CHAPTER 2

PUBLIC HOSPITAL FUNDING

The role of hospitals in the health system

2.1 The Senate referred the inquiry to the Committee following an unsuccessful call in 1999 by State Premiers and Territory Chief Ministers for the Commonwealth Government to establish an independent inquiry into the health system, preferably to be conducted by the Productivity Commission. Although their request was marked by a degree of self-interest, State and Territory leaders have not been alone in calling for a national inquiry into Australia's health system. In its 1997 report into private health insurance the then Industry Commission (now part of the Productivity Commission) recommended a 'broad public inquiry into Australia's health system'. As part of its recommendation, the Commission proposed that:

> in the event that a broad strategic inquiry is considered unmanageable, a number of specific inquiries could be undertaken, focusing on themes such as financing issues, quality of health care, and competitive neutrality.[1]

2.2 More recently, commentator Paul Gross has called for two national inquiries, the first of which would address 'the likely funding needs of Australian health care in the period 2000-2010'. Another, concurrent national inquiry would investigate 'sustainable methods of paying the doctor to achieve world's best practice outcomes at a measurable level of quality of care'. At the same time, a national policy should be developed to achieve the goal of 'informed consumers'. A means of achieving this according to Mr Gross is the development of:

> eight to ten large regional or state pilots of Internet-driven consumer information systems, with competitive bidding by third party vendors of hardware, software and networking solutions that empower large communities to be better informed buyers of health care.[2]

2.3 In addition, several participants in the inquiry requested that the Committee's terms of reference be broadened to encompass the health system more generally. For example, the joint submission from the Australian Healthcare Association (AHA), Women's Hospitals Australia (WHA), and the Australian Association of Paediatric Teaching Centres (AAPTC)[3] recommended that the inquiry's terms of reference be

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1 Industry Commission, *Private Health Insurance*, Report No.57, Canberra, the Commission, 1997, p.lvi.

2 Gross, P, 'National health policy: implications of the NSW Health Council report', *Healthcover*, June-July 2000, pp.35-40.

3 The Australian Association of Paediatric Teaching Centres is known now as Children's Hospitals and Paediatric Units Australasia, or Children's Hospitals Australasia for short (*Committee Hansard*, 18.8.00, p.703).

expanded 'to allow all health care funding systems to be considered given that they impact on the role and responsibilities of public hospitals'.[4]

2.4 Much evidence presented to the Committee has emphasised the interrelationship between the public hospital sector and the rest of the health system. Indeed, some participants have warned that the direction of health care in the 21st century is moving away from a model which locates the public hospital at the centre of health care provision. The National Rural Health Alliance (NRHA) stated that one of the underlying themes of its submission was that 'the services of hospitals are inextricably linked with other health and health-related services'.[5] The Northern Territory Minister for Health argued in evidence that Australia needed to expand its health care horizons in relation to public hospital services:

> this is not a health system, it is a medical system, and I think we should be gearing our Australian future towards funding health interventions.[6]

2.5 This is not to detract from the importance of the role of public hospitals but to note that their services form part of the continuum of care, an increasing amount of which is provided outside of hospitals. This view is one argued also by commentators such as Duckett, who has predicted that 'a much higher proportion of activity in hospitals of the future will be performed on an ambulatory basis' and 'a decreasing proportion of hospital activity will require immediate access to the expensive infrastructure associated with hospitals of today'. In addition, 'the hospital of the future will probably aspire to be the hub of a network of hospital and ambulatory care services'.[7] These types of developments have implications for the way in which all health services are funded and hence, assessing the adequacy of funding for public hospitals in isolation from health services more generally may not be a particularly meaningful exercise. Drawing on earlier work with Jackson, Duckett has warned that:

> as care becomes better integrated across organisational boundaries, classification and payment systems that are defined in terms of historical boundaries will become irrelevant–or worse, will create perverse incentives and inhibit appropriate microeconomic reform.[8]

2.6 This is an important point because genuine integration of care is stymied by Australia's current arrangements for funding and delivering health and public hospital services. Systemic fragmentation, a lack of transparency of funding arrangements, lack of knowledge about many key areas and differences between jurisdictions limit the extent to which Australia can claim to have a national health system. This

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

5 Submission No.66, p.3 (National Rural Health Alliance).

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

7 Duckett, S 'Economics of hospital care', in *Economics and Australian Health Policy*, edited by G Mooney and R Scotton, St Leonards, Allen & Unwin, 1998, p.112.

