CHAPTER 3

DIRECTIONS FOR REFORM

Background

3.1 This chapter addresses terms of reference (d) and (e) which require the Committee to inquire and report on:

> (d) options for re-organising State and Commonwealth funding and service delivery responsibilities to remove duplication and the incentives for cost shifting to promote greater efficiency and better health care;
>
> (e) how to better coordinate funding and services provided by different levels of government to ensure that appropriate care is provided through the whole episode of care, both in hospitals and the community.

3.2 The previous chapter identified and discussed a range of shortcomings in current funding arrangements as well as the key challenges facing public hospitals. While there is much that is excellent about Australia's health system, it is let down by inefficient and inequitable funding arrangements that are not transparent and a poor level of knowledge about many important areas of service provision. Although Medicare offers a universal entitlement to treatment, there are differences in the services patients actually receive depending on where they live. The Committee believes that Australia's patients, who use the system, and taxpayers, who pay for the system, deserve better.

3.3 A participant in the first Roundtable, Professor Nip Thomson, of Monash University, concisely listed the key problems in public hospitals and provided both a rationale for reform and an assessment of the possibility of change, stating that:

> it all argues for a combined funding approach or a funding mechanism which is responsive to redirection of resources according to the patients' needs, irrespective of where that care is to be provided. I would like to see hospitals as part of a health care system which is as seamless as possible. Hospitals wish to integrate with other health care services in the community, but there are major blocks–not of their making but of the system by which the seamlessness cannot occur. But I also see opportunities to make radical changes, and I think the time is right and the mood is right to facilitate some of these changes.[1]

3.4 The previous chapter acknowledged the recent agreement of Health Ministers to a 'unified approach to strengthen primary health and community care at the local

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1 *Committee Hansard*, 18.8.00, p.678 (Professor Thomson, Monash University).

level–spanning general practice, community services and hospitals'.[2] It is possible that an outcome of such a unified approach may be to encourage the development of the seamless health care system which Professor Thomson is seeking.

3.5 The Victorian Department of Human Services' Dr Chris Brook warned that any options for reform need to take account of the changing realities in the role of hospitals within the health system:

> health care is changing a lot faster than most people around this table are prepared to admit. It is a bit scary. We are at real risk of trying to deal with a set of current and future problems through past mechanisms.[3]

3.6 In its First Report, the Committee discussed a series of options for reform of current arrangements that had arisen during the course of the inquiry. These options for reform included proposals relating to fundamental overhaul of the funding and delivery of services as well as proposals for incremental reform of areas which are currently bedevilled by cost shifting, such as pharmaceutical services and medical services. The Committee noted that few of the options were new, however, it could equally be argued that the problems which the options aim to alleviate also are not new. The key options were identified for discussion at the first of two very successful Roundtable Forums, convened by the Committee, and held on 18 August and 20 November 2000.

3.7 This chapter provides a brief recapitulation of the key options identified for discussion at the Roundtables together with a synthesis of the evidence received from participants and the Committee's conclusions and recommendations.

Options for reform

3.8 In a research paper prepared for the Committee, the Centre for Health Economics, Research and Evaluation (CHERE) categorised options for reform into three broad levels (note that there is some overlap between the different levels). A few of these options, that were outlined in the Committee's First Report, including transferable Medicare entitlements, health savings accounts, and a single national insurer, were proposed by only a small number of submissions. The Committee believes that these options propose major changes to the fundamentals of the Medicare and private health insurance arrangements and are less likely than other options to be implemented in the existing environment. Consequently, these options were not considered at the Roundtables and are not discussed further in this report. This is not to deny that any or all of these proposals may have some merit but rather, that their active consideration is beyond the Committee's terms of reference.

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

3 *Committee Hansard*, 18.8.00, p.675 (Dr Brook, Victorian Department of Human Services).

3.9 The options are:

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

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

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

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

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

These options for reform of specific areas are not addressed in this chapter but rather, are discussed in the chapters relevant to the area of reform–for example, data collection and analysis or quality management and improvement.

Option 1: Major reform to funding and delivery of services

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

- Commonwealth to take responsibility for funding and delivery of health services (single funder);
- States/Territories to take responsibility for funding and delivery of health services (single funder); and
- pooling of Commonwealth and States/Territories funds.

3.11 While these options for reform are essentially aimed at rationalising Commonwealth/State overlap of responsibility, and removal of incentives to shift costs between levels of government, they may also address some of the other issues raised in submissions, such as continuity of care and equity of access to services.

Option 1(A): Commonwealth to take responsibility for funding and delivering services

3.12 This model was more commonly suggested as a solution to cost-shifting and overlap of roles and responsibilities than other models. In general, submissions that put forward this proposal as a direction for reform did not suggest mechanisms by which the Commonwealth would take responsibility for or manage services,

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

Option 1 (B): States to take responsibility for funding and delivering services

3.13 This model was less commonly suggested as a solution to the Commonwealth/State overlap issues. However, those submissions that did propose it noted the fact that the States and Territories have established infrastructure for managing hospital and community health services, and that it may be more feasible. The main obstacle to this model is the open-ended nature of the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). This, combined with the large geographical variation in utilisation of Medicare funded medical services means that the States and Territories may be reluctant to assume responsibility for funding these programs.

