is, the number and mix of patients and conditions which are expected to be treated during the year. Thus, each hospital has a capped budget, which is related to a specified volume of activity. However, a component of the State's global budget is also allocated on the basis of a tender pool, whereby rural hospitals and metropolitan health care networks can bid for additional activity in terms of volume and price. Activity-based funding arrangements (that is, funding on the basis of what is done) have also been extended to encompass ambulatory services.

2.46 Metropolitan health services in Victoria have been organised in terms of metropolitan health care networks, which are responsible for providing health services to a defined geographical region. In the recent Government Response to the Ministerial Review of Health Care Networks, a new approach was outlined to managing Victorian public hospitals, with a key change seeing the replacement of the existing seven networks with twelve Metropolitan Health Services.[20]

South Australia

2.47 South Australia implemented casemix-based funding for hospital services from 1 July 1994. Hospitals received an annual grant relating to fixed costs and an activity based payment, which covers both admitted and non-admitted patients, although since 1995 intensive care units have been separately funded. Hospital service agreements are used to specify minimum levels of service, and the scope and level of

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18 Episode funding, as described in the Menadue report, is a similar approach to that of casemix-based funding. Episode funding 'involves negotiating a price for a certain treatment based on recommended clinical practice. The cost will be influenced by the volume, length of stay, the severity of the illness and use of services such as operating theatres, nursing, pathology and accommodation'. (NSW Health Council, *A Better Health System: the report of the NSW Health Council*, p.57).

19 Minister for Health, Hon C Knowles, *Working as a Team–the Way Forward: Ministerial Statement*, 8.3.00, pp.3, 5.

20 Victoria, Ministerial Review of Health Care Networks, *Government Response to the Ministerial Review*, May 2000, p.3.

services to be provided by each hospital. Further developments are extending the use of casemix-based funding to a range of other services, including mental health services. In practice, as in Victoria, the casemix funding system involves the use of casemix adjusted volume and a unit price to determine a hospital's share of the total capped budget for hospital services.

Queensland

2.48 Since 1996-97, Queensland has separated the functions of funding, purchasing and provision of health services. State health services are organised into Health Service Districts which are responsible for the provision of services. Queensland Health purchases services from the Health Service Districts on the basis of service agreements which specify price, casemix and volume. The Queensland Hospital Funding Model consists of several variable components and three fixed components. The variable components, which include an acute inpatient payment, a sub and non-acute patient payment, a designated psychiatric unit payment and an ambulatory payment, are dependent on projections of hospital throughput in the service areas and associated average prices. By comparison, the fixed components, teaching grant, research grant and special grants are determined at the commencement of the funding period.[21]

Western Australia

2.49 Health services in Western Australia are broadly organised and funded on a purchaser-provider model. The Health Department of Western Australia acts as a purchaser of services from Health Service Boards. There are 23 Health Service Boards across the state, with the largest being the Metropolitan Health Services Board. Services are purchased on the basis of a service agreement which specifies casemix adjusted volume, price and other factors such as quality. In 1997-98, Western Australia implemented a casemix-based model for purchasing episodes of care from the Health Service Boards. This model groups admitted patient episodes into core and exceptional episodes. This latter category is used where a patient episode becomes unusually costly due to a long stay in hospital or very expensive inputs (eg high cost drugs). The Health Department of Western Australia's *Annual Report 1998-99* states that it is evaluating the nature of episodes of care through administrative audit and clinical audit processes.[22]

Tasmania

2.50 Tasmania introduced casemix-based funding for its public hospitals from 1 July 1997. The funding model comprises five components: variable payments, including admitted patients (except in designated units such as mental health, palliative and rehabilitation patients) and nursing home type patients; fixed payments,

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21 Queensland Health, *Hospital Funding Model: technical paper*, Brisbane, Queensland Health, July 1999, p.1.

22 Health Department of Western Australia, *Annual report 1998/99*, Perth, the Department, 1999, p.39.

including teaching and staff development, research, clinical development, admitted patients in designated units, ambulatory care and accreditation; site specific payments, including lease payments, magnetic resonance imaging, and transfers; a Special Purpose Payment Pool, including highly specialised drugs, risk management of high cost patients and medico-legal settlements; and a Transition Payment Pool.[23]

Northern Territory

2.51 Northern Territory hospital services are funded using a casemix based funding model. The Territory Health Services purchases services from the network of public hospitals on a purchaser-provider basis. In doing so, Territory Health Services uses a Hospital Budgeting Model which incorporates activity-based funding. Territory Health Services have established internal performance agreements with the public hospitals, based on the Hospital Funding Model. The model determines the financial requirement for Territory public hospitals based on the anticipated volume of services and activities and applies a Northern Territory Specific Price to the expected activity. The price is based on the national benchmark with adjustments to account for specific cost drivers unique to the Northern Territory.[24]

Australian Capital Territory

2.52 Since 1996-97 health services in the Australian Capital Territory have been organised broadly in terms of a purchaser-provider model, with the ACT Department of Health and Community Care purchasing services from providers on the basis of contracts. The contracts use casemix to specify the volume and price of acute inpatient services, an ambulatory classification system is used to specify the volume and price of ambulatory care services, and non-acute inpatient services are funded on a per diem basis. The ACT is also implementing output-based funding for community health services.

Adequacy of funding level for public hospitals

2.53 The majority of submissions to the inquiry regard the level of funding for public hospitals to be inadequate. Ten per cent of submissions argued that the question of adequacy was impossible to answer, while a small number stated that current levels of funding were potentially adequate, but were unable to meet current levels of demand due to inefficiencies.

2.54 This section examines the issue of adequacy of funding by reflecting the differing perspectives of participants in the inquiry about where the problems lie. It then attempts to assess the adequacy of funding for public hospitals now and in the future. When considering the data in this section it is important to note that the

23 Commonwealth Department of Health and Aged Care, Acute and Coordinate Care Branch, *State and Territory Casemix Developments*, at http://www.health.gov.au/casemix/statedev.htm, last updated 16.4.99.

24 Submission No.69, Additional information, p.1 (Northern Territory Government).

differing claims, particularly those of the two levels of government, may all be correct and accurate–to an extent. What needs to be borne in mind is that any change in underlying assumptions such as the base year used for comparative purposes will alter the outcome of any comparison. Not surprisingly, the Commonwealth selects a different base year than the States and Territories in making its comparison on relative spending efforts, with each level of government seeking to portray its own efforts as superior to the other. While all choices of a base year are defensible to an extent, the end result of the different claims tends to obscure the details of what has occurred and how this may impact on the adequacy of funding for public hospitals now and in the future.