8 Duckett, S, p.112.

fragmentation has been recognised recently by Australian Health Ministers who have agreed to 'a unified approach to strengthen primary health and community care at the local level–spanning general practice, community services and hospitals'. Commenting on the agreement, Chair of the Australian Health Ministers' Conference, Hon Dean Brown said that:

> we're aiming to improve the link between hospital and community based care by strengthening the relationship between pre and post hospital care, emergency departments, outpatient departments and general practice.[9]

2.7 The foregoing discussion encapsulates a dilemma evident in the evidence on funding issues received by the Committee in this inquiry. Some participants have argued that Australia is spending about the right amount on health at 8.5 per cent of GDP.[10] However, the majority of submissions regard the level of funding for public hospitals to be inadequate. The Australian Medical Association (AMA), for example, believes that 'just to tread water, our public hospitals need additional funding of around 5.5 per cent to six per cent a year'.[11] On the other hand, the NRHA argued in evidence that funding for public hospitals 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.[12]

2.8 While some participants and commentators may have preferred a wider debate on Australia's health system, the Committee has gathered evidence during this inquiry on its terms of reference. However, the interrelationship between public hospitals and other parts of the health system inevitably has meant that the broader perspective also is addressed in this report.

2.9 This chapter deals with the first three of the inquiry's terms of reference, encompassing funding for public hospitals and cost shifting. The Committee's First Report contained considerable discussion of the evidence received on issues around cost shifting and the adequacy of funding for public hospitals. This chapter does not revisit the detail of that discussion but rather provides an overview of the salient points, together with the Committee's conclusions and recommendations.

Overview of public hospitals in Australia

2.10 Table 2.1 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

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9 Minister for Health and Aged Care, 'Ministers collaborate to strengthen primary health and community care', *Media Release*, 31 July 2000.

10 See, for example, *Committee Hansard*, 22.3.00, p.402 (Doctors Reform Society).

11 *Committee Hansard*, 18.8.00, p.669 (Australian Medical Association).

12 *Committee Hansard*, 11.11.99, p.116 (National Rural Health Alliance).

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 1998-99, permitting an analysis of changes over time.

Table 2.1: Profile of the public hospital sector, 1993-94 and 1998-99

Public acute and psychiatric hospitals	1993-94	1998-99
Establishments		
No of hospitals	746	755
Available beds	61 260	53 885
Beds per 1000 population	3.4	2.9
Activity		
Separations (‘000)		
Public acute hospitals	3 296	3 839
Public patients	2 557	3 347
Private patients	545	319
Public psychiatric hospitals	n.a.	20
Same days separations as % of total		
Public acute hospitals	34.2	44.7
Public patients	35.0	45.2
Private patients	33.2	44.4
Public psychiatric hospitals	n.a.	11.3
Separations per 1000 population		
Public acute hospitals	185.6	198.7
Public patients	144.0	173.9
Private patients	30.7	16.3
Public psychiatric hospitals	n.a.	1.1
Patient days (‘000)		
Public acute hospitals	15 907	14 989
Public patients	12 029	12 691
Private patients	2 529	1 274
Public psychiatric hospitals	n.a.	1 285
Average length of stay (days)	A B	A B
Public acute hospitals	4.8 6.8	3.9 6.3
Public patients	4.7 6.7	3.8 6.1
Private patients	4.6 6.4	4.0 6.4
Public psychiatric hospitals	n.a. n.a.	63.4 71.4
Non-admitted occasions of service	n.a.	34 251 233
Financial data		
Total salary expenditure ($’000)	6 897 956	8 551 873
Total non-salary expenditure ($’000)	3 690 172	5 125 518
Total recurrent expenditure ($’000)	10 588 128	13 677 391
Total revenue ($’000)	1 083 619	1 175 653

A = all separations B = excluding same day separations

Source: Compiled from Australian Institute of Health & Welfare, *Australian Hospital Statistics 1997-98,* Canberra, AIHW, 1999, tables 3.1, 4.1 and Australian Institute of Health and Welfare, *Australian Hospital Statistics 1998-99,* Canberra, AIHW, 2000, tables 3.1, 4.1.

