GOVERNMENT MEMBERS MINORITY REPORT

Introduction

The Government Members of the Senate Community Affairs References Committee do not accept the findings and recommendations of the Opposition Report into Public Hospital Funding.

The Government Senators believe that the Australian health system requires a strong and universal public sector and a strong and viable public sector, neither of which should be so blatantly politicised.

Medicare ensures all Australians have equal access to high quality care, while the private system offers freedom of choice to patients. Within the public sector, the Commonwealth is responsible for providing the States and Territories with substantial and ongoing, real increases in public hospital funding over the life of the Australian Health Care Agreements, while States are responsible for providing the balance of funding and for the administration and operation of public hospitals.

Against this background Government Senators wish to voice their concern that the Committee's findings so intentionally and obviously intrude into specific areas which are the responsibility of the State and Territory Governments.

This report into the funding of the public hospital system follows the Committee's report into childbirth practices and its review of the Gene Technology legislation. A significant number of the recommendations made in both of those Reports, and now this Hospital Funding report, show an unprecedented intrusion into areas of policy and administration outside the responsibility of the Commonwealth Government.

Government Senators have become increasingly concerned that the References Committee is being used for self-indulgent inquiries into areas of policy which do not concern the Commonwealth.

The Government Senators are also concerned at the apparent use of the Committee to formulate Opposition policies at the expense of the Australian Parliament. This concern about the 'politicisation' of the Committee's Report into Public Hospital Funding was expressed by the Hon. Steve Dunham, MLA, the Northern Territory Minister for Health, Family and Children's Services in a letter to the Committee's Chair:

> 'The Northern Territory wishes to record its concern about the likelihood of the Inquiry being used as a cynical exercise and a vehicle for political posturing rather than a serious review of the health system' – Mr Dunham's letter to Senator Crowley, 4 November 1999.

In this regard, Government Senators note that the Committee's Terms of Reference closely resemble those proposed by the Opposition in a press release issued by the

Shadow Minister for Health, Ms Macklin, on 6 August 1999. The Committee's inquiry into public hospital funding and its Terms of Reference were then welcomed in a press release by Ms Macklin on 11 August 1999. This, we believe, further demonstrates the purely political motivation of the inquiry.

It should also be noted that having secured the Committee's approval for the release of the Committee's First Report as a 'working document', the Committee Chair proceeded to politicise it with unauthorised publicity far beyond its agreed intent.

Government Senators believed that this Committee Inquiry could have been a genuine attempt to assess, consider, and then provide real alternatives for hospital funding arrangements in Australia. However, there is a lack of correlation between the Chair's Report and the Committee's Terms of Reference. Instead, the Opposition in its report has simply tried to re-write elements of the current Australian Health Care Agreement without offering any considered or practical alternative for future agreements.

Government Senators wish to note that the following recommendations from the Opposition Report are already a matter of public policy whether in place at a Commonwealth or State level:

Chapter 3 recommendation 14 on the integration of pharmaceuticals in public hospitals;

Chapter 5 recommendation 20 on the Commonwealth's 'clawback' arrangements;

Chapter 5 recommendation 21 on private fund information campaign;

Chapter 5 recommendation 22 on gap free private health insurance products;

Chapter 7 recommendation 28 on funding for the Council for Safety and Quality;

Chapter 7 recommendation 34 on clinical practice.

Government Senators wish to note that the following recommendations from the Opposition Report are clearly the responsibility of the States:

Chapter 2 recommendation 5 on use of IT in public hospitals;

Chapter 2 recommendation 6 on public hospital priorities;

Chapter 2 recommendation 7 on teaching and research in public hospitals;

Chapter 2 recommendation 8 on links between public hospitals and community care;

Chapter 2 recommendation 10 on financial parties transparency;

Chapter 2 recommendation 11 on patient assisted travel;

Chapter 2 recommendation 12 on Committee inquiry into patient assist travel schemes;

Chapter 3 recommendation 18 on the 'hospital of the future';

Chapter 6 recommendation 23 on links between nearby public and private hospitals;

Chapter 7 recommendation 29 on a public hospital reporting system;

Chapter 7 recommendation 30 on investigating system failures in public hospitals;

Chapter 7 recommendation 31 on the culture of change within public hospitals;

Chapter 7 recommendation 35 on provision of health information;

Chapter 7 recommendation 36 on performance indicators for public hospitals;

Chapter 8 recommendation 39 on waiting periods;

Chapter 8 recommendation 41 on the use of IT in public hospitals.

Government Senators wish to note that the following recommendations from the Opposition Report seek to create additional, burdensome layers of health bureaucracy without improving patient care:

Chapter 2 recommendation 9 to create the National Advisory Council;

Chapter 3 recommendation 13 to consider pool funding;

Chapter 3 recommendation 16 on the development of health policy;

Chapter 3 recommendation 17 on community involvement in recommendation 16;

Chapter 7 recommendation 25 to establish a national statutory authority with responsibility for quality programs;

Chapter 7 recommendation 27 that the Council for Safety and Quality be reviewed after two years of operation;

Chapter 7 recommendation 37 on the responsibilities of the proposed new statutory authority.

The Government Senators wish to respond specifically to the Terms of Reference provided to the Committee and are disappointed that such terms of reference are not addressed by the Opposition Report, considering it was they who dictated the agenda.

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

Government Senators believe there are several issues to be considered under this Term of Reference: levels of Commonwealth funding under the Australian Health Care Agreements, the impact of the recent increases in private health membership and the levels of State and Territory own source hospital funding.

