Government Response

to the

Senate Community Affairs References Committee

Report on Public Hospital Funding

"Healing Our Hospitals"

Commonwealth Department of Health and Aged Care

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INTRODUCTION

Australians are well served by a public hospital system that provides universal access to high quality care on the basis of clinical need and regardless of geographic location. This reality led the Senate Committee to conclude that neither the Australian health system, nor the public hospital system, are in or face a crisis.[1]

The Commonwealth's commitment to the nation's public hospitals is reflected in the Australian Health Care Agreements (AHCAs). Although Australia's public hospital funding arrangements are complex and reflect our unique cultural and institutional background, the Agreements are at the core of the successful national framework that is Medicare.

The Howard Government's commitment to the public hospital system is evident at three levels.

Firstly, under the current AHCAs negotiated by the Coalition Government in 1998, the Commonwealth has made significant real increases in funding to the States and Territories to run the nation's public hospitals. These funding increases greatly exceed the growth provided by the previous Labor Government under the 1993-1998 Medicare Agreements.

Secondly, the Coalition Government has restored the balance to Australia's health system through the 30% Rebate, Lifetime Health Cover and measures to 'Close the Gap', which give Australians greater choice in their health care.

Thirdly, beyond generous real funding increases and more of a balance between the public and private hospital sectors, the nation's public hospitals also benefit from the Government's decision not to enforce the original Agreement strictly as worded, whereby the Commonwealth's contribution would have been reduced as private health insurance participation increased significantly to current levels. Over the last three years of the Agreements, this would have entitled the Commonwealth to reduce hospital funding to the States and Territories by almost $3 billion. The Government has chosen not to do so.

In this combined sense, the Commonwealth's contribution to the nation's public hospitals is unprecedented.

Notwithstanding this funding position, there is an ongoing requirement to find ways to improve the capacity of the health system to respond to patient needs. Things can always be done better and, working with the States, Territories and the Australian community, the Government is committed to ongoing improvement of the quality and accessibility of public acute care and related services.

Such commitments should not be trivialised by partisan politics. Genuine consideration of these issues should be welcomed by any Government, but using parliamentary processes for short-term political advantage rather than genuine debate

[1] Senate Community Affairs References Committee, Inquiry into Public Hospital Funding, *First Report: Public Hospital Funding and Options for Reform*, Commonwealth of Australia, July 2000, p.6; Senate Community Affairs References Committee, Report on Public Hospital Funding, *Healing Our Hospitals*, Commonwealth of Australia, December 2000, p.9.

on policy directions can often be unwise. The Government therefore hopes that although the Committee's inquiry was established by the Senate with short-term political motives in mind, it nevertheless becomes a stepping-off point for positive dialogue on hospital funding matters between those with a genuine interest in Australians' health care needs.

RECOMMENDATIONS OF THE REPORT

Recommendation 1: That, as a short term measure, the Commonwealth provide additional funding under the Australian Health Care Agreements, in line with the recommendations of the independent arbiter. This funding should ideally be provided for the remaining two years of the agreements, 2001-02 and 2002-03. On the basis of data available to the Committee, this funding would be of the order of $450 million over the two years.

The Commonwealth remains committed to the nation's public hospital system, which is the flagship of Medicare. It is therefore already making funding commitments under the Australian Health Care Agreements that exceed its strict responsibilities in terms of the provisions of the Agreements themselves.

Australia's public hospitals will benefit significantly from the Government's unilateral decision not to claw back funding as private health insurance participation has increased. As part of the Lifetime Health Cover arrangements, the Commonwealth agreed to modify the AHCA arrangements for recovering funds from the States and Territories due to increases in private health insurance participation. The effect of this is that the Commonwealth has chosen not to exercise its formal recovery options under the AHCAs in line with the strict interpretation of the Agreements.

Consequently, about $3 billion will be effectively retained by the States and Territories over the last three years of the Agreements — funds which would otherwise have been clawed back under conditions on which they signed in 1998.