2.11 Comparing 1993-94 and 1998-99, it is noteworthy that the number of available beds in public hospitals has declined by 7375. In terms of activity, while the annual number of separations has increased by 543 000, patient days have decreased by 918 000, 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 44.7 per cent of separations in 1998-99. 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 319 000 in 1998-99 and, allied to this, a decline in patient revenue as a proportion of total recurrent expenditure, from 10.2 per cent in 1993-94 to 8.6 per cent in 1998-99.

Future challenges facing the health system

2.12 Evidence received by the Committee describes 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 in an environment of funding constraints places further pressure upon them. As the Northern Territory Minister for Health commented: 'we are a victim of our own success'.[13]

2.13 Publicly funded health services are supported very strongly by the Australian community and medical practitioners. For example, the popularity of Australia's Medicare system is surveyed regularly by the Health Insurance Commission (HIC). In 2000, the HIC reported that 83 per cent of the community was satisfied with Medicare which, although high, was a decrease from 86 per cent in the previous year.[14]

2.14 In excess of $50 billion was spent on Australia's health system in 1998-99, which equates to 8.5 per cent of GDP.[15] A significant proportion of this expenditure is raised by taxation (70 per cent)[16] which is, however, a lower proportion than most other OECD countries. Many participants in this inquiry have pointed to Australia's success in keeping its health expenditure at around the same proportion of GDP for some years as evidence that the health system is not in crisis. However, while Australia's health expenditure has been relatively stable as a proportion of GDP, this does not mean that it has not been increasing (for example, Australia's total health expenditure has increased from $28.8 billion in 1989-90 to $50.3 billion in 1998-99).[17]

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

14 Health Insurance Commission, *Annual Report 1999-00*, Canberra, HIC, 2000, p.12.

15 Australian Institute of Health and Welfare, *Health Expenditure Bulletin No 16*, p.3.

16 Australian Institute of Health and Welfare, *Health Expenditure Bulletin No 16,* p.4.

17 Australian Institute of Health and Welfare, *Health Expenditure Bulletin No 16*, p.3.

2.15 The stable nature of Australia's health expenditure does not mean that the present mix of funding and spending necessarily represents best practice, nor is there certainty that the system always delivers value for money. For example, inequities are evident in the maldistribution of benefits under the Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS). Raised by several participants,[18] this issue was discussed in the Committee's First Report, which also provided an analysis of the differences in MBS benefits by region. In addition, the current lack of knowledge about several key areas of health and public hospital services, notably health outcomes, renders any evaluation of system efficiency virtually impossible.

2.16 Pressures on health expenditure are increasing in industrialised countries, including Australia, due to ageing populations, advances in medical technology and the expectations of consumers. By contrast, the ability of governments to continue increasing health expenditure to meet demand is limited by finite budgets. These three factors: ageing of the population, advances in medical technology and expectations of consumers, are those most commonly advanced to explain increasing health expenditure in developed countries. The ageing of the population has received much attention and some dire predictions have been made of its possible future effect on Australia's health expenditure. For example, the National Commission of Audit forecast in 1996 that total health expenditure as a proportion of GDP would increase from 8.4 per cent to about 17 per cent over the following 45 years due to the ageing of the population.[19]

2.17 Some commentators, such as Professor Bob Gregory, have since challenged this forecast, arguing that 'population ageing, while an important contributor to health expenditure, could not by itself add anything like this amount to increased health expenditure'.[20] The UK's Professor Chris Ham has argued however, that population changes 'will both increase the demand for health care and at the same time limit the ability of health services to respond to this demand'.[21] While changes in the population alone may be not of primary concern, when combined with the other two factors of advances in medical technology and increasing consumer expectations, pressure is likely to be placed on future health budgets. On this latter point Ham has observed that growth in technology, combined with ageing of the population, leads to 'an increasing gap between what it is possible to do as a result of medical advances and what it is possible to fund with the available budget'.[22]

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18 See, for example, Submission No.41, p.18 (Queensland Government).

19 National Commission of Audit, *Report to the Commonwealth Government*, Canberra, AGPS, 1996, p.138.

20 Gregory R, 'Ageing and health and family services: discussion', in *Policy Implications of the Ageing of Australia's Population: Conference Proceedings, Melbourne, 18-19 March 1999*, Melbourne, Productivity Commission, 1999, p.392.

