OVERVIEW AND RECOMMENDATIONS

Public hospitals are the centrepiece of the Australian health system. They are the places where most Australians go when they are very sick, the workplace for many of the best of our doctors, nurses and health professionals and the home of the best of our medical technology.

Under Medicare, Australia has a commitment to universal access to hospital care based on need. Our public hospitals have built an impressive reputation for excellence in the provision of care with strong teaching and research links to our universities. Public hospitals throughout rural Australia provide the core of the health system for many small towns.

The sector accounts for 27 per cent of total health expenditure, or around $13.6 billion each year. There are 755 public hospitals in Australia with nearly 54 000 available beds. Public hospitals treated 3.8 million patients in 1998-99.

The inquiry received the strong message that the community values its public hospitals very highly. The evidence also made it patently clear that our public hospitals are underfunded and suffering severe strain. Staff are being required to do more with less. The Committee believes that it is no coincidence that public hospitals are experiencing extreme difficulties in recruiting staff, particularly nurses.

Several major health organisations have repeated the State Premiers' earlier call for a wider inquiry into Australia's health system arguing that the problems of public hospitals have to be addressed in the context of the whole health system.

In this inquiry, the Committee has gathered evidence on its terms of reference from submissions, public hearings and two Roundtable Forums and it reports accordingly. Public hospitals are consequently the focus of this report, as they were also in the Committee's First Report. However, given the interrelationship between the public hospital sector and other elements of the Australian health system, the Committee also comments more broadly, where appropriate.

Roundtable Forums

The Committee was most encouraged by the spirit in which participants contributed to the Roundtable Forums held on 18 August and 20 November 2000. The initial forum brought together senior health bureaucrats from the Commonwealth, the States and the ACT, prominent stakeholders, public hospital administrators and key academics. Delegates discussed a range of options for reform that had been identified in the Committee's First Report.

The second Roundtable involved a broader group including representatives of consumers and clinicians. This forum provided valuable feedback from the perspective of health care workers and patients on the key challenges facing public hospitals and possible avenues for reform. While diverse views were evident on some

issues, common objectives and an eagerness to identify workable solutions ensured productive and worthwhile discussion. All groups welcomed the opportunity to take part in a national health policy debate.

The adequacy of public hospital funding

Much of the evidence placed before the Committee in this inquiry has demonstrated that public hospitals are seriously underfunded. The Committee is concerned that the quality of patient care in public hospitals will decline if funding is not increased. The goal of universal access to care is being eroded and many patients now have to wait an unacceptable time to get care.

The Committee has concluded that public hospitals in Australia need an urgent injection of funds. It has recommended that the Commonwealth should provide $450 million over the next two years in additional funding, with the States and Territories matching the percentage increase in Commonwealth funding.

Whilst the current funding shortage has arisen because of the Commonwealth's failure to properly index hospital grants, the problem is deeper. There has been a long term pattern of cost shifting by both the States and the Commonwealth which has continually squeezed the public hospital system. The Committee heard extensive evidence of cost shifting with examples where the States shifted costs to the Commonwealth and where the Commonwealth shifted costs to the States.

Evidence presented to the inquiry has indicated that the key problem that 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 in the funding and delivery of public hospital services.

Reform of State and Commonwealth funding arrangements

Medicare will soon be 20 years old. It is timely to question whether the divided hospital funding arrangements that have remained substantially unchanged since 1984 will continue to be relevant in 21st century Australia.

These funding arrangements have enabled successive Commonwealth, State and Territory Governments to simply blame each other for the shortcomings in funding for public hospitals and the wider health system. Cost shifting has become endemic as both levels of Government try to get someone else to pay for the increasing demands of our health system. It is clear that the needs of patients are not advanced by these arrangements and the community is tired of the endless squabbles over funding.

It is time to put patients first. The Committee believes that rather than constantly fighting over who pays, it is time that Governments restored hospital budgets and agreed on a basis for future sharing of responsibility so that there can be confidence in the future of our public hospitals.

Participants in both of the Roundtables were generally supportive of the option of funding for health services from the Commonwealth and the States and Territories being combined into a single fund. Such 'pooling' of funding is not a new concept in Australia, however, it has been utilised to date only for specific projects; for example, the trials of coordinated care and the Multipurpose Services introduced in rural and remote areas.

The option for reform of the current funding arrangements that received the most support was a 'single fund' or 'joint account' model at a State-wide level. This would combine State and Federal funds across a number of programs, which are currently partially funded by both levels of Government. This would also provide flexibility to enable funds to be delivered to the most appropriate and effective forms of care.

The single fund model is essentially about governments working smarter. The aim of the proposal is the creation of an environment in which the funding system facilitates, rather than obstructs, the provision of seamless, integrated health care.

It would also give the community greater transparency to ensure that the funding commitments made by both levels of Government were kept. The lengthy debates over cost shifting will end when the facts are out in the open.

The Committee also heard evidence in favour of other pooling options including:

- options where the 'single fund' is managed at a regional rather than State-wide level;
- options where the total amount of funds is capped and services rationed by doctors (capitation payments as used in the UK);
- an option where health spending is allocated on a population basis to equalise funding between regions.

Each of these options had serious problems that could conflict with the national entitlement basis of Medicare.

There was some support for a trial of pooled funding in a large geographical area to test some of the impacts of a single fund approach. It was acknowledged that the complexity of the health sector made it hard to predict all the consequences of major change and that trials were a good way to identify unforeseen issues.