Beyond this decision, the nation's public hospitals also benefit from generous real increases in Commonwealth funding. Over the life of the 1998-2003 AHCAs, it is currently estimated that the Commonwealth will pay around $31.6 billion to the States and Territories to assist with the provision of public hospital services. The AHCAs provide a real increase in financial assistance to the States and Territories of around 28 per cent, compared with the 17 per cent real increase of the 1993-98 Medicare Agreements negotiated by the Keating Government.

The Commonwealth therefore is more than meeting its funding obligations to public hospitals. It sees this commitment as no less important a part of its overall contribution to financing the health care of the Australian community as its commitments to Medicare, the Pharmaceutical Benefits Scheme (PBS) and its support to patient flexibility and choice through private health insurance.

Recommendation 2: That the provision of this additional funding by the Commonwealth should be linked to a commitment by each State and Territory to publicly report their total spending on public hospitals and to match the percentage increase in Commonwealth funding over the two years.

The Commonwealth welcomes this recommendation.

The Australian Health Care Agreements lay down the size and scope of the Commonwealth's commitment to provide Health Care Grants to help fund public hospital services. Since 1998, much of the funding debate has centred on the Commonwealth's funding contribution, while the States and Territories have largely escaped scrutiny.

Nevertheless, the Commonwealth stands by its performance, and does not dispute the need for the Agreements to define its funding commitments in terms of funding formulas and weighted population variables.

As noted in the response to Recommendation 1, by not applying the original clawback arrangements the States and Territories will receive an extra $3 billion more over the final three years of the Agreements than they would otherwise have been entitled. The response of the States and Territories is to accept this unilateral decision, without acknowledgment that this is a voluntary gesture by which the Commonwealth has foregone its entitlements.

The Commonwealth would not disagree that the time has come for the States and Territories to consider making the same public obligations to fund their public hospital services that the Commonwealth willingly accepts under the Agreements.

The Government therefore considers that State and Territory governments should report publicly their own source contributions in a nationally consistent form, and that this commitment could be incorporated in future funding arrangements between the Commonwealth, States and Territories. Additionally, and as recommended by the Minority Report, the States and Territories should be expected to match the rate of growth in Commonwealth funding, including over the remaining years of the current Agreements.

This would be beyond the scope of the strict Agreement framework, but it would be no less a positive recognition of the value of public hospitals as the Commonwealth's own decision to forego its clawback rights.

Recommendation 3: That negotiations on the next Australian Health Care Agreements between the Commonwealth and the States and Territories commence as soon as is practicable. To provide a framework for discussion, each State and Territory should prepare a health needs and priorities plan setting out the necessary funding for the period of the next Agreement.

The Government notes the principle of this recommendation, although the Government believes that there is no single right time to start formal negotiation arrangements that will succeed the current Agreements.

The development of broad policy in relation to negotiating the next round of Agreements is an ongoing process and, as highlighted in the Committee's report and elsewhere, involves governments' consideration of complex care planning, delivery and funding issues. Beyond this, the timing and commencement of actual negotiations between the parties will need to be as flexible as possible to meet the interests of both the wider Australian community and of the negotiating governments.

As June 2003 approaches, each government will be considering its position on public hospital funding in general and arrangements succeeding the current Agreements in particular. They no doubt will be exploring these positions in and out of formal negotiation processes, whenever these begin.

Recommendation 4: That these new Agreements should progress beyond the scope of the current agreements and encompass other health services, including the Medicare Benefits Scheme, Pharmaceutical Benefits Scheme, community health services and aged care. Consideration should be given also to the inclusion of funding for public health programs following the expiry of the current Public Health Outcome Funding Agreements. The inclusion of funding for most health programs should enhance flexibility, enable greater transparency and promote care across the continuum.

The Government does not support the specific recommendation that the new funding arrangements necessarily extend to other health services covered by the Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme and aged care. These are Commonwealth programs and areas for which the States and Territories have no funding responsibility. The Government also notes, from evidence to the Committee itself, that there seems to be little enthusiasm at the State or Territory level for accepting any direct responsibility for open-ended programs such as the MBS and PBS.