Assessment and discussion: options 1 (A) and (B)

3.14 With either proposal for one level of government to assume responsibility for the funding and provision of services, it needs to be recognised that incentives for cost-shifting exist wherever there are different pools of funds for different programs. While this becomes a major political issue when the different pools of funds are provided by different levels of government, there will still be cost-shifting incentives if a single level of government provides different pools of funds for programs which it manages.

3.15 Participants at the first Roundtable discussed Options 1(A) and (B) in tandem, with little support evident for either proposal. Mr David Borthwick, Deputy Director of the Commonwealth Department of Health and Aged Care (DHAC), warned that each option implied a major change to Commonwealth and State/Territory budgetary arrangements, and that 'it would involve a very big change in the way Commonwealth-state governments operate'.[4] In addition, the Director of the Australian Institute of Health and Welfare (AIHW), Dr Richard Madden, emphasised the stability of the current arrangements and argued that the 'checks and balances of federalism are in fact very important'.[5]

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4 *Committee Hansard*, 18.8.00, p.672 (Mr Borthwick, DHAC).

5 *Committee Hansard*, 18.8.00, p.684 (Dr Madden, Australian Institute of Health and Welfare).

3.16 The overall view of participants on these two variants of a single funder model was summed up by Dr Tim Smyth, representing the Australian College of Health Service Executives (ACHSE), who commented that:

> in terms of option one, which is a single funder, I do not think the will is there, and the way is not there either. So the conclusion for session 1 should be that single funder be taken off the agenda.[6]

3.17 Paul Gross was more explicit, drawing on his 37 years of experience in the health sector to argue that both options were 'dead in the water and not worth the paper they are written on'.[7]

Conclusion

3.18 The proposals for a single funder (Commonwealth or State/Territory) received scant support at the Roundtables and the Committee agrees that neither proposal would be a suitable long-term replacement for current arrangements. While either proposal would be likely to reduce the incentives and opportunities for cost shifting that exist at present, the Committee is concerned that the stability of the funding arrangements could be undermined by a single funder model. In addition, it is apparent that neither level of government sees merit in the proposals.

Option 1 (C):Commonwealth and States/Territories to pool funds

3.19 Pooled funding involves the Commonwealth and the States and Territories combining their current health funding into a pool from which health services would be funded. Ideally the pool would include all health-related funding but this would not necessarily be essential. A pooled funding model could draw its funds from all or some of the many and varied sources that comprise the present fragmented system whereby:

- the Commonwealth funds out-of-hospital medical services, partially funds in-hospital services for private patients, funds the Pharmaceutical Benefits Scheme, provides subsidies for aged care accommodation and subsidises private health insurance premiums. It also provides substantial funding to the States and Territories for the provision of public hospital services (under the AHCAs) and for public health programs (under the Public Health Outcome Funding Agreements (PHOFAs);
- the States and Territories fund public hospital services drawing, in part, on funds provided by the Commonwealth under the AHCAs, as well as funding public and community health programs drawing, in part, on funding provided by the Commonwealth under the PHOFAs with each State and Territory, and also provide funding for public dental services and State aged care accommodation.

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6 *Committee Hansard*, 18.8.00, p.683 (Dr Smyth, ACHSE).

7 *Committee Hansard*, 18.8.00, p.701 (Mr Gross, Institute of Health Economics and Technology Assessment).

The States draw on their share of revenue from the GST (previously they drew on Financial Assistance Grants) for the remainder of their funding for public hospitals and other health programs; and

- private health insurance funds provide funding for accommodation and partial funding for in-hospital medical services for private patients and partial funding for health services not covered by Medicare, such as private dental services.

3.20 The Committee's First Report noted 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. Pooled funding could be expected to minimise the incentives and opportunities for cost shifting. Decisions would be required as to whether some or all sources of funds were to be included as well as some or all services. The extent to which boundaries still remained between funding sources and programs would determine the degree to which cost shifting incentives were minimised.

3.21 The proposal to pool funding for health services between the Commonwealth and the States and Territories was the subject of considerable discussion at the Roundtables and received substantial, though not universal, support from participants. Although supportive of pooling, Professor Stephen Duckett warned that 'I think the issue with pooling is that it is easy to reach agreement when we are talking in generalities'.[8]

Assessment and discussion: option 1 (C)

3.22 Various proposals were made at the Roundtables about how the Commonwealth and the States and Territories could create a 'single fund' for health programs with differing perspectives evident among participants. Two broad options have emerged during the inquiry which are not necessarily mutually exclusive:

- A 'joint account' mechanism whereby the States and the Commonwealth put their funds into a common account from which an agreed group of programs are resourced, replacing duplicate funding and accounting arrangements.
- A 'regional pooling model' under which regional bodies are provided with a budget allocation based on population and permitted to choose which services to provide or purchase from other providers.