The Commonwealth's position

2.55 The Commonwealth Department of Health and Aged Care (DHAC) selected 1991-92 as the base year from which to make comparisons about the relative funding efforts of itself and the States and Territories for public hospitals. The Commonwealth does not fund hospitals directly, nor does it purchase hospital services. Rather, it provides funding to the States and Territories for the provision of public hospital services. DHAC argues that over the period 1991-92 to 1996-97:

> there was a significant increase in productivity over the period with the rate of separations increasing at just over twice the rate of real levels of funding;
>
> Commonwealth funding kept pace with the rate of increase in activity over the period but State funding did not; and
>
> consequent savings arising from the increase in productivity accrued to the States.[25]

2.56 DHAC drew attention in its submission to variations between the States and Territories in the level of 'States-own'[26] funding of public hospitals in each jurisdiction over this period. Increases in real terms were calculated for New South Wales, Queensland and the ACT, while funding decreased in real terms in the other jurisdictions, except Western Australia, where funding was almost the same in real terms in 1996-97 as in 1991-92.[27]

2.57 With regard to the Commonwealth's own funding under the current AHCAs, DHAC argues that funding provided in 1998-99 represents a real increase of 11 per cent when compared to 1997-98, the last year of the previous Medicare Agreement. It

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25 Submission No.38, p.9 (DHAC).

26 The term 'States-own' funding refers to the funding provided by each State and Territory for public hospital services but excludes the funding provided by the Commonwealth to each jurisdiction under the Australian Health Care Agreements. It therefore does not represent the total funding by each State and Territory for public hospital services but rather, that component of funding which the State or Territory has provided from its own revenue (including from general financial assistance grants (FAGS) from the Commonwealth)

27 Submission No.38, p.8 (DHAC).

estimates that total health care grants to the States and Territories under the AHCAs will increase in real terms by a further 4.1 per cent in 1999-2000, 2.3 per cent in 2000-01, 2.5 per cent in 2001-02 and 2.4 per cent in 2002-03.[28]

2.58 Indexation arrangements under the AHCAs are quite different to those under previous agreements. Earlier in this chapter, an overview was provided of the dispute between the Commonwealth and the States and Territories over the level at which the hospital output costs index (HOCI) should be set. The Commonwealth's view is that the HOCI is part of the overall increase in funding and should be judged in that context. This aspect of the Commonwealth's position was presented by Mr Andrew Podger, Secretary of DHAC, in evidence to a recent Senate Estimates hearing, although the comment also reflects the so-called 'blame shifting' which is endemic in this area of Commonwealth-State relations:

> so while there is a dispute over the indexation factor, it is in fact quite a generous arrangement in total adjustments each year. One of the issues, of course, is that a number of the states have not been increasing their amount of money by as much as we are, notwithstanding their disputation that we should put in more.[29]

2.59 Data in Figure 8 indicates the percentage change 1998-99 to 1999-00 in funding by the Commonwealth to each State and Territory under the AHCAs and the States'-own funding in each jurisdiction for its public hospitals. The data, provided by DHAC, supports the Commonwealth's claims that it is increasing funding to the States under the AHCAs and that some of the States and Territories are not increasing funding for their public hospitals at the same rate as the Commonwealth.

2.60 While this contention is supported by the data in respect of New South Wales and Victoria and to a lesser extent the ACT, there has been no increase in percentage terms by the Commonwealth in its funding to Western Australia and the increase in funding to Queensland and Tasmania is below the effort of the respective jurisdictions. Funding by the Commonwealth to the Northern Territory from 1998-99 to 1999-00 under the AHCA has fallen quite dramatically. DHAC has advised that the variation in funding for the Northern Territory is 'largely attributable to the removal of the one-off Transition Adjustment of $19 million included in the Health Care Grant in 1998-99 only'.[30]

2.61 Agreement was reached between the Commonwealth and the States and Territories that the percentage growth in the combined grants to each jurisdiction (comprising the health care grants and general revenue grants) in the later years of the AHCAs 'would be based on the application of the equalisation relativities determined

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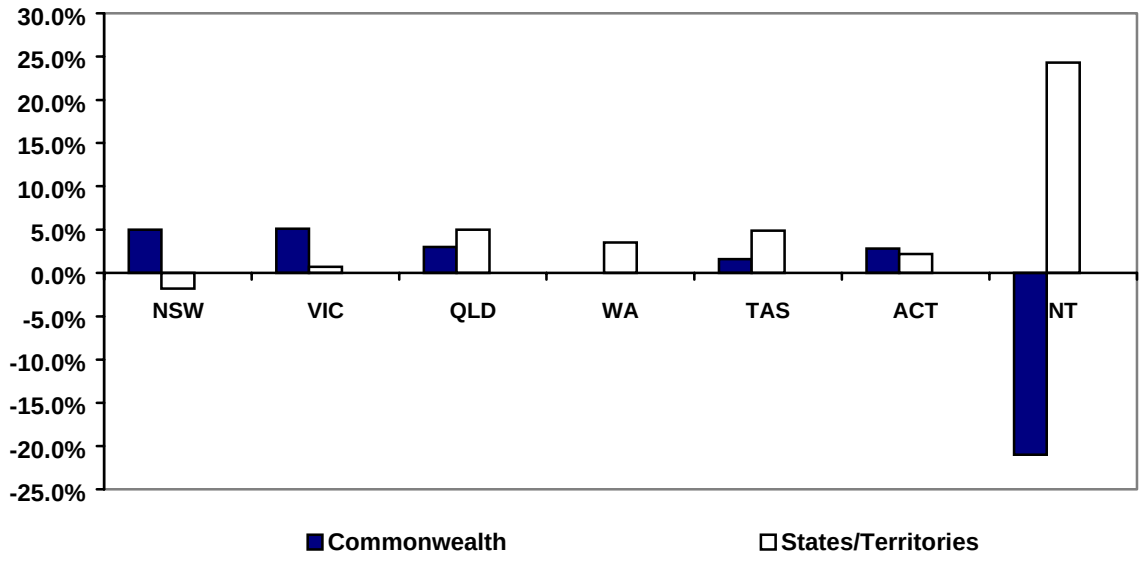
28 Submission No.38, p.11 (DHAC).

29 Senate Community Affairs Legislation Committee, Supplementary Additional Estimates Hearing, *Committee Hansard*, 2.5.00, p.68.

30 Submission No.38, Additional information, 19.6.00, p.1 (DHAC).

by the Commonwealth Grants Commission'.[31] Under these arrangements the Northern Territory is expected to receive the greatest per capita allocation of any jurisdiction in later years. The data in Figure 8 is a further example of the necessity for greater transparency in the funds available from each jurisdiction for public hospital services. A different picture would likely emerge from a chart indicating the percentage change in the following period, 1999-00 to 2000-01, in jurisdictions' funding for public hospitals.

Figure 8: Public Hospital Funding – Commonwealth funding under AHCAs and States' own funding: percentage change 1998-99 to 1999-00



Source: Compiled from: *Submission No.38, Additional Information,* 17.1.00, pp.3-10.