The Government therefore does not support the notion that the new Agreements necessarily include funding for public health programs following the expiry of the current Public Health Outcome Funding Agreements (PHOFAs). Funding under the PHOFAs is essentially a contribution to eight specific public health programs. This funding is a small but critical investment in areas that lead to long term improvements in the health of all Australians. Funding under the PHOFAs is equivalent to approximately three per cent of Health Care Grants. It is important that this funding is not subject to the pressures of the acute care sector. If this funding were to be included in broader agreements, there could be some risk that public health funding would become less transparent and secure by being absorbed in hospitals' budgets.

However, scope does exist for the Agreements or similar arrangements to be adapted in the future to meet changing community needs and care trends, particularly in relation to better linkages and care coordination across acute and other health care settings. Care needs and delivery arrangements evolve continuously: funding mechanisms, including those like the Australian Health Care Agreements, need to be sufficiently flexible to evolve with them.

Recommendation 5: The Committee recognises that funding for additional patient care is necessarily the first priority of the States and Territories. However, the Committee recommends that each jurisdiction give urgent consideration to the immediate upgrading of their IT infrastructure to enable improved collection of data on hospital performance, particularly in relation to patient outcomes.

In terms of public hospitals, the States and Territories have funding and management responsibilities for capital and supporting infrastructure, while the Commonwealth's responsibility is overwhelmingly limited to funding services through the AHCAs.

Matters relating to public hospital management and associated IT systems fall wholly within State and Territory responsibilities.

On the other hand, the National Health Development Fund (NHDF) and the National Demonstration Hospitals Program (NDHP) are two Commonwealth-funded initiatives that illustrate the Government's commitment to enhancing and expanding best practice within public hospitals.

The NHDF is funded through the AHCAs, with the Commonwealth providing over $250 million over the life of the Agreements to provide States and Territories with a separate source of funding to promote health system restructuring.

The third phase of the NDHP was completed in 2001. This phase identified innovative models that improve the quality, coordination and integration of all services provided by the hospital sector, including models that provide effective two-way links between hospitals and community providers. The success of the NDHP in identifying and promoting new approaches to hospital-based care has resulted in the Government's decision to extend the program for a fourth phase until June 2003. Projects funded under the extension of the NDHP could include specific data improvement initiatives which assist clinicians in better meeting patient needs.

Recommendation 6: That the Commonwealth address several other priorities that have emerged during this inquiry. These include the need for strategies to better meet the needs of older patients by increasing the availability of more appropriate care arrangements at home or in residential aged care accommodation and thereby decreasing reliance on acute public hospital beds for these patients. Also identified as priorities are the need for increased resources for emergency departments of public hospitals and the national shortage of nurses.

The Commonwealth is working with States and Territories through the Australian Health Ministers' Advisory Council (AHMAC) to consider the care of older people in hospitals. A collaborative workplan has been agreed to, which includes:

- a stocktake of current care options and levels of provision in each State and Territory;
- the identification of models which can be piloted to improve care;
- assessment of the influence of availability of alternative forms of care on patterns of service use; and
- examination of current assessment practices for establishing needs for care, type of care required and care delivery setting so that frail older people will get the care they need.

The specific resource requirements of emergency departments and the size of the nursing workforce fall within the responsibilities of the States and Territories. The current National Review of Nursing Education being conducted by the Commonwealth is broadly examining nursing education and training issues.

Recommendation 7: That the Commonwealth, in conjunction with the States and Territories, find ways and means to maintain and sustain teaching and research in public hospitals.

The Commonwealth recognises the importance of public hospitals as venues for essential teaching and research. Skilled and trained health professionals are the backbone of public hospital service provision, and a key to the ongoing promotion of quality and safety improvements in acute care.