21 Ham, C, 'Series Editor's Introduction', *The Global Challenge of Health Care Rationing*, edited by A Coulter and C Ham, Buckingham, Open University Press, 2000, p.xi.

22 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.

2.18 One participant in the first Roundtable convened by the Committee was concerned that Australia is ill-prepared for the future, warning that 'in Australia we have no sense of urgency'.[23] Allied to this point, another issue of concern with regard to the future was raised by several participants at this Roundtable. They argued that Australia is not particularly good at health planning. The ACT's Dr Penny Gregory commented that 'the fundamental lack of planning and leadership in the health system as a whole…shows now in the fragmented nature of the system that we have'.[24]

Identifying the key issues, problems, and challenges facing public hospitals

2.19 The Committee's First Report identified a range of issues, problems and challenges facing public hospitals. These are reproduced here in order to provide a context for the subsequent discussion on funding of public hospitals. The following issues have been raised by participants in the inquiry as factors that contribute in a major way to the problems faced by the public hospital sector:

- rationing of hospital services without any transparent priorities;[25]
- increasing level of expectations on what services public hospitals can and should provide, particularly by and for older patients;[26]
- increasing consumer demand for new technologies, especially given the above expectations;[27]
- high number of nursing home type patients in acute hospital beds, especially in rural areas, but also in some metropolitan hospitals;[28]
- allied to the previous point, in some public hospitals a large number of acute admissions are older patients.[29] There is also a view that patients today tend to be much sicker than in the past[30] (the degree to which these points apply will obviously vary between different hospitals);
- there is a lack of IT infrastructure to collect and analyse information on patient outcomes;[31]

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23 *Committee Hansard*, 18.8.00, p.700 (Mr Paul Gross).

24 *Committee Hansard*, 18.8.00, p.689 (Dr Penny Gregory).

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

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

27 Submission No.45, p.14 (Royal Australasian College of Physicians, Australian Consumers' Association, Health Issues Centre).

28 *Committee Hansard*, 21.3.00, p.344 (New South Wales Health Department).

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

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

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

- in some public hospitals, 'capital equipment has been allowed to run down to the point where it is creating serious clinical problems';[32]
- concern was expressed that current funding arrangements have 'undermined the capacity of the public system to support effective teaching, training and research';[33]
- 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:
  - 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.[34] Dialysis accounts for 32 per cent of hospital admissions in the Northern Territory;[35] and
  - many Indigenous people presenting to hospitals in the Northern Territory have 'complex co-morbidity conditions, including renal disease, heart disease and scabies';[36]
- 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 levels 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;[37]
- although residents of rural and remote areas have access to public hospitals in metropolitan areas, patients often have to travel long distances, and many require some financial assistance. The various State-financed patient travel assistance schemes were criticised during the course of the inquiry;[38]
- the average age of hospital doctors is now around 50 years of age[39] and is over 40 years of age for nurses;[40]
- issues of stress and burnout are of major importance for nurses;[41] and

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

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

34 *Committee Hansard*, 24.2.00, p.223 (Australian Medical Association, NT Branch).

35 *Committee Hansard*, 24.2.00, p.243 (NT Shadow Minister for Health).

36 *Committee Hansard*, 24.2.00, p.243 (NT Shadow Minister for Health).

37 Australian Institute of Health and Welfare, *Health in Rural and Remote Australia*, Canberra, AIHW, 1998, p. vi-viii.

38 Submission No.63, p.5 (National Rural Health Alliance).

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

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

- there is an exodus of nurses from the workplace, at least in Victoria.[42]

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.[43]

Commonwealth Government's powers over health policy

2.20 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 on the *Commonwealth's Constitutional Powers 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.[44]

Funding arrangements for public hospitals

2.21 The first three terms of reference for this inquiry concern the adequacy of funding for public hospitals now and in the future and cost shifting. Evidence received on these terms of reference was comprehensively discussed in the Committee's First Report and it is not proposed to revisit here the detail of that discussion. This section provides an overview of evidence received on these terms of reference, together with the Committee's conclusions and recommendations.