Note: The Commonwealth Department of Health and Aged Care argues that presentation of data in South Australia's Budget Papers for 1999-00 did not enable a similar calculation to the other jurisdictions. However, after adjusting for program changes, DHAC estimates that funding by South Australia for its public hospitals fell by 5.2 per cent over this period.[32]

The position of the States and Territories

2.62 Each of the States and Territories have taken the opportunity to either provide a submission to the inquiry or have appeared before the Committee and offered evidence on the issues relevant to the inquiry's terms of reference. It is not proposed to detail the position of each jurisdiction on all of the issues around the adequacy of funding because, while the particularities may vary, the States and Territories are united in their general claim that the current level of funding by the Commonwealth is inadequate. The States and Territories presented several reasons to support this claim. New South Wales, for example, draws upon the claim made by Dr Deeble in both his submission and evidence that current levels of funding by the Commonwealth will be

31 Submission No.38, Additional information, 19.6.00, p.1 (DHAC).

32 Submission No.38, Additional Information 17.1.00, p.7 (DHAC).

inadequate because unrealistically low levels of increase were built into hospital funding grants to the States in the early years of Medicare:

> the second Medicare agreement (1988 to 1993) continued the very low 'real' growth rates on the Commonwealth side. In fact, the increase in federal contributions barely covered population growth.[33]

2.63 The New South Wales Government draws also on a report prepared by consultants Access Economics for the six States and the Northern Territory during negotiations on the AHCAs in 1998. The report analysed the relative funding efforts of the two tiers of government and found that an informed analysis requires more than comparisons based on a reference year. Access Economics proposed that 'the correct approach is to assess trends over a longer period of time, comparing efforts throughout each of the five-year agreements', and concluded that:

> the assessment of the wider picture invites the conclusion that the States and Territories have pulled their weight in terms of funding the public hospital and public health systems. Relative funding efforts cannot be sensibly assessed without regard to the wider picture. In particular, it is essential to have regard to the impact of Commonwealth policies including the restrictions embodied in Medicare and the progressive reduction, since the mid-1970s, in overall Commonwealth payments to the States.[34]

2.64 This latter point is of importance to the States and Territories because the funding available for their public hospitals is a composite of the specific purpose hospital funding grants (under the AHCAs) and the general purpose financial assistance grants (FAGs) both of which are paid to them by the Commonwealth. With effect from 1 July 2000, the FAGs have been replaced with revenue from the GST which, over time, may provide the States and Territories with greater flexibility in the funding available for their public hospitals.

2.65 An indication of the gradual decline in general purpose grants as a proportion of GDP is provided in Figure 9.

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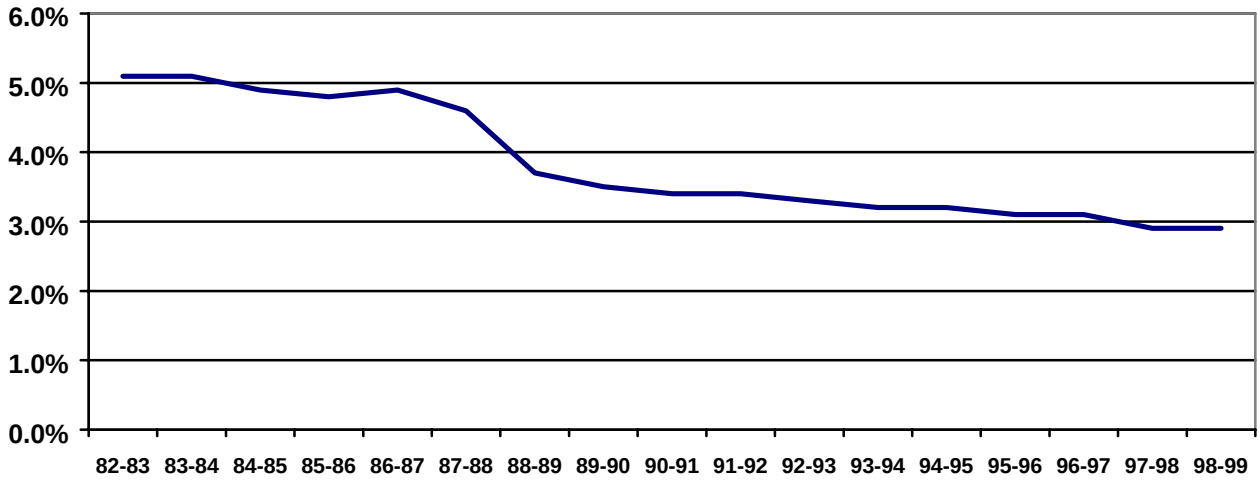
33 Submission No.50, p.14 (Dr Deeble).

34 Access Economics, *Comparative Effort in Health Financing by the Commonwealth and State Governments: report prepared for the Health Departments of the States and the Northern Territory*, Canberra, Access Economics, June 1998, p.19.

Figure 9: Commonwealth Payments to the States and Territories (a)(b)
General Revenue Assistance as a Proportion of GDP 1982-83 to 1998-99



(a) Six States and NT to 1987-88, Six States and both Territories thereafter.

(b) The chart shows gross levels of assistance. No deductions have been made for State fiscal contributions which applied for the period 1996-97 to 1998-99.

Sources: Federal Financial Relations, *Budget Paper No.3, 1999-2000* and various earlier editions. *National Income, Expenditure and Product, ABS (cat no 5206.0).*

2.66 Queensland Health and the New South Wales Government each acknowledged that the current AHCA was an improvement in several respects over the previous Medicare Agreement.[35] However, a specific area of concern for Queensland is what it regards as an underfunding of the State under the (Commonwealth-funded) Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) due to the decentralised nature of the State and the consequent relative undersupply of medical practitioners and community pharmacies in many areas. Queensland estimates that it is out-of-pocket by some $31 million.[36] The Tasmanian Government mounted a similar argument with regard to MBS benefits in Tasmania, in its submission to the inquiry.[37] If this argument were progressed to its logical conclusion, there would be a redistribution of MBS payments from New South Wales and, to a lesser extent, Victoria, to the other jurisdictions.

2.67 However, this calculation by Queensland takes no account of other Commonwealth-funded programs such as those for Indigenous health services nor does it take account of the New South Wales Government's argument that due to the horizontal fiscal equalisation arrangements, it (NSW) is 'subsidising the health

35 See, for example, *Committee Hansard*, 11.11.99, p.70 (Queensland Health) and Submission No.79, p.16 (NSW Government).

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

37 Submission No.67, p.5 (Tasmanian Government).

services of some other states and territories'.[38] New South Wales calculates that while its entitlement under the AHCAs is to about 34.2 per cent of the pool of funds, it receives only around 30.4 per cent of the pool 'after the Grants Commission redistributes a proportion of the NSW entitlement to other states and territories'.[39]

2.68 Clearly, this type of circular argument does not advance an assessment of the adequacy of funding for public hospitals. Horizontal fiscal equalisation is a reality of Commonwealth-State financial relations and can be supported on a range of social grounds. In addition, the claim for MBS funding to be equalised on a notional per capita basis on the grounds of fairness is not quite as straightforward as it might appear. There are a variety of factors which explain differences between jurisdictions and within jurisdictions with regard to the availability of, and benefits for, out-of-hospital services. While the availability of GPs in particular areas is one factor which contributes to the differences in per capita MBS benefits, it is not the only reason. For example, the ACT received a lower per capita payment of MBS benefits ($288) than any other jurisdiction, excluding the Northern Territory, in 1997-98 and was well below the Australia-wide per capita benefit of $354. Queensland received $341 in Medicare benefits per capita in 1997-98.[40]

2.69 There are two key areas where the States and Territories have concerns about the adequacy of funding for public hospitals, both now and in the future. These concerns relate to the hospital output costs index (HOCI) and to taxation issues, principally the GST (both in terms of revenue and also in its impact on public hospitals) and fringe benefits tax (FBT).

