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Members for the 39th Parliament

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OVERVIEW AND RECOMMENDATIONS

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

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

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

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

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

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

Roundtable Forums

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

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

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

The adequacy of public hospital funding

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

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

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

Evidence presented to the inquiry has indicated that the key problem that needs to be addressed as a priority is the fragmented nature of the roles and responsibilities of the Commonwealth and the State and Territory Governments in the funding and delivery of public hospital services.

Reform of State and Commonwealth funding arrangements

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

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

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

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

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

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

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

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

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

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

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

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

Private health insurance

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

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

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

Privatisation of hospitals

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

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

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

Performance reporting and information technology

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

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

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

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

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

Conclusion

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

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

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

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

RECOMMENDATIONS

Chapter 2

- Future funding

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

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

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

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

- Priorities

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

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

priorities are the need for increased resources for emergency departments of public hospitals and the national shortage of nurses.

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

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

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

- Performance reporting

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

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

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

Chapter 3

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

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

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

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

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

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

Chapter 4

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

Chapter 5

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

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

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

Chapter 6

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

Recommendation 24: In view of the difficulties currently being experienced at several privately managed public hospitals, the Committee RECOMMENDS that no further

privatisation of public hospitals should occur until a thorough national investigation is conducted and that some advantage for patients can be demonstrated for this mode of delivery of services.

Chapter 7

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 8

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

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

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

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

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

CHAPTER 1

INTRODUCTION

Background to the inquiry

1.1 In July 1999, following widespread public concern about the state of the public hospital system, State Premiers and Territory Chief Ministers called on the Federal Government to establish an independent inquiry, preferably to be conducted by the Productivity Commission, into the health system. In response to the request, the Federal Government stated that it did not believe such a review would be productive. The Minister for Health and Aged Care noted 'Australia has an excellent health care system, which is widely regarded as the best universal access model in the world. The Federal Government is committed to Medicare. Under such circumstances it cannot see any useful purpose in spending 18 months reviewing a system it supports'.[1]

1.2 The Senate subsequently agreed to establish an inquiry and on 11 August 1999 the matter was referred to the Committee for inquiry and report by 30 June 2000. The complete terms of reference are:

How, within the legislated principles of Medicare, hospital services may be improved, with particular reference to:

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

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;

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;

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;

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

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1 Minister for Health and Aged Care, 'Review of the Health System', *Media Release,* 5 August 1999.

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;

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.

Conduct of the inquiry

1.3 The inquiry was advertised in *The Financial Review* on 27 August 1999, *The Weekend Australian* on 28 August 1999 and through the Internet. The closing date for submissions was originally 22 October 1999, although the Committee continued to receive submissions throughout the course of the inquiry.

1.4 The Committee received submissions and evidence from Federal, State and Territory Governments. The Committee also received submissions and evidence from individuals, health and consumer organisations, area health services, practitioners and peak organisations. Many organisations and individuals also provided additional written information to develop the issues raised in their submissions.

1.5 In order to improve its understanding of the issues facing public hospitals, the Committee sought publicly available information relating to the operation of hospitals and health services and requested copies of their the most recent annual reports. Most public hospitals and area health services responded to the request. The material proved a valuable resource for the Committee. The Committee has also utilised a range of published material to inform itself during the inquiry. A bibliography of the major reports and articles referenced by the Committee is at Appendix 3.

1.6 The Committee received 93 public submissions in total. In addition, the Committee received 6,739 postcards, letters and emails from all States and Territories expressing support for Medicare and the public health system. The list of submissions and other written material received by the Committee and for which publication was authorised is at Appendix 1.

1.7 The Committee held eight days of public hearings in Canberra (2 days), Adelaide, Darwin, Perth, Sydney, Brisbane and Melbourne. All but the Canberra and Darwin hearings were held in public hospitals: the Women's and Children's Hospital, North Adelaide; the Sir Charles Gardiner Hospital, Perth; St Vincent's Hospital, Sydney; the Princess Alexandra Hospital, Brisbane and St Vincent's Hospital, Melbourne. The Committee had the opportunity to inspect facilities at these hospitals and, in addition, visited a number of other hospitals to inspect facilities and to hold informal discussions with administrative and clinical staff. Hansard transcripts of the public hearings may be accessed at www.aph.gov.au/hansard. Witnesses who gave evidence at the hearings are listed in Appendix 2.

First Report

1.8 By the conclusion of the public hearing schedule, the Committee had received a considerable volume of evidence relating to the terms of reference and the Australian health care system in general. From this evidence the Committee was able to identify clearly not only widespread community support for the public hospital system but also increasing disquiet by the Australian public at the way in which governments – the Commonwealth, the States and Territories – have engaged in game playing and cost and blame shifting.

1.9 The evidence pointed to some fundamental problems in the public hospital system: it is significantly underfunded; the roles and responsibilities of different levels of government are fragmented in relation to funding and delivery of services; cost shifting impacts adversely on service efficiency and delivery; and data is often not comparable between different levels of government.

1.10 The Committee considered that it would be useful to draw together funding information into a First Report, as its initial response to the terms of reference. The Committee considered that there was a need for further debate on the problems being faced by the public hospital system and that the First Report would act to stimulate that debate.

1.11 The First Report was tabled on 11 August 2000. The Report presented an overview of the public hospital sector, identified the major problems of the hospital system, examined the adequacy of funding and canvassed a range of options for reform which had been raised by participants in the inquiry. This was an initial report by the Committee and did not contain any conclusions or recommendations or endorse any particular reform option. Rather, the report reflected the views of participants with the intention that those views would be discussed further. The First Report may be accessed at www.aph.gov.au/senate_ca.

Roundtable Discussions

1.12 In order to move the debate on further, the Committee convened a Roundtable Discussion on 18 August 2000 at which expert participants considered the options presented in the First Report. The Roundtable provided a valuable evaluation of the options for reform of the hospital system. Options for funding reform were considered at a theoretical level with assessment of the likely success or otherwise of the options as the basis of reform of the hospital funding system. A discussion of the options and comments by participants is provided in Chapter 3 of this Report.

1.13 At the Roundtable, participants indicated that it would be useful if a broader discussion with clinicians and those at the ‘coal face’ of service delivery also took place. It was considered that these participants would be able to identify problems and how options may impact on the efficiency and effectiveness of public hospital service delivery. A further Roundtable was convened on 20 November 2000 at which health, allied health and consumer groups discussed reform of the hospital system and mechanisms to improve the delivery of quality care.

1.14 The Committee would especially like to thank the participants at both Roundtables for their valuable contributions. The Roundtables provided a unique mechanism to discuss the much needed reform of the hospital funding system and to identify directions for reform that, if implemented, would result in a more efficient and effective public hospital system providing quality care for all Australians.

1.15 The Roundtables allowed all present, a wide range of health experts and senior players in the delivery of health care, to exchange views and ideas. Both were highly supported by those attending and led to calls for further opportunities for health policy discussions. This is described further in Chapter 3.

Assistance with the inquiry

1.16 The terms of reference of the inquiry raised highly complex issues surrounding the current financial arrangements between the Commonwealth, States and hospitals/health services and their impact on service delivery now and in the future. Evidence received in submissions, public hearings and supplementary information provided by many inquiry participants contributed to the Committee's deliberations.

1.17 The Committee was greatly assisted by the Centre for Health Economics Research and Evaluation (CHERE) at the University of Sydney, in its consideration of the evidence. CHERE provided specialised research, information and advice addressing the more complex issues raised during the inquiry. CHERE provided a detailed research paper for the Committee which can be accessed at http://www.aph.gov.au/senate_ca.

1.18 The Committee also received expert staffing and research assistance from Mr Paul Mackey of the Social Policy Group of the Department of the Parliamentary Library. The Committee thanks the Library for its cooperative assistance with the Committee's work.

1.19 The Committee was helped as ever by the Secretariat, Mr Elton Humphery, Ms Christine McDonald, Mr Peter Short, Ms Leonie Peake and Ms Ingrid Zappe. Not only did they assist the Committee with reading submissions, preparing the report and arranging hearings, they also met the demands of two Roundtables, essentially unprecedented, and enabled both to be undertaken successfully.

CHAPTER 2

PUBLIC HOSPITAL FUNDING

The role of hospitals in the health system

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 Duckett, S, p.112.

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

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

2.7 The foregoing discussion encapsulates a dilemma evident in the evidence on funding issues received by the Committee in this inquiry. Some participants have argued that Australia is spending about the right amount on health at 8.5 per cent of GDP.[10] However, the majority of submissions regard the level of funding for public hospitals to be inadequate. The Australian Medical Association (AMA), for example, believes that 'just to tread water, our public hospitals need additional funding of around 5.5 per cent to six per cent a year'.[11] On the other hand, the NRHA argued in evidence that funding for public hospitals is not really the issue:

> the right question is not how much money is going to hospitals in rural areas but how much money is going to health services in rural areas.[12]

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

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

Overview of public hospitals in Australia

2.10 Table 2.1 provides an overview of the size, activity and financial details of public hospitals in Australia, including the number of available beds, the number of separations, the proportion of separations which are same day separations, and details of the average length of stay, both in total and excluding same day separations. An indication of the workload of accident and emergency units is provided in the number

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

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

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

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

of non-admitted occasions of service and details of expenditure are included. A breakdown of the activity of public hospitals in terms of public patients and private patients is also provided. The table contains data for both 1993-94 and 1998-99, permitting an analysis of changes over time.

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

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

A = all separations B = excluding same day separations

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

2.11 Comparing 1993-94 and 1998-99, it is noteworthy that the number of available beds in public hospitals has declined by 7375. In terms of activity, while the annual number of separations has increased by 543 000, patient days have decreased by 918 000, reflecting, in the main, the decline in the numbers of private patient separations. Same day separations have increased from 34.2 per cent of total separations in 1993-94 to 44.7 per cent of separations in 1998-99. The notable changes over this period with regard to private patients in public hospitals are a decline in the number of private patient separations from 545 000 in 1993-94 to 319 000 in 1998-99 and, allied to this, a decline in patient revenue as a proportion of total recurrent expenditure, from 10.2 per cent in 1993-94 to 8.6 per cent in 1998-99.

Future challenges facing the health system

2.12 Evidence received by the Committee describes a situation that, contrary to the perception which is sometimes portrayed through the media, the public hospital system is neither in, nor faces, a crisis. However, other evidence indicates that public hospitals are, and have been for some time, operating under severe strain. Somewhat ironically, the ability of public hospitals and their dedicated staff to continue to provide quality services in an environment of funding constraints places further pressure upon them. As the Northern Territory Minister for Health commented: 'we are a victim of our own success'.[13]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Ham, C, 'Priority setting in the health services', in *Rationing of Health and Social Care*, edited by I Allen, London, Policy Studies Institute, 1993, p.1.

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

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

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

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

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

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

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

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

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

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

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

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

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

- in some public hospitals, 'capital equipment has been allowed to run down to the point where it is creating serious clinical problems';[32]
- concern was expressed that current funding arrangements have 'undermined the capacity of the public system to support effective teaching, training and research';[33]
- several specific issues were identified which relate to the health status of Indigenous people and its impact on public hospitals, particularly in the Northern Territory. These include:
    - the high incidence of renal disease among Indigenous Australians as a driver of costs in the Northern Territory. In evidence, the President of the Northern Territory branch of the AMA stated that this is also an issue in North Queensland and Western Australia.[34] Dialysis accounts for 32 per cent of hospital admissions in the Northern Territory;[35] and
    - many Indigenous people presenting to hospitals in the Northern Territory have 'complex co-morbidity conditions, including renal disease, heart disease and scabies';[36]
- generally speaking, people living in rural and remote areas of Australia have poorer health status than people living in metropolitan areas. They have lower life expectancy and experience higher levels of hospitalisation for some causes of ill-health. People living in rural and remote areas also have less access to health care compared to their metropolitan counterparts;[37]
- although residents of rural and remote areas have access to public hospitals in metropolitan areas, patients often have to travel long distances, and many require some financial assistance. The various State-financed patient travel assistance schemes were criticised during the course of the inquiry;[38]
- the average age of hospital doctors is now around 50 years of age[39] and is over 40 years of age for nurses;[40]
- issues of stress and burnout are of major importance for nurses;[41] and

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

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

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

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

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

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

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

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

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

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

The important role of and modern challenges faced by public hospitals were emphasised by the Sydney Teaching Hospitals Advocacy Group which stated that:

> the public hospital has become the final common pathway to just about any problem. If you have a person who is psychotic, the police bring them up to the casualty department. If you have a person who is depressed, they bring them up there. If you have a person who is unconscious or they do not know what to do with them, they bring them up to casualty department because that is the only place to bring them.[43]

Commonwealth Government's powers over health policy

2.20 At the core of the tensions, buck-passing and blame-shifting that occurs between the Commonwealth and the States and Territories in health policy matters is, arguably, the unresolved nature of the exact constitutional boundaries between the two levels of government. John McMillan, in his book on the *Commonwealth's Constitutional Powers over Health*, argues that:

> the explicit references made to health matters in the Constitution define a scope of Commonwealth responsibility that is far more limited than what it has carved out for itself. By creative adaptation of the limited powers available there has been a gradual expansion of Commonwealth responsibility. Even so, there has been reticence, and Commonwealth regulation still falls far short of the most optimistic constitutional boundary.[44]

Funding arrangements for public hospitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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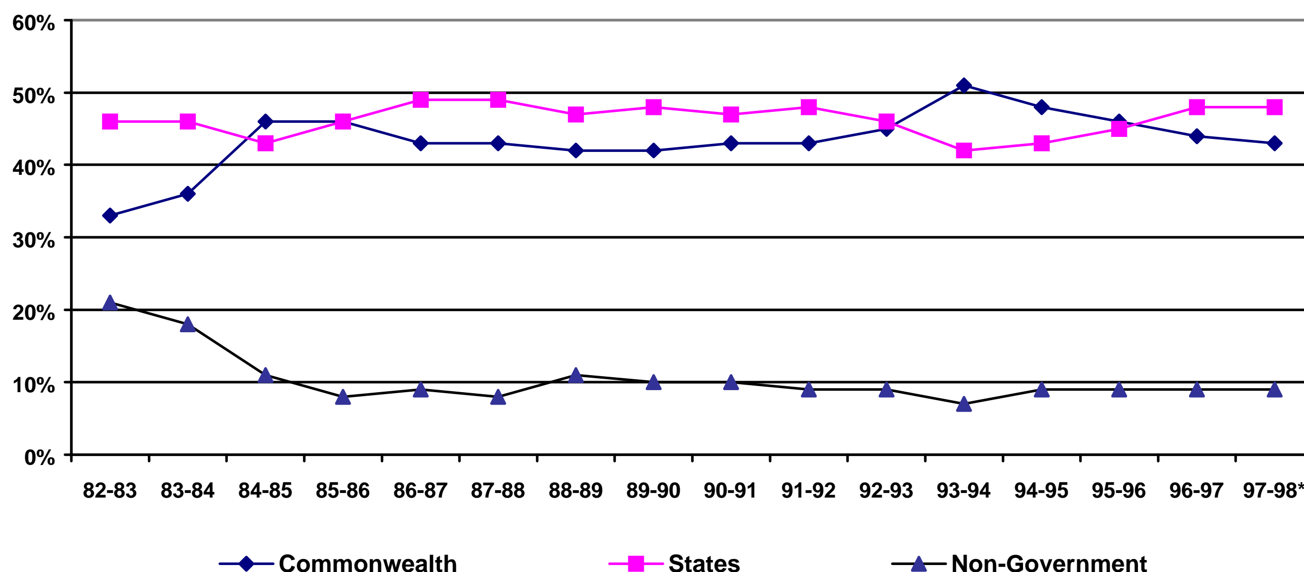
48 Submission No.50, p.14 (Dr Deeble).

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

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

Figure 2.1: Percentage Share of Recurrent Public Hospital Expenditure



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

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

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

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

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

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

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

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

Conclusion

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

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

2.36 In its First Report, the Committee stated that most participants in the inquiry had argued that the current level of funding for public hospitals is inadequate to meet the demand for their services. However, other than drawing the obvious conclusion that if current funding levels are inadequate then more funds are required, it is a difficult task to identify the actual amount of funding that would be regarded as adequate.

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

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

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

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

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

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

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

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

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

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

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

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

- **Future funding**

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

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

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

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

- **Priorities**

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

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

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

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

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

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

- **Performance reporting**

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

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

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

Cost shifting

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

2.47 The Queensland Government argued that cost shifting is an inevitable outcome of the current mix of roles and responsibilities of the different levels of government in the Australian health system: 'cost shifting is, and always will be, the outcome of an ill-defined and fragmented funding system'.[56] Offering a summary view, the New South Wales Health Department argued that whether cost shifting was perceived as good or bad depended on the view of the beholder: 'there is a terminology of cost shifting which implies an illegality and there is a terminology of cost shifting which implies maximising the benefits'.[57]

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

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

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

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

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

Committee that: 'I believe that cost shifting is occurring but I believe that it is occurring from the Commonwealth to the State and not necessarily vice versa'.[60]

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

Conclusion

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

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

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

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

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

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

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

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

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

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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

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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

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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.

CHAPTER 4

COORDINATED CARE TRIALS

4.1 This chapter discusses the evolution and development of the Coordinated Care Trials and the effectiveness of the trials in achieving better health outcomes for clients and in improving service delivery. The purpose of the Coordinated Care Trials is to test whether multi-disciplinary care planning and service coordination leads to improved health and well-being for people with chronic health conditions or complex care needs. Funds pooling between Commonwealth and State/Territory programs was trialed as a means of providing funding flexibility to support this coordinated approach to service delivery.[1]

Development of Coordinated Care Trials

4.2 The Coordinated Care Trials were developed in response to a Council of Australian Governments endorsed reform agenda in April 1995 that sought to meet Australia's health care needs in more appropriate ways while managing health expenditures more effectively.

4.3 The then Department of Human Services and Health called for expressions of interest in September 1995 to establish trials that would develop and test innovative service delivery and funding arrangements. Nine trials were approved by the Commonwealth and clients were recruited from July 1997. Due to the complexity of the design phase, slower than expected rates of recruitment and developments within the health system that affected the trials and necessitated changes to their design, the scheduled end date for the trials was extended to 31 December 1999.[2]

The coordinated care model

4.4 The coordinated care model consists of:

- a trial sponsor (such as an Area Health Service or Division of General Practice) which is contracted to Commonwealth and State governments to manage the trial;
- a funding 'pool' which combines funds drawn from a range of Commonwealth and State health care programs such as the MBS, PBS, Home and Community Care Program and hospital funding. These funds can be used to buy any services for individual patients considered appropriate;

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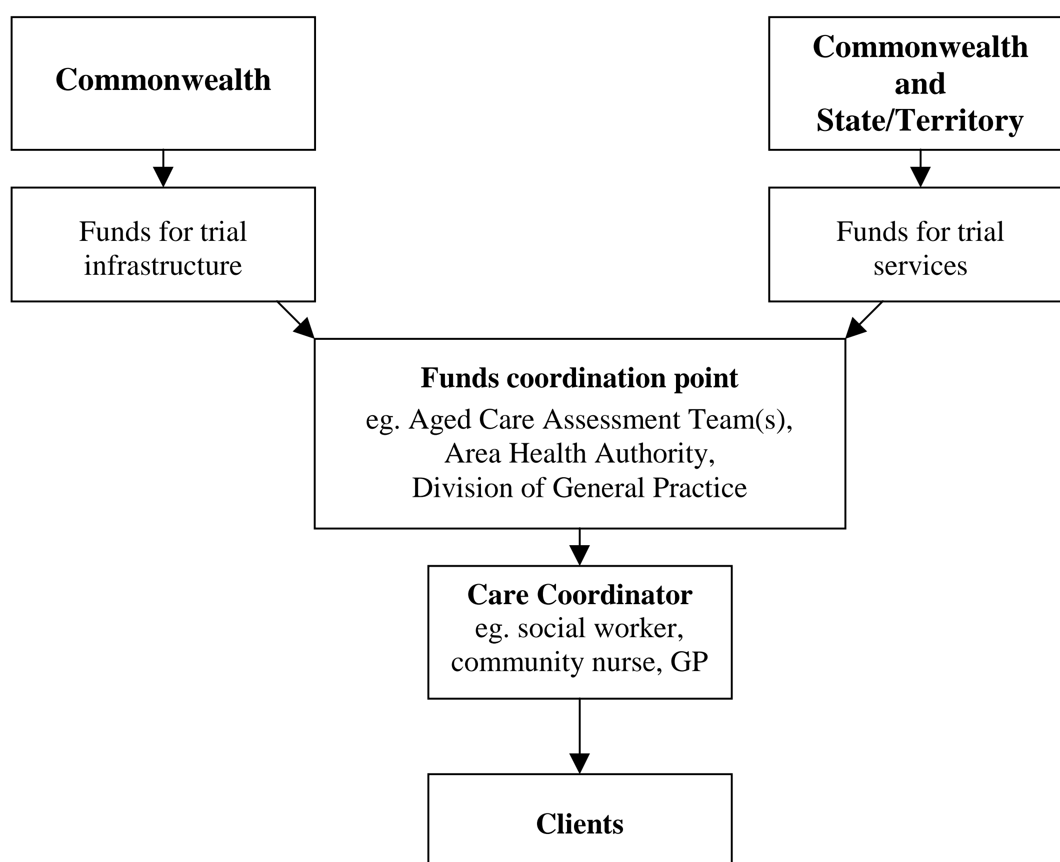
1 Submission No.38, p.22 (DHAC).

2 DHAC, *The Australian Coordinated Care Trials: Interim National Evaluation Summary*, September 1999, (referred to as the Evaluation Report), p.2.

- a care coordination process which can be undertaken by a person (a local GP, a community nurse or designated coordinator), or a service (such as an Aged Care Advisory Team); and
- a defined client group (usually people with high care needs with a particular diagnosis or condition, or those with a range of chronic illnesses).[3]

4.5 The organisational and funding arrangements for the trials are shown below.

Figure 4.1: Organisational arrangements for trials



Source: Parliamentary Library, *Coordinating Care in an Uncoordinated Health System,* May 1999, p.5.

4.6 The primary purpose of the trials was to develop and test different service delivery and funding arrangements, and to determine the extent to which the coordinated care model contributes to improved client outcomes; better delivery of services which are individually and collectively more responsive to clients' assessed needs; and more efficient ways of funding and delivering services.[4] As noted above,

3 Parliamentary Library, *Coordinating Care in an Uncoordinated Health System*, Current Issues Brief No.11, 1998-99, p.4.

4 Submission No.38, p.24 (DHAC).

the Commonwealth and the States pooled their funds for health and community services for each of the trials' participants. Infrastructure costs, relating to costs associated with IT systems, office accommodation and evaluation costs were in some cases shared between the Commonwealth and the States and in other cases were funded solely by the Commonwealth. Although initially considered for inclusion, residential aged care programs, such as nursing homes and hostels, were excluded as the funding could not be easily transferred into the pool because these services are often privately operated.[5]

4.7 Each trial had its own pool that it had to manage in order to provide the best care possible for its clients. The amount of money placed in each pool was based on an estimate of what would otherwise have been spent on services used by clients who were participating in the trials. Once an estimate for a trial client's needs for a particular service was calculated, that is, their needs were they not to enter the trial, these funds were typically notionally allocated to the trial and funds transferred monthly. Providers then billed the trial, or in the case of the MBS and PBS, the Health Insurance Commission, and funds flowed between the trial and the providers.[6] The following table shows the fund pool income for each trial by item.

Table 4.1: Coordinated Care Trials: fund pool income

	Care 21	Care Net	Care Plus	Care Works	Health Plus	Linked Care	North Eastern	Southern HCN	TEAM Care
MBS income	507 171	2 068 893	1 174 402	593 479	2 487 751	1 003 427	625 963	2 545 408	926 674
PBS income	487 197	1 825 086	763 966	502 342	1 544 598	878 971	505 600	1 164 850	731 454
DVA income	194 466	844 587	0	614 198	0	511 675	310 033	0	894 696
Hospital income	1 669 054	3 086 322	1 526 741	3 066 280	4 563 630	2 287 458	1 047 946	3 862 957	225 000
HACC income	437 500	247 122	531 088	585 353	481 685	985 883	496 888	0	0
RDNS income	267 905	0	0	152 459	638 512	683 753	219 435	53 973	0
Other income	0	0	0	0	0	71 738	0	0	0
Total	3 563 293	8 072 010	3 996 197	5 514 111	9 716 176	6 422 904	3 205 865	7 627 188	2 777 824

Source: DHAC, *The Australian Coordinated Care Trials: Interim Technical National Evaluation Report,* 1999, p.122.