Adequacy of Commonwealth funding under the AHCA

The Government Senators point out that the evidence provided to the Committee does not support the Opposition recommendation that the Commonwealth be required to provide additional funding through the Australian Health Care Agreements.

The Committee itself identified this conclusion in its First Report*: Public Hospital Funding and Options for Reform* when it stated that:

> ‘Other than drawing the obvious conclusion that if current levels are inadequate then more funds are required, it is a difficult task to identify the level at which funding would be regarded as adequate’ (page 1).

The current Australian Health Care Agreement signed in 1998 provides $5.6 billion more in real terms in public hospital funding to the States and Territories than the previous Labor Government in 1993.

On the basis of present estimates the Commonwealth contribution to public hospital funding under the Australian Health Care Agreements will be $31.3 billion. Annual funding will increase by over 25% in real terms over the life of the Agreement.

In comparison, the previous agreement increased funding to the States and Territories by 17% in real terms over the five years from 1993 to 1998.

In considering the adequacy of ongoing Commonwealth funding, it should be noted that funding under the AHCAs is now based on:

- Increases to reflect growth and ageing in the population;
- Price indexation in line with WCI-1, which combines growth in underlying CPI and wages growth; and
- A 2.1% per annum “utilisation” drift factor to reflect underlying growth in hospital utilisation.

These factors together provide for year on year growth of between 5.5% and 7% in base Commonwealth Health Care Grants under the AHCAs.

Impact of increased private health insurance membership

Another relevant consideration to the level of Commonwealth funding through the AHCA is the measure of Commonwealth funding per uninsured person. When the AHCAs were signed in 1998 the number of Australians with private health insurance was on average 30.6% across the States and Territories.

At that time, the States and Territories accepted that $5,644 million was an appropriate level of funding to provide public hospital services to the 13.1 million people without private health insurance. In other words Commonwealth assistance amounted to around $430 per capita.

The AHCA provided that if the level of private health insurance declined, then Commonwealth assistance to the States and Territories would increase in line with the number of the uninsured population. The AHCA also provided that if the number of Australians with private cover increased beyond 33% of the total population Commonwealth assistance to the States and Territories would be reduced proportionately.

A number of States, particularly South Australia, previously complained about ever-falling rates of private health insurance. It is disappointing that some are now complaining about increasing levels because they think they will lose some of their safety net money. Commonwealth funding was always meant to be a safety net, not a hammock.

The Government Senators wish to make two points here:

First, the Commonwealth has made a commitment to the State and Territories that it will not be reclaiming the funding available to it through the Australian Health Care Agreement due to the increase in private health insurance membership.

This decision means that no State or Territory will be worse off as a result of the considerable increase in the number of Australians with private health insurance membership since the AHCA was negotiated.

The decision will benefit the States and Territories to the tune of $1,050 million this financial year and to the amount of $3,150 million over the remainder of the life of the AHCA. This amount is obviously far in excess of the $630 million which the States claimed was the "cost" of not implementing the Castles recommended indexation of Commonwealth funding grants (Mr Dean Brown at the Adelaide Hearing, page CA155 of Hansard).

Second, the decision to modify the clawback arrangements will result in a massive increase in per capita Commonwealth assistance to the States and Territories for the public hospital system. By the last year of the current AHCA, 2002-2003, grants are estimated at $6,976 million.

Assuming the number of Australians with private health insurance remains at its current level, there will be an uninsured population in that year of 10.7 million people, giving a per capita rate of $650. This would represent an increase of over 50% in per capita Commonwealth assistance over the life of the Agreement.

And finally, as more patients elect to be treated as privately insured patients due to the dramatic increase in private health cover over the last two years, pressure on public hospitals will be reduced.

Adequacy of State and Territory funding

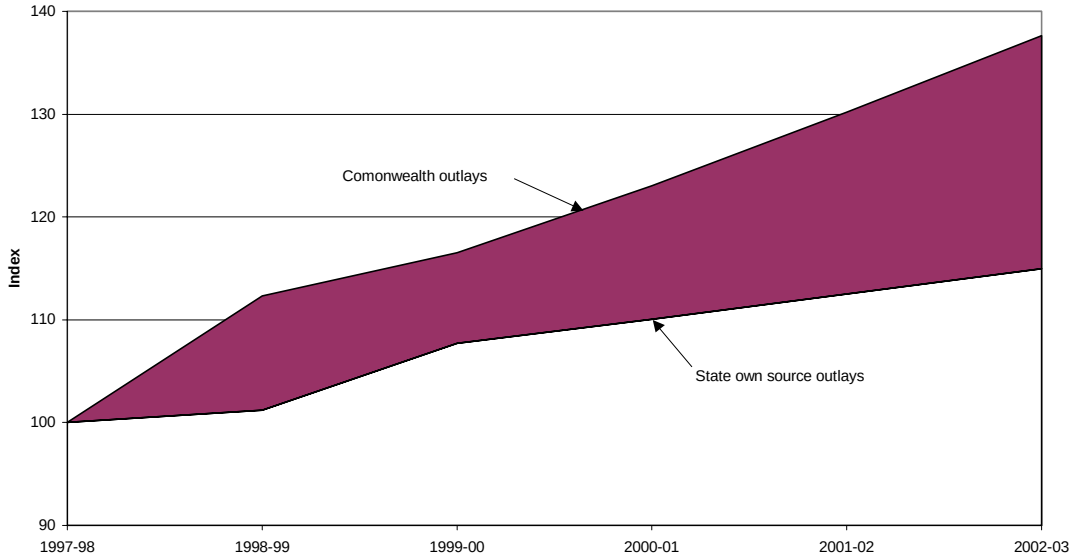
The Government Senators wish to note that the significant level of increased Commonwealth funding provided to the States and Territories for the public hospital system through the AHCA, does not seem to be matched by the States' and Territories' own source expenditure on public hospitals.