2.22 An example of the 'gradual expansion of Commonwealth responsibility', as noted above by McMillan, can be found in the agreements between the Commonwealth and each State and Territory Government which underpin the funding arrangements for public hospital services. Known formerly as Medicare Agreements, these Australian Health Care Agreements (AHCAs) afford an avenue for the

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

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

43 *Committee Hansard*, 21.3.00, p.393 (Sydney Teaching Hospitals Advocacy Group).

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

Commonwealth to achieve its national goal of universal access to free public hospital services. The Commonwealth Government does not actually purchase[45] or deliver public hospital services, relying on the States and Territories to fulfil this role and it is able to use its financial leverage through the agreements to achieve the Medicare principles of universality and equity in regard to public hospital services.

2.23 Under these funding arrangements, the Commonwealth provides grants to each State and Territory for the provision of public hospital services through the AHCAs. This is supplemented by the States and Territories from their own source funding, that includes revenue from the GST (which has replaced the general purpose Financial Assistance Grants (FAGs)). These arrangements 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 each level of government to simply 'blame shift' the responsibility for perceived shortfalls in the funding available for public hospital services. This process has achieved little and has 'done nothing to enhance the health of the community', according to the joint submission from the AHA, WHA and the AAPTC.[46]

2.24 Dr Deeble noted in his submission that the convention on hospital funding between the Commonwealth and the States, which dated back to the Chifley years, was for a 50-50 sharing of net operating costs (excluding the contribution of the non-government sector). He argued that this convention had survived into the hospital funding agreements which were in place in 1983, prior to the commencement of Medicare.[47]

2.25 The relative shares of funding for public hospitals contributed by the two levels of government during each of the three Medicare Agreements have been calculated for the Committee by the Centre for Health Economics, Research and Evaluation (CHERE) using Australian Institute of Health and Welfare (AIHW) data. This data indicates that the Commonwealth provided 42.7 per cent of funding under the first Medicare Agreement (1984-1988), while the States and Territories provided a further 46.5 per cent (the non-government sector provided the remaining 10.8 per cent).

2.26 During the second Medicare Agreement (1988-1993), the Commonwealth share increased slightly to 43.2 per cent and the State and Territory share also increased, to 47.2 per cent, reflecting a decline in the share provided by the non-government sector due to the decreasing number of private patients treated in public hospitals. The third Medicare Agreement (1993-1998) saw a change in the relative contributions, with the Commonwealth's share increasing to 46.1 per cent and the

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45 The Department of Veterans' Affairs is an exception because it does purchase hospital services for Veteran patients with a Gold Card.

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

47 Submission No.50, p.13 (Dr Deeble).

States' and Territories' contribution declining to 45.4 per cent. This data would appear to support Deeble's assessment that:

> the most destabilising influence on Medicare has been the unrealistically low rates of growth built into the Commonwealth's hospital contribution. The deficiency was greatest in the first 8 years of its life. It was to some extent corrected post-1993 but not sufficiently.[48]

2.27 During this same period, 1984-1998, the general purpose FAGs paid by the Commonwealth to the States and Territories declined as a proportion of GDP, from 5.1 per cent in 1983-84 to 2.9 per cent in 1997-98.

2.28 The Commonwealth Department of Health and Aged Care (DHAC) provided the Committee with figures on anticipated funding increases to the States and Territories for public hospital services under the AHCAs. DHAC argued that funding provided in 1998-99 represented a real increase of 11 per cent when compared to 1997-98, the last year of the previous Medicare Agreement. It estimates that total Health Care Grants under the AHCAs will increase by a further 4.1 per cent (real terms) in 1999-2000, 2.3 per cent (real) in 2000-01, 2.5 per cent (real) in 2001-02 and 2.4 per cent (real) in 2002-03.[49]

2.29 The States disputed the accuracy of the comparison between the current Agreement and its predecessor because certain items had previously been separately funded. Moreover, they argue that this rate of increase is not sufficient to meet the demand on public hospitals and that the Commonwealth's position on the disputed hospital output costs index (HOCI) will deliver them some $628 million less over the term of the AHCAs than if the recommendation of the independent arbiter had been adopted.[50]

2.30 The Committee was unable to reconcile these competing claims which were canvassed in some detail in the Committee's First Report. The available financial data is not sufficiently comparable to be conclusive. However, the Committee does note the summary graph provided by CHERE, derived from Australian Institute of Health and Welfare Health Expenditure Bulletins, which indicates that whilst the States increased health funding at a slower rate than the Commonwealth after 1993, in recent years the States' increases have outpaced the Commonwealth.