4.8 Each client in a trial had a care coordinator who worked with the client to develop a care plan. The care coordinator then drew on money from the funding pool

5 Current Issues Brief No.11, p.6.

6 Current Issues Brief No.11, p.6.

to buy the full range of services set out in the care plan. The actual process of care coordination was open to the trials to determine. The care coordination function incorporated the assessment of clients, care planning process and care plan implementation, monitoring and review. The three main models were:

- Model 1: the GP approach – under which the client's GP undertook all tasks associated with the care coordination role;
- Model 2: the GP care coordinator with the service coordinator approach – under which the GP functioned as the care coordinator and was supported by a service coordinator who acted as an agent or organiser for the GP with various delegated tasks such as implementation of the care plan through the arrangement of services;
- Model 3: the non-GP care coordinators approach – under which the tasks were undertaken by specifically designated coordinators who were not GPs.[7]

4.9 While some trials adopted one of these approaches, others used a combination of approaches.[8]

4.10 There were nine general trials operating in 5 States and the ACT. The Trials were: North Eastern Health Care Network (Vic), Southern Health Care Network (Vic), HealthPlus (SA), Care 21 (SA), Care Net Illawarra (NSW), Linked Care (NSW), TEAMCare (Qld), Careworks (TAS), Care Plus (ACT). The nine trials recruited a total of 16 533 clients with complex and chronic health needs. While the characteristics of the target population varied slightly across the trials, clients were predominantly older persons, aged over 65 years of age, who were socio-economically disadvantaged. The trials had over 2000 GPs involved in their operation.[9] The main features of the general trials are shown below.

7 Submission No.38, p.23 (DHAC).

8 Evaluation Report, p.17.

9 Evaluation Report, p.viii.

Table 4.2: Coordinated Care Trials – main features

Trial name	Location	Client Eligibility Criteria		Target population
		Age	*Other Criteria*	
Care21	Northern suburbs of Adelaide, SA	65+ (55+ ATSI)	Complex health care needs, multiple community/health service usage	1200
Care Net	Illawarra area of NSW	65+ (45+ ATSI)	At risk of falling and/or needing multiple services	1800
Care Plus	ACT	All	Complex care needs, high users of health services	2400
Careworks	Southern Tasmania	65+	Complex care needs requiring multiple health services	1200
Linked Care	Hornsby & Ku-ring-gai areas of Sydney, NSW	All	Chronic/complex care needs including elderly and people with disabilities	1500
North Eastern HCN	North-eastern suburbs of Melbourne, VIC	65+	Diseases/disabilities typical of older age (eg stroke, respiratory, cardiac)	1600
HealthPlus	Central, southern and western suburbs of Adelaide and the Eyre Peninsula, SA	18+	Condition specific project criteria (eg diabetes) or complex, chronic care needs	6000-8000
Southern Health Care Network	Outer suburbs of south-east Melbourne, VIC	All	Greater than $4000 hospital episode(s) over 2 year period	2500-3000
TEAMCare Health	Northern suburbs of Brisbane, QLD	65+ (50+ ATSI)	Multiple service needs	3000

ATSI – Aboriginal and Torres Strait Islanders

Source: DHAC, *The Australian Coordinated Care Trials – Background Trial Descriptions,* 1999, pp.9-11.

Aboriginal and Torres Strait Islander trials

4.11 In addition to the general trials, there are trials for Aboriginal and Torres Strait Islander people. The Aboriginal Trials have a somewhat different focus, arising from the importance of comprehensive primary health care and community involvement in addressing health needs of Aboriginal and Torres Strait Islander people.

4.12 The main purpose of Aboriginal trials is to develop and assess innovative service delivery and funding arrangements that are based upon community and individual care coordination through pooling of funds from State and Commonwealth agencies. Aboriginal Trials share many of the features of the general trials but there

are some important differences. Most are funded in respect of an entire community rather than chronically ill individuals. MBS and PBS equivalent contributions to the funding pool are at national average rates rather than an estimate of what would otherwise have been spent on services, in recognition of historically very low levels of MBS and PBS usage by Indigenous clients. Greater emphasis is given to empowering communities as well as individuals to take control of their own health needs. All Aboriginal trials are implementing generic and individualised care plans with their client populations as well as initiating new population health programs dealing with issues such as diabetes and antenatal care.[10]

4.13 There are 4 Aboriginal Coordinated Care Trials in 2 States and the Northern Territory: Wilcannia (Far West Ward Aboriginal Medical Service) (NSW), Tiwi Islands (Tiwi Health Board and Territory Health Services) (NT), Katherine West (Katherine Health Board, Territory Health Services) (NT), Perth/Bunbury (a two site trial, Derbarl Yerrigan Health Service, South West Aboriginal Medical Service, Health Department of Western Australia) (WA).[11]

4.14 While the formal phase of the Aboriginal trials is finalised, the trials will continue to receive funding by the Commonwealth and States/Northern Territory during 2000 under transitional arrangements after which the future of the trials will be determined.

Additional Coordinated Care Trials

4.15 The 1999–2000 Federal Budget allocated $33.2 million to additional coordinated care trials over the next four years to focus on people with chronic or complex care needs, with a particular emphasis on older people who are chronically ill or disadvantaged.[12]

4.16 As with the current coordinated care trials, the additional trials will be developed in collaboration with key stakeholders, including State and Territory Governments, the medical profession and other service providers, the non-government and charitable sectors, and the private health sector. On 4 August 1999, all Australian Health Ministers endorsed strategic directions for the additional coordinated care trials.

4.17 The primary purpose of the additional trials is to build on the lessons of the current Coordinated Care Trials, and further develop and test different service delivery and funding arrangements. The trials are expected to run for three years. Trials participating in the first round will have the opportunity to compete in the second round of trials.

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10 Submission No.38, p.23 (DHAC).

11 Submission No.38, p.23 (DHAC).

12 Submission No.38, p.24 (DHAC).

Evaluation of the trials

4.18 As noted previously, the aim of coordinated care is to achieve better health and well-being for clients within existing levels of resources (except for Aboriginal trials where increased resources can also be a feature). The purpose of the trials is to test different approaches to achieving this. Given this aim, a comprehensive evaluation is a critical part of the program.[13] Major interim evaluation reports on the general trials were published in September 1999 and a final evaluation report is due in February 2001.[14] An evaluation report on the Aboriginal trials is due in December 2000.

4.19 The Department of Health and Aged Care (DHAC) stated that for the Aboriginal trials, all have implemented public health and health service delivery initiatives targeting priority needs of communities, with the aim of improving health outcomes. There are early signs that improvements in Indigenous health indicators can be achieved when services have sufficient resources to provide a sound base for primary health care and where local communities take a strong role in developing and delivering services. For example, at one of the trials, the child immunisation rates have reached very high levels for the first time. At another trial, preliminary data indicate a significant increase in access by Aboriginal women to antenatal care services.[15]

4.20 Evidence to the Committee during the inquiry, however, indicated some problems with the trials. The Australian Medical Association (AMA) (NT Branch) argued that while in some communities the trials are working well, including the Tiwi trial, there were several problems 'on the ground' with these trials in relation to the availability of doctors in Aboriginal communities and accountability in funding arrangements. AMA (NT) stated that:

> …the trials really will not work unless there are more doctors on the ground in these areas…The second thing is there is concern about the transparency of this paying out of funds and where the money is actually going to and how it is being used by the communities or the people who are the gatekeepers for these funds.[16]

4.21 AMA (NT) further stated that the trials are 'fine in terms of identifying unwell Aboriginal people, making sure that they are followed up effectively and in getting the right investigations done, but then it is actually treating these people and making sure that you have done the groundwork, that you have worked out what is wrong with

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13 Submission No.38, p.23 (DHAC).

14 See DHAC, *The Australian Coordinated Care Trials: Interim Technical National Evaluation Report*, 1999; DHAC, The *Australian Coordinated Care Trials: Interim Technical National Evaluation Report-Appendices*, 1999; DHAC, *The Australian Coordinated Care Trials: Interim National Evaluation Summary,* 1999.

15 Submission No.38, p.24 (DHAC).

16 *Committee Hansard,* 24.2.00, p.220 (AMA (NT)).

them and you know what is needed to improve their quality of life. But actually having the doctors on the ground to supervise that and to ensure that happens is another problem'.[17]

4.22 The Northern Territory Branch of the Australian Nursing Federation (ANF) also raised problems with accountability. ANF (NT) noted that while the trials were 'positive' in that they reflected a trend in Aboriginal communities of developing local control of their own health services, the downside was a concern 'about the sorts of people that are attracted to the health boards that have been set up to run those services'. It was argued that there was a need for more Commonwealth scrutiny of the funds that are put into these programs.[18]

Effectiveness of the general trials

4.23 The interim evaluation report of the general trials found that it was too early to conclude definitively that the Coordinated Care Trials have achieved their objectives. The evaluation report stated that the interim findings 'cannot be seen as conclusive, but rather should be used to give direction to future developments in coordinated care'.[19] The report noted that the complex nature of the trials and difficulties with 'data flow, data quality and data completeness, as well as by the diversity of trial populations and processes' made evaluation of the trials difficult.[20] The key findings of the interim evaluation are outlined below.

Client health and well-being

4.24 The evaluation report stated that the interim results of the trials on client health and well-being, hospitalisation, re-admission and length of stay are inconclusive. Available data indicate, however, that care coordination has not led to any significant change in the health and well-being of the trial groups. The evaluation report noted, however, that the data set is incomplete for some trials and that, while the results are not statistically significant, trends suggest that some client groups have experienced some improvements in their physical health status.[21]

4.25 A number of indicators of health and well being were considered in the report, including hospitalisation rates, re-admission rates within 28 days for the same cause, and length of stay in hospital. The results showed that coordinated care had little or no effect on these outcomes, with the exception of one trial that had lower hospital re-admission rates.[22]

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17 *Committee Hansard,* 24.2.00, p.220 (AMA (NT)).

18 *Committee Hansard,* 24.2.00, p.208 (ANF (NT)).

19 Evaluation Report, p.ix.

20 Evaluation Report, p.vii.

21 Evaluation Report, pp.viii, 46.

22 Evaluation Report, p.27. See also *Committee Hansard,* 20.11.00, p.778 (Victorian Department of Human Services).

4.26 Regarding hospitalisation, overall 25 per cent of clients had been hospitalised at least once over the course of the trials, and this proportion was similar in the intervention and control groups. The number of admissions that each person had was also similar for the two groups. The proportion of re-admissions by trial varied considerably, ranging from 6 to 16 per cent. Patients in the intervention group of three trials had a statistically significant higher rate of hospital re-admission than the control group. Only one trial had a statistically lower rate of re-admission in the intervention group. After adjustments for age and diagnosis-related group, these differences were no longer statistically significant, with the exception of one trial that maintained a significantly lower rate of re-admission in the intervention group. Regarding length of stay, while individual trials did show some differences between intervention and control groups, they were not statistically significant.[23]

4.27 Qualitative data were also examined for evidence of the impact of care coordination on client health and well-being. There were indications that some clients experienced an increased sense of security as a result of having access to someone who could help them to negotiate through the complexities of the health system. The perceptions of moderate and high-risk clients were more positive than those of low-risk clients, who tended to see care coordination as a hindrance rather than a help. However, qualitative data were incomplete for some trials.[24]

Provider experiences

4.28 Providers include those involved in the direct process of care coordination or in the delivery of services.

4.29 In relation to GPs, not all were willing to become involved in the trials. Their main concerns were the additional administrative demands placed on them by the trials and a belief that coordinated care would compromise their independence in treating their patients. The GPs involved in the trials had different perceptions depending on the model of care coordination used. GPs undertaking the role of care coordinator had concerns about the time take to complete tasks associated with coordinated care, the training required and the ‘time costs’ for any benefits gained through the trials. GPs involved in care coordination where the tasks of coordination were shared with others expressed some of these concerns, but were generally more positive.[25]

4.30 Non-GP care coordinators expressed concerns in relation to uneven workloads, their relationship with GPs and the extent of their contribution to service coordination. Service providers differed markedly in their perceptions of the trials. Some found that coordination of care had freed them from case management, allowing

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23 Evaluation Report, pp.27-28.

24 Evaluation Report, p.46.

25 Evaluation Report, pp.31-32.

them to focus more on service provision, while others were concerned about increased workloads and reduced resources.[26]

Substitution between services

4.31 An aim of the trials was to promote further opportunities for appropriate substitution between acute and sub-acute and community based services; community based services and residential care; and a range of other community-based services.

4.32 The evaluation report stated that the interpretation of service substitution varied across the trials. While the majority of trials focussed on strategies to reduce hospital admissions, the data do not indicate any effect on the rate of hospitalisation. Due to data limitations it was not possible to establish whether any service substitution had occurred.[27]

Range of services

4.33 The scope of pooling of services can substantially influence the infrastructure costs of a trial. The report noted that trials that pooled less widely than others, for example, those that pooled only hospital, MBS and PBS have not demonstrated differences in their ability to provide care within existing resources. The non-pooling of residential care appears to have had an impact on a number of trials that have anecdotal evidence of having delayed institutionalisation. The risk of cost shifting by trials that pooled narrowly remains – however, there was no evidence of this partly because the data were not available.[28]

Care coordination process

4.34 All trials demonstrated a similar approach to the care coordination process which comprised assessment, care planning, implementation, monitoring and review. How the various components were put into operation varied according to the model of care coordination within which they were placed. In all trials, GPs played a central role, whether in the development of the care plans and/or implementation, monitoring or review. Demand placed on GPs, both as a consequence of the trials or external factors, restricted their capacity in some cases to be fully involved in care coordination. Models in which GPs were supported in their contribution to care coordination, through access to a care or service coordinator, appeared to have been more satisfactory to all those involved in the process.[29]

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26 Evaluation Report, pp.32-33.

27 Evaluation Report, p.47.

28 Evaluation Report, p.47.

29 Evaluation Report, pp.48-49.

Financial outcomes

4.35 A ‘snapshot’ of the financial status of each trial was made, and adjustments made for differences in financial reporting and fund pool estimation. This analysis found diversity in the way that trials allocated start-up and continuing costs, and also in the way that the total costs of the trials were distinguished from running costs. A comparison of trials’ total income with total expenditure, found that two trials were significantly in deficit and one trial was slightly in deficit. The report noted that, due to lack of data, conclusions about whether financial decisions were appropriately made and key priorities chosen would need to be considered in the final evaluation report.[30]

4.36 The report noted that there was little evidence of coordinated care having an impact on the average cost or distribution of services. For example, only one trial showed a statistically significant reduction in the average cost of inpatient services. For a number of trials, comparisons between the trial expenditure and the economic benchmark (resources that would otherwise have been used), suggest that there are likely to be gains made from coordinated care.[31]

Lessons from the trials

4.37 The evaluation report noted that several key lessons emerged from the operation of the trials which are outlined below:

- coordinated care – funds pooling offers potential advantages to facilitating care coordination for some, but not all clients. This needs to be set against the considerable human and financial resource costs associated with establishing and effectively managing the funds pool. Improved targeting of people who need care coordination, and the differentiation of care coordination approaches is also likely to be central in maximising the value of coordinated care;
- models of coordinated care – to be effective, coordinated care requires a primary team approach, with GPs playing an important and integral role. There needs to be a more systematic approach to coordinated care in future trials, based on agreed eligibility criteria, better defined target populations and standardised definitions of coordinated care and its processes; and
- role of GPs – given the pivotal role of GPs in continuing care of patients with chronic conditions, the reasons why GPs choose not to participate in the trials and the concerns expressed by participating GPs need to be considered in the planning of future care coordination programs.[32]

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30 Evaluation Report, pp.29, 46-47.

31 Evaluation Report, pp.40-41.

32 Evaluation Report, pp.x-xi. See also *Committee Hansard,* 20.11.00, p.768 (Professor Deeble); *Committee Hansard,* 20.11.00, p.778 (Victorian Department of Human Services).

Future directions

4.38 Some evidence suggested that the coordinated care trials should be broadened in scope and extended in time and coverage.[33] Professor Richardson of the Centre for Health Program Evaluation (CHPE) suggested that the trials could be broadened by extending the target population beyond persons with complex chronic needs to the full population of a region. This would allow preventive services to become a larger part of the model. But a longer time frame would be required to test this type of model.[34]

4.39 Professor Hindle also argued that it would be preferable to 'run a demonstration project for an entire community such the Hunter Valley or the ACT…it has to be a trial of the system as it would operate in the real world and not where people can opt out, and so on'.[35] NSW Health advised the Committee that it is currently conducting a study into the feasibility of introducing a funds pooling arrangement in two or three Area Health Services in that State. Dr Picone from the Department stated that:

> We think our area health services lend themselves more than in some of the other states to allow this to happen because they have been running for over a decade now…They are based on a population of people rather than on a disease [model] because, if we go down the disease model, there is a chance of reinforcing the lack of integration around the care of a human being that we have got. The area health services have responsibility for the care of that population and not just hospital care. Also, we have fairly sophisticated funding arrangements.[36]

4.40 The Coordinated Care Trials evaluation report also stated that extending the length of the trials would increase the likelihood that effects such as reduced rates of hospitalisation would be demonstrated within the time of the trial. The report also noted that extending the trials would also reduce the average cost per client day and improve the trials' financial position, particularly for trials with significant start-up costs.[37]

4.41 Professor Judith Dwyer representing the Public Health Association of Australia argued that what was needed was a 'move on from the second round of the coordinated care trials into some sort of experimentation at the level of what kind of system you need to have in order to deliver integrated or coordinated care, rather than

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33 Submission No.46, p.11 (CHPE); Submission No.22, p.3 (Professor Hindle).

34 Submission No.46, Additional Information, 15.3.00 (CHPE).

35 *Committee Hansard,* 21.3.00, p.320 (Professor Hindle). See also Submission No.22, pp.3-4 (Professor Hindle).

36 *Committee Hansard,* 20.11.00, p.757 (NSW Health).

37 Evaluation Report, p.41.

simply looking at it at the patient care level, which is what the coordinated care trials have done'.[38]

4.42 Professor Richardson suggested that another option in relation to the trials would be to cover a more comprehensive range of services and include, for instance, residential care, dental and disability services. He argued that the reason for including residential care is compelling because if care coordination reduces admission to residential care facilities, the benefits of that should flow into the pool. The inclusion of residential care would also increase the size of the pool, as many of the chronically ill are also elderly. Extension to other areas is desirable, as the aim is to break down program barriers and ensure access to care which is appropriate to the health needs of the client group.[39]

Conclusion

4.43 The Committee notes the interim evaluation reports on the coordinated care projects that have been published and the various suggestions made to overcome the problems identified in the initial evaluations. A full picture of the value of coordinated care and the role it may play for specific groups or wider communities has not been possible due to limitations in the data available from these studies. The Committee is disappointed that the data from these initial evaluations is not more complete and that conclusions about the effectiveness of the trials could not be drawn. It is hoped that a more complete assessment of the trials will emerge when the final studies are complete.

4.44 The Committee commends the Government for committing to a second round of Coordinated Care Trials and urges that work continue on developing the most suitable form of coordinated care for Australian circumstances within the framework of Medicare. The Committee believes that better data should be available and collected with the additional trials to allow informed conclusions about the efficacy of these trials to be drawn.

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

38 *Committee Hansard,* 20.11.00, p.763 (Professor Dwyer).

39 Submission No.46, Additional Information, 15.3.00 (CHPE).

CHAPTER 5

IMPACT OF THE PRIVATE HEALTH INSURANCE REBATE

Introduction

5.1 The Committee's terms of reference require it to report on the impact of the private health insurance rebate on demand for public hospital services. The impact of the rebate must be seen in the overall context of private health insurance and as part of a package of measures undertaken by the Government to address issues in the private health insurance sector. This chapter provides a brief overview of the private health insurance sector and recent Government policy initiatives in this area as well as discussing the impact of the rebate.

Background

5.2 Health insurance funds operated by organisations registered under the *National Health Act 1953* have offer benefits to members for approved hospital services. Services may be provided in both public and private hospitals. Funds also offer members benefits through ancillary tables for a wide range of non-hospital and health-related services.

5.3 In 1998-99, the health funds received $3,872 million in contributions from members and $1,055 million in direct payments and tax subsidies from the Government. This compares to $4,404 million in contributions from members in 1996-97, the year before the introduction of the Private Health Insurance Incentives Scheme.[1]

5.4 Excluding the Government subsidies, in 1998-99 the health funds paid out $3,785 million in benefits of which $2,200 or 58 per cent went on hospital services, $198 million on in-hospital medical services and the balance of $1,387 million on ancillary health care, ambulance services and administration. The share of total health spending met by private health insurance from private contributions dropped from 9.99 per cent in 1996-97 to 7.5 per cent in 1998-99.[2]

5.5 The downward trend in spending on private patients in public hospitals also continued over this period. Only 10.2 per cent of the spending on health insurance

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1 1998-99 is the latest year for which detailed figures are available. The direct payments and subsidies relate to the means tested Private Health Insurance Incentives Scheme which was introduced in 1997 and was available during the first half of the financial year and the 30% rebate on premiums which applied to the second half of the year. See paras 5.13, 5.19 for a description of these schemes. Australian Institute of Health and Welfare, *Australia's Health 2000: the seventh biennial health report of the Australian Institute of Health and Welfare*. Canberra, AIHW, p.253.

2 1998-99 figure based on AIHW preliminary estimate for 1998-99 of total health expenditure of $50,335 million. AIHW, *Australia's Health 2000*, p.233.

subsidies in 1998-99 went to public hospitals. Private hospital care represented 89.7 per cent of all total hospital-related benefits paid. Hospital bed days in private hospitals accounted for 84.1 per cent of all hospital bed days for which hospital benefits were paid in 1998-99.[3]

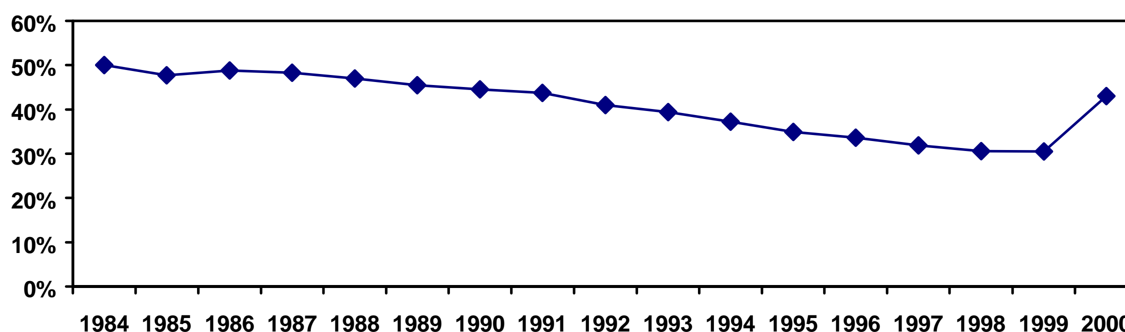
Table 5.1: Private health insurance fund spending on hospital services

	1996-97 ($M)	1998-99 ($M)		
		Privately funded	Subsidy	Total
Public hospitals	360	226	63	289
Private hospitals	2437	1974	550	2524
Total	2797	2200	613	2813

Source: AIHW, Australia's Health 2000, p.253.

5.6 While total benefits paid by funds have increased steadily, membership of private health insurance diminished and has done so since the introduction of Medicare (at least until recently). Between June 1984 and December 1998, the proportion of the Australian population covered by private health insurance fell from 50.2 per cent to a low of 30.1 per cent. As will be discussed later in this chapter, the effect of various incentives has significantly increased participation since December 1998 with levels now back to where they were in the early 1990's.

Figure 5.1: Proportion of the Population with Private Hospital Cover



Source: Private Health Insurance Council (PHIAC), http://www.phiac.gov.au.