The 1999-2000 Budget papers show that the States and Territories, on average, increased their own source hospital expenditure by only 0.3%, compared to an increase in Commonwealth funding for the public hospital system of 7.1%, after the WCI-1 indexation announcement in December 1999.

In the current financial year, 2000-2001, State and Territory own source expenditure on public hospitals is expected to increase on average by 2.4%. At the same time, Commonwealth contributions through the Australian Health Care Agreement will increase by 5.6%.

The following graph shows relative Commonwealth and State contributions to hospital funding under the Agreements so far and projections for the balance of the Agreements based on trends to date.

GROWTH IN PUBLIC HOSPITAL SPENDING
Commonwealth and State Contributions under the AHCAs if current trends continue



It is relevant to note that no jurisdiction expects to increase its own source funding this financial year - in percentage terms - above what the Commonwealth is providing through the AHCA. South Australia and Tasmania are actually decreasing their nominal own source contributions over 1999-2000 – see detailed comments at the end of this section.

The States themselves acknowledge the low level of own source contributions to their public hospital systems. For example, the 1999-2000 South Australian Budget Papers stated that the Budget provided 'savings of around $46 million from the level of real spending that occurred in 1998-99'.

The Commonwealth Department of Health and Aged Care, in evidence to the inquiry, estimated that if the States and Territories had increased hospital funding at the same rate in 1999-2000 as the Commonwealth, an extra $460 million would have been available for public hospitals in that year.

Against this background, the Government Senators support the recommendations contained in the Opposition Report that funding for public hospitals be increased by $450 million over the next two years. This extra funding for the public hospital system should come from the States and Territories keeping pace with the Commonwealth's contributions through the AHCA.

Any inadequacy in the overall levels of funding could be addressed by modifying the Agreements to require the States to match the rate of increase in Commonwealth funding or by requiring the States and Territories to maintain a minimum amount of own source funding for their State's public hospital system.

The absence of such a requirement was raised in evidence to the Committee by the Australian Healthcare Association:

> 'I think we need to look at it in a revised agreement between the Commonwealth and States, is some commitment to growth from both parts of government. Presently, the agreement is not really that explicit about the states committing to growth. It certainly does commit the Commonwealth to growth'
>
> (Mark Cormack, Australian Healthcare Association, Hansard CA 754)

The absence of such a requirement in the past has resulted in many public disagreements between Commonwealth and State and Territory Governments of all persuasions. For example, in 1995 the Chair of the Committee, in her capacity as Minister for Family Services, responding to a question without notice for Senator Lees on public hospital funding stated:

> 'The states are shifting the money out of the hospital system and then blaming the Commonwealth. The record is that Commonwealth money is increasing and state money is decreasing'. Hansard 27 March 1995

Further, in its 1996 election policy the Australian Labor Party commented:

> 'Over the period of the Medicare Agreements, 1988-89 to 1993-94, the Commonwealth Government increased its funding share from 47% to 55%. But this has not translated into improved service and waiting lists because over the same period (page 7).

The Government Senators recommend that the next Australian Health Care Agreements contain a clause requiring the States and Territories to maintain a minimum level of own source expenditure for public hospitals.

Tasmanian Public Hospital Funding

The Tasmanian Budget Papers indicate that the State will spend a total of $329.6 million this financial year on the admitted patients, non-admitted outpatients and non-admitted accident and emergency components of the Hospitals and Ambulance Service output group (including spending from the Private Practice Scheme and the Patient Trust and Hospitals Bequest Account). This compares with $335 million spent in total in 1999-2000.

As the following table shows, Commonwealth grants to Tasmania under the Australian Health Care Agreements will increase from $129.9m in 1999-2000 to $135.7m in 2000-2001.

Commonwealth and Tasmanian spending on public hospital services

	1999-2000 Budget $m	2000-01 Budget $m	Change $m	Change %
Admitted patients (a)	273.5	268.9	-4.7	-1.7%
Non-admitted - outpatients	46.4	45.8	-0.5	-1.2%
Non-admitted - emergency	15.1	14.9	-0.2	-1.2%
Total	335.0	329.6	-5.4	-1.6%
AHCA funding	129.9	135.7	5.8	4.5%
Net own source Tas funding	205.1	193.9	-11.2	-5.5%

(a) Includes in 2000-01 spending from Private Practice Scheme and Patient Trust and Hospitals Bequest accounts.

The table shows that total spending on Tasmanian public hospitals is going to decrease by 1.6%, and that while the Commonwealth is increasing its grant by 4.5% the Tasmanian government is reducing its owns source spending by 5.5%.