These issues are also recognised as important by State and Territory governments that manage and run teaching hospitals. The training role is additionally a key to hospitals attracting and retaining high calibre professional staff. This is therefore a complex and broad issue involving national dialogue and coordination, which is best provided by the Australian Health Ministers' Conference.

Recommendation 8: The Committee notes the Australian Health Ministers' recent agreement to improve the links between hospital and community based care. The Committee recommends that the Commonwealth and the States and Territories consider the inclusion of all stakeholders in the early implementation of this proposal.

Under the Australian Health Ministers' Conference decision, the Commonwealth, States and Territories are already working with key stakeholders to consider and design improvements to the hospital and community care interface. The Government welcomes this positive and cooperative approach.

Recommendation 9: The Committee recommends the establishment of a National Advisory Council which brings together the major players in the health sector and provides them with a voice in the formulation and development of new Commonwealth-State health funding agreements.

The Australian Health Care Agreements are agreements between the Commonwealth and State and Territory governments, which together fund the public hospital system. The Government does not believe there is a need for another consultative body to participate in the formulation and development of these agreements. Governments should consult and listen to stakeholders in every aspect of their health policy involvement, both in and out of formal structures, before taking final responsibility for their decisions. Successive Commonwealth governments have certainly applied this approach.

Recommendation 10: That the new Agreements be a vehicle for the introduction of transparent financial reporting by all parties to the agreements. The agreements should provide for annual reporting of the financial commitment by each jurisdiction in each area of patient care covered by the agreements. The emphasis of this financial reporting should be on transparency rather than obfuscation, which characterises much of the reporting at present.

A productive and constructive relationship between the Commonwealth, States and Territories depends on appropriate information sharing and exchange. Nevertheless, the dynamics of Commonwealth-State relations are sometimes a disincentive to information sharing. It is important that, in the public interest, there is more

consistent financial reporting on Agreement-related activities, just as there is output-based performance reporting. The Government therefore supports this recommendation.

Recommendation 11: That the Commonwealth Minister for Health and Aged Care discuss with his State and Territory counterparts an amendment to the performance reporting requirements of the Australian Health Care Agreements with a view to requiring each State and the Northern Territory to report on the number of patients assisted for travel for essential public hospital services and the average expenditure per patient so assisted.

The Commonwealth Isolated Patients Travel and Accommodation Assistance Scheme was abolished in the 1986-87 Budget and sole responsibility for the management of such schemes was transferred to the States and Territories. It is not a matter covered by AHCA arrangements. As such, reporting on performance in this area is a matter for the States and Territories.

It is important that adequate, consistent data collection and reporting methods are present in all areas of health services provision, including patient travel assistance. The Commonwealth is therefore committed to promoting and encouraging good data management processes in this and other areas through appropriate forums, while noting the States' and Territories' direct responsibilities in this area.

Recommendation 12: That after the first such report that includes data on patient assisted travel, if a substantial degree of variance is apparent between jurisdictions, that the Senate consider referring the funding and administration of patient assisted travel schemes to the Committee for inquiry.

This is a matter for the Senate. The Government would not, however, support such a reference being given to the Committee because it would be inquiring into a matter of State and Territory jurisdiction.

Recommendation 13: That the Australian Health Ministers' Conference examine the option of combining the funding sources for health programs which currently separately draw funds from State and Commonwealth sources.

Along with the States and Territories, the Commonwealth is committed to exploring new models of funding and service delivery with the potential to improve standards of patient care. Recent examples of this commitment include developing the second round of Coordinated Care Trials.

Although the issue of funds pooling received considerable attention by the Committee, particularly through the roundtables convened in August and November 2000, it remains only one of a range of policy options to address the challenges of better integrating service planning, provision and delivery with funding structures.

Recommendation 14: That the Commonwealth advance the integration of payments for pharmaceuticals in public hospitals by establishing trials with at least one public hospital in each State and Territory, to enable different models to be tested.