5.7 The age group distribution of those covered by private health insurance also changed between 1983 and 1998. The AIHW reported that in all age groups below 60 years, the level of coverage by hospital insurance fell markedly. Excluding the age groups 60 years and over, coverage ranged from 54.6 per cent (age group 15-24 years)

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3 AIHW, *Australia's Health 2000*, p.252.

to 75.6 per cent (age group 35 to 49 years) in 1983. In 1998, coverage in those age groups had fallen to 16.3 per cent and 32.0 per cent respectively. In the case of contributor units headed by persons aged 60 years and over, the decline was less dramatic. Coverage of contributor units headed by persons aged 60-69 years fell from 45.3 per cent to 39.6 per cent, while there was little change in the 70 years and over range which remained relatively constant at around 36 per cent.[4]

5.8 The fall in membership coincided with a rapid rise in the cost of premiums. The premiums of health insurers with the largest memberships in each State increased, in real terms, between 58 per cent and 173 per cent from 1984 to 1996.[5] The Industry Commission, in its 1997 report on private health insurance, stated that the average price of private health insurance had risen at a rate of 3.5 times CPI inflation since 1990. The Commission found that the major contributions to the rise in premiums included a substantial rise in the proportion of fund members using private hospitals; an increase in private hospital admission charges, due to changes in technology and clinical practice; and an increase in average hospital admissions by private patients.[6] The rise in the cost of premiums resulted in a decline in affordability, particularly among the lowest income groups.[7]

5.9 The Industry Commission also noted that unpredictable 'out-of-pocket' expenses following episodes of hospitalisation and the difficulties faced by consumers in comparing the products offered had diminished the attractiveness of private health insurance by various funds.[8]

Response to the fall in coverage

5.10 A number of incentives have been introduced to address the continued fall in membership of funds. In the late 1980s the 'front-end deductible' (FED) was introduced. Funds may offer cover for that part of hospital charges that exceed a given amount in a year. Between 1995-96 and 1998-99, coverage by FEDs grew by 0.8 million and coverage by non-FED tables fell by 1 million. In 1995, exclusionary and non-exclusionary tables were introduced. Funds were able to offer tables which excluded coverage of certain types of treatment such as obstetrics.[9]

5.11 In 1995, the Health Legislation (Private Health Insurance Reform) Amendment Act, in part, facilitated contracting between private health insurance funds and hospitals (Hospital Purchaser Provider Agreements), private health

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4 AIHW, *Australia's Health 2000*, p.256.

5 AIHW, *Australia's Health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare,* Canberra, 1997, p.178.

6 Industry Commission, *Private Health Insurance,* Report No 57, Canberra, the Commission, 1997, pp.xxxi, xxxv-xxxvi.

7 Australian Institute of Health and Welfare, *Australia's Health 1998,* p.178.

8 Industry Commission, pp.xxxi-xxxii.

9 *Australia's Health 2000*, p.253.

insurance funds and doctors (Medical Purchaser Provider Agreements) and hospitals and doctors (Practitioner Agreements).

5.12 In May 1996, the Minister for Health and Family Services, Dr Michael Wooldridge, stated that 'the continuing decline in the number of Australians with private health insurance is perhaps the single most serious threat to the viability of our entire health system' and announced that the Government would introduce incentives to 'encourage people into private cover and to help retain those who still have private insurance'.[10] Initially, these incentives were the Private Health Insurance Incentives Scheme (PHIIS) and a Medicare levy surcharge. A number of other measures have subsequently been introduced by the Government to address the issue of declining health insurance coverage.

5.13 The PHIIS provided, from 1 July 1997, an income-tested benefit for those holding private health insurance. The benefit was provided by way of either reduced premiums or tax offset. The incentive amount was dependent upon the type of policy held. The incentive was aimed at making private health insurance more affordable for lower and middle-income earners. The Government's funding estimates were based the assumption that coverage of private health insurance would increase from 32 per cent of the population (expected at 1 July 1997) to 34 per cent in 1997-98.[11]

5.14 The Medicare levy surcharge was introduced, with effect from 1 July 1997, to provide a disincentive for higher income earners to rely on the Medicare system and not take out private health insurance. Where individuals, with gross taxable incomes exceeding $50 000, and families, with combined gross taxable incomes exceeding $100 000, did not hold private health insurance providing hospital cover, an additional Medicare levy of one per cent applied.

5.15 In introducing the PHIIS, the Minister for Health and Family Services stated:

> The private health insurance incentive scheme…is the centrepiece of the Government's strategy to assist Medicare from collapsing under the weight of demand for publicly funded hospital and medical services…The private health insurance incentive scheme, and the addition to the Medicare levy…are essential measures designed to arrest the catastrophic decline in the level of participation in private health insurance.[12]

5.16 In 1997 the Government introduced legislation aimed at making contracting between funds, hospitals and doctors more attractive and to reduce some of the cost pressures on health insurance premiums. For the first time, funds were allowed to pay medical benefits above the MBS to doctors who have practitioner agreements with private hospitals. These agreements are permitted only where the hospital also has a

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10 Minister for Health and Aged Care, 'United Effort Needed to Address Health Insurance Crisis', *Media Release*, 24 May 1996.

11 Health and Family Services Portfolio, *Portfolio Budgets Statements 1996-97*, p.145.

12 House of Representatives, *Debates*, 13.12.96, pp.8573-74.

fixed cost (HPPA) contract with the fund. The effect of the reforms were to either 'exclude out-of-pocket costs altogether or to allow for a predetermined amount of such costs known by the person in advance'.[13] Other reforms were aimed at removing unnecessary costs on funds, improving the regulatory environment and making refinements to the legislation to improve the operation of the industry.

5.17 The Government's 1998 tax reform package, *Tax Reform: not a new tax, a new tax system,* contained measures to assist families and individuals with the cost of private health insurance through the introduction of a 30 per cent tax rebate. The Minister for Health and Aged Care, in introducing the legislation for the scheme, stated:

> This is an important Bill for it proposes a measure that will prove to be of enduring benefit to the Australian health system, and to the Australian public, namely to cut the cost of private health insurance by 30 per cent through a rebate outlined in this Bill…This is one of the simplest, most effective and most important changes that could be made to restore the balance in our health system by working to slow the drop-out from private health insurance. The proposed cut in the cost of private health insurance will help the private sector, take pressure off public hospitals and help restore much needed balance to our health care system.[14]

5.18 The Minister noted that the PHIIS had achieved a slowing down of the drop-out rate but the continuing decline in coverage was 'proof of the need for further action'.[15]

5.19 The new scheme, known as 'the rebate', replaced the PHIIS from 1 January 1999. The rebate scheme provided for a non-income tested financial incentive for individuals and families who take out or maintain private health insurance. It is provided by a 30 per cent reimbursement of premiums paid or a 30 per cent premium reduction. The incentive is generally available to an individual who pays for appropriate private health insurance cover with a fund registered under the *National Health Act 1953* and who is eligible for Medicare.

5.20 Under the rebate scheme all health insurance funds which offered the rebate as a premium reduction were required to establish no/known gap products by 1 July 2000.

5.21 The Commonwealth's original estimate of the cost to revenue of the rebate was $1.09 billion in 1999-2000 (the first full year of operation); $1.8 billion in 2000-01; $1.27 billion in 2001-02 and $1.36 billion in 2002-03.[16] Additional information provided to the Community Affairs Legislation Committee indicated that these

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13 House of Representatives, *Debates*, 27.11.97, p.11436.

14 House of Representative, *Debates*, 12.11.98, p.263.

15 House of Representatives, *Debates*, 12.11.98, p.264.

16 Explanatory Memorandum, Private Health Insurance Incentives Bill 1998, p.58.

estimates were ‘a cash estimate, which does not take account of accrued expenses (ie, year-on-year liabilities). These figures represent the net cash cost of the Rebate.’[17] The Department provided the following full combined cost estimate of the rebate which ‘are the result of further refinement of the original estimates using the hard data that was not available when the Budget estimates were developed’. The Committee was also provided a split between outlays and revenue:

Table 5.2: The Additional Estimates for the Total Cost of the 30% Rebate

Year	Outlays ($M)	Revenue ($M)	Total ($M)
1998-99	545[a,b]	not available	not available
1999-00	1394	223[b]	1617
2000-01	1516	400	1916
2001-02	1623	428	2051
2002-03	1735	458	2193

[a] Figure reported in 1999-00 Portfolio Additional Estimates Statement.
[b] Half year effect only.

Note: the cost of the 30% Rebate is split between outlays, administered by the Department of Health and Aged Care, and revenue, administered by the Australian Taxation Office. Outlays consist of claims made via premium reductions and direct payments. Revenue is made up of claims made through the tax system.

Source: Senate Community Affairs Legislation Committee, Answer to Question on Notice, No.59, Additional Estimates, February 2000.

5.22 Expenditure of $1.6 billion on the rebate in 1999-00 represents 6.7 per cent of the Commonwealth’s appropriation for the Health and Aged Care Portfolio in the 1999-00 Budget.[18] The November 2000 Mid Year Economic and Fiscal Outlook report indicates that the above Budget estimates of outlays will increase by a further $390 million in 2000-01 as a result of higher membership. No figure has been provided for the increase in cost of the tax rebate.

5.23 The Community Affairs Legislation Committee was provided with the following updated information at a supplementary estimates hearing on 22 November 2000 for the 2000-01 Budget.

17 Senate Community Affairs Legislation Committee, DHAC Answer to Question on Notice No.58, Additional Estimates 1999-2000, February 2000.

18 Health and Aged Care Portfolio, *Portfolio Budget Statements 1999-2000*, p.18. Total appropriation for the Health and Aged Care Portfolio was $23,844 million in 1999-2000.

Table 5.3: Variation from the 2000-01 Budget for 2000-01 Additional Estimates due to increases in Private Health Insurance Participation Rates

Year	2000-01 Budget Estimates ($M)	2000-01 Additional Estimates ($M)	Variation ($M)	2000-01 AEs increase in MBS* ($M)	Total Variation ($M)
1999-00	1567	1533	-34	na	na
2000-01	1882	2214	332	130	462
2001-02	2021	2358	337	185	522
2002-03	2155	2435	280	245	525
2003-04	2296	2527	231	240	471

* These are temporary figures which are due for review, as such they have not been identified separately in Additional Estimates.

Source: Community Affairs Legislation Committee, Supplementary Estimates, November 2000, Tabled Paper, Department of Health and Aged Care.

5.24 The estimate now for 2000-01 is $2.2 billion – nearly twice the Government's original estimate. There will also be a flow on cost of $130 million in costs for the MBS which pays 75 per cent of the cost of 'in-hospital' medical expenses for private patients.[19]

5.25 In the 1999-2000 Budget the Government announced that it would introduce 'Lifetime Health Cover' from 1 July 2000. Under this arrangement funds are required to set different premiums depending upon the age at which a member first takes out hospital cover with a registered health fund. People who join early in life will be charged lower premiums throughout their life compared to people who join later. Existing fund members are protected and pay the base rate (set at 30 years of age) for the rest of their lives, provided they stay insured. The starting date of 1 July was adopted to allow for a 12 month period during which people who did not have private hospital cover could join a health fund and pay the 30 year old rate.

5.26 The Government's aim was to discourage 'hit and run' behaviour thereby contributing to the stability of the private health insurance industry and restraining pressures for increases in premiums.

5.27 In June 2000, the *Health Insurance Amendment (Gap Cover Schemes) Act 2000* was passed. It provides for gap cover schemes to enable registered health

19 Joint Statement by the Treasurer and Minister for Finance and Administration, *Mid-Year Economic and Fiscal Outlook 2000-01*, November 2000, p.41.

benefits organisations to provide no gap and/or known gap private health insurance without the need for contracts.

5.28 The 'gap' is the difference, paid by the health fund member, between fees charged by doctors for in-hospital medical services and the combined health insurance benefit and Medicare benefit.[20] The cost of medical gaps for in-hospital medical services provided to people with private health insurance was around $200 million in 1997-98. The average medical gap for an episode for a private patient in a private hospital was $151 and for a private patient in public hospital was $69, though for some procedures the gap payment can be much higher.[21] The presence of gaps has been shown to be a major contributor to consumer perception that private health insurance does not offer value for money. It remains a major cause of consumer complaint about private health insurance.

5.29 Previous legislation allowed the gap to be covered in circumstances where the service is rendered by, or on behalf of, a medical practitioner:

- with whom the registered health fund has a medical purchaser-provider agreement (MPPA); or
- who has a practitioner agreement (PA) that applies to the professional service provided, with the hospital where treatment occurred, and that hospital has a hospital purchaser-provider agreement (HPPA) with the registered fund.

5.30 While many health insurance funds had successfully negotiated HPPAs with hospitals, most medical practitioners were opposed to the agreements as a means of limiting out-of-pocket costs for health fund members. Their opposition was based on a perception that the arrangements would permit health insurance funds to interfere in the doctor-patient relationship, thereby leading to 'US-style managed care'. As a result, very few MPPAs had been negotiated. The gap cover schemes in the new legislation are entirely voluntary and provide an alternative mechanism through which the medical gap may be covered by funds, without the need for formal contracts between doctors and funds.

Impact of the rebate on participation rates in private hospital insurance

5.31 The Government expected that access to the rebate would 'lead to a significant increase in private health insurance membership'.[22] Private Health Insurance Administration Council (PHIAC) data shows that by the September 2000 quarter, coverage had increased to 45.8 per cent of the Australian population having private health insurance.

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20 Where health funds have reached agreements with individual doctors and signed Medical Purchaser Provider Agreements, health fund contributors with the appropriate level of cover are eligible for reimbursement of fees charged above the schedule fee.

21 Community Affairs Legislation Committee, *Report on the Health Insurance Amendment (Gap Cover Schemes) Bill 2000*, p.1.

22 Commonwealth Government, *Tax reform, not a new tax system*, AGPS, 1998, p.49.

Table 5.4: Coverage of Hospital Insurance Tables Offered by Registered Health Benefits Organisations by State

Persons and Percentage of Population

Quarter ended		NSW	VIC	QLD	SA	NT	WA	TAS	AUST
30 Sept 2000	Coverage '000 **P**	3,190	2,167	1,521	697	73	930	211	8,789
	% Population **P**	47.0%	45.3%	42.5%	46.5%	37.1%	49.2%	44.8%	45.8%
30 June 2000	Coverage '000**R**	3,035	2,009	1,436	651	68	833	204	8,236
	% Population **PR**	44.8%	42.1%	40.3%	43.5%	34.9%	44.2%	43.4%	43.0%
31 Mar 2000	Coverage '000	2,211	1,478	1,077	492	49	688	162	6,157
	% Population **R**	32.7%	31.1%	30.3%	32.9%	25.3%	36.6%	34.5%	32.2%
31 Dec 1999	Coverage '000	2,140	1,440	1,037	477	47	670	159	5,970
	% Population **R**	31.6%	30.4%	29.3%	31.9%	24.1%	35.7%	33.8%	31.3%
30 Sep 1999	Coverage '000	2,113	1,416	1,023	472	46	661	158	5,890
	% Population	31.4%	30.0%	29.0%	31.6%	24.0%	35.4%	33.6%	31.0%
30 Jun 1999	Coverage '000	2,070	1,398	1,006	465	46	651	157	5,793
	% Population	30.8%	29.7%	28.7%	31.2%	23.8%	35.0%	33.4%	30.5%
31 Mar 1999	Coverage '000	2,048	1,382	996	459	46	645	156	5,733
	% Population	30.5%	29.4%	28.5%	30.8%	23.7%	34.8%	33.2%	30.3%
31 Dec 1998	Coverage '000	2,021	1,374	986	459	45	634	156	5,676
	% Population	30.2%	29.3%	28.3%	30.8%	23.6%	34.3%	33.2%	30.1%
30 Sep 1998	Coverage '000	2,027	1,378	989	461	45	641	158	5,699
	% Population	30.4%	29.5%	28.5%	31.0%	23.6%	34.8%	33.4%	30.3%
30 Jun 1998	Coverage '000	2,050	1,381	996	465	45	634	157	5,728
	% Population	30.8%	29.6%	28.8%	31.3%	23.7%	34.6%	33.3%	30.5%
31 Mar 1998	Coverage '000	2,084	1,399	1,014	472	46	639	161	5,814
	% Population	31.4%	30.1%	29.4%	31.8%	24.2%	35.0%	34.1%	31.1%
31 Dec 1997	Coverage '000	2,107	1,428	1,022	479	46	639	164	5,885
	% Population	31.9%	30.9%	29.8%	32.3%	24.4%	35.3%	34.7%	31.6%

R = Revision P = Preliminary

Source: Private Health Insurance Administration Council, <http://www.phiac.gov.au/phiac/stats/MEMCov/hos_quar.htm>

For the period 1 July 1997 to 1 January 1999 when both the PHIIS and Medicare levy surcharge both operated, coverage of hospital insurance tables generally continued to decline (there was a small rise in the quarter ended 30 September 1997). During 1999, there was a small rise of some 300 000 members attracted by the 30% rebate over the first year of its life followed by a sharp increase of 2.26 million new members in the weeks prior to the cut off date for Lifetime Health Cover (15 July 2000). The Government argues that both polices complemented each other. However, it is evident that the stick of penalties under Lifetime Health Cover was much more effective in achieving the Government's aim than the incentive of a rebate.

Private health insurance participation and the demand for hospital services

5.32 A range of views on the impact of the rebate on demand for public hospital services was submitted to the Committee. It was considered by some that the introduction of the Rebate would reduce demand on public hospital services[23] while others were supportive of the Rebate but did not know if demand would be reduced.[24] Many submissions argued that there would be little or no fall in demand.[25] Others stated that it was too early to tell if there will be an impact in the public sector or if other initiatives are also affecting demand.[26]

5.33 DHAC stated that while the Commonwealth is increasing real spending on the public hospital system 'the Government realises that this additional funding for public hospitals will not be enough to maintain the integrity of the Australian health care system if the viability of the private health care sector is not supported'. This is because insured people cost the Commonwealth less for health services than the uninsured who do not make any direct contribution to the costs of their health care; and 80 per cent of private hospitals services are provided to privately insured persons, hence a decline in membership 'runs the genuine risk of not properly utilising the major capital stock base of private hospitals'.

5.34 DHAC went on to state that 'declines in private health insurance coverage lead to more people becoming entirely reliant on the public system for their health care, increasing the cost pressures on public hospitals'.[27] Further, that 'it is expected that people with private health insurance have a greater opportunity to use the private hospital system because they have got a system of financing behind them, so the expectation is that that will relieve some of the pressure on the public hospital

23 *Committee Hansard,* 18.8.00, p.669 (AMA).

24 Submission No.60, p.22 (SA Government); Submission No.61, p.17 (Australian Physiotherapy Association).

25 Submission No.11, p.3 (DRS (WA)); Submission No.16, p.10 (QNU); Submission No.17, p.8 (Public Hospitals, Health & Medicare Alliance of Qld); Submission No.41, p.26 (Qld Government).

26 Submission No.40, p.4 (Committee of Presidents of Medical Colleges); Submission No.45, p.24 (RACP, ACA & Health Issues Centre); Submission No.61, p.17 (Australian Physiotherapy Association).

27 Submission No.38, p.31 (DHAC).

system'.[28] DHAC also stated that the impact of the rebate on the demand for public hospital services could only be assessed in the long term and that even preliminary data for 1998-99 would not be available for some considerable time.[29]

5.35 In answering a question on notice on 14 August 2000, the Minister for Health and Aged Care, stated that DHAC had estimated, 'on the basis of very conservative assumptions about utilisation rates' that over the next two to three years the increase in participation in private health insurance 'will mean an extra 400 000 treatments will occur for people who are privately insured, a majority of them in the private system, thus taking some of the pressure of demand off the public hospital system'.[30]

5.36 The Australian Health Insurance Association (AIHA) estimated that had the pre-incentive trend continued 'the pressures this would have placed on Medicare would have been unsustainable. Government action to halt such freefall, or deal with its effects, would have placed enormous strain on the taxation base.'[31]

5.37 The Review of NSW Health noted that reductions in private health insurance coverage 'increases the stress on the public systems' but the notion that the public health system would collapse if the level of coverage fell below a specified point 'is an exaggeration and unproven'.[32] The South Australian Government supported the reforms being implemented by the Commonwealth but stated that although these were expected to halt the decline in coverage rates, 'it is much more difficult to say whether they will have any significant impact on the demand for public hospital services'.[33] The Queensland Government stated that the rebate 'will do little to reduce demand on the public hospital system' and that the issue of demand for public hospital services 'is complex and it is overly simplistic to assume that the demand on the public system is directly related to the level of private health insurance'.[34] The Tasmanian Government stated that 'the only impact of the private health insurance rebate has been the stabilisation in the numbers insured…there has been no observable impact on workload in public hospitals, nor is one expected in the near future'.[35]

5.38 A number of submissions supported the States' view. Evidence was provided pointing to the complexity of the relationship between private health insurance coverage and the demand for public hospital services and the difficulties of making a

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28 *Committee Hansard,* 11.11.99, pp.32-33 (DHAC).

29 Submission No.38, p.32 (DHAC).

30 House of Representatives, *Debates*, 14.8.00, p.18844.

31 Submission No.55, p.8 (AIHA).

32 Independent Pricing and Regulatory Tribunal of New South Wales, *A Review of NSW Health*, 1998, p.43.

33 Submission No.60, p.22 (SA Government).

34 Submission No.41, p.26 (Qld Government); See also *Committee Hansard,* 11.11.99, p.58 (Queensland Health).

35 Submission No.67, p.10 (Tasmanian Government).

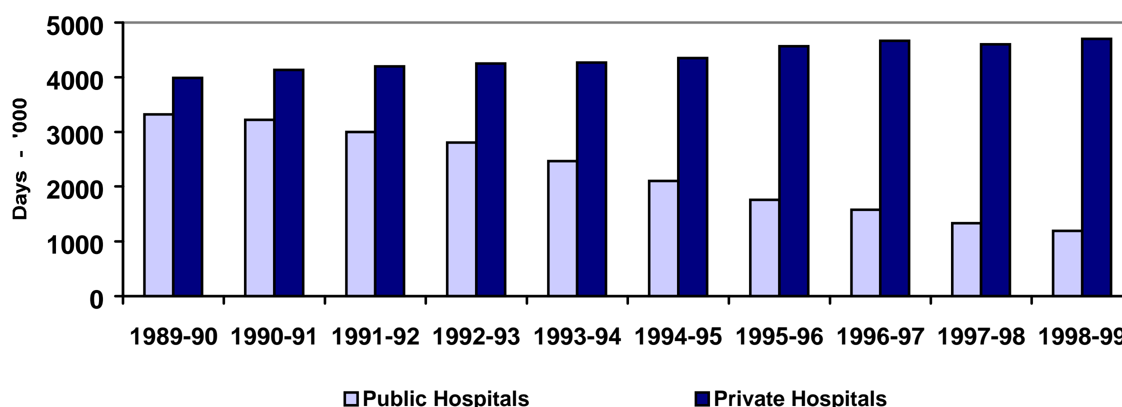
direct link between the decline in private health insurance and pressures on public hospitals.[36]

5.39 For example, it was pointed out that private hospital utilisation has been steadily increasing during the period private insurance coverage was decreasing.[37] Between 1993-94 and 1997-98 there was a 10 per cent increase in separations from public acute hospitals and a 28 per cent increase in separations from private hospitals. There was a decrease of 5 per cent in patient-days for public hospitals over this period but an increase of 14 per cent for private hospitals.[38]

5.40 Other indicators also point to increased utilisation of the private sector. Private hospitals in 1996-97 accounted for 22.1 per cent of all hospital expenditure, up from 15.6 per cent in 1989-90. Expenditure on public hospitals increased by an average of 3.2 per cent per annum over the period 1989-90 to 1996-97 while expenditure on private hospitals has increased by 8.4 per cent per annum over the same period.[39]

5.41 Since 1994-95 the proportion of public hospital patient days attributable to private patients fell from 14 per cent to 10 per cent.[40] In 1989-90, 45 per cent of total private hospital days were in public hospitals. This reduced to 20 per cent in 1998-99.[41] Average lengths of stay have been falling in each sector. Thus the bed-day changes do not simply reflect longer stays in the private hospital sector.

Figure 5.2: Privately Insured Hospital Days by Type of Hospital 1989 to 1999



Source: PHIAC, Operations of the Registered Health Benefits Organisation Annual Report 1998-99, Figure 36B.

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36 See for example, Submission No.45, p.24 (RACP, ACA, HIC); Submission No.46, p.12 (CHPE).

37 Submission No.17, p.7 (PHH & MAQ); Submission No.46, p.12 (CHPE); Submission No.65, p.12 (ANF (SA)); *Committee Hansard,* 11.11.99, p.58 (Queensland Health) and 22.3.00, p.429 (QNU).