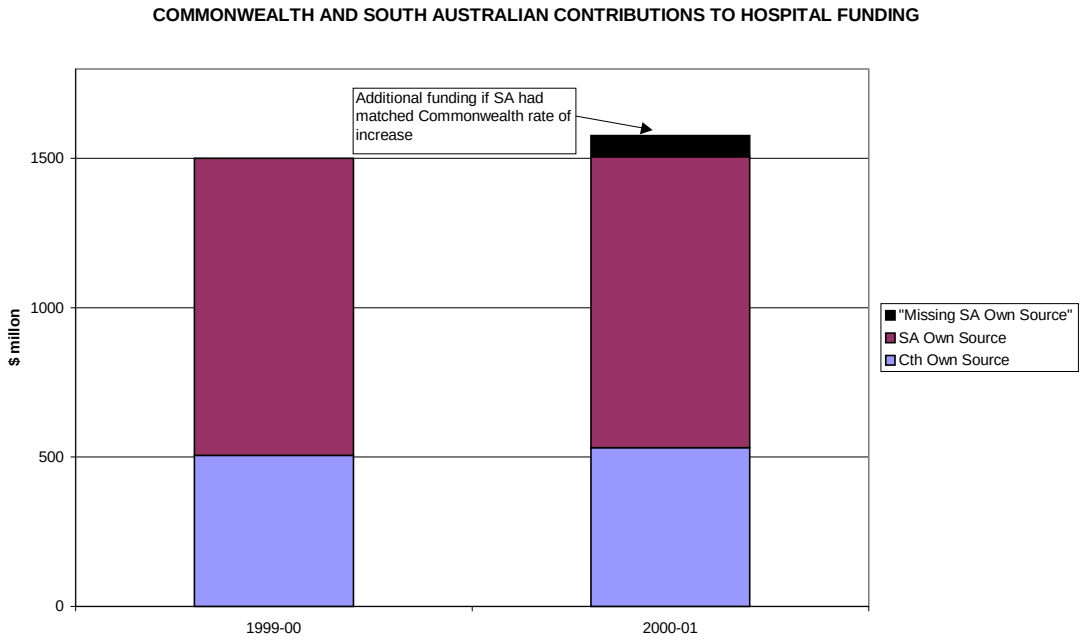
South Australian Public Hospital Funding

The Commonwealth will be increasing its contribution to the South Australian Government through the Australian Health Care Agreement by $26 million this financial year. The South Australian Budget Papers estimate total expenditure on public hospital services for 2000-2001 to increase by $6 million, suggesting a reduction of $20 million in the South Australian Government's own source funding level from 1999-2000.

Commonwealth and South Australian spending on public hospital servies

	1999-2000 Budget $m	2000-01 Budget $m	Change $m	Change %
Admitted patients	1216.6	1219.8	3.2	0.3%
Non-admitted patients	283.5	286.1	2.6	0.9%
Total	*1500.1*	*1505.9*	*5.8*	*0.4%*
AHCA funding	506.1	532.0	25.9	5.1%
Net own source SA funding	*994.0*	*973.9*	*-20.1*	*-2.0%*

Source: 2000-01 State Budget Papers, pages 6.20-24 and Commonwealth Government Budget Paper 3



As the graph shows, an additional $71 million would have been available if South Australia had increased its funding at the same rate as the Commonwealth.

The next AHCA

Government Senators do not accept the recommendation of the Opposition Report that the negotiation rounds for the next Australian Health Care Agreement, due to apply from July 2003, should commence now. This is a completely impractical recommendation.

The recommendation also suggests that the next AHCA should include MBS, PBS and PHOFA spending. Government Senators are unable to ascertain from the Opposition as to how the States and Territories could be parties to an agreement about MBS and PBS, when these are payments from individuals to medical practitioners through the Commonwealth.

Integration of pharmaceutical payments

Government Senators also have difficulty with the recommendation to test the integration of payments for pharmaceuticals models in a public hospital in each of the States and Territories.

The Commonwealth already has offered to assume responsibility from the States and Territories for funding the supply of discharge and out patient pharmaceuticals. Presently, only one State has agreed in principle to this offer, and only two others have expressed an interest in the proposal.

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

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

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

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

The Opposition Report makes little reference to the issues surrounding alleged cost shifting between the different jurisdictions.

Despite the evidence to this committee and to the Community Affairs Legislation Committee over many years of efforts by public hospitals to shift costs to patients and to Commonwealth-funded benefit programs, the Opposition Report has chosen not to make a meaningful finding in this area.

Evidence from the States and Territories alleged "cost shifting" by the Commonwealth in the form of providing insufficient aged care residential places so that aged people have to stay in hospital and through a lack of GPs in rural areas so that people have to attend hospitals for primary health care.

The Government Senators wish to make several points about these allegations.

First, particular geographic and historical circumstances have meant that public hospitals have always provided some places for aged persons and they have always provided some outpatient services that otherwise would be provided by a GP if available.

Secondly, not withstanding ample opportunities, the Committee was not presented with any evidence of a deliberate decision by the Commonwealth Department of Health and Aged Care to avoid allocating aged care placements in particular regions to shift the cost of patient care to the States.

The Government Senators believe there is a general benefit to rural communities when aged persons reside in hospitals near their homes and families rather than moving to a nursing home in the city. The same can also be argued for people receiving primary care from a hospital where there is no GP to provide the equivalent medical service.

However, the same cannot be said of the patients who have been inconvenienced and financially disadvantaged by the wholesale closure of public hospital outpatient facilities and through the failure of hospitals to provide appropriate pharmaceuticals upon discharge.

Government Senators are aware that the Minister for Health and Aged Care receives correspondence from patients who have undergone treatment in public hospitals as public patients and then received substantial medical bills for radiotherapy because of the "privatisation" of the radiotherapy clinic.