Specific concerns: the Hospital Output Costs Index

2.70 The general issues around the hospital output costs index (HOCI) were discussed earlier in this chapter but specific State and Territory government concerns are outlined below. The recommendation of the independent arbiter, Mr Ian Castles, was that the HOCI should comprise the CPI plus 0.5 per cent.

2.71 The Queensland Government argued that the adoption of the recommendation of the independent arbiter would mean that:

> effectively, this formula would mean a $21 million increase in funding for Queensland this year and $237 million over four years.[41]

2.72 The Health Department of Western Australia commented on the inappropriateness of the Commonwealth Government's offer of wage cost index 1 for the HOCI:

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38 Submission No.79, p.18 (NSW Government).

39 Submission No.79, p.18 (NSW Government).

40 Commonwealth Department of Health and Aged Care, *Electorate Profiles*, May 1999.

41 *Committee Hansard*, 22.3.00, p.469 (Queensland Minister for Health).

> wage cost index 1 is not a health related index, it is a general index, and so it does not relate in particular to either wages or other costs in the health sector. The purpose of the hospital costs output index and the agreement that we came to in negotiating Australian health care agreements was to reflect the costs in the health sector, not some more arbitrary figure like wage cost 1.[42]

2.73 The Northern Territory Government estimated that 'under the current offer from Dr Wooldridge, we are to get an extra $600 000. We believe that figure should be $1.4 million'.[43]

2.74 In the view of the Health Department of New South Wales:

> the estimated difference between the Commonwealth's offer and the arbiter's recommendation, which is CPI plus 0.5 per cent, in New South Wales is enough to run one rural hospital–$23 million.[44]

2.75 The Victorian Government claimed that the issue of the HOCI indexation was the 'most urgent problem facing the Australian health system' and that the difference between the Commonwealth's offer and the arbiter's recommendation represented a 'reduction in the real value of the Health Care Grants to Victoria' of the order of $220 million over four years.[45]

2.76 The South Australian Government provided the Committee with a table which included the estimated variation between the Commonwealth Government's offer of wage cost 1 as an index and the arbiter's recommendation. According to the South Australian Government's calculations, it would receive $54.2 million less over four years under the Commonwealth's offer than under the arbiter's recommendation, while the States and Territories combined would receive some $628.6 million less over the four years to 2002-03.[46]

2.77 The Tasmanian Government argued that the Commonwealth's default position 'is considered inadequate'[47], while the ACT Government stated that 'if the result of that arbitration had been accepted, we would have approximately $7 million coming to the ACT'.[48]

2.78 It is possible to argue that the States and Territories held high expectations of the process specified in the AHCAs with regard to the HOCI and that these

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42 *Committee Hansard*, 25.2.00, p.278 (Health Department of Western Australia).

43 *Committee Hansard*, 24.2.00, p.239 (NT Minister for Health).

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

45 Victorian Government, Additional Information, 23.3.00, p. 4-5

46 Submission No.60, Additional Information p.1 (South Australian Government).

47 Submission No.67, p.3 (Tasmanian Government).

48 *Committee Hansard*, 11.4.00, p.643 (ACT Minister for Health).

expectations have not been met. The process for establishing an agreed HOCI has held no more guarantees for the States and Territories than did the so-called '2 per cent review' process under the previous Medicare Agreement (described earlier) which the States and Territories had expected would deliver them compensation for the decline in the proportion of the population covered by private health insurance. The important feature of both of these compensatory mechanisms was that ultimately the Commonwealth Government reserved the power to decide the outcomes.

Specific concerns: the GST

2.79 Taxation issues, particularly the impact on funding for public hospitals, are of concern to the States and Territories. Although public hospital services are largely GST free, there is some degree of uncertainty on just how the introduction of the GST will affect public hospital services. There are concerns also over the new funding arrangements for the States and Territories which will come into effect from 1 July 2000. The changes to fringe benefits tax (FBT) are also of concern, but the degree of concern varies between the jurisdictions.

2.80 Concerns raised with regard to the GST include its effect on programs such as the isolated patients' travel schemes, whereby patients from remote areas receive financial assistance to travel for necessary medical and surgical attention. These schemes are funded by the States and Territories. The Health Department of New South Wales argued that the GST will increase the price of, for example, a train ticket for an isolated patient and this increase will need to be met by the NSW Government as part of its reimbursement of the patient:

> in this state, we have just put an extra $500 000 into running a program which we announced two weeks ago and all of that and more will be lost through the application of the GST.[49]

2.81 The Health Department of New South Wales also expressed concern over the unresolved nature of the possible effect of the GST on, for example, donations to major public hospitals. Rulings on this and other issues are awaited from the Australian Taxation Office (ATO).[50] An example of how the GST may impact on public hospital services and, therefore, public hospital funding, was provided by the Health Department of NSW and concerned a ruling by the ATO in Western Australia:

> to give one example, in Western Australia the ATO has given a ruling that a nurse ringing a doctor on call for advice about how to manage someone presenting as an emergency is not direct patient care. It is actually a service of the doctor to the hospital and therefore GST is payable on the payment to the doctor. The ATO just does not understand the Australian health system.[51]

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49 *Committee Hansard*, 21.3.00, p.355 (Health Department of NSW).

50 *Committee Hansard*, 21.3.00, p.356 (Health Department of NSW).

51 *Committee Hansard*, 21.3.00, p.356 (Health Department of NSW).

2.82 The South Australian Government raised the issue of the compliance costs which will be required as a result of the introduction of the GST. Preliminary estimates compiled for the State by consultants Ernst and Young indicate a possible first year cost of $20 million for the South Australian Department of Human Services (which includes the South Australian Health Commission) and then ongoing compliance costs of $10 million per year.[52]

2.83 The Queensland Government provided the Committee with some estimates of how the GST may impact on public hospitals in Queensland. The Government estimates that direct costs incurred by Queensland Health for the implementation of the GST are in the order of $1.15 million while possible annualised costs are expected to reach $4 million.[53]

2.84 Following the introduction of the GST on 1 July 2000, the payment of general purpose financial assistance grants (FAGs) to the States and Territories will be replaced by revenue from the GST. The payment of GST revenues to the States and Territories will be as follows:

> Subject to the transitional arrangements and other relevant provisions in this Agreement, the Commonwealth will distribute GST revenue grants among the States and Territories in accordance with horizontal fiscal equalisation (HFE) principles.
>
> The pool of funding to be distributed according to HFE principles in a financial year will comprise GST revenue grants and health care grants as defined under an Australian Health Care Agreement between the Commonwealth and the States and Territories. A State or Territory's share of the pool will be based on its population share, adjusted by a relativity factor which embodies per capita financial needs based on recommendations of the Commonwealth Grants Commission. The relativity factor for a State or Territory will be determined by the Commonwealth Treasurer after he has consulted with each State and Territory.[54]

2.85 It is of concern for the States and Territories that it is likely that there will be no increase in funding under these new arrangements for at least several years. This has been acknowledged by the Commonwealth Government, which has undertaken to ensure that the budgetary position of each State and Territory will be no worse in the initial years following the introduction of the GST.[55] The key issue here is that following the introduction of the GST, there is unlikely to be any extra funding, for at least the initial few years, available to the State and Territories which could be applied

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52 *Committee Hansard*, 23.2.00, p.165 (South Australian Minister for Health).