The Commonwealth is continuing to advance this option with the States and Territories in relation to discharge pharmaceutical arrangements. This possibility is provided for under Clause 35 of the Agreements. Clause 35 recognises that the existing arrangements, whereby pharmaceuticals are subsidised by the Commonwealth through the Pharmaceutical Benefits Scheme for community patients and by the States for public hospital patients, have the potential to lead to inequities in the range of drugs available in each sector and perverse incentives for cost-shifting between the States and the Commonwealth. One jurisdiction, Victoria, is well advanced in negotiating an arrangement with the Commonwealth. Other jurisdictions have expressed an interest.

The participation of the States and Territories in Clause 35 arrangements is encouraged by the Commonwealth because it promotes patient-centred reform. This process may well be the forerunner of future reform and innovation in funding arrangements. Nevertheless, it is important to let these arrangements operate and be evaluated before judgments are made.

Recommendation 15: That all such projects be subject to independent assessment and public reporting in order for the lessons learnt to be transferred to a wider stage.

While acknowledging the intention of this recommendation, the Government notes that this is a matter that would need to be agreed to by the Commonwealth and those States and Territories that participate in Clause 35 arrangements. It could be expected that performances under these arrangements will be monitored and evaluated.

Recommendation 16: That Health Ministers give urgent consideration to the development of a national health policy, informed by community consultation, that offers an overarching articulation of the values of the Australian health system and that provides a framework for linking all of its component parts.

Medicare is at the core of Australia's national health policy and is informed by community values and a broad national consensus. Strongly supported by the Government, Medicare is a successful national framework, providing all Australians with high quality health care that is equitable, affordable and accessible. The Australian Health Care Agreements, and their fundamental principles of public patient access to public hospital services, form part of this national Medicare framework. By signing those Agreements, States and Territories accept a commitment to the underlying national policy goals and principles that they represent.

The Government is itself committed to ensuring that the Commonwealth leads the further development of national health policies and promotes those that exist in areas as diverse as mental health and injury prevention, as well as universal access to health services. Nevertheless, the States and Territories already have clearly articulated funding and service delivery responsibilities: it is important that these are respected in planning and delivering policy outcomes, nor that the freedom of sovereign Commonwealth, State and Territory governments to determine policies in their areas of jurisdiction are not restricted unduly.

Recommendation 17: That Commonwealth, State and Territory Health Ministers commence a process of community consultation on health care issues, such as the values that should inform the development of a national health policy.

The Government supports the principles of consultation and community engagement implied by this recommendation. As noted in respect of Recommendation 9, the Government already consults and listens extensively to stakeholders and the community in developing health policy and programs.

Recommendation 18: That the Department of Health and Aged Care commission research on the 'hospital of the future' to examine alternative models for acute care and options for managing demand on hospitals for in-patient and out-patient services.

The Government appreciates the intent of this recommendation.

The Department of Health and Aged Care supports innovation in acute care service delivery through the National Demonstration Hospitals Program, which provides funding for hospital-based projects. The three phases of the program have achieved impressive outcomes in relation to waiting times for elective surgery, integrated bed management, and integration across the continuum of acute and primary care.

Building on this success, the 2001-02 Budget provides an additional two years' funding for innovative hospital-based projects to improve the quality of patient care and encourage the transfer of best practice in care delivery, including linkages between regional and rural hospitals and leading metropolitan hospitals.

The Government also notes that over and above and such programs, and other research that may be commissioned, there is already a great body of research and literature in Australia and overseas reflecting on all aspects current and future hospital activity, and health care delivery. This body of expertise and advice is available to Commonwealth, State and Territory governments, policy-makers and other stakeholders.

Recommendation 19: That Health Ministers ensure that the additional Coordinated Care Trials be designed to include adequate and appropriate data for collection and analysis to enable informed conclusions about the effectiveness of these trials.

The Government agrees with this recommendation, and notes that it has already effectively been implemented. The evaluation of the second round of Coordinated Care Trials is being designed in consultation with, and to meet the needs of, all relevant stakeholders, including Commonwealth, State and Territory Governments.