In other cases the hospital decides to "privatise" the chemotherapy costs – so patients are referred to a community pharmacy with a PBS script to obtain pharmaceuticals. PBS data shows that in one State in 1998-1999 the cost of certain chemotherapy drugs dispensed under the PBS increased by 148% compared with a rate in a neighbouring jurisdiction of 36%. The only plausible explanation for such a differential is a concentrated campaign to shift costs onto the Commonwealth through the PBS.

In the situation where the States and Territories do not fully meet their obligations, patients are not only inconvenienced but face significant out of pocket expenses because they are denied free access to public outpatient services unless they have a referral from their GP. This not only costs the patient time and money for the GP consultation, but they are ultimately charged for the public hospital service they were expecting to receive free of payment.

Government Senators wish for it to be noted that Commonwealth funding to the States and Territories for the provision of public hospital services under the 1998-2003 AHCA is at record high levels. Yet while the Commonwealth is increasing funding in real terms by over 25% over the five year life of the Agreement, the States and Territories are requiring patients to fund more public hospital services through the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme and from their own out-of-pocket payments.

The Government Senators are concerned at the detrimental financial effect cost shifting by the States and Territories has on patients and notes that it continues to be a vexed problem for the Australian public hospital system.

This report notes that Clause 19 of the AHCAs provides that:

> "where it can be demonstrated that a change in service delivery arrangements would improve patient care or patient outcomes, the Commonwealth and [the State] undertake to implement such changes and modify financial responsibilities by agreement".

Yet the Opposition Report remains silent on a resolution of this issue. Government Senators recommend that the Commonwealth should actively seek such modifications whenever it becomes aware of systemic shifting of costs out of public hospitals onto Commonwealth funded programs.

Better integration

A significant proportion of hospital admissions are the result of acute manifestations of chronic disease that are potentially preventable by better primary care. Barriers between the hospital system – managed and paid for by the States – and the community medical system – paid for by the Commonwealth – exacerbate poor management of people with chronic disease.

These barriers can only be overcome with a high level of co-operation from both levels of government, hospitals and the medical profession. However, initiatives developed under a range of programs (including the National Demonstration Hospital Program, the Co-ordinated Care Trials and the Division Hospital Integration Program) point the way to improved integration.

The Government has funded the National Demonstration Hospital Program to foster innovation and reform in service delivery in public hospitals, including a focus on elective surgery management.

Patient Assisted Travel

The recommendations around Patient Assistance Travel Schemes pay little regard to the responsibility of different levels of government. In 1986-87 the program was transferred to the States and Territories with a significant injection of additional funds. The Government Senators do not believe there is any valid reason for this Committee to engage in a review of a State and Territory Government program, as the Opposition Report suggests.

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

Private Health Insurance

The Government Members of this Committee note that following the introduction of the 30% Rebate on private health insurance in January 1999 a significant number of Australians have joined private health funds.

Since January 1999 over 3.1 million Australians have taken out private hospital cover. At the end of the September 2000 quarter, nearly 9 million Australians enjoyed the benefits and freedom of choice that the private health insurance membership brings.

The percentage of the Australian population with private health insurance at 30 September 2000 was 45.8% - the highest coverage since March 1989. This represents a dramatic reversal in the fortunes of private health insurance since coverage reached its nadir in December 1998 when only 30.1% of Australians had private health membership.

The need for a viable private health system to complement Medicare is well documented. The Department of Health, Housing, Local Government and Community Services in the 1993 Report titled 'Reform of Private Health' noted that:

> 'It must be remembered that Medicare was always intended to coexist with the private health system, not to replace it. Initial estimates of the cost of Medicare assumed that at least 40% of Australians would maintain their private cover'.

The turn around in private health membership must be attributed to the Government's efforts to make private cover more attractive to Australians. This strategy has included:

- the 30% Rebate which has assisted in making private health insurance more affordable, particularly for Australian families.
- the introduction of the Lifetime Health Cover scheme in July 2000 to encourage and reward long-term membership of private health by eliminating the incentive for 'hit and run' membership of a fund.
- recent legislative changes have required all private funds to offer 'no or known gaps' policies which addresses one of the greatest disincentives to private health membership - out-of-pocket expenses.

The Government Senators assume the Committee is reluctantly supporting the Government's 30% Rebate as it has failed to make any reference to its abolition or suggested reform in the report. This is particularly pleasing to Government Senators given that in February 2000 and at the Labor Party Conference in July the Opposition had refused to rule out scrapping or means-testing the 30% Rebate.

The Opposition Report, and its minimal references to the 30% Rebate, stands in contrast to the Committee's First Report: *Public Hospital Funding and Options for Reform* which stated that 'arguably, the 30 per cent rebate can be seen to run counter to the Medicare principles of universality, equity and access' (page 102).

There is no difference in the principles behind the Government's 30% Rebate to those that supported the Family Health Rebate that the Australian Labor Party incorporated in its 1996 election health policy, *Australia's Health*. That is, by assisting Australian families afford private cover, this will result in an increase in private health membership which will help alleviate pressure on the public hospital system.

Indeed the Labor Party's 1996 election policy stated 'in recent years, membership of private insurance funds has gradually declined and this is of some concern' (page 12). The Government has recognised that concern and through its measures to address the decline in private health insurance has restored balance to the Australian health system and thereby ensured that Medicare will remain sustainable into the future.

A number of witnesses before the Committee argued that the level of spending associated with the 30% Rebate would be better directed to the public hospital system. These arguments, while demonstrating a degree of unfamiliarity, focus on the increase

in the cost of the 30% Rebate owing to the rise in private health insurance membership since January 1999.