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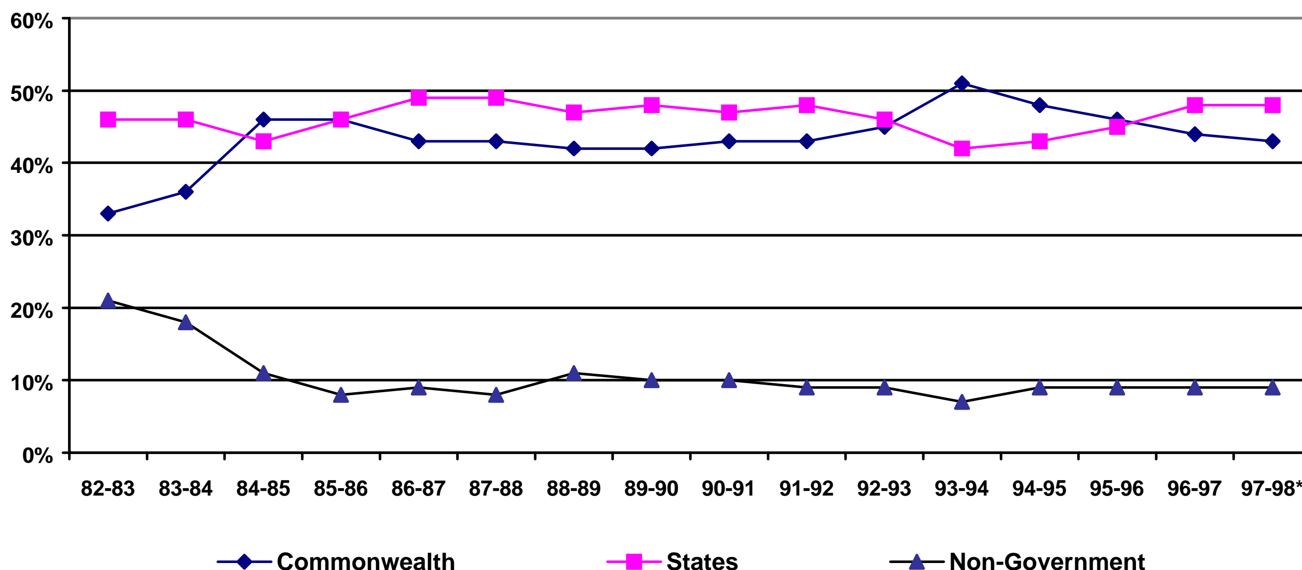
48 Submission No.50, p.14 (Dr Deeble).

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

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

Figure 2.1: Percentage Share of Recurrent Public Hospital Expenditure



Source: Derived from AIHW Health Expenditure Bulletins 12 (1996) and 15 (1999)
*Excludes psychiatric hospitals

2.31 During the inquiry, the States and Territories have expressed concern also about the impact of the GST on public hospital services and funding. These concerns have included the anticipated compliance costs and ongoing costs (the Queensland Government estimated that it would incur additional costs of $1.15 million for implementation and a possible $4 million in annualised costs);[51] the effect of rulings by the Australian Taxation Office;[52] and the actual quantum of funds which will be raised by the GST.

2.32 Independent research for the Committee undertaken by CHERE has concluded there is about a 1 per cent per annum shortfall in current Commonwealth funding for public hospitals. This shortfall was determined by Mr Ian Castles, the independent arbiter appointed under provisions of the Australian Health Care Agreements. The States have disputed the Commonwealth’s decision to index the HOCI in line with the Wage Cost Index 1 (WC1) and continue to argue that the amount recommended by Mr Castles is what they are entitled to under the Agreements. This difference is of the order of $450 million over 2001-02 and 2002-03, the remaining two years of the current 5 year Agreements.

2.33 With regard to patients in rural and remote areas of Australia, the Committee noted in its First Report that evidence had indicated[53] that there was considerable

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

52 *Committee Hansard*, 21.3.00, p.356 (New South Wales Health Department).