53 Submission No.41, Additional Information, p.4 (Queensland Government).

54 *Intergovernmental Agreement on the Reform of Commonwealth-State Financial Relations*, 20 June 1999, p.14.

55 Treasury, *Mid-Year Economic and Fiscal Outlook*, Canberra, Treasury, 1999, p.67.

to their public hospitals. Over the longer term, however, the States and Territories are expected to have greater flexibility as a result of the revenue from the GST.

Specific concerns: FBT

2.86 The possible impact of changes to FBT was raised by each jurisdiction, however some States, notably Western Australia, South Australia and Victoria appear to have much more widespread usage of salary packaging for public hospital staff of all types and levels than other jurisdictions and consequently view the changes with greater concern. Interestingly, South Australia argued that the use of salary packaging and the FBT exemption 'has been used to keep down costs within the public hospital system'.[56] However, these cost savings for South Australia can also be described as cost shifting from the State to the Commonwealth which forgoes revenue from taxation. If it is considered desirable that the salaries of public hospital staff should be further subsidised by other taxpayers, then the subsidy should be transparent rather than hidden within the FBT arrangements.

2.87 Some of the concerns about the FBT changes have been addressed by legislative amendments and, in addition, the Commonwealth Government announced in its 2000-01 Budget that it will provide grants of $240.5 million for public and not-for-profit hospitals over the three year period 2000-01 to 2002-03 to assist with the transition to the new FBT arrangements.[57] It is likely that this funding will be required by the States and Territories because the AHA has estimated that the changes to the FBT arrangements will have a financial impact of approximately $250 million per year on public hospitals, with a disproportionate effect on rural and regional services.[58]

Assessing the adequacy of capital funding

2.88 Capital funding has long been the poor relation to recurrent funding in many areas of government enterprise, but perhaps nowhere more noticeably than in public hospitals. Broadly speaking, capital funding comprises spending on buildings, facilities and equipment, rather than services. It is primarily the responsibility of State and Territory governments and as such needs to be included in any analysis of the adequacy of funding available for public hospitals.

2.89 Several participants in the inquiry raised concerns about the adequacy of capital funding. For example, the RACP stated that serious problems existed with the lack of adequate resourcing for public hospital infrastructure. The College noted that the urgency of the problem varied between public hospitals but that in some public hospitals 'capital equipment has been allowed to run down to the point where it is

56 *Committee Hansard*, 23.2.00, p.165 (South Australian Minister for Health).

57 Health and Aged Care Portfolio, *Portfolio Budget Statements 2000-01*, Canberra, Department of Health and Aged Care, 2000, p.80.

58 Submission No.63, Additional Information, p.2 (AHA, WHA, AAPTC).

creating serious clinical problems'.[59] The Queensland Government pointed to its large investment in capital works for its public hospitals, explaining that part of its objective is to provide more efficient public hospitals.[60] In their joint submission, the RACP, ACA and the Health Issues Centre drew on Professor Stephen Leeder's book *Healthy Medicine* to comment that:

> less than 4 per cent of the total health budget goes to capital works…as a result of this lack of commitment in Australia we have an ageing fleet of public hospitals unable to take full advantage of the new technologies that enable more patients to be treated out of hospital, or more comfortably in hospital if that is the best place for them.[61]

This view indicates that continuing underfunding of the capital requirements of public hospitals may be at the expense of their efficiency.

The consumer perspective

2.90 Several consumer bodies provided consumer input into the inquiry. The Consumers' Health Forum (CHF) drew upon its consultations with members to outline issues which consumers regard as important in relation to the adequacy of funding for public hospitals. The Australian Consumers' Association and Consumers' Council of WA also discussed issues of concern to their members. Key concerns raised by these groups included:

- the current level of funding is not adequate to properly meet existing needs;
- existing funding should be allocated in a way that better targets the needs of consumers, including the promotion of Consumer-oriented care;
- the closure of specific purpose services and long waiting lists for others;
- reduction in public hospital outpatient and allied health services which could be used to prevent hospitalisation;
- the length of waiting lists and last minute cancellations and bookings;
- decreasing length of stay, particularly where patients are discharged without adequate support or into isolated situations; and
- negative effects on patient care of hospital staff with very heavy workloads.[62]

2.91 A consumer viewpoint was also provided by the President of the Deafness Association of the Northern Territory who identified a range of particular problems with regard to the Northern Territory, including:

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59 *Committee Hansard*, 21.3.00, p.372 (RACP).

60 *Committee Hansard*, 22.3.00, p.466 (Queensland Minister for Health).

61 Submission No.45, p.8 (RACP, ACA, Health Issues Centre).

62 Submission No.72, p.8 (CHF); Submission No.45, p.14 (RACP, ACA, Health Issues Centre); Submission No.7, p.2 and *Committee Hansard*, 23.2.00, pp.272-3 (HCC of WA).

- premature discharge from hospital leading to unnecessary readmission–although this may become less of a problem following the introduction of the Transitional Care Project;
- understaffing of the public hospital which may result in, for example, inadequate attention to the dietary needs of older and disabled patients;
- overlong waiting times in outpatient clinics; and
- in summary, 'the public hospital gives a good service for able-bodied people, but for elderly or disabled people the picture is not so rosy'.[63]

Perceptions of a funding 'crisis' in public hospitals

2.92 Discussion in Chapter 1 indicated that the Australian health system generally worked well and that most Australians enjoy a very high standard of health and health care. However, The casual reader of newspaper headlines in 1999 such as 'Hospital held together by chewing gum' could be forgiven for imagining that the public hospital sector was in 'crisis'. Adding to this sense of 'crisis' were highly critical comments contributed at the time by senior hospital clinicians, such as: 'every year you think this is the worst, but no, next year is worse' (Professor John Dwyer, Prince of Wales Hospital); 'it seems to me that we have been coping with a crisis for a long time' (Dr Malcolm Fisher, Royal North Shore Hospital); and 'this place is on a knife-edge' (Professor Rick Kefford, Westmead Hospital).[64]

2.93 It is difficult to distinguish hyperbole from fact in this regard, in part because some public hospitals and their advocates have proven adept at using the media effectively to project their messages. However, it is apparent from some of the submissions and evidence provided to the inquiry that there is a considerable level of concern about the funding situation facing public hospitals. One of the key issues for the Committee, however, is whether greater amounts of funding alone will be an effective and sustainable remedy.

2.94 The Australian Medical Association (AMA) told the Committee that 'we believe that the system is primarily running now on goodwill'[65] and that 'almost everybody who works in the system says we need more dollars'.[66] In addition, the joint submission from the Australian Healthcare Association (AHA), Women's Hospitals Australia (WHA), and the Australian Association of Paediatric Teaching Centres (AAPTC) argued that 'the consensus view is that the absolute level of funding for public hospitals and healthcare is inadequate'.[67]

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63 *Committee Hansard*, 24.2.00, p.228 (Deafness Association of the Northern Territory Inc.).

64 quoted in Ragg, M 'Keeping thorns by your side', *Sydney Morning Herald*, 26.5.00, p.21.

65 *Committee Hansard*, 11.11.99, p.77 (AMA).