These arguments ignore the impact the 30% Rebate and the Lifetime Health Cover scheme have had on reversing the trend of declining coverage of Australians with private cover. The Government Senators wish to consider what would have happened to the public hospital system if the decline in private health insurance had been allowed to continue unabated.

If the fall in private health membership apparent under the previous Commonwealth Government had been allowed to continue, public hospitals would now be operating under unsustainable pressures.

This threat was identified by the Health Department of Western Australia: 'one of the other pressures that has come on the state health system in recent years has been the decrease in private health insurance' (Ms Ford, HansardCA274).

The current Commonwealth Government's policies have been successful in restoring private health insurance membership to a sustainable level and in turn, ensuring a viable future for Medicare.

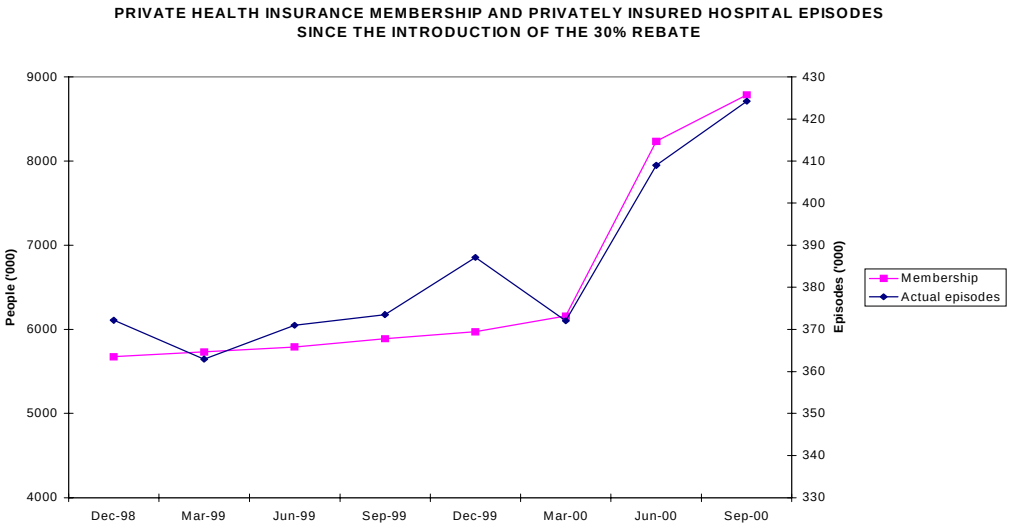
The Opposition Report claims that there is no evidence of a direct link between private health insurance membership and demand for public hospital services.

This conclusion overlooks the findings of the successive "2% reviews" under the previous Medicare Agreements that found a clear relationship between people leaving health insurance and increased costs to the public hospital system.

In recognition of the link between the decline in private health cover and the increase in demand for public hospital services, the current AHCAs relate Commonwealth funding to the States and Territories to the level of private health insurance membership.

The Department of Health and Aged Care has estimated that as newly enrolled private health insurance members begin to use their private health membership fully some 567,000 extra procedures a year will be performed on privately insured patients by 2003. This will result in significant pressure being taken off the public hospital system as one in every six current public patient episodes becomes a private one.

As the following graph based on data from the Private Health Insurance Administration Council shows, changes in hospital utilisation by insured patients are closely tracking changes in membership.



The Opposition Report makes a number of minor recommendations regarding the conduct of the private health industry.

The Government Senators wish to note that at this stage gap cover is being provided through agreements between the funds and doctors and agreements between funds and hospitals that have agreements with doctors. In addition, recent Commonwealth legislation enables funds to develop gap cover schemes without the need for agreements.

Recent PHIAC figures quoted by the Minister for Health and Aged Care in the Parliament on 30 November 2000 indicate that in the September 2000 quarter almost 2 million or 60% of in-hospital medical services were provided with no gaps payments. This compares to the September quarter of the previous year when less than 10% of services were provided with no medical gap payments.

Government Senators also note that as far as awareness of policy coverage and pre-existing ailment rules are concerned, they are informed that most health funds have already contacted new members to confirm policy coverage and the exclusions surrounding the pre-existing ailment rule.

Government Senators note that the Government has worked with representatives of private hospitals, health insurance funds, Treasury and the Australian Competition and Consumer Commission to facilitate industry development of a voluntary 'Code of Practice' for the private health industry.

The code aims to improve the efficiency of business arrangements between health funds and hospitals and maintain confidence in the private health industry by ensuring that contract negotiations between health funds and hospitals is conducted in a fair and reasonable manner.

The code is expected to be in operation from 1 January 2001.

The Department of Health and Aged Care has recently reviewed the Private Patients' Hospital Charter, which is intended to help consumers receive the greatest benefit

from their private health insurance membership. The Charter provides a guide to what it means to be a private patient with health cover in a public hospital, a private hospital or a day hospital facility.

These measures by the Government and private health funds to make consumers aware of their private health product and to reduce the cost disincentives associated with private cover, like the gaps, will ensure the private sector remains viable and that pressure is removed from Australia's public hospital system well into the future.

Government Senators are satisfied that the Commonwealth's policies to address the affordability and attractiveness of private health cover will ultimately benefit the entire health system, ensuring Medicare remains sustainable.

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

Privatisation of public hospitals

The Opposition's Report recommends that the Commonwealth should commission independent research on co-location and carry out a national investigation into the privatisation of public hospital services by the States and Territory Governments.