53 See, for example, Submission No.66, p.26 (NRHA).

variability in the State-funded patient travel schemes in different jurisdictions. The Committee is concerned that as a result, patients in rural and remote areas may be disadvantaged in accessing public hospital services beyond their immediate region of residence.

Conclusion

2.34 The discussion and analysis above indicates that any attempt to evaluate the relative funding shares of each level of government will be affected by the period used for the comparison. It will also be affected by the inclusion or exclusion of FAGs in any such comparison. It is questionable whether this is a particularly useful exercise and it may be more productive to investigate options that promote greater financial transparency.

2.35 The Committee has faced a difficult task throughout this inquiry in attempting to assess and report on the situation of public hospitals in Australia. Long standing problems, a fragmented health system, split roles and responsibilities between different levels of government, blame shifting, cost shifting and a multitude of interest groups with separate agendas all work to obscure the current situation as well as obstructing the development of a clear way forward.

2.36 In its First Report, the Committee stated that most participants in the inquiry had 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 actual amount of funding that would be regarded as adequate.

2.37 Also in its First Report, the Committee stated that a central difficulty for the inquiry was the lack of available data upon which to base informed decisions and that its efforts to assess the adequacy of funding for public hospitals were hampered by the fact that 'there has really been no process put in place for assessing and determining what that right level should be'.[54] While it is possible to identify the funding provided by the Commonwealth to the States and Territories for the provision of public hospital services and to also identify funding provided by the States and Territories from their own resources (although this latter task is noticeably more difficult), there is no objective means of assessing whether this is 'adequate' or not.

2.38 The Committee is concerned that much appears to be unknown about the performance of the public hospital sector and the reasons why, for example, Australia appears to have such a high rate of hospitalisation compared to other countries. There is a strong case for much more detailed and up-to-date reporting of actual spending on health by each level of government and for outcomes to be reported against nationally agreed benchmarks. It should be possible to compare how spending has changed and where funds have moved from one area to another as priorities have changed over

54 *Committee Hansard*, 11.11.99, p.98 (AHA, WHA, AAPTC).

time. At present it is too easy for one level of government to reduce spending in an area that receives increased funding from another source. This scenario is likely to leave the public hospital patient no better off. Although the current AHCAs do provide for reporting against a range of performance indicators developed jointly by the Commonwealth and the States and Territories, the first report is yet to be released, some 2½ years after the Agreements commenced.

2.39 The Committee acknowledges the recent agreement of Health Ministers to commit $5 million to a national pilot program for priority driven health and medical research. Announcing the agreement of Health Ministers, the Commonwealth Minister for Health and Aged Care, Dr Wooldridge, stated that 'priority driven research is undertaken into such areas as the best ways of delivering health services to ensure that on-the-ground health care is of the highest quality and the best value for money'.[55] The Committee hopes that by funding appropriate research, this program will reverse the knowledge deficit that is apparent in several aspects of public hospital and health services.

2.40 It is clear that most participants in this inquiry believe that public hospitals are underfunded. On the basis of evidence received, the Committee concurs with this view. However, the Committee believes that while additional funds are necessary in the short term, other measures are required for sustainable, long-term solutions to the problems besetting public hospitals. As was discussed earlier, the Commonwealth has increased funding to the States and Territories under the current AHCAs. The States and Territories believe that the Commonwealth should provide further funding, based on the recommendations of the independent arbiter, Mr Castles, on the disputed hospital output cost index (HOCI). However, the Committee is concerned that there is considerable variance between the States and Territories in the extent to which each is committing its own source funds to public hospitals (ie over and above the funding provided to them under the AHCAs).

2.41 In the Committee's view, it is necessary also to examine options for reform of the current arrangements rather than to continue the situation of the last 16 years whereby the States and Territories call continuously for increased funding from the Commonwealth for public hospital services. It is not always clear that any additional funds provided by the Commonwealth necessarily increase the funding available in each jurisdiction for patient care.

2.42 The Committee believes that the Australian community deserves better treatment than has been delivered to date by successive Commonwealth, State and Territory governments with regard to the transparency of funding arrangements for public hospital services and health services more generally, particularly in relation to the funds available for patient care. There is a lack of consistency between jurisdictions in the way in which such details are currently reported. It is the

55 Minister for Health and Aged Care, 'Ministers agree: Health and medical research–a top priority', *Media Release*, 31 July 2000.