3.23 The first model would allow much of the current arrangements to continue and would be easier to implement progressively over time. The second option would involve some major changes to current elements of Medicare because entitlements are not presently capped and a regional fund holder would need to cap services in order to operate within its budget.

8 *Committee Hansard*, 18.8.00, p.716 (Professor Duckett, La Trobe University).

3.24 A third option utilising pooled funding is managed competition. This model, developed by Professor Richard Scotton, was discussed in the Committee's First Report. During the second Roundtable Forum, support for managed competition was advanced by Professor Scotton:

> I believe that it is the only systematic model that has the potential to function under our present Constitution and within the present set of arrangements that we have for delivery and financing of health care.'[9]

3.25 However, other participants expressed reservations about the model. These included Dr Picone (New South Wales Department of Health) who argued that:

> I do not know whether I would go as far as Dick Scotton has suggested and go to HMOs, because I really do not think there is as much evidence as people would suggest that that is a good way to provide health care to citizens.[10]

3.26 Dr Segal from Monash University's Centre for Health Program Evaluation (CHPE) pointed to shortcomings of the managed competition model when compared to the proposal to pool funds on a regional basis:

> Under a competitive model, depending on the nature of the insurance arrangement, you might get substantial turnover, which means that there might be certain incentives by the fund holder not to manage the clients for the long term; whereas with the regional model, apart from geographic movements in and out of the region, people are often there for the long haul. So there is perhaps less incentive to skimp on services if you know you are still going to be looking after that person in 20 years time.[11]

3.27 Support was evident at both Roundtables for the concepts of pooled and capped funding. However, other participants expressed strong reservations about the practicalities of their implementation. Some interest was expressed in piloting the proposal in a location such as Wollongong or Canberra to test the strengths of the proposal in a moderately large population group.

3.28 Jim Davidson from the South Australian Department of Human Services argued that a pooled funding arrangement could be introduced without much difficulty in South Australia, Tasmania and the ACT and that this could be followed by a focus on the scope of the pool as well as patient outcomes, improvements in equity and reducing costs.[12] However, Queensland Health's Dr Filby argued that it was essential first to identify the 'model or models of integration, coordination and service delivery

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9 *Committee Hansard*, 20.11.00, p.752 (Professor Scotton, Centre for Health Program Evaluation, Monash University).

10 *Committee Hansard*, 20.11.00, p.757 (Ass Professor Picone, New South Wales Health Department).

11 *Committee Hansard*, 20.11.00, p.767 (Dr Segal, Centre for Health Program Evaluation, Monash University).

12 *Committee Hansard*, 20.11.00, p.791-3 (Mr Davidson, South Australian Department of Human Services).

that we want and then develop a pooling structure that supports them'.[13] Dr Gregory from the ACT Department of Health and Community Services cautioned that models of pooled funding may not be a panacea for all problems and shortcomings of the present arrangements: 'what I see is that we think that, if we put all the funds together, it will all be solved, but the arguments will only just be starting'.[14]

3.29 Paul Geeves from the Tasmanian Department of Health and Human Services was pessimistic about the likely success if pooling was to be regionally-based, arguing that 'you are just putting another layer of bureaucracy in there that does not have the chance to control its own destiny'.[15] He drew on Tasmania's six-year experience with pooled funding on a regional basis to conclude that although there was 'perhaps some evidence of improved responsiveness to local needs…':

> the movement of resources tended to follow the power structures which were with hospitals, so you did not see the redistribution to community services, even though that was the policy of the central part of the agency at the time.[16]

3.30 Dr Segal summarised the reservations about the concept of pooled funding as follows:

> There are challenges under any model. The sorts of challenges are around the level of expertise one needs at the planning level to plan services, contract with providers and establish quality assurance processes. There are challenges in the achievement of cost control without at the same time jeopardising quality. There are challenges in maintaining a responsiveness to the community and to consumers and in being able to integrate private health insurance into the model.[17]

3.31 For any proposal to pool funding to operate beyond a trial context would entail significant change to funding, particularly the funding of medical services in the community. This is because medical services under the MBS are not funded by the Commonwealth on the basis of population need but rather, on the basis of the location of medical practitioners. Thus, services provided and benefits paid under the MBS tend to reflect the oversupply of medical practitioners in metropolitan areas, particularly Sydney and Melbourne, and the undersupply in non-metropolitan areas. In its submission, the Queensland Government expressed its concern about what it regards as an underfunding of the State's needs (by the Commonwealth) due to the decentralised nature of the State and the attendant relative undersupply of medical

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13 *Committee Hansard*, 20.11.00, p.797 (Dr Filby, Queensland Health).