38 AIHW, *Australia's Health 2000*, p.272.

39 Submission No.46, Additional Information, p.9 (CHPE).

40 AIHW, *Australian Hospital Statistics, 1998-99,* AIHW cat.no. HSE 11, Canberra, p.53.

41 PHIAC, *Operations of the Registered Health Benefits Organisations Annual Report 1998-99,* p.47.

5.42 The Centre for Health Program Evaluation (CHPE) indicated that the total demand (public plus private) for public hospitals has not increased sharply while private hospital insurance membership has declined. In 1982-83 it was 75.1 per cent of total hospital admissions and in 1996-97 it was 75.6 per cent.[42]

5.43 CHPE argued that the increased use of private hospitals was due to the fact that those holding basic insurance dropped out, while the membership level of those with supplementary insurance–upon which private hospitals depend–had declined significantly less. The proportion of the population holding supplementary insurance in 1984 (29.6 per cent) was almost the same as in 1999.[43] CHPE concluded 'it is not possible to argue that the demand pressure on the public hospital sector is due to a shift in demand from the private hospital sector'.[44] This view was supported by other submissions.[45]

5.44 CHERE, in its review of issues for the Committee, noted that the relationship between private insurance participation and the demand for public hospital services is also complicated by the fact that the demand for public hospital services comes from both public patients and private patients. While the number of private patients in public hospitals has declined, 20.3 per cent of total private health insured days in the year ending 30 June 1999 were in public hospitals. This was due, in part, to the lower premiums paid for hospital cover that is limited to private treatment in public hospitals. CHERE concluded that 'this form of demand on public hospitals is unlikely to be dampened by the rebate and may in fact increase'.[46]

5.45 A further factor to be noted is that the coverage has fallen significantly in the under 24 year age group (see para 5.7) – a group that is healthy and therefore would not be expected to place a high demand on public hospital services.

5.46 Another matter impacting on the complexity of the relationship between demand for public hospitals and health insurance levels is that privately insured persons can elect to be public patients in a public hospital. It is difficult to be precise about the proportion of those holding health insurance exercising their right not to declare their status on admission to a public facility. However, some evidence is available which would indicate that a significant proportion of privately insured persons do not declare their status on admission to a public hospital.

5.47 The June 1998 health insurance survey carried out by the Australian Bureau of Statistics indicated that 15.4 per cent of Medicare patients in public hospitals had private health insurance.[47] An analysis of patient status was provided in the *Final*

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42 Submission No.46, p.13 (CHPE).

43 Submission No.46, p.12 (CHPE).

44 Submission No.46, Additional Information, p.9 (CHPE).

45 See also Submission No.17, p.7 (Public Hospitals, Health & Medicare Alliance of Queensland).

46 CHERE, Discussion Paper 3, p.6.

47 Australian Bureau of Statistics, *Health Insurance Survey, June 1998,* p.24.

Report Hospital Data Analysis Consultancy provided to the Committee by the NSW Government. The consultancy matched 956 010 separations taking place in private and public hospitals with members of five major health funds. The analysis indicated that of this sample of 956 010 matched separations taking place in both public and private hospitals, 25.9 per cent were treated as public patients. Of the 403 707 matched separations which took place in public hospitals 39 per cent used their private health insurance status. The remaining 61 per cent did not declare their private health insurance status and were admitted as public patients.[48]

5.48 Submissions indicated a range of reasons for people taking out private health insurance and then not using it.[49] These factors include:

- large and unknown gap payments;
- the Medicare surcharge for individual incomes over $50 000 or couples earning over $100 000; and
- the availability of products with high front end deductibles (FEDs) or co-payments, which therefore have relatively, low premiums.

5.49 The increased use of FEDs and exclusionary health insurance policies was seen as having a significant impact on the trend not to declare health insurance status. PHIAC reported that in 1998-99 nearly 50 per cent of the insured population in some States had some form of FED. Australia wide, 38.4 per cent of persons covered have FED tables.[50] This was a growth of approximately 75 per cent from July 1997 to July 1999. Over the same period exclusionary policies increased by 67 per cent.[51] It was argued that this trend would result in high income earners avoiding payment of the Medicare levy, while still using the public health system rather than the private where the person would be faced with an up-front excess payment.[52] The Queensland Government noted that some FEDs have excesses of $1 000. This amount is more than the charge for an average length of stay (3.5 days) in a Queensland hospital and would act to discourage a person from using their insurance in a public hospital. The Queensland Government also argued that exclusionary policies generally exclude

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48 *Committee Hansard,* 21.3.00, p.341 (NSW Health Department).

49 Submission No.16, p.10 (ANF(SA)); Submission No.41, p.26 (Queensland Government); Submission No.60, p.23 (SA Government); Submission No.67, p.10 (Tasmanian Government); *Committee Hansard,* 23.3.00, pp.509,517 (Victorian Minister for Health); *Committee Hansard,* 25.2.00, p.274 (Health Department WA); *Committee Hansard,* 21.3.00, p.358 (NSW Health Department); *Committee Hansard,* 11.4.00, p.646 (ACT Minister for Health and Community Care).

50 PHIAC, p.2.

51 Submission No.41, p.26 (Queensland Government).

52 Submission No.16, p. 10 (QNU). See also Submission No.41, pp. 26-7 (Queensland Government); Submission No.60, p.23 (SA Government); Submission No.17, p.9 (Public Hospitals, Health & Medicare Alliance of Qld).

more complex care, and that the policy holder would use public hospitals for their complex needs not covered by their private health insurance.[53]

5.50 The Commonwealth has partially recognised the problem of the use of cheaper FED policies to avoid the Medicare levy surcharge. From 25 May 2000 the exemption from the surcharge is no longer available to singles who take out a new policy after that date with a FED of $500 or more a year or to families or couples with a FED of $1 000 or more.

5.51 The AHIA did not support the view that people were buying cover and not intending to use it:

> there have been some suggestions that, because of the surcharge or other reasons, people may buy very cheap cover and then not use it. That is unlikely. Our experience has been that people who buy health insurance cover are very selective about the cover they use, and whenever they have the opportunity to do so they make a very rational judgment based on their own state of health. So the people who are buying cheap products are buying products which, in their own assessment, they are probably not going to use because they are pretty healthy. They just want it as a backup in case something goes wrong.
>
> However, by having people who otherwise would not have bought those products buy those products, there is money going into the pool.[54]

5.52 It was also argued that a number of other factors influence demand for hospital services including changes in technology, the ageing population, increases in the size of the population and changes in the type of private health insurance policy.[55] The Queensland Government, for example, stated that demand in Queensland public hospitals has grown at a consistent rate of approximately three times that of the average population growth in Queensland.[56] The South Australian Government also noted that many factors contributed to demand for hospital services and it was difficult to determine the relative impact of each of these factors on demand.[57]

5.53 Submissions pointed out the public and private sectors have different roles in the provision of health care. It was argued that private hospitals frequently provided high volume, comparatively low cost procedures as these are more profitable. More expensive procedures such as paediatric and intensive care services are infrequently provided in private hospitals. Similarly, emergency care is more frequently provided by public hospitals as is the management of complex, chronic conditions. As a result, public hospital workloads contain a larger proportion of higher cost, longer stay and

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53 Submission No.41, pp.26-27 (Queensland Government).

54 *Committee Hansard,* 11.11.99 p.142 (AHIA).

55 See for example *Committee Hansard,* 22.3.00, p.402 (DRS).

56 Submission No.41, p.26 (Queensland Government).

57 Submission No.60, pp.22-3 (SA Government).

more intensive work. It was argued that because of the different roles of the public and private sectors, the impact of the demand for public services is unclear. However, the AHA, WHA and AAPTC argued that the end result might be that per bed day costs of public hospitals might increase due to changes in the casemix.[58]

5.54 Evidence was received that there was now a significant proportion of those in private hospitals who self-funded their care. Estimates of self-funding ranged from 10 to 15 per cent of private patient admissions.[59] The Australian Private Hospitals Association (APHA) stated that 13 per cent of patients treated in private hospitals in 1997-98 self-funded. The proportion in day surgeries (33 per cent) was far higher than in acute and psychiatric hospitals (9 per cent).[60] DHAC indicated that a TQA survey had found that 12 per cent of private hospital admissions were by people who were self-funded. This was about 215 000 people. DHAC estimated that with an average treatment cost of $2 500, self-funders saved the public hospital system some $540 million per year.[61]

5.55 The Public Hospitals, Health and Medicare Alliance of Queensland concluded:

> there are a number of people who do not have private health insurance and are able to fund their own. So the crisis that the government paints as a reduction in private health insurance may not be a crisis or of as great a magnitude as what we are led to believe in the public arena…But there is no doubt that, although private health insurance was reducing, the usage was not reducing at the same rate. So the perception that has been painted out there is, 'We have a crisis. Private health insurance is going down.'…What we are saying is that it may not be quite that way because this group of people are not being taken into account in the equation and they should be.[62]

Estimates of the impact of the Rebate

5.56 Submissions to the Committee argued that it was too early to tell whether the rebate had had an impact on the demand for hospital services. However, some witnesses did provide the Committee with some analysis of the impact.

5.57 CPHE argued that 'the net effect of the PHI subsidy upon the hospital sector, at least in the short run, will almost certainly be less than the effect upon the hospital sector of a direct subsidy of equal magnitude to public hospitals'. CPHE stated that the greater part of a rebate will be received by existing fund members and will result in increased expenditure on existing goods and services by the already insured and

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58 Submission No.45, p.25 (RACP, ACA, HIC); Submission No.63, p.29 (AHA, WHA, AAPTC).

59 Submission No.16, p.9 (QNU).

60 Submission No.18, p.6 (APHA).

61 *Committee Hansard,* 11.11.99, p.32 (DHAC).

62 *Committee Hansard,* 22.3.00, pp.459-60 (Public Hospitals, Health & Medicare Alliance of Queensland).

therefore will not alter the overall level of insurance or funds available for hospitals.[63] It was estimated that the 'break even' point where the subsidy had the same impact on hospital expenditures as direct payment would occur when the subsidy increased the insured by 12.5 percentage points. CPHE concluded that 'in the short run this is very unlikely to occur and consequently, the direct payment to the public hospital would achieve a greater impact on hospital spending'.[64]

5.58 Professor Don Hindle noted that while there was some freeing up of beds in public hospitals, it was a relatively small proportion, and that between one per cent and four per cent of public hospital costs would be transferred to private hospitals (between $117 and $483 million per year). This estimate was based on an upper and lower estimate in October 1999 of the expected membership levels in May 2000 with a lower estimate of 30.5 per cent and an upper estimate of 34.3 per cent. Professor Hindle concluded:

> although up to four per cent of patients had moved out and vacated beds in the public hospitals, there are other patients out there who are waiting to get in. In other words, there is an unmet need and an unmet demand for public hospital services so that, as soon as you free that bed, some other patient who would not otherwise have got in is now admitted to hospital…the statistics that I have been able to obtain around Australia, comparing calendar year 1998 with calendar year 1999, suggest that the change in the hospital admission rates in the public hospitals is negligible…overall, as far as I can see, the change has been negligible for the reason that patients come in.[65]

5.59 In its comments, CHERE stated that since Professor Hindle had undertaken his analysis two sets of figures had become available which would suggest that the rebate would have an even smaller effect than estimated by Professor Hindle. The first figure is that at 31 March 2000, private health insurance membership was 32.2 per cent of the population. Secondly, the report of the hospital data analysis consultancy indicated that 25.9 per cent of those patients in the sample with private insurance had been treated as public patients. CHERE argued that if this figure is reflective of the entire population, 'then this indicates that 25.9 per cent of the additional people taking out private health insurance will still choose to be treated as public patients. Both figures indicate that the upper [band] of the percentage of public cost likely to be transferred to private hospitals is in fact an over estimate.'[66]

5.60 The Australian Hospitals Association (AHA), Women's Hospitals Australia (WHA) and the Australian Association of Paediatric Teaching Centres (AAPTC) commented that it had reviewed Dr Hindle's estimate of four per cent and suggested

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63 Submission No.46, p.12 (CHPE).

64 Submission No.46, Additional Information p.9 (CHPE).

65 *Committee Hansard,* 21.3.00, p.323. See also Submission No.20, p.14 (DRS).

66 CHERE, Discussion Paper 3, p.7.

that it was overstated as it did not take into account casemix effects and the waiting list effects were understated.[67] AHA, WHA and AAPTC also argued that while there may be a reduction in waiting lists through the transfer of patients to the private system, this will in itself not reduce demand in the public system – it simply shortens the time that patients have to wait.[68]

5.61 The Queensland Government commented on the impact of the rebate on public hospital admissions:

> it is Queensland's view that the rebate arrangements do not appear to be delivering a tangible benefit to the public hospital system, that our demand continues to grow, that our private patient numbers continue to decline while the new rebate arrangements are in place–either the current scheme or the previous one…It is not as if the total number of patients are declining correspondingly. People are coming in as public patients when historically they might have come in as private patients. So we find ourselves with an increasing aggregate workload and a declining revenue stream from private patients when it is our understanding at least that there was some expectation that the new arrangements would be encouraging patients, as the number of privately insured people grows, to access the private hospital system, in which case we would get the benefit that you have implied. But that does not appear to be happening for us at all.[69]

5.62 As noted by the Queensland Government, public hospitals have experienced a fall in revenue from private patients. Payments by health insurance funds accounted for 6.0 per cent of expenditure on public non-psychiatric hospitals in 1989-90 and fell to 3.0 per cent in 1996-97.[70] The NSW Government stated that revenue from private patients in NSW hospitals had declined by about $180 million since 1990-91. Private bed days in public hospitals fell from 1 410 320 in 1990-91 to 537 634 in 1998-99. Private patient revenue now accounts for only $133 million.[71] The South Australian Government noted that between 1984-85 and 1997-98 private patient revenue in the State's public hospitals had fallen from 11.3 per cent of the cost to 5.1 per cent.[72]

5.63 CHPE and other witnesses argued that the fall in revenue from private patients at a time when State governments were capping hospital budgets was a significant problem for public hospitals and not the excessive demand for their services. CHPE concluded that the fall in revenue contributed to a reduction in public hospital capacity to *supply* hospital services without first effecting significant internal reform.[73]

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67 Submission No.63, p.30 (AHA, WHA, AAPTC).

68 Submission No.63, p.29 (AHA, WHA, AAPTC).

69 *Committee Hansard,* 11.11.99, p.60 (Qld Government).

70 AIHW, *Health expenditure bulletin, No.15: Australia's health services expenditure to 1997-98*, p.12.

71 Submission No.79, p.20 (NSW Government).

72 *Committee Hansard,* 23.2.00, p.155 (South Australian Minister for Human Services).

73 Submission No.46, p.13 (CHPE). See also Submission No.63, p.30 (AHA, WHA, AAPTC).

5.64 The NSW Government and other witnesses also noted that the charging system for private patients in public hospitals contributed to revenue problems. The NSW Government argued that the gap between the costs of services provided to private patients in public hospitals and the benefits paid has widened significantly in recent year. The benefits paid by private health insurance funds for private patients in public hospitals – the default rate – is set by the Commonwealth. This rate, according to the NSW Government, represents just over one third of the real costs of providing these services. It has calculated the subsidy to private patients at $286 per day for NSW and ACT hospitals. While the NSW Government acknowledged that it could set a higher rate, 'to do so would provide a major incentive for privately insured patients to elect for public patient status'.[74]

Cost and equity considerations

5.65 A number of witnesses questioned the economic justification of the rebate and pointed to some possible additional costs of increased use of private health insurance and equity implications of the rebate.

5.66 CHPE argued that the rebate may lead to higher health care costs. Research in the area of acute myocardial infarction has suggested that private hospitals are more likely to employ costly procedures and that the unit cost of such procedures are significantly greater in the private sector.[75] Therefore, it argued if an increased use of private hospitals leads to an increase in the number of medical services per patient, then the impact of the rebate would be 'less favourable from a global perspective. That is, Medicare spending on private medical services will be disproportionately increased.'[76] During the second Roundtable, Professor Barclay also noted that research shows that there is a greater likelihood of privately insured women not having a normal birth and that 'the costs of post-natal care [for privately insured women]…are very much higher than they are in the public sector. So there are long-term spin-off effects of a change in private insurer.'[77] The CHPE study is discussed further in Chapter 6 (see paras 6.41-47).

5.67 AHA, WHA and AAPTC also supported CHPE's argument. They concluded that the greater use of the private sector as a percentage of total hospital care, the greater the overall cost. AHA, WHA & AAPTC noted that the larger pool of privately insured patients might result in increased per capita utilisation because private hospital patients receive higher volumes of services. There may thus be no positive impact other than higher income for private care providers and higher overall costs to the community.[78]

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74 Submission No.79, pp.21-22 (NSW Government).

75 Submission No.46, p.18 (CHPE).

76 Submission No.46, Additional information, p.9 (CHPE).

77 *Committee Hansard,* 20.1.00, pp.750-51 (Professor Barclay).

78 Submission No.63, pp.29-30 (AHA, WHA, AAPTC).

5.68 At the second Roundtable, Mr Mark Cormack of the Australian Healthcare Association also cautioned:

> The private health insurance arrangements as they now stand do not contain any real checks, balances and incentives to look at per capita utilisation. There is already good evidence around that the privately insured have higher levels of utilisation for certain service types, and we need to look very carefully at this to see that the increase in funding available through private health insurance does not simply lead to an overall increase in acute hospital utilisation rather than some sort of release of pressure off the public system.[79]

5.69 Professor Hindle noted that his estimate of the reduction of public hospital costs by $483 million as a result of the rebate, 'is more than counterbalanced by the higher costs of providing the transferred patients with care in private hospitals. We estimate that private hospital care for privately insured patients is 27% higher.'[80] Professor Hindle stated that the average cost of a public patient is about $2 400 while the average cost of a private patient in a private hospital is about $2 850.[81]

5.70 In a recent study, Professor S Duckett and Dr T Jackson commented that the rebate is 'effectively a subsidy to the health insurance industry and is larger than budgetary assistance for the mining, manufacturing and primary agricultural production industries combined'. Duckett and Jackson went on to argue that the economic justification for subsidising the private sector should demonstrate improvement in one or more of three economic criteria: technical, allocative and/or dynamic efficiency. They concluded that the private health sector preforms worse than the public health sector on all three criteria and therefore the subsidy is not justified on efficiency grounds.[82]

5.71 Some witnesses also pointed to the impact of higher costs of private hospital episodes on health insurance premiums. For example, increases in premiums may result from the movement from the public to the private sectors as higher benefits are paid to private hospitals when compared with private care in public hospitals.[83] For example, it was estimated that health insurance funds had faced added costs of $400 million in extra benefits payable due to the shift from private beds in public hospitals to private hospital that occurred between 1989-90 and 1997-98.[84] However, the

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79 *Committee Hansard,* 20.11.00, p.755 (Australian Healthcare Association).

80 Submission No.22, p.8 (Professor Hindle).

81 *Committee Hansard,* 21.3.00, p.323 (Professor Hindle).

82 Duckett, SJ and Jackson, TJ, 'The new health insurance rebate: an inefficient way of assisting public hospitals', *The Medical Journal of Australia*, 172, pp. 439-42.

83 Submission No.63, p.30 (AHA, WHA, AAPTC).

84 Messenger, A, 'Rebate reprieve for private hospitals', *Australian Medicine*, 4-18 January 1999, p.14.

Minister for Health and Aged Care stated that the higher levels of participation would ‘give the industry stability and encourage funds to lower their premiums’.[85]

5.72 The AHIA noted that pressure on premiums would continue because funds had to meet costs and the costs of increasing private hospital utilisation. As well, more complex procedures were being undertaken in the private sector. AHIA stated:

> Ten years ago we were paying for very minor surgical procedures. Today we are paying for very high–tech ones and they are growing and growing. The simple example...is the [heart] stent…It is a very complex, high-tech operation. The stent itself costs us $2,700. The operation can cost $12,000 to $15,000 or maybe even $20,000…About five years ago we paid for none and this year we will pay for 5,000. Next year I would expect 7,000 and the year after that probably 10,000 or 20,000.[86]

5.73 Concerns were also expressed that public hospitals could face difficulties in retaining and attracting professional medical staff as they may be attracted to the private sector. The public sector would then be forced to pay premium rates of pay in specialist areas to compete with the private sector.[87]

5.74 Witnesses argued against the rebate on equity grounds and noted that many people in rural and remote Australia could not access private health care.[88] CHERE argued that the rebate is not means tested and is accessible to those who choose to purchase health insurance for either ancillary tables, hospital tables or both. While some lower income families do have private health insurance, the ABS Health Insurance Survey found that ‘the likelihood of having private health insurance increased as the income of the contributor unit increased, from 20% of people in units with an annual income of less than $20 000 to 76% in units with income of $100 000 or more per annum’.[89] CHERE concluded that:

> This would suggest that this policy provides a subsidy to middle and upper class Australia who, in general, are not the sector of society government usually aims to assist financially. The opportunity cost in terms of equity is that those on lower incomes are less likely to receive this subsidy since even with the rebate, private health insurance may still be out of reach for many Australians.[90]

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85 *The Sydney Morning Herald*, 28.8.00.

86 *Committee Hansard,* 11.11.99, p.131 (AHIA).

87 Submission No.16, p.10 (QNU); Submission No.20, p.15 (DRS); Submission No.63, p.30 (AHA, WHA, AAPTC).

88 Submission No.41, p.27 (Queensland Government); Submission No.66, p.27 (National Rural Health Alliance).

89 Australian Bureau of Statistics, 1998, *Health Insurance Survey*, p.6.

90 CHERE, Discussion Paper 3: Key Issues, p.8.

This view was supported in other submissions.[91]

5.75 It was also argued rural and remote areas with poor health services and indigenous health sectors will not benefit from the rebate as traditionally these areas have low health insurance levels. Private services in rural and remote Australia are few. The Northern Territory, for example, has only one private hospital located in Darwin. There would be little impact on demand for public hospital services in these areas.[92] However, evidence was provided that even though there are few private facilities, people in rural and remote areas are joining private health insurance funds in order to minimise costs. The AMA (NT) state that:

> There is a general feeling, particularly since the introduction of Lifetime Community Cover Ratings, that residents of the Territory are being punished by the Commonwealth by attempts to force them to expend money on an insurance that in essence a significant proportion of residents cannot access.[93]

Other options for the funding

5.76 Much evidence to the Committee asserted that the rebate represented poor value for money and that it would have been of greater benefit to have the Commonwealth's expenditure on the rebate paid directly into the public hospital system.[94] The Committee was provided with a number of estimates of the impact on health services if this had occurred.

5.77 CPHE argued that had the $1.5 billion private health insurance subsidy in 1996-97 been allocated to public hospitals, 'their capacity would have increased at least 14 per cent[95] (which significantly exceeds the likely affect of the subsidy – at least in the short run – upon PHI and the indirect effect upon public hospitalisation'.[96]

5.78 Professor D Hindle argued that his analysis indicated that 3 to 12 times more health care could have been provided from the original estimate of $1.7 billion per

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91 See for example Submission No.20, p.16 (DRS); Submission No.63, p.31 (AHA, WHA, AAPTC).

92 Submission No.17, p.8 (Public Hospitals, Health & Medicare Alliance of Qld); Submission No.41, p.27 (Queensland Government); Submission No.89, p.10 (AMA (NT)); *Committee Hansard,* 11.11.99, p.122 (National Rural Health Alliance).

93 Submission No.89, p.10 (AMA (NT). See also *Committee Hansard,* 22.3.00, p.474 (Queensland Minister for Health).

94 Submission No.17, p.8 (Public Hospitals, Health & Medicare Alliance of Qld); Submission No.26, p.2 (Medical Consumers Association of NSW);. Submission No.39, p.7 (ANF); Submission No.65, p.12 (ANF(SA)).

95 This figure represents the percentage increase in the public hospital budget that would have occurred. As the marginal cost of hospital care is significantly less than the average cost, the increase in capacity would have significantly exceeded 14 per cent.

96 Submission No.46, pp.13-14 (CHPE).

year in rebate expenditure if it had been allocated instead directly to public hospitals or made available for competitive tendering by both public and private hospitals.[97]

5.79 The Victorian Minister for Health stated:

> For the $500 million [Victoria's share], the public hospital system could treat thousands more patients more efficiently and increase quality, infection control and other issues facing our hospitals now…with that $2 billion Victoria could treat an additional 150,000 patients, could increase throughput by 25 per cent and could dramatically reduce waiting lists.[98]

5.80 The Doctors Reform Society (DRS) stated that for $1.5 billion a year, 'no more than 100 000 people are covered by private health insurance. The government could have bought 1.5 million individual memberships each year with the same money or opened an extra dozen 500 bed public hospitals.'[99]

The Rebate and the Australian Health Care Agreements

5.81 Under the Australian Health Care Agreements (AHCAs), provision was made for fluctuations in the private health insurance participation rate. Should the participation rate decline in 1999-2000 and later years, thereby placing greater demands on public hospitals, Commonwealth funding under the Agreements would increase at around $82 million per percentage point change. Should the participation rate increase above certain levels, funding would decrease at the same rate of $82 million per percentage change. As a consequence, the risk of fluctuations was 'explicitly shared between the Commonwealth and the States as one part of the risk sharing structure that improves on the previous arrangements'.[100]

5.82 In his second reading speech for the Private Health Insurance Incentives Bill 1998, the Minister for Health and Aged Care stated that if the drop-out rate of private health insurance continued to follow the long term trend of two per cent per year, by July 2001 the Commonwealth would have to provide $500 million per year to the States in additional funding.[101]

5.83 Witnesses, including State governments, expressed concern that the arrangements under the AHCA was based on the assumption that rising levels of private health insurance will automatically result in comparable reductions in demand for public hospitals services.[102] Dr Filby of Queensland Health stated:

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97 Submission No.22, p.4 (Professor Hindle).