Committee's view that the community has a right to know the actual funding being made available by each level of government each year for patient care.

2.43 As a means of increasing flexibility and transparency, the Committee has recommended that the Commonwealth, States and Territories commence negotiations on the next Australian Health Care Agreements as soon as is practicable and that these new agreements should encompass other health services, including the Medicare Benefits Scheme, Pharmaceutical Benefits Scheme, community health services and aged care services.

2.44 The Committee is concerned that residents of rural and remote areas may have varying degrees of access to patient assisted travel depending on their state of residence. While it believes that the States and the Northern Territory are the appropriate jurisdictions to fund and administer patient assisted travel schemes, the Committee believes that such schemes should be required to meet national objectives.

- **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.

2.45 A particular issue raised repeatedly by witnesses was the importance of funding for teaching and, particularly, research in public hospitals. The Committee heard that under funding constraints, hospital research was often the first area to be cut. While it takes no time to cut funding for research, a long lead time is required for it to be re-established. Hospital research is important for good health outcomes and is a vital part of our public hospital culture.

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.

Cost shifting

2.46 Although participants in the inquiry offered many views on cost shifting, little evidence was available, with most comments being of an anecdotal nature. In its First Report, the Committee discussed the views of participants on cost shifting and identified the different ways in which costs were shifted: from the Commonwealth to the States and Territories, from the States and Territories to the Commonwealth, and from both levels of government to patients. The Committee found that it was a difficult task to estimate the value of cost shifting that occurs because so little data is available on its extent.

2.47 The Queensland Government argued that 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: 'cost shifting is, and always will be, the outcome of an ill-defined and fragmented funding system'.[56] Offering a summary view, the New South Wales Health Department argued that whether cost shifting was perceived as good or bad depended on the view 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'.[57]

2.48 The Committee was intrigued, however, by the positions taken by the different levels of government on cost shifting. DHAC, for example, told the Committee that it did not know the extent of cost shifting and only became aware of an occurrence when it was brought to DHAC's attention, often through the media.[58] However, it did oversee a Commonwealth program in 1996-97 and 1997-98 which the New South Wales Government described as having 'unilaterally withheld $153 million from the Hospital Funding Grants to the States and Territories as a penalty for cost shifting practices'.[59] A State and Territory perspective on cost shifting was provided by an official of the Health Department of Western Australia who told the

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

57 *Committee Hansard*, 21.3.00, p.366 (New South Wales Health Department).

58 *Committee Hansard*, 11.11.99, p.39-40 (DHAC).

59 Submission No.79, p.12 (New South Wales Government).

Committee that: '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'.[60]

2.49 The inability of the different levels of government to agree on funding issues and cost shifting issues indicates that, as the AHA, WHA and AAPTC argued, Australia needs to move beyond these discussions between governments about their relative contributions, and focus instead on 'overall levels of funding, achieving agreed outcomes, provision of quality, cost effective services and value for the community's money'.[61]

Conclusion

2.50 On the basis of evidence received, the Committee believes that it is not a productive exercise to pursue issues around cost shifting. Governments have and are shifting costs. As the President of Children's Hospitals Australasia, Professor White told the first Roundtable, 'the costs have shifted and they are not going to go back'.[62] However, this does not mean that the Committee is unconcerned by cost shifting; on the contrary, it remains most concerned about the effects of cost shifting, particularly any effects on patient care.

2.51 The Committee believes that a more sustainable approach is to examine what reforms are possible that may minimise the opportunities and incentives for cost shifting which are so endemic under the current arrangements. With this is mind, a range of options for the reform of current funding arrangements that have been raised by participants in the inquiry and debated at the Roundtables, are discussed in the following chapter.

2.52 The Committee notes that one of these options, for the Commonwealth to assume responsibility for payment for pharmaceuticals in public hospitals, is under active consideration between the parties and that Victoria has reached agreement with the Commonwealth on the proposal.

2.53 The Committee considers that the Minister for Health and Aged Care should consult with his State and Territory counterparts on the directions for reform that are discussed in the following chapter, paying particular attention to those options that minimise the opportunities and incentives for cost shifting.

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

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

62 *Committee Hansard*, 18.8.00, p.728.