Recommendation 20: That the Federal Government confirm its statement that no funds will be withdrawn from public hospitals through use of the 'clawback arrangements' in the Australian Health Care Agreements.

As highlighted in response to Recommendation 1, the Government is honouring the

undertaking the Minister for Health and Aged Care made to Senator Lees in September 1999. The result is that, in terms of the clawback provisions of the Australian Health Care Agreements, the States and Territories effectively will retain around $3 billion in funding that is rightfully due to the Commonwealth under the strict terms of the Agreements.

Recommendation 21: That the health insurance industry takes urgent steps to adequately inform their new members about the features of the policies they have sold. There is currently a high level of confusion in the community about the extent of coverage, waiting periods, the rules on pre-existing ailments and the limitations on cover for many products.

The Government agrees that consumers should have reliable information about private health insurance products and their benefit entitlements.

The Government has implemented several initiatives to ensure that health fund members have access to such information. These include requirements that health funds notify members in plain English of changes to their policies and that, in respect of both the 30% Rebate and Lifetime Health Cover, annual statements be provided stipulating entitlements and levels of cover. The first of these Lifetime Health Cover statements are in the process of being issued to members by private health insurance funds.

Hospitals and health funds are also working together to institute systems to confirm health fund members' benefit entitlements for hospital treatment prior to admission.

Recommendation 22: That the health insurance industry take urgent steps in relation to providing wider availability of gap free products so that a large proportion of their members can access medical services on this basis.

In the course of the passage of the *Private Health Insurance Incentives Act 1998*, measures were introduced requiring health funds to offer at least one no or known gap policy by 1 July 2000 in order to continue to offer the 30% Rebate as a premium reduction. By this time, 43 of the 44 health funds had met this requirement.

As a further way to promote flexibility in the provision of gap free products, the Government introduced additional legislative reforms enabling health funds to develop gap cover schemes that enable them to pay doctors above the MBS schedule fee without the need for contracts. Gap cover schemes under these new arrangements have been approved for 33 health funds, which represent approximately 80 per cent of the national market. It is understood that other funds are developing proposals.

Recommendation 23: That independent research be commissioned by the Department of Health and Aged Care to examine the strengths and weaknesses of current examples of co-location and cooperative sharing of resources between nearby public and private hospitals.

The administration of the public hospital system, including their siting and co-location with private hospitals, is a matter for State and Territory governments. However, the Commonwealth has a role in the regulation of co-located public and private hospitals for health insurance benefits purposes. Before a private co-located facility obtains

such recognition, it must demonstrate compliance with Commonwealth guidelines that address the following issues:

- Will the proposal affect public patient access to a reasonable range of services?
- Will it affect the right of all patients to elect to be treated as a public patient?
- Will it result in a transfer of costs from a State government to any other party?; and
- Will data be made available to the Commonwealth to enable the issues raised in the guidelines to be monitored?

Evidence of compliance with these criteria are provided to the Commonwealth by the relevant State health authority and the Chief Executive Officer (or equivalent) of the private facility.

Recommendation 24: In view of the difficulties currently being experienced at several privately managed public hospitals, the Committee recommends that no further privatisation of public hospitals should occur until a thorough national investigation is conducted and that some advantage for patients can be demonstrated for this mode of delivery of services.

The administration of the public hospital system is a matter for State and Territory governments, but the Commonwealth notes that there are also some successful privately managed public hospitals, some of which have been operating successfully for many years. Therefore, there may be benefit in the sharing of lessons and best practice across State jurisdictions that would ultimately contribute to the success of privately run public hospitals.

Recommendation 25: That a national statutory authority be established with responsibility for improving the quality of Australia's health system. This authority would be given the task of:

- **Collecting and publishing data on the performance of health providers in meeting agreed targets for quality improvements across the entire health system;**
- **Initiating pilot projects in selected hospitals to investigate the problem of system failures in hospitals. These projects would have a high level of clinician involvement; and**
- **Investigating the feasibility of introducing a range of financial incentives throughout the public hospital system to encourage the implementation of quality improvement programs.**

While noting its intent, the Government does not support this recommendation as it would duplicate the functions of a number of existing national bodies, including the Australian Council for Safety and Quality in Health Care and the National Health Performance Committee.