14 *Committee Hansard*, 20.11.00, p.788 (Dr P Gregory, ACT Department of Health and Community Care).

15 *Committee Hansard*, 18.8.00, p.704 (Mr Geeves, Tasmanian Department of Health and Human Services).

16 *Committee Hansard*, 18.8.00, p.704 (Mr Geeves).

17 *Committee Hansard*, 20.11.00, p.767 (Dr Segal, CHPE).

practitioners and community pharmacies. It estimates that it is out-of-pocket by some $31 million.[18]

Planning

3.32 Discussion in the previous chapter indicated that several participants in the first Roundtable were critical of what they regarded as a lack of planning in the health sector. For example, Mr Gross stated that 'we do not talk about planning any more',[19] while Dr Brook was concerned that 'we just do not plan', not even for 'the bleeding obvious, the things we can predict with certainty albeit perhaps not with precise timing'.[20]

3.33 Planning is an essential element of any pooled funding model. Professor Duckett commented that 'if you are going to have some sort of funds pooling, then it becomes inevitable that you have to do some planning about how you are going to distribute funds from that pool'.[21] Similarly, Dr Segal from the Centre for Health Program Evaluation (CHPE) regarded that the opportunity for planning was a key advantage offered by the pooling of funds. However, she did caution that the difficulty 'is who takes on a planning function and who has that responsibility'.[22]

Flexibility

3.34 By breaking down the barriers which currently exist between health programs that receive their funding from different sources, a pooled funding arrangement could be expected to offer enhanced flexibility for purchasers of services such as the States and Territories. For example, the current situation of nursing home-type-patients occupying (State funded) acute care beds in public hospitals because of the unavailability of (Commonwealth funded) nursing home beds could be expected to diminish with funds distributed from the pool according to local priorities.

3.35 Such flexibility would be a natural extension of the current situation under which States and Territories have gained an increased degree of flexibility in the way Commonwealth specific purpose funds can be spent through, for example, provisions of the AHCAs (such as 'measure and share') and the PHOFAs, both of which were discussed earlier.

Accountability

3.36 A necessary trade-off for increased flexibility would be greater accountability. Based on evidence received, the Committee's First Report identified a lack of transparency in the current financing arrangements which led to cost shifting and

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

19 *Committee Hansard*, 18.8.00, p.702 (Mr Gross).

20 *Committee Hansard*, 18.8.00, p.676 (Dr Brook).

21 *Committee Hansard*, 18.8.00, p.687 (Professor Duckett).

22 *Committee Hansard*, 18.8.00, p.687 (Ms Segal, CHPE).

blame shifting. A greater degree of accountability than currently exists[23] would be required for a pooled funding model to prove superior to current arrangements. Information sharing, trust, openness and honesty would be prerequisites but further accountability measures also would be necessary. Dr Brook told the first Roundtable that:

> it is critical that if we go down this path we have very clear objectives: exactly what is it that we are trying to achieve, exactly what is it that we are able to measure…it is very important to have some things that are explicit and measurable.[24]

It is possible that, based on benchmarks, financial incentives/penalties could be applied to effect changes in performance, although Dr Smyth warned the Roundtable that the nature of the particular financial incentives/penalties determined whether behaviour change was achieved, or whether the effect instead led to decisions about simply moving or curtailing a health program.[25]

3.37 Performance measures and benchmarking are discussed in greater detail in Chapter 7 which deals with quality improvement programs.

Pooled funding and incremental change

3.38 Although pooled funding does represent a major change to the current Commonwealth-State funding arrangements, existing programs could continue, so that patients would be unlikely to notice any change to the provision of health services. It is also important to note at the outset that pooling of all Commonwealth and State/Territory health funding can be seen as an extension of developments already underway, or being trialed in the health sector. For example, the trials of coordinated care (discussed at length in Chapter 4) draw on pooled funding from the Commonwealth and States and Territories. Multipurpose Services and the new Regional Health Authorities, both operating in non-metropolitan areas, also use pooled funding from the Commonwealth and the States and Territories.

3.39 In addition, the 'measure and share'[26] provisions of the Australian Health Care Agreements (AHCAs) permit the joint (ie the Commonwealth and the State or Territory) consideration of 'proposals which move funding for specific services

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23 The PHOFAs provide a useful example of inadequate accountability. Under these agreements, the States and Territories have gained greater flexibility in the way funding is expended for public health programs, however the reporting mechanisms under the agreements leave much to be desired, with little data available on patient outcomes.

24 *Committee Hansard*, 18.8.00, pp.705-6 (Dr Brook).

25 *Committee Hansard*, 18.8.00, p.683 (Dr Smyth).

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

between Commonwealth and State funded programs'. Certain criteria need to be met by each proposal and:

> reform proposals may result in the cashing out of State funded programs and/or Commonwealth funded programs, including the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme. [27]

A proposal is being explored at present under the 'measure and share' provisions that seeks to reform the method of payment for hospital pharmaceuticals. This proposal is discussed below as Option 2 (A).