98 *Committee Hansard,* 23.3.00, pp.509-10 (Victorian Minister for Health).

99 Submission No.20, p.14 (DRS).

100 Submission No.38, p.31 (DHAC).

101 House of Representatives, *Debates*, 12.11.98, p.265.

102 See for example, Submission No.20, p.15 (DRS); Submission No.45, p.24 (RACP); Submission No.63, p.31 (AHA, WHA, AAPTC).

> The difficulty for us is that the Health Care Agreement implies a relatively straight line relationship between the proportion of people insured and the use of public hospital systems. It implies that in the funding arrangement, albeit with a benchmark or a level upon which the finances will continue to flow, that straight line relationship does not appear to us to be operating. Therefore we find ourselves in circumstances where the demand for our service continues to rise without us getting the benefit.[103]

5.84 The South Australian Government was 'strongly of the view', that given the uncertainty of the relationship between demand for public hospitals services and private hospital insurance rates, 'that Commonwealth funding should not be reduced just because health insurance levels rise above the target rate'.[104] Other witnesses supported the need for more detailed study of the relationship between private health insurance and hospital utilisation.[105]

5.85 The Committee notes that during the passage of the National Health Amendment (Lifetime Health Cover) Bill 1999 through the Senate, the Government agreed to address the concerns of the States. It was announced that the Commonwealth would guarantee that the States would not be worse off as a result of any increase in private health insurance participation rates. In the event that participation rates rise above the level where Commonwealth grants would be reduced, 'revenue from privately insured patients and veterans will be compared to revenue received from those patients during 1997-98. If the increase in revenue from these patients does not match or exceed any loss in revenue under the agreements, the Commonwealth will waive the additional reduction. For example, if Commonwealth funding to a state would otherwise be reduced by $7 million and the increase in revenue in that state was $5 million more than in 1997-98, the Commonwealth will waive $2 million.'[106]

Conclusions

5.86 The Committee considers that it is difficult to come to a conclusion that the rebate has been a substantial factor in influencing people to take out private health insurance. The Committee has considered two matters: first, the rebate is only one of a package of government measures, including the Medicare levy surcharge and Lifetime Health Cover, aimed at improving coverage by private health insurance. These measures have acted in concert to influence decisions to either retain private health insurance or to take out private health insurance.

5.87 Secondly, while it would be extremely difficult to identify the change in participation in private health insurance attributable to any one particular measure, it

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103 *Committee Hansard,* 11.11.99, p.61 (Queensland Health).

104 Submission No.60, p.24 (SA Government).

105 Submission No.63, p.31 (AHA, WHA, AAPTC).

106 Senate, *Debates*, 27.9.99, p.8939.

is possible to identify general trends because of the staggered introduction of the measures. During the period of operation of the PHIIS and Medicare levy surcharge (from 1 July 1997) the decline in coverage continued. During 1999, when the rebate replaced the PHIIS (from 1 January 1999) and the Medicare levy surcharge continued, participation rates rose only 1.2 per cent. However, in the first half of 2000 as the deadline approached for the introduction of Lifetime Health Cover (initially 30 June and subsequently extended to 15 July), participation rates jumped significantly: from 31.3 per cent at 31 December 1999 to 43.0 per cent at 30 June 2000 and 45.8 per cent at 30 September 2000. This increase has seen another 2.8 million people covered by private health insurance.

5.88 The Committee is persuaded by the evidence to conclude that the impact of the rebate on health insurance participation rates has been much less significant than the impact of the Lifetime Health Cover.

5.89 The Committee is concerned about claims that there is a direct link between private health insurance participation rates and the demand for public hospital services. It was argued that higher levels of participation would result in a fall in demand for public hospital beds as patients move into the private system. However, evidence to the Committee indicated that the relationship between health insurance participation and public hospital demand is highly complex and that a number of factors mitigate against rising participation leading to a fall in public hospital demand.

5.90 A recent analysis of patient status found that only 39 per cent of people with private health insurance in the public hospital system actually elected to declare it and be treated as private patients in a public hospital. It was suggested that there were a range of reasons for people to continue to enter hospital as public patients including high, unknown ‘gap’ payments and the availability of insurance products with front end deductibles or co-payments.

5.91 A further issued raised was that there is continuing unmet demand for public hospital services, so that even if the rebate resulted in a move to the private system, people would continue to be admitted to the public system and so no fall in demand would occur.

5.92 The Committee concludes that these factors undermine the argument that there is a direct relationship between an increase in participation rates and a fall in public hospital demand. There is serious risk that public hospitals will be worse off due to changes in the pattern of usage and the threat that funds may be withdrawn.

5.93 The Committee is also concerned that, as new members of health funds reach the end of their waiting periods and start to utilise their insurance for more frequent or more expensive health care than they would have previously sought, the total cost of health care will rise. This will drain limited health resources and increase waiting times at both public and private hospitals and produce further upward pressure on health insurance premiums.

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

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

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

CHAPTER 6

THE INTERFACE BETWEEN PRIVATE AND PUBLIC HOSPITALS

Introduction

6.1 Australia has had a long tradition of provision of health services by private providers to fee-paying private patients. There has also been provision of services for public patients by not-for-profit religious/charitable institutions. Until the late 1970s many private for-profit hospitals were small, often owned and run by medical practitioners. However, developments over recent times have seen an expansion of the operation of private for-profit operators with corporations entering the market. There has also been an impact on the private sector as new technologies emerge, more complex procedures are undertaken in private hospitals and the population ages. In addition, the private sector delivers services to some public patients under contract to governments and also provides clinical and non-clinical services to many public hospitals. This has resulted in a blurring of the boundaries between the public sector and the private sector.

6.2 This chapter provides an overview of the delivery of hospital services by the private sector and models of ownership, management and financing now in place in Australia. This is followed by a discussion of the impact of changes on private and public hospitals. The Committee has drawn on two recent papers for its overview of the private sector below: in December 1999, the Productivity Commission published a research paper on private hospitals in Australia and the Australian Competition & Consumer Commission (ACCC) reported to the Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance.[1]

Overview of the private sector

6.3 The private sector plays a significant role in the provision of health services in Australia. In 1998-99, there were 312 private hospitals providing treatment to both overnight and day patients and 190 freestanding day facilities.[2]

6.4 The services provided by private hospitals have been growing, particularly in the provision of day facilities. The following table provides an overview of activity and growth in the private sector.

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1 Productivity Commission 1999, *Private Hospitals in Australia*, Commission Research Paper, AusInfo, Canberra, 1999; Australian Competition & Consumer Commission, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance*, ACCC, Canberra, 1999.

2 Australian Institute of Health and Welfare, *Australian hospital statistics 1998-99,* AIHW cat. No. HSE 11, Canberra, 2000, p.27.

Table 6.1: Profile of the private hospital sector, 1993-94 and 1998-99

	1993-94	**1998-99**
Private hospitals		
Establishments		
No of hospitals	329	312
Available beds	21 241	23 746
Private free standing day hospitals		
Establishments		
No of hospitals	111	190
Available beds	556	1 460
Private hospitals and free standing day hospitals		
Activity		
Separations ('000)	1 313	1 875
Same days separations (‘000)	568	1 028
Same days separations as a % of total	43.3	54.8
Separations per 1000 population	74.7	95.5
Patient days (‘000)	5 117	6 045
Average length of stay, all separations (days)	3.9	3.2
Average length of stay, excluding same day separations (days)	6.1	5.9
Private hospitals		
Financial data		
Total recurrent expenditure ($'000)	2 225 893	3 613 591
Total revenue ($'000)	2 491 674	3 797 681
Private free standing day hospitals		
Financial data		
Total recurrent expenditure ($'000)	61 092	137 480
Total revenue ($'000)	76 502	161 400

Source: Compiled from Australian Institute of Health and Welfare, *Australian hospital statistics 1997-98,* Canberra, AIHW, 1999, tables 3.1, 3.2 and 4.1 and *Australian hospital statistics 1998-99,* Canberra, AIHW, 2000, tables 3.1, 3.2 and 4.1.

6.5 Private hospital revenue has been increasing steadily over the last decade, with total revenue of more than $3 959 million in 1998-99.[3] Private acute and psychiatric hospital revenue grew by more than 40 per cent and free standing day hospital revenue grew in real terms by some 190 per cent during the period 1991-92 and 1997-98.[4]

6.6 The ACCC found that despite the dramatic increase in revenue there had not been a corresponding increase in private hospital profitability. Free standing day hospitals increased gross profit (revenue minus recurrent expenditure) from $10.1 million in 1991-92 to $23 million in 1997-98. Gross profit from private acute and psychiatric hospitals increased from $222 million to $285 million over the same period.[5] It has been reported that a number of private hospitals face a difficult financial position with pressure from private health funds to provide beds and services.[6]

6.7 The principle source of private hospital revenue is received from payment for patient services – about 92 per cent – while the remainder is derived from such things as investment income, accommodation and facility fees paid by doctors.[7] Patients in private hospitals may be fee-paying private patients, both those with private health insurance (76 per cent of separations) or self-funding (9 per cent); patients provided for by the Department of Veterans' Affairs (9 per cent); compensible patients (5 per cent); and public patients being provided services (2 per cent).[8]

6.8 In broad terms, in-hospital services to fee-paying patients with private health insurance are generally funded as follows:

Medical services – (including pathology/ diagnostic services)	Commonwealth: Medicare benefit of 75 per cent of the MBS schedule fee; Health insurance fund: health insurance benefit of 25 per cent of the MBS, although funds may pay more under contract or gap cover schemes; Patient: any gap due to the difference between fee charged by doctor for in-hospital medical services and combined Medicare and fund benefit;
Hospital services –	Health insurance fund: health fund benefit, often total cost depending on contractual arrangements;

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3 Australian Bureau of Statistics, *Private Hospitals Australia 1999-00*, June 2000, p.27, Table 3.1.

4 Productivity Commission, p.30.

5 ACCC, p.63.

6 *The Sydney Morning Herald,* 'Four private hospitals go into receivership, and there's more on the critical list', 6.9.00.

7 ACCC, p.63.

8 Productivity Commission, p.22.

Patient: any gap between fee charged by hospital and fund benefit;

Pharmaceuticals –

PBS	Commonwealth: cost of pharmaceutical less patient contribution; Patient: contribution under the PBS, although the fund may pay the copayment under some types of cover;
non-PBS	Health insurance fund depending on type of cover.

As well, there may be additional expenses to the patient due to the type of cover purchased, including policies with front end deductibles, policies which do not cover non-PBS drugs or the full hospital charge (eg only cover private patients in public hospitals) and exclusionary policies.

6.9 There are four main ownership types in the private sector: for-profit group; for-profit independent; not-for-profit religious/charitable; and, other not-for-profit hospitals (includes bush nursing, community and memorial hospitals). The for-profit group and religious/charitable operators provide around 80 per cent of available beds in private acute care and psychiatric hospitals. The size of individual hospitals varies from very small (fewer than 25 beds) to major facilities with several hundred beds.[9] Large private hospitals are mostly located within metropolitan areas. Those in regional Australia are mostly very small and often not-for-profit hospitals.

6.10 Some private hospitals are co-located with public facilities. They may form a joint medical facility or precinct and may share some facilities. The co-located private hospitals vary in size from very small (10 to 20 beds) to medium size hospitals of 200 or more beds. However, the private hospital is not usually involved in the delivery of any public hospital services and they operate at arm’s length.[10]

6.11 Co-location has become increasingly popular over the last decade. In 1999, there were approximately 32 co-located private hospitals operating in Australia. While there are some co-located not-for-profit hospitals, most recent examples involve the establishment of co-located for-profit hospitals. Expansion in this area is expected to continue, for example, five new co-located private hospitals were due to open in Queensland in 1999.[11]

6.12 Commonwealth legislation ensures that public hospitals that are co-located with private hospital facilities continue to provide access to a comprehensive range of services for public patients. The Minister for Health and Aged Care must consider a range of criteria listed in Ministerial guidelines set out in a disallowable instrument pursuant to subsection 23 EA(5) of the *Health Insurance Act 1973* before ‘declaring’

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9 Productivity Commission, p.xii.

10 Productivity Commission, p.9.

11 Submission No.38, p.37 (DHAC).

private hospital premises to enable payment of health insurance benefits for private patients treated in the facilities. Similar provisions under the *National Health Act 1953* apply to co-located day hospitals.

6.13 The services offered by the private sector have changed significantly over the last decade, particularly over the last five years. Although there are still differences in the casemix profile of public and private hospitals, the range of services in private hospitals has increased. Many more complex services are available with private hospitals now offering intensive care services, cardiac and oncology units. In 1981, there were only two intensive care unit (ICU) facilities in private hospitals. By 1997-98, there were 30 ICU, 21 coronary care units (CCU) and 33 combined ICU/CCUs. The number of private hospital accident and emergency units increased from none in 1981 to 27 in 1999.[12] However, there is still limited provision of some services in the private sector, for example, paediatric services, and no provision of some very specialised services such as transplants and burns units.[13]

6.14 The private sector dominates some areas of elective surgery. For some surgical procedures, the private sector is the primary provider:

- 71% of knee procedures;
- 68% of lens procedures;
- 66% of colonoscopy; and
- 59% of gastroscopy.[14]

6.15 The private sector has faced some significant developments in the 1990s:

- as noted above, with the growth of the private sector has come a greater diversity and complexity of the services offered, particularly for overnight patients;
- same day procedures are accounting for an increasing proportion of activity;
- changes in the relationship between private hospitals and health insurance funds, including contracting with hospitals by funds for services required by their members (known as hospital purchaser provider agreements (HPPAs)), have increased pressures on hospitals to deliver their services efficiently; and
- increasing delivery of services to public patients under a variety of contractual arrangements with government.

The interface between the private and public hospital sector

6.16 The interface between the private and public sectors arises through a variety of means:

12 Submission No.18, p.7 (APHA).

13 Submission No.38, p.34 (DHAC); Submission No.63, p.29 (AHA, WHA & AAPTC).

14 Submission No.44, p.3 (Mayne Nickless Limited).

- informal links such as providers working across both sectors;
- outsourcing of clinical and non-clinical services in public hospitals;
- co-location of public and private hospitals;
- private hospitals purchasing services from the public sector;
- private provision of services for public patients; and
- privatisation of public hospitals.

Outsourcing

6.17 There are now many private contractors providing various clinical and non-clinical services to public hospitals. There is extensive contracting of services such as catering, cleaning, maintenance, laundry, car parks and security.

6.18 Increasingly governments are turning to the private sector for the provision of clinical services such as radiology and pathology. For example, the Queensland Government has entered into arrangements with private providers for services such as radiology and surgical services.[15] There are also examples of privatisation of outpatients' clinics, whereby hospital outpatients' clinics have been replaced by private clinics run by hospital specialists.

6.19 Services are contracted out for a variety of reasons including opportunities to reduce costs, improve quality of services provided and increase flexibility.

6.20 There are examples of public facilities which have been sold to private operators and which continue to provide some services to government under contract, for example the Repatriation General Hospital, Hollywood, WA and the Repatriation General Hospital, Greenslopes, Queensland. Access for veterans to these facilities continues through specific Hospital Services Agreements between the Department of Veterans' Affairs and the hospitals.

6.21 The 1998-2003 Australian Health Care Agreements allow for public hospital services to be provided in any appropriate environment, provided that the patient continues to receive care free of charge, on the basis of clinical need and within a clinically appropriate time. (See also paras 6.81-85)

Co-location

6.22 The interface between public and private hospitals also occurs with the co-location of private facilities with public hospitals. As stated above, co-location is increasingly occurring in Australia with more than 30 co-located private hospitals now in operation. (See also paras 6.88-95)

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15 Submission No.41, p.31 (Queensland Government).

Private provision of public hospital services

6.23 In Australia there are now a number of arrangements which combine public and private sector involvement in ownership, management, delivery of services and financing of hospitals.

Joint ventures with religious groups

6.24 There has been a long tradition of private operators providing public hospital services. In the past, these have generally been provided by religious/charitable institutions. The first dates from 1857, when the Sisters of Charity established St Vincent's Hospital at Potts Point, Sydney, as a free hospital for all people. There are now more than 20 religious/charitable hospitals, including seven major teaching hospitals, providing about 3 000 beds for use by the public under arrangements with State and Territory governments.

6.25 Under these arrangements the institutions finance the construction and operation of facilities and the government pays them for treating public patients. There may be one management structure covering both the public and private components of the hospital and staff may be shared. However, the private hospital component is operated and licensed as a separate entity within the hospital complex.[16]

Franchised public hospital services

6.26 Franchising of public hospitals involves a state government contracting out the entire management of an existing public hospital to a private health care company, for example, Mersey Hospital in Tasmania was contracted to Health Care of Australia in 1995.

BOOT-type arrangements

6.27 BOO and BOOT arrangements involve private sector financing of the construction and operation of facilities for treating public patients. These arrangements allow the private sector to build and finance new public hospital facilities to treat public patients in return for the right to operate the facilities and receive patient payments from state governments.

- *BOO arrangements*: the private sector Builds, Owns and Operates a hospital facility. The state government purchases hospital services for a specified time (usually 20 to 25 years) after which ownership of the facility is retained by the private operator. Private facilities are also provided. For example, Port Macquarie Base Hospital, NSW, Latrobe Regional Hospital, Victoria, and Joondalup, WA;

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16 Productivity Commission, p.8.

- *BOOT arrangements*: the same as a BOO arrangement, however, at the end of the contract period ownership is transferred to the state government, for example, Hawkesbury Hospital, NSW, Robina, Queensland, Noosa, Queensland;
- *BOLB arrangements*: the private sector Builds, Owns and Leases Back a hospital facility. The private operator constructs the hospital and leases it back to the public sector which runs the facility, for example Mount Gambier Hospital, South Australia.[17]

The impact of the change in the delivery of public hospital services

6.28 The private sector has expanded in all states and, as the Productivity Commission has stated, governments have sought increasingly to involve the private sector with the provision of health care. Factors contributing to this include (self imposed) funding constraints on governments which have limited their capacity to invest in new or to expand existing public hospital facilities and the perception that there would be cost savings and improvements in quality of care through greater private sector involvement.[18]

6.29 State Governments have used a combination of the models described above in their commercial dealings with the private sector. The Queensland Government stated that there were no privatised public hospitals in Queensland. It has instead pursued a partnership approach with the State retaining ultimate ownership of public health assets.

6.30 The Queensland Government saw direct benefits of its joint ventures including:

- reduction in duplication between private and public sectors which allows government to take advantage of excess private capacity and therefore meet unmet public sector demand;
- increased flexibility in service provision which allows the issue of unmet demand in the public sector to be addressed in a more effective manner; and
- sharing of infrastructure costs given the high cost of health capital.[19]

6.31 The West Australian Government also indicated that it was satisfied with the quality of service provided through a contract with a private hospital to provide services for public patients and that the services were being provided at a price that 'is more than comparable with the rest of the metropolitan area'.[20]

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17 Productivity Commission, pp. 6-7.

18 Productivity Commission, p.5.

19 Submission No.41, p.30 (Queensland Government).

20 *Committee Hansard,* 25.2.00, pp.278-9 (Health Department Western Australia).

6.32 DHAC and the Productivity Commission noted that those supporting the greater involvement of private sector management of public hospitals claim the following benefits:

- private sector operators have more ready access to capital for the construction of infrastructure;
- there is scope for private firms to exploit synergies from bundling construction, financing and hospital operations;
- the private sector can provide hospital services more efficiently than the public sector and thus there are better outcomes for limited public sector budgets;
- the use of private sector operators allows government to transfer risk of both capital expenditure and recurrent costs; and
- improvements in quality of care.[21]

6.33 Many witnesses pointed out that the Australian health care system was a blended one, with the private sector seen as performing an important complementary role to the public health care system. It was emphasised that the private sector should not be seen as a replacement for the public system.[22] Arguments were put to the Committee by those opposing moves towards further expansion of private sector provision of services for public patients, particularly through privatisation. These arguments included the differing motivation of each sector; uncertainty about the level of benefits; cost increases; equity considerations; and lack of reliable research.

6.34 Many submissions supported a continuation of the primacy of the public sector and argued that the 'community role, quality and non-profitable services currently provided in public hospitals could be compromised or limited in the name of profit if public hospitals were privatised'.[23] Barwon Health, for example, stated:

> The other key point to emphasise in this topic is the distinctly different ethos of private and public providers, the former motivated by profit and dividends to shareholders, the latter serving the community stakeholder through equity of access and efficiency.[24]

This view was supported by AHA, WHA & AAPTC:

> It should be acknowledged that the private sector, including profit and not for profit organisations, will always seek a return on its investment…Most importantly the public sector is motivated not by profit but by access to care based on need…[The public sector] focus on equity is clearly resonant with

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21 Submission No.38, p.37 (DHAC); Productivity Commission, p.5.

22 *Committee Hansard,* 22.3.00, p.429 (QNU).

23 CHERE, Discussion Paper 3: Key Issues, p.12.

24 Submission No.37, p.5 (Barwon Health).

> prevailing societal values and there appears little social or economic justification for diminution of its role in delivery of health care.[25].

6.35 Catholic Health stated that the interface between public and private hospitals is changing to meet demand and improve efficiency and that the Catholic health sector has participated in this approach and would ‘ensure that issues of equity and access are monitored and understood so that issues of community benefit are not sacrificed for the need to ensure shareholder return’.[26]

6.36 Some commentators have argued that privatisation is an ‘ideology or a belief structure’. The RACP, ACA and Health Issues Centre noted:

> …a privatised system is based on a free market, in which market forces determine supply and demand. A perfectly competitive market does not feature interference with the laws of supply and demand, such as government regulation. Such a system sees health as a commodity for which individuals must make their own choices in relation to consumption. This is contrary to the belief that health is a right, and that the community (and therefore government) has a responsibility to ensure that all its members have access to health and social services according to need.[27]

Efficiency gains and access to capital through privatisation

6.37 The major benefits claimed by the supporters of privatisation are increases in efficiency and access to capital. CHERE noted that the former is ‘the standard economic rationale for privatisation in most industries, that is that the profit motive, assumed to be a driving force in the private sector, and competition would increase technical and allocative efficiency’.[28]

6.38 Evidence received by the Committee argued that this is in fact not the case, that costs in the private sector were higher, as operators need to make a profit and the number of services per patient are higher.[29] On the other hand, the RACP argued that it was not helpful to make blanket statements about public or private hospitals being more or less efficient. Rather, the key issues are about equity and access to quality care and opportunities for teaching, training and research, something that is rarely taken into account in arguments emphasising efficiency.[30]

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25 Submission No.63, p.36 (AHA, WHA, AAPTC).

26 Submission No.56, p.21 (Catholic Health Australia).

27 Submission No.45, p.26 (RACP, ACA, HIC).

28 CHERE, Discussion Paper No.3: Key Issues, p.11.

29 Submission No.17, p.9 (Public Hospitals, Health & Medicare Alliance of Qld); Submission No.20, p.17 (DRS); Submission No.45, p.28 (RACP, ACA, HIC).

30 *Committee Hansard,* 21.3.00, p.371 (RACP).

6.39 While it is acknowledged that there has been little data on the comparative efficiency of the private and the public sectors, some recent research may give an indication of a comparison of the two sectors.

6.40 A study by Stephen Duckett and Terri Jackson assessed the argument that the private sector is more efficient than the public sector.[31] They concluded that in the case of provision of hospital services the public sector is in fact more technically, allocatively and dynamically efficient than the private sector. Duckett and Jackson argued that past efficiency comparisons of public and private hospitals have been flawed because of the use of bed-day costs. However, changes to data mean that differential casemix of each sector can now be taken into account as well as costing discrepancies between the two sectors. These differences relate to medical services including pathology and imaging which in the private sector are not incorporated in hospital costs; pharmaceutical costs which are borne by patients in the private sector (reimbursed through the PBS); and, depreciation expenses which have not been well attributed in the public sector. They provided cost differences as follows.