Recommendation 26: That the mechanism for distributing Commonwealth funds for quality improvement and enhancement through the Australian Health Care Agreements be reformed to ensure that these funds are allocated to quality improvement and enhancement projects and not simply absorbed into hospital budgets.

This is an issue for consideration in the development of the funding arrangements that succeed the current Agreements. The Government also notes that it already promotes quality and innovation through substantial targeted funding through the National Health Development Fund and the National Hospitals Demonstration Program.

If quality improvement and enhancement are seen by the Committee as being one goal of hospital funding arrangements, the Government would agree with the Committee on this point. It would therefore be just as desirable, as reflected in the Committee's Recommendation 2, to ensure that the States maintain and enhance their funding effort against stated minimum public commitments. Only then would the overall level of government funding provided to public hospitals be sufficient to assure the Australian community that quality and innovation are a normal part of public hospital management.

Recommendation 27: That the Commonwealth Government undertake a review of the structure, operations and performance of the Australian Council for Safety and Quality in Health Care after two years of operation.

The Council is required to report annually to the Australian Health Ministers' Conference on its structure, operations and performance. Its first report was presented to the Australian Health Ministers' Conference in August 2000.

The Government is working with the Council to ensure that its contribution to improving quality and safety in health care, including public hospitals, is as positive and effective as possible.

Recommendation 28: That Commonwealth and State and Territory Health Ministers ensure that the Australian Council for Safety and Quality in Health Care receives sufficient funding to enable it to fulfil its functions.

As part of the 2001-02 Budget, the Government committed $22 million over the next four years for the Commonwealth's contribution to the work of the Council. The Government is also supporting the work of the Council as part of a joint funding approach with the States and Territories. Another $4.1 million has been allocated by the Government to support complementary areas of reform, including work to improve risk management systems and processes, performance measurement and improvement initiatives, legislative reforms, and the design of services for safer care.

Recommendation 29: That a mandatory reporting system, especially for hospital acquired infection rates and medication errors, be developed as a matter of urgency.

Recommendation 30: That the new statutory authority to oversee quality programs initiate pilot projects in selected hospitals to investigate the problem of system failures in hospitals and that these projects have a high level of clinician involvement (see Recommendation 25).

Recommendation 31: That the issue of cultural change within the hospital system be addressed, particularly the capacity for improvements in information technology to drive change through greater transparency and the adoption of consistent protocols.

Recommendation 32: That the new statutory authority overseeing quality programs investigate the feasibility of introducing a range of financial incentives throughout the public hospital system to encourage the implementation of quality improvement programs (see Recommendation 25).

Recommendation 33: That the Australian Council for Safety and Quality in Health Care review the current accreditation systems in place with a view to recommending measures to reduce duplication in the accreditation processes.

Response to Recommendations 29-33:

The Government does not support the establishment of a new statutory authority overseeing quality programs (see Recommendation 25). These recommendations are largely a matter for State and Territory governments who administer the public hospital system, noting that the Australian Council for Safety and Quality in Health Care and the National Health Information Management Advisory Council are also supporting national work and coordination in a number of these areas.

Recommendation 34: That initiatives by the National Health and Medical Research Council, the Colleges and other relevant groups to encourage the development and implementation of evidence-based practice, including the use of clinical practice guidelines, be supported.

The Government strongly supports this recommendation and has established the National Institute of Clinical Studies to further work in this area in conjunction with other relevant groups.

Recommendation 35: That strategies be developed to improve the provision of health information to consumers, improve the accountability of the health system to consumers by the release of information and comparable data and increase consumer involvement in the health system, including consumer participation in the development of quality improvement programs.