3.40 Other possible incremental approaches to the pooling of all health funding were raised at the first Roundtable. For example, Dr Gregory from the ACT Department of Health and Community Care suggested that 'we could work towards a complete pooled arrangement by starting to plan some of the bits–maybe it is a hepatitis C clinic or it is a mental health change'.[28] Dr Smyth proposed that extending the Department of Veterans' Affairs (DVA) Gold Card to all people aged 70 years and over would provide a useful base to trial the effectiveness of pooled funding.[29] The Gold Card entitles recipients to effectively seamless health care which is purchased by DVA utilising funding which is drawn from its various repatriation health schemes (medical, pharmaceutical and private patient).

3.41 A summary perspective on the possibilities offered by a move towards pooled funding, particularly its links with integration of care, was provided by Professor John Dwyer, Chair of the Senior Medical Staff Advocacy Committee, who told the first Roundtable that:

> I do think as we move further and further to integrated hospital and community services that this is pooling of funds and this is going to aid and abet our increased efficiency and bring all those other reforms at the same time that we need.[30]

Conclusion

3.42 The Committee believes that pooling of health funding between the Commonwealth and the States and Territories is worthy of further exploration. Essentially, this proposal is about governments working smarter, creating an environment in which the funding system facilitates, rather than obstructs, the provision of a seamless continuum of care.

3.43 While participants in the Roundtables did not underestimate the difficulties involved, they believed that the time is ripe for a trial of pooled funding on a

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27 Australian Health Care Agreement, Part 5, clause 28.

28 *Committee Hansard*, 18.8.00, p.690 (Dr Gregory, ACT Department of Health and Community Care).

29 *Committee Hansard*, 18.8.00, p.694 (Dr Smyth).

30 *Committee Hansard*, 18.8.00, p.711 (Professor Dwyer, Senior Medical Staff Advocacy Committee).

geographical basis. Such a geographically-based trial could proceed, for example, in Newcastle, Wollongong or Geelong.[31] In its submission, Barwon Health, an integrated health service based in Geelong, expressed interest in an extension of the coordinated care trials to 'broader target populations involving a larger vertically integrated organisation, for example, Barwon Health for the Barwon sub-region, ie cashing out all programs for a defined general population'.[32] Alternatively, a trial could be conducted at a larger geographic level, such as a State or Territory.[33]

3.44 The Committee notes the support of participants at both Roundtables that a feasibility study be undertaken to examine the option of conducting a regional trial of pooled health funding in a suitable region to identify the difficulties and ascertain the possibilities offered by large scale pooling of Commonwealth and State and Territory health funds. The Committee was interested to learn that New South Wales is proceeding with an assessment of the possibility of trialing pooled funding in several of its Area Health Services, but is concerned that this assessment is proceeding without the active involvement of the Commonwealth.[34]

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.

Option 2: Funding and delivery of services: incremental/partial reforms

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

Option 2 (A): Commonwealth to fund all pharmaceutical services

3.46 This proposal involves the Commonwealth assuming responsibility for funding pharmaceutical services in public hospitals. A number of alternative models were proposed in submissions.

3.47 The primary motivation of the proposal for the Commonwealth to assume responsibility for funding of all pharmaceutical services is the removal of incentives for cost shifting. In particular, it is seen as a way of addressing the concern that

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31 *Committee Hansard*, 18.8.00, p.706 (Dr Brook).

32 Submission No.37, p.3 (Barwon Health).

33 *Committee Hansard*, 18.8.00, p.693 (Dr Smyth).

34 *Committee Hansard*, 20.11.00, p.757 (Ass Professor Picone, New South Wales Health Department).

patients discharged from hospital are issued with small starter packs which therefore requires them to visit their general practitioner soon after leaving hospital for a PBS prescription. Evidence from the Commonwealth suggests that this would involve significant cost-savings. However, a number of issues need to be considered in relation to this proposal:

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

Assessment and discussion: option 2 (A)

3.48 As was noted earlier, the 'measure and share' provisions of the AHCAs provide for discussions between the Commonwealth and the States and Territories with regard to removing the barriers between particular Commonwealth-funded and State-funded programs. A proposal for the Commonwealth to assume funding for hospital pharmaceuticals has been accepted by Victoria[35] and negotiations are underway between the Commonwealth and other States/Territories, although some jurisdictions have expressed reservations about the proposal. In evidence, DHAC described the Commonwealth's proposal as allowing the States 'to dispense against the Pharmaceutical Benefits Scheme the full cost of treatment. We see that as an all-round win'.[36]

3.49 Both Victoria[37] and the Commonwealth[38] described the impetus for this proposal as achieving improvements in quality and safety in health care, rather than a means of reducing cost shifting (which is likely also to occur). Dr Brook described it

35 *Committee Hansard*, 18.8.00, p.719 (Dr Brook).

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

37 *Committee Hansard*, 18.8.00, p.719 (Dr Brook).