Table 6.2: Estimated average cost per weighted separation, public hospital casemix, financial year 1996-97

	Public hospital costs	*Private hospital costs*
Unadjusted average cost per separation	$2 283	$2 058
Average cost per separation adjusted for discrepant elements*	$1 774	$1 941

*Discrepant elements removed are public medical, pathology, imaging and pharmacy costs and depreciation costs for the private sector. Costings use national public hospital DRG cost weights.
Source: Authors' estimates using National Cost Weight Study data

6.41 Duckett and Jackson concluded:

> These deficiencies in the data have fostered a longstanding but mistaken view that the private sector is more efficient than the public sector in providing hospital care. Even casemix data give this misleading result if costing discrepancies are not taken into account. Our analysis has shown that, when appropriate adjustments are made to these cost estimates, the public sector provides care at a lower cost per case, and thus there is no economic basis for directing additional expenditure to the private sector.[32]

6.42 The Centre for Health Program Evaluation (CHPE) submitted that the impact of privatisation depends upon the relative administrative efficiency of private and

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31 Duckett, SJ, Jackson, TJ, The new health insurance rebate: an inefficient way of assisting public hospitals, *The Medical Journal of Australia*, Vol 172, May 2000, pp.439-42.

32 Duckett and Jackson, p.442.

public hospitals when the quality of care is similar; and the effect of private hospital status upon the type of service provided to the patient.

6.43 In relation to administrative efficiency, CHPE reported no reliable studies (to 1998) in the literature which demonstrated significant differences in administrative efficiency between public and private hospitals. It concluded 'in the absence of empirical evidence the case for the privatisation of public hospitals is weak and the likelihood of significant health sector benefits from this activity are correspondingly small'.[33]

6.44 In relation to the type of service provided, two studies were noted. The first, by Professor J Richardson and I Robertson, studied the likelihood of patients receiving a costly hi-tech procedure after hospitalisation with an acute myocardial infarction (AMI). It was found that those in private care were, at the end of eight weeks, 100 to 400 per cent more likely to receive a high technology, high cost procedure (angiography or a revascularisation) than patients treated in public hospitals. After 12 months a 100 per cent differential was preserved.

6.45 Professor Richardson stated that there was no indication of differences in quality of life from the study (or whether these results suggest overservicing in the private sector, or underservicing in the public sector or a mix of both). However, 'if there is no difference there then that simply means we are doing more [in the private sector] for the same outcomes. That is costly.'[34]

6.46 CHPE noted that as the reason for the difference 'is associated with the more permissive environment in the private sector (facilities being more readily available in order to attract private doctors), it is highly probable that the same differential pattern of service provision will occur in privatised public hospitals. Mechanisms have not yet been developed and implemented to regulate the type of procedures doctors choose to undertake in private hospitals.'[35]

6.47 The second study by Harper at the Monash Medical Centre examined the unit cost of coronary procedures in the public and private wards. The study found that private expenditures significantly exceeded public costs and 'perversely, because of the public reimbursement of medical and pharmaceutical costs, generated higher costs for public Medicare than if the patient had been admitted to the public hospital'.[36]

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33 Submission No.46, p.16 (CHPE).

34 *Committee Hansard,* 23.3.00, p.597-98 (CHPE).

35 Submission No.46, p.17 (CHPE).

36 Submission No.46, p.16 (CHPE).

6.48 CHPE concluded:

- data suggests that private hospitals may be more likely to employ costly procedures and that the unit cost of such procedures may be significantly greater in the private sector;
- private hospital care may cost the public more than public care; and
- these results imply that the expansion of private hospitalisation and the privatisation of public hospitals may significantly increase the cost of health care.[37]

6.49 Similar research was cited by a number of the midwifery submissions which indicated that the rate of Caesarean section births is significantly higher in private hospitals.[38] Excluding Victoria and the Northern Territory, which did not have data on status in hospital, in 1995 the Caesarean rate of 24.8 percent for women who had private status in hospital was 51 percent higher than the rate of 16.4 percent for those with public status. This difference is partly attributable to a higher proportion of older women among those with private status.[39] The Victorian Branch of the Australian College of Midwives stated that a rate of Caesarean section births in excess of 15 per cent of all births in a region is above the maximum acceptable level (UNICEF 1997), and is an indicator of inappropriate use of obstetric services.[40]

6.50 Barwon Health noted that in a recent costing exercise, 'public hospital costs were found to be about the same after adjusting for competitive neutrality and comparing like with like. So there is no evidence that the private sector can manage hospitals more efficiently.'[41]

6.51 In its report on private hospitals, the Productivity Commission looked at three non-financial indicators of private hospital performance: hospital efficiency; service quality; and appropriateness of services provided.

6.52 For hospital efficiency the Commission evaluated cost efficiency, labour productivity and average length of stay. Findings included that:

- the casemix-adjusted costs per separation for all private acute care hospitals between 1993-94 and 1996-97 have fallen by 3 per cent, due mainly to a reduction in unit labour costs;

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37 Submission No.46, p.18 (CHPE).

38 See for example, Submission No.64, p.7 (Australian Midwifery Action Project); Submission No.75, p.10 (Australian College of Midwives (Vic)).

39 Australian Institute of Health and Welfare, *Australia's Mothers and Babies 1995*, 1998, p.17.

40 Submission No.75, p.10 (Australian College of Midwives (Vic)). See also *Committee Hansard,* 20.11.00, p.750 (Centre for Family Health and Midwifery).

41 Submission No.37, p.4 (Barwon Health).

- total unit costs in religious/charitable hospitals were considerably higher than in other ownership groups;
- costs per casemix-adjusted separation increase with hospital size, this may reflect the greater prominence of religious/charitable hospitals in the larger size categories although the Commission did not have access to data based on size;
- the smallest hospitals have relatively high labour costs. However, these are offset by lower non-labour costs; and
- both unadjusted and case-mix adjusted average length of stay (ALOS) fell during the 1990s, with ALOS for the top 15 DRGs in for-profit hospitals on average 5 to 6 per cent lower than for other ownership groups.

6.53 The Productivity Commission noted although for-profit hospitals may appear to be more efficient than the not-for-profit hospitals, other factors may explain the variations in efficiency. One reason is that the cost per separation and ALOS do not pick up differences in the complexity of cases within DRGs. With larger hospitals, often the religious/charitable hospitals, treating more complex cases within individual DRGs, costs will be higher. Larger hospitals may also devote proportionately more resources to non-clinical functions such as teaching and research, leading to higher costs per separation. It was also noted that the cost per separation and ALOS indicators do not make any allowance for variations in the quality of service delivered to patients.

6.54 The Commission indicated that there were broader influences on efficiency outcomes in the private sector. These included the regulatory and policy environment and the market relationships between the hospitals, doctors and health funds. In particular, changes in the relationship between health funds and private hospitals have strengthened the incentives for private hospitals to deliver their services efficiently.

6.55 In relation to quality of service, the Commission concluded that quality indicators ‘paint a reasonably positive picture of quality in the private health industry’. However, the Commission noted that there were concerns with the use of quality indicators and the overall assessment of quality of care.

6.56 The Commission also addressed the issue of appropriateness of care and noted that studies had found that patients in private hospitals are more likely to receive a greater number of in-hospital medical services than they would have as private patients in public hospitals. The Commission noted the comments by Richardson that it is unknown whether these measures indicate overservicing in the private sector or underservicing in the public, or both.[42]

6.57 The Queensland Government provided the Committee with a comparison of the top 30 DRGs (by volume of patients) in both public and private hospitals. It was stated that, in general, the results indicate that:

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42 Productivity Commission, pp.45-58.

- overall, there was a zero difference between the average costs of public and private hospitals on a simple unweighted DRG by DRG basis;
- for core costs (salaries etc), public hospital costs were 14 per cent higher than private hospital costs;
- for over head costs (administration etc) public hospital costs were 31 per cent less than private hospital costs; and
- the different proportions of core and non-core costs in the total cost allow this outcome where the two components differ markedly but the overall difference is zero.[43]

It was noted that this was a simple comparison between two groups of hospitals and did not entirely control for differences in factors known to impact on costs such as teaching, tertiary or secondary status, location etc.

6.58 The other potential benefit of privatisation was that private hospitals have greater access to capital. Some submissions supported the involvement of the private sector in the development of public infrastructure on the grounds that the private sector could provide facilities at a time when governments were faced with tight fiscal circumstances.

6.59 However, CHERE noted that it is unclear whether this is a benefit, given governments can probably access capital at a cheaper rate than individual or groups of private hospitals. Collyer in her analysis of the privatisation of the Port Macquarie Base Hospital noted that the objective behind the privatisation was, in part, to address a shortage in available capital for the provision of public infrastructure. It was said that public finance was unavailable, given the constraints on global borrowing set by the Commonwealth. Collyer stated that this was never tested and it is possible that a loan may have been approved under Loans Council Guidelines.[44]

Potential costs

6.60 Evidence pointed to the complex nature of health services and the difficulties which that imposed on measuring benefits for public patients of expanded involvement of the private sector. It was argued that the public sector plays an important community role and as such provides numerous services that may not be profitable. For example, it was noted that the larger public teaching hospitals undertake many activities which go beyond routine clinical care, such as education, research and audit. Other services include many of the health services in rural and remote Australia. Other concerns were raised about ensuring equity and access to high quality care.

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43 Submission No.41, Additional Information, p.2 (Queensland Government).

44 CHERE, Discussion Paper 3, p.12; Collyer, F, 'Privatisation and the Public Purse: The Port Macquarie Base Hospital', *Just Policy*, No.10, July 1997.

Casemix

6.61 The Queensland Government noted that while private hospitals have extended the range and complexity of services offered, public hospitals still treat more complex and costly patients than in the private sector. Public hospitals also treat more medical cases and patients with chronic and complex conditions.[45] AHA, WHA & AAPTC also noted that while the private sector did some things very well, for example, ophthalmology, a range of services was not available in the private sector, for example, in the field of paediatrics and women's health, 'because they are not profitable services for the private sector'.[46]

6.62 The Royal Australasian College of Surgeons also stated that patients with complex or catastrophic illnesses are treated in the larger public hospitals and under present casemix funding, the costs usually result in a major loss. As a consequence, these patients would likely to be avoided by a privately managed private hospital.[47]

Education, training and research

6.63 Submissions noted that generally, undergraduate teaching, postgraduate training and quality assurance activities are not adequately funded in current hospital funding models and are often cross subsidised from other activities.[48] As a result, where services are privatisated these activities may not be recognised in contractual arrangements and therefore funded inadequately or not at all.

6.64 Concern was expressed that the private sector has generally failed to provide the same commitment to education and training as the public sector.[49] The DRS stated that 'despite claims of private institutions to be committed to education, their commitment rarely extends to the employment of adequate numbers of training registrars'.[50]

6.65 It was argued that the failure to provide adequate education opportunities is already causing difficulties and will result in serious shortages of appropriately trained staff in the future.[51] It was noted that privatisation of some services, particularly pathology and radiology, is removing training opportunities. The Royal Australasian College of Physicians stated that privatisation of ambulatory care facilities (usually

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45 Submission No.41, pp.30-1 (Queensland Government).

46 Submission No.63, pp.33-4 (AHA, WHA, AAPTC).

47 Submission No.28, p.4 (RACS).

48 See for example, Submission No.49 p.1 (Faculty of Medicine, Monash University). See also Submission No.61, p.18 (Australian Physiotherapy Association).

49 *Committee Hansard,* 23.2.00, p.541 (Australian College of Health Service Executives).

50 Submission No.20, p.16 (DRS); see also *Committee Hansard,* 21.3.00, p.371 (RACP); *Committee Hansard,* 23.3.00, p.496 (Committee of Presidents of Medical Colleges), *Committee Hansard,* 23.3.00, p.541 (Australian College of Health Service Executives).

51 Submission No.28, p.4 (RACS); *Committee Hansard,* 23.2.00, pp.147-48 (Professor Roberton).

outpatients departments) has reduced training opportunities for physicians 'in a major way, leading to the re-evaluation of ambulatory care training by the RACP'.[52] Professor Roberton voiced concern for the training of medical students in a private environment where 'practitioners feel that they have a different responsibility and a greater constraint on their ability to discuss, to intellectualise, to think broadly as they are discussing matters with our trainees'.[53]

6.66 The Australian Healthcare Association also expressed concern over the future of research opportunities in the private sector. AHA stated that virtually all clinical medical research is conducted in the public sector:

> Despite the fact that the same clinicians may care for patients in the private and the public sector, it is much less common for research activities to be based in the private sector. This presumably relates to the nature of the reimbursement of clinicians in the private sector and the relative lack of support for such initiatives by private hospitals, health insurance funds and so forth.[54]

Equity and access to quality care

6.67 The RACP, ACA and HIC noted that 'in health care, the public sector has a crucial role in ensuring equity, that is ensuring access to good quality care for those in greatest need, commonly those with the least capacity to pay. It is also critical in ensuring geographic access'.[55]

6.68 Evidence was received that following changes to management arrangements, ie moves to the private provision of public services, difficulties had been experienced with services being reduced or closed. For example, it was stated that services have been closed at Latrobe Hospital 'in an argument that they are not being funded adequately through the private-public agreement'.[56] Concerns have also been expressed about the level, variety and quality of services provided at Modbury Hospital, SA, where a private company manages the public hospital. The hospital's 24-hour emergency surgery service had been reduced with some periods being covered by 'on-call' services.[57]

6.69 The changes to the level of service provision have significant implications for access to care. This is particularly so when the hospital in question is the only provider

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52 Submission No.45, p.28 (RACP, ACA, HIC).

53 *Committee Hansard,* 23.2.00, p.148 (Professor Roberton).

54 Submission No.63, Additional information, p.5 (AHA). See also Brooks, P. 'Privatisation of teaching hospitals', *Medical Journal of Australia*, 1999;Vol 170, pp.321-22.

55 Submission No.45, p.27 (RACP, ACA, HIC).

56 *Committee Hansard,* 23.3.00, p.537 (ANF (Vic)).

57 Submission No.65, p.13 (ANF (SA)); *Committee Hansard,* 23.2.00, p.175 (ANF(SA)).

for the region. This is the case for the Latrobe Hospital which replaced two public hospitals that were closed at Moe and Taralgon.

6.70 A further matter raised in relation to access to quality care concerned the changes in the public health sector workforce. Concerns were expressed that the supply of specialist medical staff in public hospitals may decline as a result of co-locations and expansion of the use of private hospitals. It was argued that this might lead to fewer specialists available to provide services in the public sector and thereby impact adversely on public sector waiting lists.[58] The increased reliance on part-time and casual hospital staff was also noted as an outcome of recent changes. It was argued that this increased pressures on staff and was detrimental to the quality of care.[59]

Financial viability

6.71 Concerns were also raised in evidence about the economic viability of some contracted out services and the impact of financial instability on the standard of care provided.[60] The AMA (Vic) pointed out that private operators in Victoria are funded in the same way as traditional Victorian public hospitals, which are the lowest cost providers of care in Australia. The AMA (Vic) considered that given this and the need for the private sector to deliver adequate returns on investment and that the for-profit sector does not have access to input tax exemptions, there are significant financial risks in the private sector operators, 'which given the nature of hospitals, cannot be quarantined to the operators. There would be risks to patients, staff and Government, if these competing pressures were not effectively managed'. The AMA (Vic) considered that the operating risks, in terms of the range and quality of services, are of such a magnitude, that they can only be safely borne by the public sector.[61] (See Box 2 for a discussion of Latrobe Regional Hospital.)

6.72 AHA, WHA & AAPTC also noted:

> Concerns now clearly exist as to whether these [co-locations] were sound business investment decisions. The returns on the high capital investment cost appear not to be sufficient to meet debt servicing and profit expectations. There are clear signs of the private sector wanting to increase its share of government funded work, arguably to improve its cash flow and enhance profitability.[62]

6.73 Catholic Health Australia also voiced a note of warning, stating that 'certainly a feature of more recent contracts is a risk shift to the owners and operators of the

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58 Submission No.72, p.28 (Consumers' Health Forum of Australia). See also Submission No.45, p.28 (RACP, ACA, HIC).

59 Submission No.16, p.13 (QNU).

60 See for example, *Committee Hansard,* 22.3.00, p.433 (QNU).

61 Submission No.27, p.3 (AMA Vic).

62 Submission No.63, p.35 (AHA, WHA, AAPTC).

projects which has the potential to be unsustainable in the longer term. Competitive pressures may have also resulted in operators offering discounts on benchmark prices that are unsustainable in the long term'.[63]

Accountability issues

6.74 Concern was expressed about the possible lack of accountability arising from greater contracting with the private sector. It was argued that commercial-in-confidence contracts did not allow for full transparency.[64] Some submissions cited the example of Port Macquarie Base Hospital and Modbury Hospital where many details of the contracts entered into were unavailable due to commercial-in-confidence claims.[65] The Australian Nursing Federation (SA) stated:

> This cloak of secrecy is a major problem in an area of service delivery that impacts very directly on the health and welfare of the community and is paid through the public purse. It works to remove genuine public accountability for both economic efficiency but also for achieving appropriate standards of care and service to the community the hospital was intended to serve.[66]

Contracting and administration costs

6.75 DHAC noted that contracting also brings with it specific costs, which need to be factored into any analysis of potential savings. These costs include bargaining costs, opportunism costs, and transaction and monitoring costs.[67]

6.76 The RACP argued that in fact, the complexity of the arrangements may increase administrative costs, often to the detriment of clinical resources, and while the private sector may enjoy financial gains, the government continues to have the overall responsibility and financial risks.[68]

6.77 Together with the specific costs of contracts, there was also concern about the difficulties in defining in contracts all the services currently undertaken by public hospitals. In particular, submissions pointed to teaching and research activities and community services.

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63 Submission No.56, p.21 (Catholic Health Australia). See also *Committee Hansard,* 23.2.00, p.158 (SA Minister for Human Services).

64 Submission No.16, p.12 (QNU); Submission No.39, p.6 (ANF); Submission No.72, p.28 (Consumers' Health Forum of Australia); *Committee Hansard,* 21.3.00, p.373-74 (RACP).

65 Submission No.26, p.3 (Medical Consumers Association of NSW); Submission No.65, p.13 (ANF (SA)).

66 Submission No.65, p.13 (ANF (SA)).

67 Submission No.38, p.36 (DHAC).

68 Submission No.45, pp.28-9 (RACP, ACA, HIC).

Recent examples of private sector involvement in provision of public hospital services

6.78 There have been a number of reviews by State Parliamentary Committees and Auditors General of private sector provision of public services. These include the Port Macquarie Base Hospital (PMBH), the first arrangement whereby a private operator (Health Care of Australia) was contracted to provide public hospital services, Modbury Hospital in South Australia, Noosa and Robina Hospitals in Queensland, and Joondalup Hospital in Western Australia.

6.79 The reviews identified a range of deficiencies in the contractual arrangements entered into including problems with data and modelling used to compare private and public options; lack of tangible benefits to the state; limited government control over quality; cost overruns; poor contracting management and increased risk for the state. In the case of one parliamentary committee, it was found that commercial-confidence provisions prevented it from concluding its inquiry.

6.80 While these reviews have uncovered major problems with contracting, it was pointed out to the Committee that more recent contracts have included improved arrangements for funding and the types of services provided.[69]

69 Submission No.45, p.29 (RACP, ACA, HIC).

Box 1: Modbury Hospital, South Australia

In 1995, the South Australian Government signed a contract with Healthscope Ltd to manage the Modbury Public Hospital for a period of 10 years with an option to extend the term in addition to the construction of a private hospital on land close to the public hospital. The hospital pays a service fee to Healthscope which is set annually for the management of the public hospital.

In July 1996, the Legislative Council Select Committee on the Proposed Privatization of Modbury Hospital tabled an Interim Report. The Committee reported that it had been unable to obtain information from Healthscope, the Health Commission and the Modbury Hospital Board.

By 1997, Healthscope had raised a number of matters of concern with the contract including continued losses. It was alleged that the contract price was insufficient to enable it to support the long term completion of the contract.

In 1997, Coopers & Lybrand were engaged to report on matters concerning the contract and identified a number of key deficiencies in the contract management process and in the original management agreement.

In 1997 the contract was substantially amended and re-executed after the Government decided that it would be acting against the public interest in not proceeding to amend the contract. It was estimated that the renegotiated contract reversed losses of around $2 million in 1996-97.

The SA Auditor General, in its audit of the Hospital contract in 1997, reported that difficulties had arisen between 1995 and 1997 between the Government and Healthscope over a number of ambiguities in the original management agreement. Further, Healthscope considered that it should be funded on the basis of the same principle as other public hospitals, but as the management agreement did not provide for this, the SA Health Commission refused to provide funds on this basis. Substantial problems also appeared to have occurred because the amount of money the parties had agreed would be paid to Healthscope under the management agreement was allegedly insufficient to allow Healthscope to make a profit.

The Auditor General also noted that the management agreement did not provide any guarantees from Healthscope and there were deficiencies in the Government management of the contract. The Auditor General concluded that the Modbury Hospital contract provided an example of some of the difficulties associated with contracting out and that the Government had a non-delegable duty of care in matters of the provision of public health. The Auditor General also noted that the original and amending contracts would be disclosed.

Concerns continue to be expressed about the level, variety and quality of services provided at the Hospital. For example, the ANF (SA) reported that the Hospital's 24-hour emergency surgery service had been reduced with some services being provided by on-call services. The ANF (SA) stated that it believed that there was not a drop in user rates of the service, but that Healthscope had sought this as a cost-saving device.

Source: SA Auditor General, Report on Summary of Confidential Government Contract under s41A of the Public Finance and Audit Act 1987 Modbury Hospital: Audit Commentary and Recommendations, 1997-98; Submission No.65, p.13 (ANF (SA)); Submission No.16, p.12 (Queensland Nurses Union), Committee Hansard, 23.2.00, p.183.

Box 2: Latrobe Regional Hospital

Latrobe Regional Hospital was opened after the closure of public hospitals as Moe and Taralgon. Australian Hospital Care (Latrobe) Pty Ltd, a wholly owned subsidiary of Australian Hospital Care Pty Ltd, was contracted by the Department of Human Services to build, own and operate the new hospital, with exclusive rights to provide public hospital services in the region for a period of 20 years.

The contract was not made public. In 1999, the Victorian Civil and Administrative Appeals Tribunal ordered that the then Government release the contract. The Government appealed to the Supreme Court.

In October 2000, Australian Hospital Care announced that the Latrobe Hospital would be transferred to the Victorian Government on 31 October. Australian Hospital Care had reported a loss of $6.2 million in 1999 for the hospital and was forecast to lose $2.7 million in the current year (until the transfer to the Government). The company had written off its $17 million investment in the hospital. The Victorian Minister for Health, The Hon John Thwaites, stated that ‘the losses incurred by Australian Hospital Care meant it could no longer guarantee the hospital’s standard of care’.

Under the transfer arrangement, Australian Hospital Care will be released from its contract in return for dropping legal action against the Government, selling its $12.6 million stake in the hospital building for $6.6 million and giving the Government a cash payment of about $1 million.

Australian Hospital Care stated that under the terms of the contract signed with the previous Victorian Government, the company had incurred heavy losses and were ‘unviable’.

Source: Rollings, A, ‘La Trobe hospital returns to public control’, The Age, 24 October 2000; Victorian Legislative Assembly, Debates, 14.5.99, p.1111.

Box 3: Port Macquarie Hospital, NSW

In 1990, the NSW Health Department sought ways to provide a new hospital at Port Macquarie. The Department compared the costs of a new public hospital with those of allowing the private sector to build and operate a public hospital. Under the private option it was expected that the new facility would cost $15 million less and that operational costs over 20 year would also be $46 million less than for public sector operation.

This assessment was examined by the NSW Public Accounts Committee. It concluded that there was no significant difference in operational costs of providing patient care either through the private or the public sector. It recommended that the private sector should be allowed to build the hospital, but that the NSW Government should keep the delivery of hospital services in public hands by leasing the hospital from the private sector.

The PAC recommendations were not accepted. In 1992, the then NSW Government contracted Health Care of Australia (HCOA) to construct and manage a new privately operated 161 bed public hospital in Port Macquarie. Under the arrangement, the hospital is owned by Port Macquarie Base Hospital Limited, which is leased to HCOA. The buildings will revert to HCOA after 20 years. HCOA is contracted to provide public hospital services to public patients under a 20 year contract. In exchange, the NSW Health Department pays the private operator an annual service charge for the treatment of public patients (the service charge is calculated on a set fee per service, which is equivalent to the top cover private hospital rebate). In addition, the Department pays an availability charge to ensure the hospital remains available for public patients. This was the first such arrangement in Australia.