This recommendation ignores the fact that it is not the Commonwealth that owns and operates public hospitals, and it is the States and Territories that are responsible for the provision of public hospital services under the AHCA. These issues fall entirely within the jurisdiction of the State and Territory Governments.

Under the Australian Health Care Agreement the States and Territories are responsible for the provision of public hospital services, including admitted and non admitted patient services, free of charge to public patients, on the basis of clinical need and regardless of geographic location. These services may be provided by public or private facilities.

Government Senators point out that how States and Territories choose to deliver public hospital services has no impact on the Commonwealth's commitment to the Australian public hospital system through the AHCA.

The level of Commonwealth funding will remain at an estimated $31.3 billion over the five years to 2002-03 regardless of whether public hospitals are privatised by the State and Territory Governments.

Government Senators note that there are only two examples in Australia of hospitals that were public hospitals and that are now licensed as private hospitals: Hawkesbury in New South Wales and Mersey in Tasmania.

Two public hospitals, until recently, were entirely operated by the private sector – Modbury in South Australia and Latrobe in Victoria. However, Latrobe has recently returned to public operation.

Finally, there are two hospitals built as private hospitals with a contract to supply public hospital services: Port Macquarie in NSW and Joondalup in Western Australia.

In total less than 1% of public hospitals and under 2% of public hospital beds are subject to some type of private management.

Government Senators wish to have it recorded that some of these arrangements have now been in place for over five years – both Port Macquarie and Mersey were approved as private hospitals when Dr Carmen Lawrence was the Minister for Health and Human Services. The handover of Modbury took place at the same time.

Against this background, Government Senators consider an investigation into the privatisation of public hospital services would be a futile and pointless exercise. Such a review by the Senate Community Affairs Committee would also be a further, unwarranted intrusion into the affairs of State and Territory Governments.

Public v Private efficiency

The Opposition Report and the Committee's First Report gave considerable attention to issue of public and private hospital sector efficiency. The Government Senators wish to point out that in the 1991 Issues Paper No. 2 from the National Health Strategy, conducted by the now Shadow Minister for Health, Ms Macklin, considered the issue and concluded that:

> "Data analysed in this paper provides support for the view that the private sector is, on balance, more efficient than the public sector" (page A210).

The paper went on to note that deficiencies in public hospital costing systems prevent any "conclusive costs study".

Furthermore, a recent article by Badham and Brandrup in Australian Health Review considered the question using average length of stay as a proxy for efficiency. The authors come to the conclusion that each sector was more efficient at those types of cases where it had the greatest share of the market.

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

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

A number of the recommendations of the Opposition Report in relation to these Terms of Reference largely reflect the work already under way through the Australian

Council on Safety and Quality in Health Care and the National Institute of Clinical Studies.

The Australian Council for Safety and Quality in Health Care will provide leadership and co-ordination for the systemic improvement of the quality and safety of health care in Australia. – need to improve information flow within the health system – development of the national health information network, health Connect based on electronic health records – substantial reduction in the number of adverse events.

The National Institute of Clinical Studies aims to make continuous improvement to the delivery of clinical practice while engaging stakeholders including practitioners, consumers and researchers in the improvement of clinical services. The Institute has also been established to inform and evaluate the implementation of best practice clinical standards.

The Government Senators question the need and value of establishing additional statutory authorities to oversee national performance reporting of health providers and public hospitals - especially given the potential constitutional impediments to their powers and the split responsibility for health services and financing.

A number of organisations, including the Australian Institute of Health and Welfare, the National Health Performance Committee, the Productivity Commission and the ACHA Implementation Working Group already report on performance elements of the health system.

Government Senators believe that, given that the Safety and Quality Council is effectively reviewed by Commonwealth and State and Territory Health Ministers on a yearly basis, it is not clear that a biennial review of the Council, as proposed in the Opposition Report, would add any value to the Council's operations.

The Opposition Report also recommends a project based approach to quality improvement and enhancement.

However, evidence suggest that the project by project approach under the last Medicare Agreements was not effective in achieving State-wide integration of funded projects and synthesis of the outcomes.

Proposed National Advisory Council

Government Senators are concerned that the recommendation to establish a National Advisory Council to advise on Commonwealth-State funding will promote an extra layer of bureaucracy and duplication that would not contribute to improved outcomes for patients in hospital care.

The Government Senators also note that there are already a wide range of advisory bodies on health that allow groups and individuals with appropriate expertise to provide appropriate input into the creation of health policy: AHMAC, ACCC, ACSQHC, ADEC, AIHW, AMWAC, ANCAHRD, ANCD, APAC, ATAGI, CCDI,

CDNANZ, CMEC, MSAC, NATSIHC, NDPSC, NHIMG, NHIMAC, NHPC, NHDC, NHMRC, NICS, NPAAC, NPHPG, PBAC, RHSET and TDEC to name but a few.

The proposed Advisory Council would be hard put to find an acronym that would distinguish it from these existing bodies, let alone to find a function to justify its existence.

Information technology

There are a number of recommendations in the Opposition Report relating to increased use of information technology within the health and hospital sectors. These recommendations appear to be made without regard to the very substantial ongoing agenda in this area by the Commonwealth and the States and Territories.

The Commonwealth Government has established the National Health Information Management Advisory Council (NHIMAC), to facilitate collaboration between the Commonwealth, States and Territories, and other key stakeholders to achieve a national approach to the development, uptake and implementation of new online technologies in the health sector.