38 *Committee Hansard*, 18.8.00, p.721 (Mr Borthwick).

as a 'win-win all round', although he did caution that 'we have a number of concerns'.[39] Mr Borthwick acknowledged that 'this is really an arrangement which is being put in place in advance of that electronic health record information system'.[40] Electronic health records are discussed in some depth in Chapter 8). In evidence to the Committee, the Northern Territory Minister for Health commented that 'I think it is an appropriate move. It is early days, so I guess there will be problems along the way, but as a first move I think it is good'.[41]

3.50 An important benefit of this proposal should be a greater investment in appropriate information management systems and consequently, improved data collection and analysis in an area where existing knowledge is poor.[42] Dr Brook told the Roundtable that a key incentive for Victoria to reach agreement with the Commonwealth was to gain access to Commonwealth payments for the high cost oncology drugs under the Pharmaceutical Benefits Scheme (PBS). However, the Commonwealth insists as part of the agreement that, at the hospital level, all PBS procedures be implemented. Dr Brook acknowledged that as a result, access to oncology drugs would be limited to only a few Victorian hospitals in the first instance: 'we know there are only a few hospitals who have the necessary information technology systems and pharmacy systems in place to do it'.[43]

3.51 Reservations about the proposal were expressed in evidence by both the New South Wales Health Department and the Queensland Government. New South Wales was concerned that the proposal 'simply transferred the risk to the States'.[44] The Queensland Government held a similar view, arguing that 'we do not think at this stage the proposed risk sharing arrangements are acceptable'.[45] The Society of Hospital Pharmacists of Australia was also critical of the proposal and holds the view that:

> the PBS, a community based system, is not suitable for use in hospitals. The lack of drug choice and complexity of the system is unsuited to hospitals and seriously detracts from its usefulness. The States are discovering this during the present negotiations.[46]

The preferred position of the Society for the short and medium term is for the Commonwealth 'to fund inpatient and non-inpatient pharmaceuticals for public hospital patients', (but not through the PBS) a model that would include requirements

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39 *Committee Hansard*, 18.8.00, p.719 (Dr Brook).

40 *Committee Hansard*, 18.8.00, p.722 (Mr Borthwick).

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

42 *Committee Hansard*, 18.8.00, p.724 (Mr Matthews, Society of Hospital Pharmacists of Australia).

43 *Committee Hansard*, 18.8.00, p.720 (Dr Brook).

44 *Committee Hansard*, 21.3.00, p.349 (New South Wales Health Department).

45 *Committee Hansard*, 22.3.00, p.483 (Queensland Minister for Health).

46 Submission No.52, Additional information, 17.8.00, p.2 (Society of Hospital Pharmacists of Australia).

for quality use of medicines and incentives. A possible longer term alternative may be the use of casemix-based funding for hospital pharmaceuticals.[47]

Conclusion

3.52 The Committee is encouraged that the Commonwealth and Victoria have reached agreement on the Commonwealth's proposal to reform the funding arrangements for hospital pharmaceuticals. It is possible that this proposal could be an incremental step towards a wider pooling of funding by the different levels of government for other health services.

3.53 However, the Committee notes with concern the history of this issue and the arguments above advanced against change underline the barriers to progress on health financing reform, when so many jurisdictions are involved–even with a win/win proposal that offers better outcomes and lower costs.

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.

3.54 The Committee recognises that such a model of 'leadership by example' could speed the pace of reform on this and other challenges facing public hospitals. Pilot projects and trials can be used to demonstrate the benefits of change and involve staff interested in finding practical solutions to problems.

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.

Option 2 (B) Commonwealth to fund all medical services

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

Assessment and discussion: option 2 (B)

3.56 This option was supported by only a few participants at the first Roundtable, with most believing such a proposal to be a retrograde step which, while it may alleviate cost shifting, would be unlikely to enhance patient care. Opponents described

47 Submission No.52, Additional information, 17.8.00, pp.1-2 (Society of Hospital Pharmacists of Australia).

this proposal as one that was 'premature' and likely to 'face fairly strong opposition'[48] (AMA), as one that was 'too late'[49] (CHA), as a 'second priority' compared to pooling of funds[50] (ANF), and as one that 'would only make a more divisive system and complicate it even more'[51] (Monash University). Supporters, meanwhile, felt that the proposal may be 'actually more interesting' than the previous proposal for the Commonwealth to fund all pharmaceuticals[52] (Queensland Health), and as one that had 'significant merit', which would be useful to explore in relation to the Commonwealth assuming responsibility for funding all medical services in rural areas[53] (Duckett).

Conclusion

3.57 Most participants believed that this proposal ran counter to the possibilities offered by pooling of funding between the Commonwealth and the States and Territories and that the current structure of the MBS would be an impediment to the proposal being introduced. A lack of interest by most participants, combined with the likely opposition of the medical profession, led the Committee to conclude that the proposal did not warrant further consideration as a stand-alone proposal.