On balance, the Committee supports a move to a single fund model in time for the next Commonwealth-State Health Care Agreement starting in July 2003. The Committee recommends that hospital funding agreements should in future contain specific dollar commitments by both levels of Government for each year during that period. Ideally, these should be paid into a single fund for each State covering a range of agreed programs. This would avoid a repeat of the uncertainty caused by the unresolved indexation dispute, which has blighted the current 5-year agreement.

Private health insurance

During the inquiry, the Committee has received a great deal of evidence and comment on the 30 per cent rebate for private health insurance. The Committee believes that it is difficult to conclude that the rebate has been a substantial factor in encouraging people to purchase private health insurance. The rebate is one element of the Government's strategy but cannot alone be regarded as the main reason for recent increases in membership. In this regard, Lifetime Health Cover would appear to have had far greater influence.

The Committee saw no evidence that there is a direct link between the level of coverage of private health insurance and demand for public hospital services and that as the level of coverage increases, so the demand for public hospital services will fall. Evidence to the inquiry has indicated that the relationship between private health insurance participation and the demand for public hospital services is highly complex. Under Medicare, all patients have an entitlement to be treated as public patients and there is no compulsion for patients to use their private health insurance. This policy should not be changed.

A number of witnesses claimed in evidence that the expenditure of over $2 billion a year now allocated to the private health insurance rebate would have produced greater dividends for the Australian community if it had been provided directly to the already stressed public hospital system.

Privatisation of hospitals

In recent years a number of public hospitals have been privatised but there has been very little research and little evidence of benefits for patients. Governments have embarked on the path of increased privatisation without rigorous analysis of the benefits and costs or much public debate.

The Committee has been concerned to learn of individual examples of privatisation that have resulted in costs rather than savings to the public purse. One major contract has been surrendered by the private operators because they were unable to provide the full range of services required at a public hospital for the price that they had bid. In part, these may have been due to problems arising from poor contracting arrangements and inexperience.

The Committee has concluded that no further privatisations should occur until a detailed review has been undertaken and benefits for patients have been demonstrated.

Performance reporting and information technology

If the Committee was to select a single thread that links all aspects of this inquiry, lack of data would be an obvious choice. It is quite staggering just how little is known about many important aspects of the operation of public hospitals. The Committee is concerned at evidence which has indicated that much appears to be unknown about the performance of the public hospital sector.

Data relating to finance and costs as well as hospital output, is collected and reported upon regularly. However nationally consistent data on important areas such as waiting times in emergency departments and for elective surgery, let alone patient outcomes, is poor. Transparency and accountability require much improvement in a sector of the health system that is responsible for around $13 billion in expenditure each year.

The Commonwealth and the States and Territories have reached agreement on a number of initiatives that may allieviate several of the problems that have been identified during the course of this inquiry.

- Schedule C of the Australian Health Care Agreements commits the Commonwealth and the States and Territories to work together to develop performance indicators in several areas including waiting times for elective surgery, measures of quality of care, public hospital activity and indicators of Aboriginal and Torres Strait Islander health. The first annual report under Schedule C is overdue but should provide, for the first time, nationally comparable data on at least some of these issues.
- Australian Health Ministers have agreed to support the development of a national health information network, *HealthConnect*, which will provide for the creation and storage of electronic health records. Participation in the network will initially be voluntary. There need to be measures to safeguard privacy and provisions to ensure that people have access to their own medical records and control over who else can access that information. As this proposal is unfunded, the Committee recommends that the Commonwealth and the States commit the necessary resources to implement these changes.
- Health Ministers have agreed to provide $50 million over five years to the Australian Council for Safety and Quality in Health Care for programs to reduce the impact of adverse events on patient health. Australians have always prided themselves on having a first class health system. However, in its first report to Health Ministers, the Australian Council for Safety and Quality in Health Care noted that the cost of unsafe care in Australia is extremely high, with estimates of the direct cost to the hospital system at between $867 million and $1 billion per year.

Health Ministers have recently acknowledged the fragmented nature of the Australian health system and have agreed to a unified approach to improve the links between hospital-based care and community-based care, encompassing general practice, community services and hospitals.

Conclusion

This has been a timely and fruitful inquiry. The Committee appreciates the strong interest shown by the many contributers to the Inquiry through submissions or partipation in the Roundtable Forums.

What has emerged is a strong desire for change and improvement in the standard of care available in public hospitals. In summary, the way to heal our hospitals depends on four key measures:

- an urgent increase in funding to address the desperate shortage of resources;
- an end to the divided funding of health programs and the beginning of a new era of inter-Governmental co-operation;
- a move to open reporting of funding and performance against national standards; and
- a new focus on improving the quality of health care through the use of new information technologies.

Australia's patients who use public hospitals, and taxpayers who pay for them, deserve nothing less.

RECOMMENDATIONS

Chapter 2

- Future funding

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.

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.

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.

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.

- Priorities

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.

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.

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.

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.

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.

- Performance reporting

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 obsfucation, which characterises much of the reporting at present.

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.

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.

Chapter 3

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.

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.

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.

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.

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.

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.

Chapter 4

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.

Chapter 5

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.

Recommendation 21: That the health insurance industry take urgent steps to adequately inform their new members about the features of the polices 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.

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.

Chapter 6

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.

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.

Chapter 7

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.

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.

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.

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.

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 currently in place with a view to recommending measures to reduce duplication in the accreditation processes.

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.

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.

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.

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

Chapter 8

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.

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.

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.

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.

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