66 *Committee Hansard*, 11.11.99, p.78 (AMA).

67 Submission No.63, p.12 (AHA, WHA, AAPTC).

2.95 Evidence of the available resources failing to meet demand may be inferred from the waiting lists and waiting times for elective surgery and the waiting times in emergency departments of public hospitals. However, in its recent report on government services, the Productivity Commission notes that differences in recording practices of waiting times for elective surgery and in the scope of the data collections in the States and Territories affects 'the comparability of reported results'.[68] From 1999-2000 all jurisdictions are to adopt a similar recording practice. With regard to emergency department waiting times, although nationally agreed definitions exist, differences in how the data is collected are apparent between jurisdictions.[69] A recent report from the AIHW provides data on waiting times for elective surgery in 1997-98[70] but again, variations in the data collection methods between the jurisdictions hampers any firm conclusions. Given that the available data appears to require several caveats, the Committee has not presented any data on waiting lists/waiting times because it is unlikely to assist in an evaluation of the adequacy of funding for public hospitals.

2.96 These instances of inadequacies in the available data are indicative of the frustration which the Committee has faced in its attempt to evaluate the position of public hospitals in Australia. While a huge volume of data is collected, and reported on, by agencies such as the Australian Institute of Health and Welfare, there appears to be much about the financing and operation of public hospitals which is either unknown or not particularly useful because, for example, of gaps, or concerns about consistency of data collection across jurisdictions.

2.97 Transparency of financial reporting by the different levels of government leaves much to be desired as does the availability of data which may be of use to patients such as waiting times for elective surgery. The overall situation was summed up by Qual-Med's Dr Wilson, who concluded that 'the information systems are poor'[71], and the Sydney Teaching Hospitals Advocacy Group, who argued that 'we were a long way behind in information technology in hospitals–a long, long way behind'.[72] The Queensland Nurses Union acknowledged that Queensland 'is getting a little better' in this regard but were concerned that 'the systems are still not out there to accurately measure anything else other than costs'.[73]

2.98 The Sydney Teaching Hospitals' Advocacy Group (which draws its membership from senior clinicians such as those quoted earlier in this section) argued

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68 Steering Committee for the Review of Commonwealth/State Service Provision 2000, *Report on Government Services 2000*, Canberra, AusInfo, 2000, p.293.

69 Steering Committee for the Review of Commonwealth/State Service Provision 2000, p.294.

70 Australian Institute of Health and Welfare, *Waiting Times for Elective Surgery in Australia 1997-98*, Canberra, AIHW, 2000.

71 *Committee Hansard*, 21.3.00, p.319 (Dr Wilson).

72 *Committee Hansard*, 21.3.00, p.396 (Sydney Teaching Hospitals Advocacy Group).

73 *Committee Hansard*, 22.3.00, p.439 (Queensland Nurses Union).

that more funding needs to be spent on patients, which is not exactly the same as spending more on public hospitals. The analogy was used that a large amount of funding could be put in at the top and by the time it filtered down to the patient 'there is not much coming out'.[74] Professor Hindle took this approach even further by arguing that:

> ..simply adding $2 billion to the budget of the public hospitals would produce no significant impact that people would recognise. The reason for this is that the boundary between what is appropriate care and what is not is ill-defined.[75]

2.99 Professor Hindle's argument is that any increase in funding would eventually be absorbed by the system as it adjusted to the new level of funding. The real need, in his view, is for any available funding to be spent on structural change.[76] This and other options for reform are discussed in the next chapter.

Public hospital sector efficiency

2.100 The Health Department of New South Wales drew upon the findings of the recent report of the NSW Health Council to state that 'there were limited gains to be had in terms of efficiencies within our public hospital system'.[77] The Centre for Health Program Evaluation (CHPE) argued, however, that it is only once adequate quality assurance mechanisms are in place that informed decisions can be made on efficiency in public hospitals. CHPE made the point that merely placing a budget cap on the funding for public hospitals may create undesirable outcomes in the short term, such as a decline in quality.[78] This would appear to indicate that the Victorian Government's policy of a '1.5 per cent productivity improvement requirement each year',[79] which was drawn to the Committee's attention by ACHSE, may not be a desirable or efficient practice in the absence of adequate quality assurance mechanisms.

2.101 Another view of the efficiency of public hospitals was provided by some States and Territories, which asserted that efficiency could be judged on the basis of the cost per casemix-adjusted separation.[80] Thus, Victoria argued that its 'hospitals are

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

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

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

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

78 *Committee Hansard*, 23.3.00, p.592 (CHPE).

79 *Committee Hansard*, 23.3.00, p.550 (ACHSE).

80 The cost per casemix-adjusted separation is a measure of the average cost of providing care for a patient admitted to hospital, adjusted for the relative complexity of the patient's condition and of the hospital services provided. It does not take account of the quality of care provided nor of the health outcomes achieved (Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98*, Canberra, AIHW, 1999, p.222).

extremely efficient. They spend less per casemix than other states'.[81] Queensland, meanwhile, claimed that the available costing of separations data indicated that it had the most efficient hospital services.[82] The latest available data indicates that Queensland has the lowest cost per casemix-adjusted separation at $2354, followed by South Australia ($2458) and Victoria ($2462), the only other jurisdictions below the Australia-wide average.[83]

2.102 In its recent Budget for 2000-01, the ACT Government announced that it is to introduce a four-year 'efficiency improvement' program which is expected to save $25 million over four years[84], from the 2 ACT public hospitals, with $2.5 million in savings expected in 2000-01. Savings 'will be achieved through a process of continuous improvement in hospital and acute care services'.[85]

2.103 It will be interesting to see where the $25 million in savings accrue. A glance at the mix of costs which comprise the cost per casemix-adjusted separation indicates that the ACT has costs which are well above the Australian average for salaried/sessional staff, Visiting Medical Officer (VMO) payments, nursing costs, diagnostic/allied health costs, administrative costs and superannuation. The cost of medical supplies is a further area of difference.[86] If the ACT does succeed in lowering its cost per casemix-adjusted separation closer to the Australian average, presumably the average itself (and therefore the measure of efficiency) will also fall, if the costs of the other jurisdictions do not increase.

2.104 A problem with using the cost per casemix-adjusted separation in this way is that at best it is only informative in a relative sense, that is, how different jurisdictions perform relative to others. It takes the average of the existing performance and uses that as a benchmark. Accordingly, this measure of efficiency may tell us little more than the average amount which each jurisdiction is prepared to pay for its public hospital services. For example, the Health Department of Western Australia explained that as a purchaser of public hospital services from the Metropolitan Health Service, it specifies the volume of services required in various diagnostic groupings, quality indicators and 'the price that the department will pay for those services'.[87]

2.105 The cost per casemix adjusted separation does not assist in measuring optimal efficiency. As Qual-Med's Dr Wilson put it: 'there is no real costing of the product'.[88]

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81 *Committee Hansard*, 23.3.00, p.511 (Victorian Minister for Health).

82 *Committee Hansard*, 22.3.00, p.468 (Queensland Minister for Health).

83 Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98*, Canberra, AIHW, 1999, p.10.