Further options

3.58 In addition to the options to reform funding arrangements that have been discussed above, several other options for reform were proposed by participants during the course of the inquiry. Time considerations restricted discussion of these further options at the first Roundtable. Although these proposals do not relate primarily to funding issues, several options could be considered to underpin or may facilitate the adoption of some of the funding proposals. These further options are discussed below.

A national health policy

3.59 Australia does not currently have a national health policy, although the formulation of such a policy has been on and off the health policy agenda for some time. Submissions and evidence to the inquiry have indicated that a national health policy underpins some of the other options for reform. This is particularly the case for options which aim to overcome problems around the split of roles and responsibilities of governments, such as a single pool of funding[54] and for reforms aimed at improving

48 *Committee Hansard*, 18.8.00, p.727 (Dr Phelps, AMA).

49 *Committee Hansard*, 18.8.00, p.728 (Professor White, Children's Hospitals Australasia).

50 *Committee Hansard*, 18.8.00, p.730 (Mr Jones, Australian Nurses Federation).

51 *Committee Hansard*, 18.8.00, p.729 (Professor Thomson, Monash University).

52 *Committee Hansard*, 18.8.00, p.726 (Dr Filby, Queensland Health).

53 *Committee Hansard*, 18.8.00, p.727 (Professor Duckett).

54 *Committee Hansard*, 21.3.00, p.364 (New South Wales Health Department).

information systems and data collection in public hospitals.[55] Several participants, including representatives of nurses, such as the Queensland Nurses Union[56] and consumers, such as Western Australia's Health Consumers Council (HCC),[57] offered their support for the formulation of a national health policy.

Assessment and discussion: national health policy

3.60 The issues around a national health policy sparked a lively discussion at the first Roundtable. Views of participants were somewhat polarised, with differences evident in the perspective to be accorded such a policy: for example, is a national policy the sum of its component parts, as suggested by Mr Borthwick,[58] or is an overarching articulation of the system's values required as proposed by Professor Leeder?[59] The point was made by both Dr Smyth[60] and Mr Borthwick[61] that Australia has many national health policies, such as Medicare, the National Drug Strategy, National HIV/AIDS Strategy and the Australian Health Care Agreements and Dr Deeble argued that it was not possible to have a single national health policy.[62] However, Professor Dwyer argued that this situation can result in a lack of cohesion,[63] while Dr Segal was concerned that 'a lot of the separate programs that people are talking about actually have quite contradictory purposes'.[64]

3.61 The important symbolic role played by a national health policy in articulating values was submitted by Dr Gregory, who also called for a national health plan that would offer directions for implementation of the policy. She also linked the need for adequate planning to earlier discussion on pooled funding.[65] This theme was reflected in comments by Dr Phelps who highlighted the role that a national health policy could play in facilitating linkages between the different parts of the health system and the possibilities offered for system planning and coordination.[66]

3.62 The necessity to involve all players in the development of a national health policy was emphasised by several participants, including Mr Gross who made the point that this was not 'a government problem'.[67] Dr Smyth commented that the

55 *Committee Hansard*, 23.3.00, p.544 (Australian College of Health Service Executives).

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

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

58 *Committee Hansard*, 18.8.00, p.738 (Mr Borthwick).

59 *Committee Hansard*, 18.8.00, p.732 (Professor Leeder, University of Sydney).

60 *Committee Hansard*, 18.8.00, p.737 (Dr Smyth).

61 *Committee Hansard*, 18.8.00, p.738 (Mr Borthwick).

62 *Committee Hansard*, 18.8.00, p.739 (Dr Deeble).

63 *Committee Hansard*, 18.8.00, p.734 (Professor Dwyer).

64 *Committee Hansard*, 18.8.00, p.739 (Ms Segal).

65 *Committee Hansard*, 18.8.00, p.738 (Dr Gregory).

66 *Committee Hansard*, 18.8.00, p.734 (Dr Phelps).

67 *Committee Hansard*, 18.8.00, p.736 (Mr Gross).

development of such a policy was necessarily a long term objective, one that would require 'far more education, information, debate and discussion at a community level and at a media level and an interest group level in order to get some common bases underneath it'.[68] Mr Forbes, of the University of New South Wales, observed that Australia does have a national health policy but because it is not defined and unstated it remains a 'top-down' policy inclusive of only the major stakeholders. This restricts the ability of such a policy to be informed by genuine community input:

> the difficulty with not having some kind of stated policy is that we cannot extend it to the community and to the disadvantaged groups or decide what values we do want to have and whether or not the actions we are taking–that is, the bottom up policy–is consistent with national values and national views.[69]

3.63 Both Christine Charles, from the South Australian Department of Human Services and Dr Smyth addressed the issue of whether a national health policy is too restrictive. Ms Charles spoke about the interface between health and community services and the impact that areas such as adequate public housing and adequate heating can have on efforts in preventive health.[70] Similarly, Dr Smyth argued that 'increasingly, perhaps it is more a human services policy'.[71]

Conclusion

3.64 Differing views on the value of a national health policy were evident among participants at the first Roundtable. The Committee acknowledges that Australia already has a substantial set of health policies but believes that the lack of a national health policy reflects the fragmented nature of the health system. The Committee believes that Australia needs a genuinely national health system. It regards the development of an overarching national health policy, informed by community consultation, as a necessary prerequisite for health policy reform. This is the case for any health policy reform, not only the options canvassed in this report.