The Commonwealth has established *HealthInsite* as an internet-based gateway to quality health information for Australians.

Through its support of the Consumer Focus Collaboration, the Commonwealth has been supporting the development of a range of resources and strategies to facilitate broad-based consumer participation in many aspects of service planning, delivery, monitoring and evaluation, including locally based quality improvement programs.

Recommendation 36: That the Commonwealth work with the States and Territories to develop a comprehensive set of national performance indicators in relation to quality issues for the public hospital sector, including the range of performance indicators as provided for under the current AHCAs, and that this information be released publicly as a matter of priority.

The National Health Performance Committee (NHPC) already involves all jurisdictions and is developing a high level set of national performance indicators, including for the public hospital sector. The Committee is planning to publish regular reports. Complementary indicator development is to be undertaken by the National

Health Priority Action Council and the Australian Council for Safety and Quality in Health Care.

Recommendation 37: That the development of a comprehensive set of national performance indicators be the responsibility of the new statutory authority (see Recommendation 25).

The Government does not support the establishment of a new statutory authority overseeing quality programs (see Recommendation 25). The responsibility for the development of a comprehensive set of national health performance indicators primarily lies with the National Health Performance Committee. Other groups active in collecting national health performance information include the Australian Institute of Health and Welfare and the Productivity Commission.

Recommendation 38: The Committee notes the range of developmental work which is proceeding in the area of performance indicators and recommends that Health Ministers release the first annual report on hospital and other health performance measures under Schedule C of the AHCAs. It is possible that some of the gaps in data collection that have been identified by participants in the inquiry may be filled by these annual reports under the AHCAs.

The *Australian Health Care Agreements: Annual Performance Report 1998-99* was released in February 2001. The data for the 1999-00 Report currently is being collated from Commonwealth, State and Territory sources.

Recommendation 39: That as a matter of urgency data on waiting times for elective surgery be standardised so that meaningful comparisons between States can be made.

The Government supports the principle of this recommendation and notes that it is being applied in practice. The Australian Institute of Health and Welfare's National Health Data Dictionary defines urgency categories for elective surgery waiting times. All States and Territories have agreed to report against these categories under the AHCAs.

Recommendation 40: That funding for patient care and funding for data collection and performance measurement should be separately and transparently identified and acquitted. Sufficient staff should be employed in public hospitals to ensure that both functions are undertaken effectively.

As stated earlier, public hospital workforce issues fall within the responsibilities of the States and Territories, as they have direct management responsibility for the funding and management of public hospital systems. The Commonwealth certainly does not want public hospital systems tied up in excessive red tape. Nevertheless, the Commonwealth expects the States and Territories to meet their service delivery and accountability responsibilities under the Agreements.

The collection, analysis and dissemination of timely and relevant performance information therefore is a necessary part of understanding current public hospital performance, fostering improvements and planning for the future. While noting that the streaming of performance information can have significant value, the Government

does not hold this to be a necessary step. The Government maintains that it is more important to reach a national consensus on data collections and reporting standards with the States and Territories in the interests of transparency and comparative analysis.

Recommendation 41: That the urgent development of adequate IT systems in the health sector be undertaken, especially in relation to integrated management systems within hospitals and integrated patient records.

The development of management systems in public hospitals falls wholly within State and Territory responsibilities.

At a national level the Commonwealth has been working with the States and Territories to develop Health*Connect,* which is expected to lead to integrated patient records across the health sector.

Recommendation 42: That the Commonwealth and the States commit the necessary resources to implement the HealthConnect proposal.

As part of the 2001-02 Budget, the Commonwealth committed $16 million over two years to fund research and development work to test and evaluate the feasibility of a national health information network, Health*Connect*. Including $2.5 million of previously committed funding, the total Commonwealth contribution will be $18.5 million over the two years. The States and Territories are seeking to match this contribution.

This document can be accessed from the Department of Health and Aged Care's website at: http://www.health.gov.au/pubs/publichospitalfunding.htm