84 ACT Government, *Budget 2000: Budget estimates: Budget paper No. 4*, Canberra, ACT Government, p.104.

85 ACT Government, *Budget 2000: Budget paper No. 2*, Canberra, ACT Government, 2000, p.11.

86 Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98*, p.10.

87 *Committee Hansard*, 25.2.00, p.275 (Health Department of Western Australia).

88 *Committee Hansard*, 21.3.00, p.315 (Dr Wilson).

The knowledge about public hospital efficiency which is really required would explain why, for example:

> a hip replacement in one hospital can cost up to 1.5 times more than in another hospital of similar size and function without any discernible difference in quality of care or severity of condition.[89]

Unfortunately, much evidence presented to the inquiry on the adequacy of data collection systems in public hospitals indicates that there is some considerable way to go before any factually-based assertions can be made about the efficiency of the public hospital sector.

Adequacy of funding in rural Australia

2.106 Generally speaking, people living in rural and remote areas of Australia have poorer health status than people living in metropolitan areas. They have lower life expectancy and experience higher rates of hospitalisation for some causes of ill-health. People living in rural and remote areas also have less access to health care compared to their metropolitan counterparts.[90]

2.107 Table 3 provides an overview of the number of hospitals and available beds in each of the rural, remote and metropolitan areas (RRMA) classification.[91] Data in the Table is instructive to the extent that it provides an indication of the available beds per 1000 of the population in each of the RRMAs. This reveals that 'other metropolitan centres', such as Newcastle and Geelong, have the lowest number of available beds, at 2.2 per 1000 population, while 'other remote areas', such as Cloncurry Shire and Coober Pedy District Council, have the highest at 5.1 beds per 1000 of the population.

2.108 While this data may appear surprising, some possible reasons for these differences include: greater availability of private hospitals in metropolitan areas; hospitals in remote localities provide services to their surrounding areas; a higher percentage of nursing home type patients in the remote areas compared to metropolitan areas (ie fewer nursing home beds in remote areas); higher morbidity in remote areas; and differences in medical practice.[92] It is important to remember also that the data in the Table represents the average for each region and as such, while useful in a comparative sense, it is not actually informative about the experience of individual locations.

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89 New South Wales Health Council, *Report of the NSW Health Council: a better health system for NSW*, Gladesville, NSW Better Health Centre, 2000, p.xxi

90 Australian Institute of Health and Welfare, *Health in Rural and Remote Australia*, p. vi-viii.

91 Details of the composition of each area in the Rural, Remote and Metropolitan Areas (RRMA) classification can be found in: Australian Institute of Health and Welfare, *Health in Rural and Remote Australia*, Canberra, AIHW, 1999, pp. 115-130. This publication contains a listing, by State and Territory of the statistical local areas which comprise each area of the classification.

92 Australian Institute of Health and Welfare, *Health in Rural and Remote Australia*, p.79.

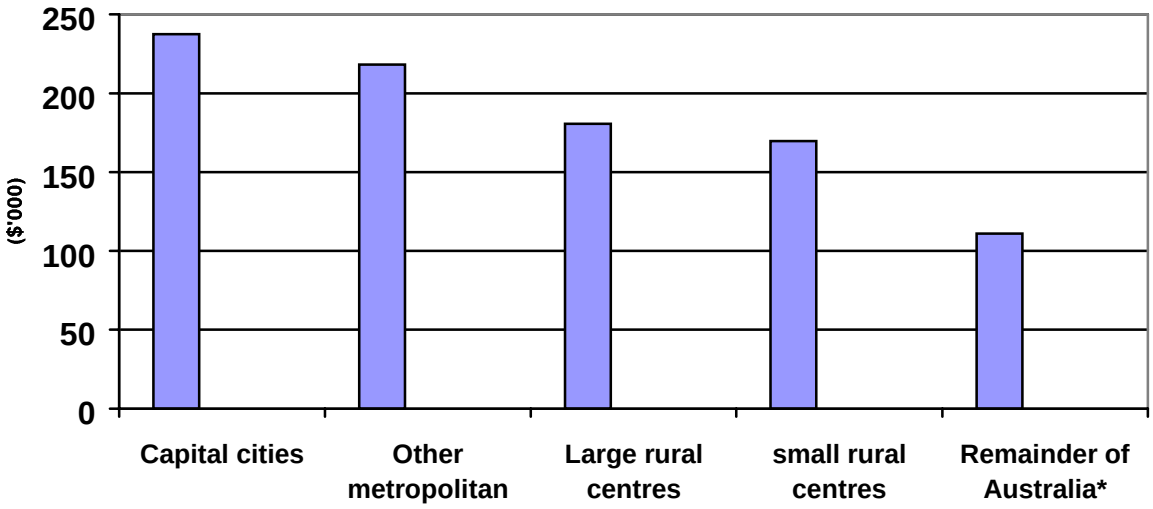
Table 3: Number of hospitals and available beds per 1 000 population by RRMA, public acute and psychiatric hospitals, 1997-98

Hospitals	
Capital cities	176
Other metropolitan centres	21
Total metropolitan	197
Large rural centres	28
Small rural centres	52
Other rural centres	324
Total rural	404
Remote centres	26
Other remote areas	137
Total remote	163
Total all regions	*764*
Available beds per 1 000 population	
Capital cities	2.8
Other metropolitan centres	2.2
Total metropolitan	2.7
Large rural centres	4.3
Small rural centres	3.5
Other rural areas	3.3
Total rural	3.6
Remote centres	4.2
Other remote areas	5.1
Total remote	4.7
Total all regions	*3.0*

Source: AIHW, *Australian Hospital Statistics*, table 3.4

2.109 The data in Figure 10 can be contrasted to that in Table 3. The data indicates that although rural and remote areas, on average, have a higher provision of available public hospital beds than metropolitan areas, the expenditure per bed is much higher in the capital cities and other metropolitan areas, declining as the degree of rurality increases. This largely reflects the mix of services provided in the different regions, with, for example, more complex cases treated in the larger metropolitan public hospitals. The expenditure on public hospitals is a State and Territory responsibility.

Figure 10: Expenditure per available public hospital bed 1995-96 ($'000)



*****Remainder of Australia includes 'other rural areas', 'remote centres', and 'other remote areas'.

Source: Australian Institute of Health and Welfare, *Health in rural and remote Australia,* Canberra, AIHW, 1998, p.80.

2.110 The data in Table 4 contains, for regions in each State and Territory, data on per capita benefits paid for Medicare services which include: GP and specialist consultations, pathology and diagnostic imaging services (out-of-hospital) and in-hospital services and procedures for private patients. These benefits are the responsibility of the Commonwealth Government.

2.111 Data in the Table indicates that, generally speaking, per capita benefits from Medicare are lower in non-metropolitan areas compared to metropolitan areas. However, some care needs to be exercised when interpreting the data. It can be observed, for example, that the average per capita benefit for residents in the ACT is lower than the average benefit in each State and is lower also than the per capita benefits in non-metropolitan regions in New South Wales, Victoria and Queensland. There are a range of reasons why per capita benefits vary across regions and, as with the data presented earlier, no one set of data presents the whole picture. Missing from the data in this section is, for example, expenditure on Indigenous health services, nursing homes, and Multipurpose Services (pooled funds from the Commonwealth and States and Territories).