The NSW Auditor General reported in 1996 that the final costs had increased significantly over those contained in the tender documents. In addition, the Health Department did not have accurate costing systems to identify reliably the costs of operating an individual hospital at a particular level of service delivery. Thus the output of the model of public sector operation it had used to compare with the private sector was basically a ‘best guess’ estimate.

The Auditor General also found that the cost of capital construction of the hospital would be totally met by the State under the annual availability charge paid to the HCOA over the 20 year period, but that the State does not receive the hospital at the end of the term, unless it purchases it at market value. The Auditor concluded that the cost of financing the hospital through the private sector was substantially higher than it would have been through the public sector.

In 1996, the then NSW Minister for Health reported that the running costs of the Hospital were between $4.5 million to $6.5 million more than running a public hospital of the same size providing the same services.

Collyer concluded ‘the privatisation strategy has transferred, and continues to transfer, significant public funds from the public sector into the private sector. Private hospital operators, previously relying on patient contributions and health insurance company payments, can now rely more heavily on public funds for the financing of profitable patient services’.

Sources: Collyer, F, Privatisation and the Public Purse: The Port Macquarie Base Hospital, Just Policy, No. 10 June 1997; NSW Auditor, NSW Auditor General’s Report for 1996, vol.1.; Radio National, Background Briefing, 20 October 1996.

Box 4: Joondalup Health Campus, Western Australia

In 1996, the Western Australian Government contracted Mayne Nickless Ltd to provide public hospital services at what had previously been known as Wanneroo Hospital. Under the contract, Mayne Nickless was to rebuild, manage and operate a combined private and public hospital (70 private beds and 265 public beds). It also provides emergency facilities, operating theatres, a medical centre as well as providing for the construction of new community health facilities which will be leased and operated by the public sector.

The State pays the operator service and availability charges for a period of 20 years, after which time the public facilities will revert to the control of the State. The private facilities revert to the State after 40 years.

The WA Government stated that by transferring capital expenditure to the private sector, a net present value saving of $21 million would be provided compared to public sector provision. This was based on a benchmarking exercise which put the cost of public provision of the new hospital at $51 million. However, by June 1997 the operator's costs had increased by 56 per cent on the original estimate of capital costs of the project to $42.4 million.

In 1997, the WA Auditor General conducted a performance examination and reported that:

- there were doubts about the validity of the benchmarking exercise that the Department of Health had conducted and that 'the benchmark figure used by the Department to estimate the capital saving has a number of limitations so that there is no reliable estimate of the extent of any savings';
- the benchmarking exercise did not reflect costs savings that might have been expected if a competitive public sector bid had been developed and did not take into account the value and utility of the existing hospital buildings;
- the contract price did not provide any direct savings in service prices; and
- the contract resulted in additional risks to the State including reduced flexibility and lack of competition for new services and facilities; limited contractual control over the quality of services; financial incentives for the operator to influence admission, treatment and discharge patterns; and potential overpayments because of incorrect coding of treatments.

The Auditor General concluded that there was 'not reliable information to establish that the contract provides net tangible benefits to the State relative to the public sector alternative from either services or facilities'.

Source: WA Office of the Auditor General, 'Performance Examination - Private Care for Public Patients - The Joondalup Health Campus', Report No.9, November 1997; Centre for Development and Innovation in Health at www.cdih.org.au/marketpplace/case.htm; Submission No.45, p.29 (RACP, ACA, HIC).

Provision of services for public patients in private hospitals

6.81 The 1998-2003 Australian Health Care Agreements allow for public hospital services to be provided in any appropriate environment, provided the patient continues to receive care in line with the AHCAs principles. That is, eligible persons must be given the choice to receive public hospital services free of charge as public patients, on the basis of clinical need regardless of geographical location.

6.82 DHAC stated that the 'Commonwealth's focus is on public hospital services rather than public hospitals, provided that:

- arrangements do not result in the transfer of costs from State Budgets to other parties such as consumers, health funds or the Commonwealth; and
- levels of public patient access to free hospital services are not compromised'.[70]

6.83 A number of arguments were put to the Committee about the difficulties of placing public patients in private hospitals as well as some unintended consequences of such a move. It was argued that those taking out private health insurance did so because they wanted choice of doctor, ready access to care and the quality of the private hospital infrastructure. If public patients were treated in private hospitals, private patients may question the need for health insurance, as public patients would also have access to the benefits of the private system at no cost. As a consequence, the Commonwealth Government policies aimed at improving private health insurance uptake would be eroded.[71]

6.84 It was also noted that the same difficulties of demonstrating the benefits of private provision of public hospital services arise in the case of a public patient in a private hospital. The private provider would have to demonstrate a comparative advantage in the provision of the service and the public sector would have to develop the means to monitor services purchased.

6.85 The Australian Private Hospitals Association (APHA) suggested that there was a need for contracting guidelines to be developed where governments sought to contract services for public patients in private hospitals. APHA pointed to a number of disincentives to the expansion of services for public patients in private hospitals:

- current financing arrangements: medical costs are the major cost differences between private and public hospitals. For private hospital services with large volumes, medical practitioners are often willing to negotiate their fees but not to as low as the sessional rates received in public hospitals. 'For this reason, it is unlikely that large numbers of public patients will be treated in private hospitals';

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70 Submission No.38, p.38 (DHAC).

71 Submission No.18, p.8 (APHA); Submission No.27, p.3 (AMA (Vic)); Submission No.37, p.5 (Barwon Health); Submission No.55, p.29 (AHIA); Submission No.86, p.3 (Australian Association of Surgeons).

- ‘discounting’: often under HPPAs a hospital offering a price to a non-insured patient that is lower than the contracted price with a health insurance fund, is required to offer the same price to the contracting fund; and
- transparency of contracts: contracts between a hospital and a public health department ‘would essentially be on the public record. This may discourage some hospitals, reliant on their contractual arrangements with insurers, from accepting a contract with a public health department.’[72]

Competition between the private and public sectors

6.86 The Productivity Commission considered the level of competition between the public and private sectors for insured private patients. The Commission found that with many private hospitals now offering services and treatments that were previously only available at major teaching hospitals, there was competition for private patients. The commonality in the leading DRG groups for insured patients treated in public and private hospitals was a further indication of the scope for some competition between the two sectors: four of the top 10 DRGs for insured patients are common to public and private acute care hospitals.[73]

6.87 The Commission found that in competing for private patients public hospitals face both advantages and disadvantages due to regulatory/policy arrangements:

- *Advantages:* private hospitals face costs from the bed licensing system; accommodation charges for private patients in public hospitals are set at a default rate, which have not generally covered costs;
- *Disadvantages:* the capacity of public hospitals to actively compete for private patients is constrained as they do not have access to capital market funding for refurbishment of facilities and they have not been able to give private patients preference over public patients; the financial incentive for them to treat more private patients or to seek to negotiate accommodation benefits with health funds that more closely reflect costs may be limited as this might lead to lower levels of Commonwealth funding.

Co-location

6.88 As stated earlier, the number of co-located facilities is increasing. It is argued that major benefits arise from co-location of private facilities on public hospital sites through complementary provision of services and economies of scale. These included benefits from:

- reduction in the duplication of services and facilities between the private and public sectors;

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72 Submission No.18, p.8 (APHA).

73 Productivity Commission, p.92.

- increased flexibility in service provision;
- increased efficiencies from sharing the infrastructure costs given the high costs of health capital as well as operating efficiencies by the sharing of facilities such as pathology, radiology, laundry, catering and parking;
- increased ability to recruit and/or retain senior staff in co-located facilities who are able to work across the public and private facilities. As well as contributing to the quality of patient care, this may increase the viability of teaching services, allow public hospitals to install better technology and assist in nursing recruitment;
- increased competition among providers and institutions by creating markets where none might have otherwise existed;
- provision of revenue to the public sector through the leasing and sharing of capital infrastructure and the contracting of services into the private facility;
- provision of backup for each sector. Co-locations occur at major teaching hospitals and this can provide a degree of comfort for the private sector in knowing that hi-tech tertiary care is available on-site if difficult cases arise. In addition, specialists may prefer to work in conditions that enable them to interact with their peers and to have access to a wider range of cases; and
- greater opportunities to provide additional private services in rural locations which may be unable to support a separately sited private hospital.[74]

6.89 Barwon Health provided evidence of the benefits of co-location of facilities in Geelong where a decease in waiting lists and opportunities to purchase services for public patients has arisen:

> For example, in the emergency department if a person comes in with private health insurance, they have got the option of being transferred immediately across through the tunnel into the co-located hospital or remaining with the public system…I think what we have been successful in doing is shifting the emphasis of our facilities onto what I believe they are there for—that is, the proper care of public patients. That has had an enormous impact on our ability to admit public patients, to reduce our waiting list and to increase the turnover of elective work.
>
> ...There have been many occasions over the last 18 months where, for patients that we have had difficulties admitting in an acceptable time frame, we have actually contracted with a co-located hospital to treat those patients…On many other occasions where we have been faced with cancelling major surgery, we have been able to buy intensive care beds from a co-located hospital and then bring the patients back as quickly as we can.

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74 Submission No.32, p.2 (Dr G Masters); Submission No.38, p.38 (DHAC); Submission No.41, p.31 (Qld Government); Submission No.63, pp.34-5 (AHA, WHA & AAPTC); *Committee Hansard,* 11.11.99, p.100 (Australian Association of Paediatric Teaching Centres); Productivity Commission, p.9.

> It has been an arrangement where it has certainly assisted us in coping with peak workload pressures, and it has obviously been of assistance to them in smoothing out their workload. There are many other cases where we work to mutual advantage. They were able to access our specialised medical staff and also our specialised facilities…
>
> We have approximately 18 to 20 pricing agreements for services that we have between us. It has certainly worked to our mutual advantage in a whole range of ways for us.[75]

6.90 However, some concerns were also expressed about the co-location of private facilities on public hospital sites.[76] In particular, the opportunity to cost shift was raised. This could occur if services that were accessed by public patients in a public hospital, at State Government expense, were provided, after co-location, by the private hospital. In this case, the Commonwealth would incur some of the expense for the medical services involved.

6.91 DHAC noted that legislative provisions are in place to ensure that the public hospital involved continues to provide access to a comprehensive range of services for public patients. Before 'declaring' the private hospital premises to enable payment of health insurance benefits for private patients treated in the facility, the Minister for Health and Aged Care must also take into account the co-location's effect on:

- access to services for public patients and the patient's right to choose to be treated as a public patient;
- whether the co-location would result in a transfer of costs; and
- whether the hospital will supply information in order for the Commonwealth to monitor access, adequacy and costs of treatments.[77]

6.92 The Productivity Commission noted that these provisions 'are principally designed to reduce the Commonwealth's exposure to cost shifting'.[78]

6.93 While there may be cost savings to State Governments through the co-location of facilities, there may also be loss of private patient revenue in public hospitals. As noted in the previous chapter, the fall in revenue from private patients in public hospitals has been marked and has impacted adversely on hospitals' ability to provide services. Co-location of private and public facilities may exacerbate this trend.

6.94 DHAC noted the potential impact on private patient revenue but stated:

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75 *Committee Hansard,* 23.3.00, pp.563-54 (Barwon Health).

76 Submission No.17, p.10 (Public Hospitals, Health and Medicare Alliance of Queensland).

77 Submission No.38, p.37 (DHAC).

78 Productivity Commission, p.9.

> However, the relationship between this marginal revenue and the marginal cost of services to private patients is not clear. In some instances the marginal revenue forgone as private patient numbers in public hospital decline has been offset by non-patient revenue (such as lease payments) raised from private hospital operators participating in co-location initiatives.[79]

6.95 The Australian Nursing Federation (SA) also offered a specific example of problems arising from the co-location of a public and private hospital. The ANF (SA) stated that the co-located private hospital at the Flinders Medical Centre was guaranteed a significant volume of public day surgery, cardiac investigations and some other work. As a result, limitations have been imposed on Flinders Medical Centre to make decisions about managing its own budget and activity. When Flinders was faced with a budget reduction, it had very little capacity for adjustment as 'the contract with the private hospital meant that it was required to make those payments regardless of whether the public sector had the services carried out or not'.[80]

Evaluation of changes to provision of services

6.96 While there has been a number of reviews of specific cases of privatisation, the Committee heard that there was no wide ranging evaluation of the increasing trend of private delivery of public services. The Department of Health and Aged Care noted that the arguments used by those supporting privatisation are still to be evaluated as most of the initiatives 'are very recent'.[81]

6.97 However, other commentators voiced stronger concerns about the lack of evaluation in the light of government policy promoting greater private sector involvement. Professor J Richardson stated:

> Concerning public use of private hospitals, the broader issue here is whether or not we get a better deal if the public uses private hospitals. The unknown factor here is whether or not that is of any benefit at all. We simply do not know the quality and the costs of the public versus the private hospitals. In fact, because of the lack of research in this area we have engaged right around Australia in privatisation with virtually no evidence to suggest that that will actually give the benefits that are claimed.[82]

6.98 The lack of research and evaluation also has implications for government's ability to assess the benefits to the public of changes in service arrangements. The Productivity Commission stated:

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79 Submission No.38, p.38 (DHAC).

80 Submission No.65, p.14 (ANF (SA))

81 Submission No.38 p.37 (DHAC).

82 *Committee Hansard,* 23.3.00, p.597 (Professor J Richardson)

> The increasing role of the private sector in the delivery of public patient services also puts a much greater premium on governments having access to good information on the quality of services and clinical outcomes in both public and private hospitals. In addition, further research and evaluation of policy experimentation will be necessary to help determine which forms of private sector involvement are best suited to particular circumstances.[83]

6.99 The Productivity Commission also noted that the Victorian Health Services Policy Review, in a comparison of a number of approaches to increased private sector involvement in the delivery of public services, had concluded that there was a need for further evaluation:

> …we believe that there is insufficient evidence at this stage to support the wholesale tendering of public patient services in Victoria…The next few years should provide rich evidence of the success or otherwise of that model of service delivery as privately operated hospitals are established and placed under the social microscope. Further, tendering under that model should await the outcome of rigorous evaluation.[84]

6.100 In its analysis for the Committee of research needs, CHERE stated that the following matters need to be examined in relation to the interface between public and private sectors:

- quality - development of performance measures for ongoing monitoring of quality;
- comparative performance - comparison of overall performance and performance in particular areas; and
- identification of potential relationships between the two sectors and appraisal, demonstration projects and evaluation.

Conclusions

6.101 Recent initiatives by State and Territory Governments have seen a blurring of the roles of private and public sectors. Whilst there has been a long history of the provision of public services by private providers, those providers have in the past been religious/charitable institutions operating jointly with government. However, governments are now pursuing a variety of other models of delivery of public services. Many different services are involved ranging from the outsourcing of certain clinical and non-clinical services to the total management and provision of a large public hospital. For-profit organisations, including large corporations, are now providing public services under a variety of contractual arrangements.

6.102 The Committee received evidence from those who supported the greater involvement of private operators and from those who did not. Many of those who did

83 Productivity Commission, p.114.

84 Quoted by the Productivity Commission, p.114.

not support the current trend emphasised the lack of clear benefits for public patients and the lack of research in this area.

6.103 It is this lack of research and evidence of benefits that is of major concern to the Committee. It appears governments have embarked on the path of increased privatisation without the benefit of rigorous analysis of the benefits and costs. Individual examples of privatisation have highlighted many problems which have resulted in costs rather than savings to the public purse. In part, these may have been due to problems arising from poor contracting arrangements. However, there is a fundamental lack of data and research about the comparative merits of the models proposed.

6.104 Some research was provided to the Committee which may call into question the benefits put forward in support of privatisation. For example, the analysis by Duckett and Jackson suggests that one of the main arguments for privatisation – the greater efficiency of the private sector – cannot be maintained.

6.105 The Committee also recognises that the private sector is not homogeneous and that certain types of care may well be more efficiently provided through the private sector. This adds to the complexity of any comparative analysis as does difficulties of costing many of the services provided in public hospitals. For example, a vigorous public health system also provides many benefits to health care through training, education and research. As well, public hospitals provide a range of community services. These activities are difficult to cost and appear, on the evidence received, more difficult to establish in a for-profit environment.

6.106 The Committee concludes that research is required into the comparative performance of the public and private sectors to appraise and evaluate measures of efficiency and effectiveness before further privatisation takes place.

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

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

CHAPTER 7

QUALITY IMPROVEMENT PROGRAMS

7.1 This chapter discusses the inquiry's terms of reference relating to the effectiveness of quality improvement programs to reduce the frequency of adverse events. While the terms of reference specifically focus on programs for quality improvement much of the evidence received by the Committee discussed quality improvement in general terms. This chapter focuses on these broader issues as the evidence indicated that a discussion of quality improvement cannot be solely restricted to its impact in addressing adverse events given the impact of these programs on other quality of care issues.

7.2 It was highlighted during the inquiry that the community has a right to expect that the quality of care in public hospitals meets the highest standards. While most treatments carry some risk, the hospital system should be organised to minimise those risks and the extent of any injury which might result from an adverse event. A concern for safe, high quality care should permeate the whole public hospital system.[1] While evidence to the Committee indicated that the quality of public hospital services in Australia is of a generally high standard it was emphasised during the inquiry that in several critical areas safety and quality could be enhanced.[2]

7.3 Several Australian studies in the 1990s have focussed on the issue of quality and safety in health care. The 1995 Quality in Australian Health Care Study focussed particular attention on safety issues by suggesting that a higher than expected number of hospital admissions were associated with adverse events. Following the release of the findings of the study, the Taskforce on Quality in Australian Health Care was established in June 1995 to consider the data and report to Australian Health Ministers on measures to reduce the incidence and impact of adverse events in the health care system. The Taskforce reported to Health Ministers in June 1996. In March 1997, the National Expert Advisory Group on Safety and Quality in Australian Health Care was established to provide practical advice to Health Ministers on further steps to improve safety and quality of health care services. The National Expert Group presented its Interim Report to Health Ministers in July 1998 and its Final Report in August 1999.[3]

Definition of quality improvement

7.4 The subject of quality in health care has been described as 'bedevilled with definitional confusion and ambiguities'.[4] Terms such as 'quality', 'quality

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1 Taskforce on Quality in Australian Health Care, *Final Report*, June 1996.

2 *Committee Hansard,* 21.3.00, p.334 (Dr O'Connor); *Committee Hansard,* 21.3.00, p.369 (RACP).

3 For further details see DHAC, *The Quality of Australian Health Care: Current Issues and Future Directions*, Occasional Paper, Health Financing Series, Volume 6, 2000, pp.3-4.

4 Submission No.6, p.3 (Dr Wilson).

improvement' or 'quality assurance' are often difficult to precisely define and are often used interchangeably. During the inquiry, a number of terms were referred to when describing quality of care issues including 'quality improvement', 'quality management' and 'quality assurance'. 'Quality improvement' in the context of hospitals has been defined as the end result of effective quality management and can be measured in relation to the degree to which practices in hospitals result in the production of known or assumed maximum health status improvement for patients. Quality improvement has three components – identifying problems within hospitals, for the most part identifying system defects; resolving those problems; and measuring the resultant improvement.[5]

7.5 'Quality management' has been described as an umbrella term that includes a wide range of hospital activity designed to produce a 'quality mature' hospital. Quality management includes such activity as quality assurance, risk management, credentialling of medical staff, incident reporting and analysis, adverse events monitoring, quality assessment and quality improvement. A 'quality management program' is defined as an organised, coherent, range of activities that will enable the hospital and its medical staff to improve the quality of care provided.[6] 'Quality assurance' has been described as the process of ensuring that clinical care conforms to criteria or standards and is a subset of quality management.[7] Generally the term 'quality improvement' is used throughout this chapter as it relates directly to the terms of reference and is the term most commonly used in submissions and other evidence to the inquiry.

Nature and extent of adverse events

7.6 There is little data on adverse events in Australia. The 1994 the Quality in Australian Health Care Study (QAHCS) was commissioned by the then Commonwealth Department of Human Services and Health to determine the proportion of admissions associated with an adverse event (AE) in Australian hospitals.[8] This was the first published study in Australia that attempted to identify quality of care problems in Australian hospitals.

7.7 There is no nationally or internationally agreed definition of what constitutes an adverse event. In the Australian context, the Quality in Australian Health Care Study defined an adverse event as 'an unintended injury or complication which results in disability, death or prolongation of hospital stay, and is caused by health care management rather than the patient's disease'.[9]

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5 Submission No.6, p.4 (Dr Wilson).

6 Submission No.6, pp.3-4 (Dr Wilson).

7 Wilson, L and Goldschmidt, P, *Quality Management in Health Care*, Sydney, McGraw-Hill, 1995, p.xli.

8 Wilson, R *et al*, 'The Quality in Australian Health Care Study', *Medical Journal of Australia*, Vol.163, 6 November 1995, pp.458-71(referred to as QAHCS). The study reviewed the medical records of over 14 000 admissions to 28 hospitals in NSW and South Australia in 1992.

9 QAHCS, p.461.

7.8 The QAHCS study found that 16.6 per cent of hospital admissions were associated with an adverse event and 51 per cent of the adverse events were considered preventable.[10] While in 77.1 per cent of cases the disability had resolved within 12 months, in 13.7 per cent the disability was permanent and in 4.9 per cent the patient died. For the two categories of 'death' and 'greater than 50 per cent permanent disability', the proportion of high preventability were 70 per cent and 58 per cent respectively. There was a statistically significant relationship between disability and preventability, with high preventability being associated with greater disability.[11] The proportion of admissions associated with permanent disability or death due to adverse events increased with age; however temporary disability and preventability were not associated with age or other patient variables.

7.9 A significantly lower proportion of the adverse events were reported for obstetrics (7.2 per cent) and ear, nose and throat surgery (7.9 per cent) than for other specialities, while a higher proportion were associated with digestive (23.2 per cent), musculoskeletal (21.9 per cent) and circulatory (20.2 per cent) disorders.

7.10 The study found that extrapolating the data on the proportion of admissions and the additional bed-days associated with adverse events to all hospitals in Australia in 1992 indicated that about 470 000 admissions and 3.3 million bed days were attributable to AEs.[12] The study also found that the number of patients dying or incurring permanent disability each year in Australian hospitals as a result of AEs was estimated to be – 18 000 deaths, 17 000 cases with permanent disability, 50 000 cases resulting in temporary disability and 280 000 cases of temporary disability.[13]

7.11 A Victorian study recorded an adverse event rate of 5 per cent of separations using inpatient data from all public and private acute care hospitals in that State in 1994-95. Most (81 per cent) were complications after surgery or other procedures; 19 per cent were adverse drug effects; and 1.7 per cent were misadventures.[14] The study has, however, been criticised on the basis of the less rigorous definitions it employed than the Quality in Australian Health Care Study.[15]

7.12 The cost to the Australian health care system of adverse events in hospitals has been estimated at $867 million per year. Over a five year period this would amount to $4.3 billion. This estimate does not include any subsequent hospital admissions and out-of-hospital health care expenses, loss of productivity of the patients involved, and the long term community costs of permanent disability from

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10 QAHCS, p.459.

11 QAHCS, p.465.

12 QAHCS, p.459.

13 QAHCS, p.465.

14 O'Hara, D and Carson, N, 'Reporting of adverse events in hospitals in Victoria, 1994-1995', *Medical Journal of Australia,* Vol.166, 5 May 1997, p.460.

15 Wilson, R and Harrison, B, 'Are we committed to improving the safety of health care?', *Medical Journal of Australia*, Vol.166, 5 May 1997, p.452.

AEs.[16] The National Expert Advisory Group estimated that the extrapolated potential savings from preventable AEs in 1995-96 would be $4.17 billion.[17]

7.13 Regarding overseas comparisons of AEs, the Australian study found that when expressed as a rate of adverse events per admission, the rate of hospital admissions associated with an adverse events was 13 per cent compared to the rate of 3.7 per cent in the Harvard Medical Practice Study in the United States on which the Australian study was modelled. The study noted that the considerably higher rate recorded in the Australian study may have been due to the fact that the US study was concerned with medical negligence and malpractice, whereas the Australian study focussed on prevention – which may produce different incentives for the reporting of AEs. In addition, while both studies surveyed medical records – the US study in 1984 and the Australian study in 1992 – the quality of the medical records may have improved in the intervening years. These factors suggest that the US study could have underestimated the AE rate.[18]

7.14 The Committee considers that the extent of adverse events highlighted in these various studies are disturbing. The implications in terms of preventable adverse outcomes and the use of health care resources are substantial, especially as the Quality in Australian Health Care study suggests that in up to half of all adverse events practical strategies may be available to prevent them.