3.65 Discussions at the Roundtables provided clear evidence that participants welcomed the opportunity to take part in national health policy debates. That enthusiasm and good will is something that the Committee believes is a basis for the development of a national health policy.

3.66 Medicare will be 20 years old within a few years. At that time, the development of, or substantial progress towards, a national health policy would in the Committee's view, provide cause for celebration.

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68 *Committee Hansard*, 18.8.00, p.738 (Dr Smyth).

69 *Committee Hansard*, 18.8.00, p.735 (Mr Forbes, University of New South Wales).

70 *Committee Hansard*, 18.8.00, p.733 (Christine Charles, South Australian Department of Human Services).

71 *Committee Hansard*, 18.8.00, p.737 (Dr Smyth).

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.

Community debate and transparent priorities

3.67 The foregoing discussion on a national health policy included references to community input, community education and dissemination of information as necessary elements of the development of a national policy.

3.68 The Committee's First Report noted that a number of submissions raised the need for the consultation, involvement and/or education of the community in setting priorities for the health system, including the level of funding and methods of paying for services. Governments generally have failed to acknowledge (and to inform the community) that there are limits to services provided in the public hospital sector and the Australian health system–it is impossible to provide all possible services to all patients all of the time. No health system is capable of doing this because there are limits on health budgets. The acceptance that limits exist implies that priorities need to be established. While the issue of limits and priorities is difficult to grapple with, it is one that needs to be addressed. Priorities are set now at several levels of the health system and the public hospital sector, but few are transparent.

3.69 The Committee's First Report contained a comprehensive synthesis of evidence received on this issue, together with discussion of a range of different methods that have been used in other countries to engage the community on health policy matters. It is not proposed to revisit here the detail of the discussion.

Assessment and discussion: community debate and transparent priorities

3.70 Little time was available at the first Roundtable for discussion of issues around this proposal, however, Professor Jane Hall, of the Centre for Health Economics, Research and Evaluation (CHERE), provided some insights into the difficulties surrounding community consultation. She noted, for example, that multiple agendas are likely and that a 'strife of interests' exists also within and between community groups as well as in the broader health policy arena. She warned that 'we should be surprised if we get any consensus' and that the views and values of individuals were not static, changing with the information provided to them. She cautioned against a view of the community as some sort of monolith, noting that:

> individuals are patients and potential patients in the system, they are payers of the health service in some form or another and they are also citizens with a view about what a good and healthy society means and what that means in terms of its health care.[72]

72 *Committee Hansard*, 18.8.00, p.741 (Professor Hall, CHERE).

3.71 Professor Hall also remarked on the important role played by the media in creating and informing the public debate. Of particular interest here is that 'any debate about health policy is presented as a political game with winners and losers in political terms'.[73] This has clear implications both for health policy reform and for any attempt to engage the community in discussions over priorities and values for the health system.

Conclusion

3.72 The Committee regards the views and values of the community to be of central importance to Australia's health system and to its public hospitals. The Committee does not underestimate the difficulties involved in assessing these views and values and notes in particular the points raised above by Professor Hall. However, in the Committee's view, this should not stop attempts being made by government to at least try to identify what the community thinks about the fundamentals of the Australian health system. We already know the superficial picture. It is now time to discover the detail.

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.

Redesigning the 'hospital'

3.73 A number of submissions proposed that a means of ameliorating the pressures on public hospital finances was to reduce the demand for hospital services. Several methods were suggested, including a greater emphasis on preventive services. Submissions from the NRHA and ACHSE included details of how hospital services may be redesigned in the future, both of which were described in the Committee's First Report. Time did not permit a discussion of this proposal at the first Roundtable, although Professor White did point out that debate during the day on a range of proposals also had incorporated discussions 'about the changing patterns of hospital care and its role in the continuum of care'.[74]

3.74 Other evidence dealt with the growing importance of day surgery conducted at stand-alone facilities, the increasing use of same day procedures performed in hospitals and the management of surgery lists to work on a "5 day a week" cycle. These strategies could also be complemented by "medi-motel" models to provide moderate cost accommodation for patients and family members adjacent to a hospital. This model can provide rehabilitation care at a far lower cost than a fully serviced acute bed yet the patient can still benefit from ready access to care as required.

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73 *Committee Hansard*, 18.8.00, p.741 (Professor Hall).

74 *Committee Hansard*, 18.8.00, p.741 (Professor White).

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.