Table 4: Medicare Services By Region 1997-98

Region	Services per capita (number)	Benefits per capita ($)
New South Wales		
Metropolitan	13.7	430
Non-metropolitan	10.5	330
Total NSW	12.3	386
Victoria		
Metropolitan	12.5	394
Non-metropolitan	9.7	305
Total Victoria	11.5	363
Queensland		
Metropolitan	12.2	377
Non-metropolitan	10.4	318
Total QLD	10.8	341
South Australia		
Metropolitan	11.7	376
Non-metropolitan	8.6	277
Total SA	10.6	342
Western Australia		
Metropolitan	11.2	340
Non-metropolitan	7.3	221
Total WA	10.0	304
Tasmania		
Metropolitan	10.8	340
Non-metropolitan	9.4	280
Total Tasmania	9.9	304
Northern Territory		
Non-metropolitan	4.3	126
A.C.T.		
Metropolitan	9.3	288
Australia		
Metropolitan	12.5	392
Non-metropolitan	9.8	304
Total Australia	11.2	354

Source: Calculated from: Commonwealth Department of Health and Aged Care, *Electorate Profiles*, May 1999.

2.112 An assumption which is evident in the submissions and evidence from the Queensland and Tasmanian Governments is that some parts of metropolitan Australia (notably Sydney and Melbourne) are overserviced and much of rural and remote Australia is underserviced with regard to their respective access to medical and diagnostic services. However, precise knowledge is lacking because this is not an area which has received much research attention. If spending on health bore some relationship to health status then it could be expected that residents of Sydney and Melbourne would be, on average, far healthier than the rest of Australia. This is clearly not the case and many other variables are involved, such as average age of people in particular regions and the proportion of people with private health insurance.

2.113 A similar concern with regard to rural and remote areas was raised with the Committee by CHPE and Professor Richardson. A study of certain hospital procedures in Statistical Local Areas (SLAs) in Victoria revealed 'something like a 500 to 800 per cent variation in how much is being given between SLAs that cannot be explained by population, by age or by sex'.[93] Professor Richardson concluded that the findings were:

> quite stunning in terms of the implications for bad allocation of resources. It strongly implies that either some areas are massively underservicing or some other areas are massively overservicing, and we do not research that in Australia.[94]

2.114 Assumptions can be made about the location of doctors or practicing preferences as some of the reasons behind these differences. The Committee has been surprised about how little appears to be known or understood about the public hospital sector and the health system more broadly, particularly in light of the vast resources which are spent.

2.115 More than 25 per cent of submissions to the inquiry discussed the adequacy of funding to meet demand for public hospital services in rural Australia. None of these submissions judged the level of funding to be adequate. The National Rural Health Alliance (NRHA), which comprises 22 member organisations and represents both consumers and providers of services, argues that people living in rural and remote areas of Australia should receive a 'fair' share of health expenditure, which would be in the order of 30 per cent of that expenditure. The NRHA acknowledges that data is not completely adequate in this area 'but there is a great deal of anecdotal evidence to support the intuitive judgement that this criterion is not met where public hospitals are concerned'.[95]

2.116 However, the NRHA argued in evidence presented to the inquiry that funding for public hospitals in rural areas is not really the issue:

> the right question is not how much money is going to hospitals in rural areas but how much money is going to health services in rural areas.[96]

This view encapsulates the dilemma inherent in assessing the adequacy of funding for public hospitals both in rural areas and metropolitan areas. Public hospitals are a part of the health system and, as such, it is difficult to separate the sector completely from the broader health system.

2.117 It is difficult, therefore, to consider the adequacy of funding for public hospitals in rural areas in isolation from other health services. The next chapter

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

94 *Committee Hansard*, 23.3.00, p.590 (Professor Richardson).

95 Submission No.66, p.21 (NRHA).

96 *Committee Hansard*, 11.11.99, p.116 (NRHA).

discusses a range of options aimed at providing remedies for the problems and challenges facing Australia's public hospital system, including particular issues relating to rural and remote areas. Also discussed are existing models such as the Multipurpose Services[97], emerging models like the Regional Health Services, and the trials of coordinated care, all of which aim to overcome the shortcomings of the existing system. The Committee is aware that a joint project is underway between DHAC and the NRHA, which is investigating new options for health financing in rural and remote areas. The project is expected to report in mid-2000.

Patient travel assistance schemes

2.118 It is important to note that people living in rural and remote areas do have access to public hospital services in larger centres and the capital cities. It is estimated, for example, that around 25 per cent of services provided by the public hospitals in the ACT are provided to residents of the south-east region of New South Wales. Consequently, the issue of patient travel has also been raised by participants in the inquiry. A Commonwealth-funded program, the Isolated Patients' Travel Accommodation and Assistance Scheme, began in 1978 and ceased in 1987. Since then, patient travel has been the responsibility of the States and Territories. The NRHA argues in its submission that:

> following the devolution of these schemes to the States and the Northern Territory, they have developed in different ways and there has been a lack of national uniformity and focus….difficulties with travel for health purposes are becoming a major and pervasive problem for rural and remote people.[98]

2.119 The NRHA is concerned that the variability of the patient travel schemes in different jurisdictions has and is disadvantaging rural people and limiting their access to public hospital services beyond their immediate region of residence. As an indication of this concern, the NRHA has called for a national review into the schemes.[99]

Concluding comments

2.120 One of the central difficulties for this inquiry has been the lack of available data upon which to base informed decisions. With regard to assessing the adequacy of funding for public hospitals, a key obstacle is that 'there has really been no process put in place for assessing and determining what that right level should be'.[100] The task

97 Multipurpose Services (MPS) are usually small hospitals where (Commonwealth) aged care funding is cashed out to enable the provision of both aged care and acute hospital care in the one facility. More recently, the Regional Health Services (RHS) have been introduced and are to be established only where there is demand from the local community. The emphasis of the RHS is on health services, rather than aged care services, with a broader range of services able to be offered than in the MPS (including, for example, primary care services). The exact mix of services is negotiated with the local community.

98 Submission No.66, p.26 (NRHA).

99 Submission No.66, p.27 (NRHA).

100 *Committee Hansard*, 11.11.00, p.98 (AHA, WHA, AAPTC).

for the Committee would be immeasurably easier if all that was required was to conclude that the Commonwealth needs to do more or that the States and Territories need to lift their performance and one or the other should simply provide more funding for public hospitals. Unfortunately the issue is more complex and unlikely to be addressed through simple measures.

2.121 A cautionary note was adopted by the AHA, WHA and the AAPTC in their joint submission to the inquiry. The groups argued that resolving core issues such as securing adequate funding for public hospitals was not possible 'until such time as there is a comprehensive reform of intergovernmental arrangements'.[101]

2.122 The first term of reference of this inquiry requires the Committee to assess and report on the adequacy of current funding levels to meet future demand for public hospital services in both metropolitan and rural Australia. It is unlikely that demand for public hospital services will decrease due to factors such as ageing of the population, developments in technology and increasing consumer expectations. In order to address current problems and to equip Australia's public hospitals with sufficient resources to confidently approach the future, the following chapter canvasses a range of options for reform.

101 Submission No.63, p.5 (AHA, WHA, AAPTC).

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.