Over 1998-1999 *Health Online: A Health Information Action Plan for Australia* was developed under the auspices of NHIMAC. *Health Online* provides a basis for a national strategic approach to using information in the health system to build a better health care system and to promote new ways of delivering health services.

Finally, Commonwealth and State Governments have established the Australian New Zealand Telehealth Committee, which has made substantial progress in considering the many issues related to the rapid expansion, application and sustainability of telehealth services across Australia and New Zealand.

Pooled funding

The Opposition Report projects ‘funds pooling’ as a panacea to the issues surrounding Commonwealth and State and Territory funding of hospital and health services. Such a belief overlooks two fundamental points:

First, the difficulty in the different levels of government agreeing on what funds are to be pooled and how this is to be done.

Second, the Opposition Report has failed to identify whether pooled funding is really a necessary and sufficient condition for change. Evidence presented to the Committee suggests that it is neither sufficient nor necessary.

Government Senators believe that even with pooled public hospital funding arrangements between the Commonwealth and the States and Territories, the manager of the single fund would still contend with the same issues as the current funding system:

- How to provide primary medical care in rural and remote areas;

- How to provide residential aged care in rural and remote areas;
- How to allocate resources appropriately between hospital emergency departments and general practice;
- How to ensure that patients leave hospital with an effective discharge plan that their community care givers can implement;
- How to transfer funding between doctors, hospitals and other providers appropriately.

These are complex issues, and funds pooling will not of itself solve any of them.

There was no evidence before the Committee to suggest that pooled funding is necessary. Comments from Mr Jim Davidson of the South Australian Department of Human Services at the 20 November Round Table summarise the position very well:

> "So from our point of view I do not feel all that optimistic that those issues are going to be resolved simply by saying, "We've created a funds pool".

Conclusion

The Government Senators believe that the opportunity provided by this Inquiry could have resulted in some substantial and long lasting recommendations for improvement to the delivery of health services in Australia.

For example the Government Senators believe that addressing the management of demand in hospitals through the better management of chronic illness in the community would result in reduced pressure and demand on our public hospitals while leading to improved patient care. (Management of chronic illness trials in Australia and overseas have shown that this can lead to at least a 10% reduction in hospital demand).

To adequately achieve this the States and Territories would be required to think long term as opposed to attempting to survive day to day. It would also require the Commonwealth and the States and Territories to work together in two main areas: to break down the barriers between public care, which is mainly hospital based and community care which is predominantly GP based.

While the States and Territories pay for the former, and the Commonwealth the latter, there are immense opportunities for improved outcomes and relief of funding pressures if there is to be a degree of cooperation which has not previously occurred.

It would involve cooperation between the two levels of Government to better manage the transition from the community into the hospital and back again, ie. preventing illness in the first place and managing chronic illness better once one is sick.

Not only would this have the lasting significance of better health care, but it would also have such significance in terms of cost, demand and improved public outcomes.

Most significantly it should be noted (as it was in the Committee's First Report) that the hospital system is not in 'crisis'. When we look at Australia's system, its professionalism, its facilities and its outcomes it is hard to imagine, compared to the rest of the western world, that the overwhelming majority of people are not satisfied with the treatment they receive.

The Opposition's Report into Public Hospital Funding is the final product of a lengthy and costly exercise that could have explored and presented real alternatives for hospital funding arrangements in Australia. However, it does not shed any new light on how to improve upon existing arrangements. Nor does it make a case for the need for any significant reform of current hospital funding arrangements.

Government Senators believe that the Report is the outcome of a completely politicised process. The Opposition Report's support for funds pooling appears to be dictated by Opposition policy rather than any detailed evaluation of the proposal. Pooled funding approaches, which would necessitate difficult decisions as to what funds would be pooled and how this will be done, are not an end in themselves.

Government Senators are amazed that the simple, but significant, recommendation to ensure that the States' and Territories' contribution keeps pace with the Commonwealth's funding level has not been included in the Opposition's Report. Instead, the Opposition has pursued the vacuous notion that pooled funding is the panacea for public hospital funding arrangements.

Similarly, the finding that the Commonwealth should provide additional funding over the next two years ignores the evidence that the States and Territories have not been increasing their funding at anything close to a rate comparable to that of the Commonwealth. That recommendation also ignores the very substantial benefits that will flow to the States and Territories as a result of the unprecedented increase in private health insurance membership.

In other areas the Opposition's Report shows a lack of discipline and originality: it engages in forays into areas of policy outside the responsibility of the Commonwealth; it endorses many areas of policy already pursued at either the Commonwealth or State level; and makes a series of recommendations that either ignores established facts on public hospital and health funding arrangements or threatens to burden them with layers of bureaucracy.

In summary, the Opposition Report is neither original, balanced nor particularly useful to advancing consideration of how to improve upon the present system of hospital funding arrangements between the Commonwealth and the States and Territories.

Government Senators re-affirm that the Commonwealth Government remains committed to ensuring that all Australians have adequate access to high quality, public hospital facilities. Under the Australian Health Care Agreements, the Commonwealth is providing substantial real increases in public hospital funding to the State and Territory governments.

Additionally, through the 30% Rebate and Lifetime Health Cover, the Commonwealth is strengthening the ability of Australians to enjoy the benefits and freedom of choice that private hospital cover brings. These measures and many others spanning quality and safety and better use of information technology will allow Australians to continue to benefit from a world class public hospital system.

Senator Sue Knowles, Deputy Chairman
(LP, Western Australia)

Senator Tsebin Tchen
(LP, Victoria)