Current approaches to quality improvement

7.15 The main quality improvement standard in the Australian health care sector is the Australian Council on Healthcare Standards (ACHS) accreditation and quality improvement program. The Council supports health care organisations in their implementation of quality improvement; develops and reviews quality standards and guidelines in consultation with the industry, professional bodies and consumers; benchmarks clinical care through the collection, analysis and dissemination of clinical indicators; and advises on health care quality improvement.

7.16 ACHS' quality improvement program – the Evaluation and Quality Improvement Program (EQuIP) – is a continuous quality improvement program that provides a framework for establishing and maintaining quality care. EQuIP requires an integrated organisational approach to quality improvement by assisting health care organisations to improve overall performance; develop strong leadership; and focus on a culture of continuous quality improvement with an emphasis on patients and outcomes.[19]

16 Taskforce on Quality in Australian Health Care, *Final Report*, Appendix 7.

17 National Expert Advisory Group on Safety and Quality in Australian Health Care, *Interim Report,* July 1998.

18 QAHCS, p.470.

19 http://www.achs.org.au/open/abou01.htm

7.17 ACHS conducts surveys of hospitals and awards accreditation on the basis of the demonstrated ability of a hospital to demonstrate significant and continuous improvement. Participation in the accreditation process is voluntary and larger hospitals are more likely to seek accreditation.[20] As the table shows, in 1995-96, 40 per cent of public hospitals were accredited, representing 69 per cent of accredited public hospital beds. In 1997-98, 47 per cent of public hospitals were accredited, representing 75 per cent of beds in public hospitals.[21]

Table 7.1: Accreditation of public acute care hospitals [(a)] and average available beds, 1995-96

Public Hospitals	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Accredited hospitals	100	55	25	26	38	3	2	–	249
Non-accredited hospitals	73	60	119	61	37	12	–	5	367
Total hospitals	173	115	144	87	75	15	2	5	616
Proportion hospitals accredited	58%	48%	17%	30%	51%	20%	100%	–	40%
'Accredited' beds	13,861	9,410	4,401	3,432	3,098	1,061	769	–	36,032
'Non-accredited' beds	4,300	2,787	5,567	1,439	1,653	174	–	570	16,489
Total beds	18,161	12,197	9,968	4,870	4,751	1,235	769	570	52,521
Proportion beds 'accredited'	76%	77%	44%	70%	65%	86%	100%	–	69%

(a) All acute care hospitals are included in this table whether or not accreditation was sought. Hospitals are included in this table for performance indicator purposes and for some jurisdictions excludes multipurpose facilities, mothers and babies facilities and dental hospitals.

Source: AIHW, *Australia's Health 1998*, Canberra 1998, p.210.

7.18 There are a number of other accreditation systems involved in the health care sector including those related to community health, mental health, aged residential care, and general practice. In addition, a number of other professional accreditation systems exist through specialists' colleges, health professional organisations and the post graduate medical council.[22]

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20 AIHW, *Australia's Health 1998*, Canberra, 1998, p.210; Submission No.16, p.17 (QNU); Submission No.63, p.40 (AHA, WHA, AAPTC).

21 AIHW, *Australia's Health 2000*, Canberra, 2000, pp.325-26.

22 Submission No.63, p.41 (AHA, WHA & AAPTC).

7.19 At the Commonwealth level there are a range of activities and initiatives to promote safety and quality of health care, which attempt to promote a national focus and an integrated approach to quality and safety. The Department of Health and Aged Care (DHAC) stated that 'although the Commonwealth does not have responsibility for the day to day running of public hospitals, [there]… are examples of where the Commonwealth is currently working with other stakeholders to support quality and safety improvement'.[23]

7.20 These initiatives are detailed below:

- Australian Council for Safety and Quality in Health Care – the Council was established in January 2000 to act as a national partnership between governments, health care providers and consumers to improve the safety and quality of care. The Council will initiate research and identify strategies to improve the quality and safety of health services and strengthen the link between existing quality improvement programs.[24]
- National Institute of Clinical Studies – the Institute, which is yet to be established, will work with the medical profession to identify, develop and promote best clinical practice across a range of clinical settings, and encourage behavioural change by the medical profession.[25]
- Consumer Focus Collaboration – this organisation was established in April 1997 and is a national body consisting of representatives from consumer organisations, professional associations, State and Territory health departments and the Commonwealth. Its aim is to strengthen the focus on consumers in health service planning, delivery, monitoring and evaluation. The goals of the organisation is to facilitate the provision of information to consumers; to facilitate active consumer involvement in health service planning, monitoring and evaluation; improve health service accountability and responsiveness to consumers; and promote education and training that supports active consumer involvement in health service planning and delivery.[26]
- National Resource Centre for Consumer Participation in Health – the Centre became fully operational in May 2000. Its aim is to assist service providers, such as hospitals, to improve their strategies for involving consumers in developing their services and practices. It has two functions, namely as a clearinghouse for information about methods and models of community and consumer feedback and participation; and in the longer term as a centre of excellence in consumer

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23 Submission No.38, p.47 (DHAC).

24 ACSQHC, Terms of Reference.

25 http://www.health.gov.au/hsdd/nhpq/quality/natsafet.htm

26 http://www.health.gov.au/hsdd/nhpq/consumer/concolab.htm

participation where clients can seek assistance to develop, implement and evaluate feedback and participation methods and models.[27]

- Clinical Support Systems Project – the Royal Australasian College of Physicians (RACP) is undertaking a consultancy for DHAC to focus on the measurement and improvement of clinical care through the implementation of clinical support systems. The College is working with innovative and leading clinicians and hospitals to explore whether combining the use of evidence with a systematic approach to clinical practice results in more effective and efficient health care with a view to improving patient outcomes.[28]
- National Demonstration Hospitals Program – NDHP is a Commonwealth funded program designed to identify and disseminate information about best practice models for innovation in acute hospital care. The effectiveness and transferability of these innovations are evaluated through demonstration projects conducted in a range of hospitals. Phases 1 and 2 focussed on innovation in internal processes in hospitals to improve patient care and resource management. Projects in Phase 3 are reaching beyond the immediate acute care sector and are focussing on identifying and developing systems and processes that link and coordinate all services delivered by the acute and related areas of the health sector. [29]

7.21 Further information on these projects is provided in discussion in this chapter on measures to improve quality and safety in hospitals.

7.22 In addition to these initiatives, under the current Australian Health Care Agreements (AHCAs) approximately $660 million is allocated to the States and Territories to fund and support quality improvement and enhancement practices in hospitals. This requires Ministers to agree, on a bilateral basis, to a strategic plan for quality improvement during the term of the Agreement. Progress under each plan will be reviewed during the 2000-01 financial year.[30]

7.23 For example, in Queensland a quality improvement program is being implemented by funding provided under the AHCAs. Under the program over the period from 1999-2004 major activities to be undertaken include requiring all services funded or provided by Queensland Health to have in place quality and continuous improvement systems; ensuring that all services participate in an endorsed accreditation program; implementing systems to assess risk, including the monitoring of adverse incidents and monitoring and evaluating quality performance criteria. The program also aims to provide relevant information to consumers, which allows them to make informed decisions regarding their own health and to measure patient

27 http://nrccph.latrobe.edu.au

28 http://www.health.gov.au/hsdd/nhpq/quality/3quality.htm

29 Submission No.38, pp. 26-27, 53-55 (DHAC). See also DHAC, *The Quality of Australian Health Care*, Occasional Paper, pp.21-2, 43-61; www.health.gov.au/healthonline

30 Submission No.38, p.7 (DHAC); DHAC, Occasional Paper, p.46.

satisfaction and patient experience of health services particularly with respect to outcomes.[31]

7.24 The Committee notes that there is no means of knowing if the quality enhancement funds provided by the Commonwealth are being spent effectively by the States. Under Clause 23 of Schedule E of the AHCAs, each State and Territory has agreed to provide the Commonwealth the following reports within five months of the end of each grant year:

- a statement to acquit the amount of funds provided in the relevant grant year as Health Care Grants under the terms of the Agreements; and
- a certification that the Health Care Grant funding received in the relevant grant year was expended on the provision of public hospital services.

7.25 Under Clause 24 of Schedule E, each State and Territory has agreed that the reports referred to in clause 23 of Schedule E will be in the form agreed with the Commonwealth from time to time. This acquittal form includes separate identification of components of Health Care Grants paid to each State and Territory, including for quality improvements and enhancement.

7.26 However, DHAC cannot provide details of how each State/Territory has spent its quality improvement and enhancement funds in the 1998-99 financial year because they are not required to allocate the quality funding against specific projects or to reconcile this funding at the end of each financial year. It is therefore not possible to determine whether the $660 million provided to the States is being used to drive quality improvements. Unless better financial accountability mechanisms are put in place the ad hoc and unsystematic approach to quality improvements in the Australian health care system will continue.

7.27 A range of activities are also undertaken at the State and Territory levels towards supporting safety and quality in health care. In NSW the *Framework for Managing the Quality of Health Services in NSW Health* was developed in 1998 to provide a comprehensive approach to assessing the performance of Area Health Services in NSW. The Framework which is currently being implemented on a State wide basis identifies a number of dimensions of quality relevant to patients and health providers, in the areas of 'safety', 'effectiveness', 'appropriateness', 'consumer participation', 'efficiency' and 'access'.[32]

7.28 In South Australia, the Department of Human Services has engaged the Australian Patient Safety Foundation (APSF) to provide service infrastructure and monitoring software for a comprehensive package to measure risk and the incidence of adverse events and provide for analysis of these factors. The APSF system has been

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31 Submission No.41, pp.36-37 (Queensland Government); Additional Information, 10.12.99 (Queensland Government).

32 Submission No.79, p.23 (NSW Government).

trialed and is being introduced across the State.[33] In Tasmania the State Government indicated that it is developing a comprehensive quality plan to address adverse events and other quality issues.[34]

7.29 Evidence to the Committee suggested that current quality improvement programs need to be improved to reduce the frequency of adverse events. The Royal Australasian College of Physicians (RACP), Health Issues Centre (HIC) & the Australian Consumers' Association (ACA), reflecting much of the evidence stated that:

> While there have been extensive efforts at Commonwealth, State and hospital level in relation to quality improvement in hospitals, much of the effort remains unsystematic and ad hoc.[35]

7.30 The Consumers' Health Forum (CHF) also noted that 'effective quality improvement programs are essential to reduce preventable injury and death in hospitals. These programs are currently very ad hoc and "process", rather than "outcome" oriented.[36]

7.31 Dr Lionel Wilson of Qual-Med put the view starkly when he stated that:

> …few if any such programs exist and those that do are largely ineffective…Unfortunately, quality management programs barely exist in most hospitals although sporadic efforts exist to implement a range of quality management projects. It is this absence of program activity that accounts for the fact that current activities are quite ineffective in reducing the frequency of adverse events, or indeed, a wide range of additional quality of care issues.[37]

7.32 Dr Wilson stated that the overall results of this situation are that 'no patient in Australia can be guaranteed high quality of care in any of our hospitals and there are no worthwhile initiatives to reduce or even identify adverse events in most hospitals resulting in high levels of avoidable mortality and morbidity'.[38]

Improving quality and safety in public hospitals

7.33 During the inquiry a number of areas were highlighted where improvements to safety and quality of care in public hospitals could be made. These issues are

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33 Submission No.60, p.30 (SA Government).

34 Submission No.67, p.10 (Tasmanian Government).

35 Submission No.45, p.30 (RACP, HIC & ACA). See also Submission No.53, p.5 (Professor Duggan); Submission No.32, p.2 (Dr Masters).

36 Submission No.72, p.33 (CHF). See also *Committee Hansard,* 20.11.00, pp.787-59 (Professor Richardson).

37 Submission No.6, p.1 (Dr Wilson).

38 Submission No.6, p.1 (Dr Wilson).

discussed below and include a discussion of the role of the Australian Council for Safety and Quality in Health Care; the need for improvements in data collection on adverse events, the need for pilot projects to find solutions to system failures, the role of financial incentives, improved accreditation processes, improved education and training for health professionals; encouraging best clinical practice; promoting greater consumer participation; and the development of performance indicators.

Australian Council for Safety and Quality in Health Care

7.34 At the August 1999 meeting of Australian Health Ministers' Conference all health ministers agreed to establish the Australian Council for Safety and Quality in Health Care (ACSQHC) to address the need for a national coordination mechanism to improve Australia's health care system and to support action at the local level.[39]

7.35 The National Expert Advisory Group on Safety and Quality in Australian Health Care (the Expert Group) recommended in 1999 that the Council be established to improve safety and quality in health care through:

- providing national leadership and coordination of health care safety and quality activities;
- developing an overall coherent plan for improving the quality of health care services;
- facilitating action by dissemination of information about quality activities and their outcomes through appropriate agencies and organisations;
- promoting a systematic approach to safety and quality within the health care system and within the community at large; and
- providing advice to Ministers and the public about the safety and quality of the Australian health care system.[40]

7.36 The Council's subsequent terms of reference reflect the recommendations of the Expert Group. The Council's stated role is to lead national efforts to promote systemic improvements in the safety and quality of health care in Australia with a particular focus on minimising the likelihood and effects of errors. The aims of the Council are to:

- provide advice to Health Ministers on a national strategy and priority areas for safety and quality improvement;
- develop, support, facilitate and evaluate national actions in agreed priority areas;

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39 Submission No.38, p.47 (DHAC).

40 National Expert Advisory Group on Safety and Quality in Australian Health Care, *Implementing Safety and Quality Enhancement in Health Care,* Final Report, July 1999, (referred to as the Expert Group report), p.22.

- negotiate with the Commonwealth, States and Territories, the private and non-government sectors for funding to support action in agreed priority areas;
- widely disseminate information on the activities of the Council including reporting to Health Ministers and the public at agreed intervals.

In undertaking these tasks, the Council will:

- work collaboratively with stakeholders, in particular building on the existing efforts of health care professionals and consumers to improve the safety and quality of health care;
- establish partnerships with existing related national bodies and organisations, in particular the National Institute of Clinical Studies (NICS) and the National Health Information Management Advisory Committee (NHIMAC) to facilitate action in agreed priority areas;
- consider and act to improve health care in the priority areas identified as a result of national consultations undertaken by the National Expert Advisory Group on Safety and Quality in Health Care including:
    - methods to enable increased consumer participation in health care;
    - implementation of evidence-based practice;
    - agree a national framework for adverse event monitoring, management and prevention including incident monitoring and complaints;
    - effective reporting and measurement of performance, including research and development of clinical and administrative information systems;
    - strengthening the effectiveness of organisational accreditation mechanisms;
    - facilitate smoother transitions for consumers across health service boundaries; and
    - education and training to support safety and quality improvement; and
- co-opt members with specific expertise, and establish sub-committees and reference groups as required.[41]

7.37 The Council comprises 23 members including experts in the areas of health care quality and safety; education, training and research; and consumer members. Its membership reflects the view of the Expert Group that the Council members be appointed from a range of stakeholders including Commonwealth and State representatives, members of learned Colleges and professional associations, hospitals and consumer representatives.[42] The Commonwealth and the States were asked to

41 ACSQHC, Terms of Reference.

42 Expert Group report, p.20.

nominate members for the Council with the Commonwealth negotiating with the States on the final list of nominees. All Health Ministers agreed on the list of nominees for the Council. Mr Bruce Barraclough, currently President of the Royal Australasian College of Surgeons and Vice Chair of the Committee of Presidents of Medical Colleges was appointed Chair of the Council on 21 January 2000. The Council will receive $5 million in core funding over five years from all governments.[43]

7.38 The Council has identified a number of key priority areas that need to be addressed. These priority areas are to:

- develop a national reporting system for errors that result in serious injury and death of patients;
- address medication errors across the system, including investigating IT support for health professionals;
- provide support for consumer incident reporting and feedback – what goes wrong and what goes right;
- establish mechanisms to review causes of preventable deaths and the interventions that would improve practice;
- establish programs to educate health professionals across the spectrum – undergraduate and postgraduate – about safe practice, quality improvement and communication;
- investigate workforce issues such as skill mix, supervision and workplace constraints across all professional groups;
- examine methods of auditing practice to provide feedback to clinicians about their performance against best practice standards;
- examine a system to track implanted medical devices;
- look at the issue of credentialling and licensing of health professionals with a view to development of national standards; and
- provide support for a national/international conference on safety and quality in health care.[44]

7.39 It is envisaged that the Council will initiate a detailed plan of action on these priority areas by June 2001.[45] The Council has identified three priority areas in which it will focus its efforts in the first instance. These are improvements in data collection and reporting mechanisms; more effective ways to support the safe practices of health

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43 Minister for Health and Aged Care, *Media Release*, 21 January 2000, p.1.

44 ACSQHC, *Press Release*, 18 February 2000.

45 Health and Aged Care Portfolio, *Portfolio Budget Statements 2000-01*, p.243.

care professionals; and re-design of systems to strengthen a culture of 'safety improvement' within health care organisations.[46]

Role of the Council

7.40 Evidence to the Committee indicated that there was general support for the establishment of the Council.[47] The Committee of Presidents of Medical Colleges (CPMC) stated that with the establishment of the Council 'we have every hope that we will now get quality, particularly in dealing with adverse events higher on the agenda, and that we will get some effective ways of dealing with that'.[48] The Australian Medical Association (AMA) noted that, in supporting the Council, 'individual doctors and hospitals are putting in an enormous amount of effort to improve quality, yet it needs a national focus that the Council can give'.[49]

7.41 The Centre for Health Program Evaluation (CHPE) stated that an important role of a permanent quality assurance group 'would be the determination of core measurement and performance indicators for each sector and specialisation, and the determination of the validity of these instruments. This suggests the desirability of a capacity to monitor work in other countries and to run pilot studies in Australia'.[50] The Expert Group envisaged that the Council would support a number of pilot programs aimed at establishing national standards and evaluation tools.[51] The nature and extent of pilot programs undertaken by the Council have yet to be considered by Health Ministers.

7.42 Professor Jeff Richardson, Director of the Health Economics Unit, also stated that the Council should be put under 'very close scrutiny' that they are implementing examples from around the world in regard to best practice medicine.[52] Professor Guy Maddern representing the South Australian Salaried Medical Officers Association (SASMOA) expressed the view that while the Council may initiate action at the Commonwealth level there is a concern that initiatives will 'not get down to the state level where in fact most or all of the public hospital dollars are spent'.[53]

7.43 Dr Wilson also added a note of caution in relation to the Council questioning its composition the breadth of its expertise. He noted that, while acknowledging the need for such a national monitoring body on quality issues:

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46 Australian Council for Safety and Quality in Health Care, *Safety First: Report to the Australian Health Ministers' Conference*, July 2000, p.6.

47 Submission No.45, p.31 (RACP, HIC, ACA); Submission No.72, p.34 (CHF); Submission No.47, p.38 (AMA).

48 *Committee Hansard,* 23.3.00, p.491 (CPMC).

49 Submission No.47, p.38 (AMA).

50 Submission No.46, p.23 (CHPE).

51 Expert Group report, p.23.

52 *Committee Hansard,* 23.3.00, p.601 (Professor Richardson).

53 *Committee Hansard,* 23.2.00, p.197 (SASMOA).

> Unfortunately, what has been established is a reflection what I call the Australian disease: it's full of state representatives, and in some case, their role would be to see that nothing changes the status quo in that state. What is more, apart from some exceptions–notable exceptions–there is a minimum of expertise on that council because they have been chosen for other reasons, and this is a complex area and there is little expertise in this country...What is required of a council like that is not something that addresses the political difficulties between the federal government and the states…but one which applies a good deal of expertise to the problem...I have some hesitation as to whether that council will be terribly effective.[54]

7.44 With regard to composition of the Council, of its 23 members, nine are representatives of Commonwealth and/or State and Territory health departments. This indicates that of the total Council membership some 40 per cent are Commonwealth or State representatives. The Committee shares the concerns expressed by Dr Wilson that this may be an overly large representation of government officials, a representation that would need to be matched by a strong commitment of those representatives to establish an effective partnership between the Commonwealth, the States and other key stakeholders to advance safety and quality issues in Australia.

7.45 As to the perceived lack of expertise on the Council the Committee notes the concerns expressed. The Committee notes, however, that the Council has a number of noted professionals and other experts in the area of quality and safety. The Committee does, however, consider that the composition of the Council and the range of expertise represented should be kept under review.

7.46 The Council's lack of formal links with the health system is also of concern to the Committee. Under the current structure the Council lacks the ability to make sure its strategies are implemented across the health care system. The Council can produce reports and strategies and make recommendations to the Health Ministers but it has no mechanism to directly drive cultural change and institutional reforms.

7.47 The Expert Group considered that the Council and its performance should be reviewed prior to the conclusion its first four year term.[55] The Government determined that the term of the Council would be five years but did not put a formal review process in place. The Committee believes that the Council should be reviewed after two years of operation, and that this review should consider, among other things any change in the structure and composition of the Council and the degree to which its aims and objectives are being met.

7.48 Some evidence suggested that there should be a statutory body established to oversee quality issues. The Australian Healthcare Association (AHA) argued that the most effective way to deal with these issues would be to have an independent statutory

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54 *Committee Hansard,* 21.3.00, pp.312-13 (Dr Wilson).

55 Expert Group report, p.21.

body at least to oversee the implementation of the Expert Group's report.[56] AHA also suggested that while there are a number of organisations that are involved in various aspects relating to quality 'none of them…have the independence, freshness or breadth in their current brief to be able to do that'.[57] The Committee sees merit in this proposal and believes that a statutory authority should be established to oversee the quality programs.

7.49 The Committee has some concerns at the level of resources devoted to the Council. As noted above, Health Ministers have agreed to funding of $1 million per year over five years ($5 million in total) for operating costs. The Task Force argued that funding of $17.4 million ($4.35 million per year over four years from 1999-00) should be provided, which would allow for a number of targeted research, development and dissemination activities suggested by the Expert Group (as outlined above).[58] The Council advised that Health Ministers would consider additional resources for the Council at their meeting in July 2000.[59] At their meeting, Health Ministers agreed, in principle, to provide $50 million over five years for the Council to lead a 'national program of work to improve the safety and quality of care'.[60] The Health Ministers agreed to provide $5 million for a one year work program and the Council will provide a report to Ministers on progress. Both of these commitments were in line with the recommendations of the Council in its first report to Health Ministers.[61] Further commitment of funds by Health Ministers to the Council will be dependent on the progress and results of this one year program of work.

Conclusion

7.50 The Committee believes that new quality funding arrangements that include financial incentives and penalties linked to agreed national quality targets are required. To be effective the new funding arrangement would need to be supported by an institutional body or authority with the capacity to monitor and report on the achievements of quality and safety outcomes of different health systems. Under the current system there is no body that oversees quality and drives the required reforms.

7.51 Quality improvements are currently limited to pilot projects and consequently there is no overall requirement for the system to commit to quality improvements. Quality improvements will remain an 'optional extra' in our health system until new funding arrangements are developed and implemented that require specific quality measures to be built into the entire system.

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56 *Committee Hansard,* 11.11.99, p.111 (AHA).

57 *Committee Hansard,* 11.11.99, p.111 (AHA).

58 Expert Group report, p.23.

59 ACSQHC, *Press Release*, 18 February 2000.

60 Australian Health Ministers' Conference, '$50 million plan to improve safety and quality in health care', *Media Release*, 31 July 2000.

61 Australian Council for Safety and Quality in Health Care, *Safety First*, p.1.

7.52 The Committee believes that the Australian Council for Safety and Quality in Health Care has the potential to place quality improvement high on the national health agenda and to provide the essential national leadership and coordination of safety and quality activities. However, under the current funding arrangements State and Territory health systems are not obliged to adopt the Council's agenda. The Council's work needs to be supported by an independent statutory body that sets quality improvement targets and reports on their implementation across the different systems. An independent statutory body would overcome the ad hoc and unsystematic approach that has characterised quality reforms in Australia. Funding for quality programs needs to be made more accountable, especially the funds provided through the AHCAs.

7.53 The Committee considers that the Council should pursue a vigorous and pro-active program of reform aimed at improving the quality of health care across the nation and that this program of reform should be adequately resourced. In this regard, the Committee notes the recent decision of Health Ministers to provide $5 million to the Council for a one year program of work. The Committee notes, however, that this is only a fraction of the funding needed, especially considering that the Taskforce on Quality in Australian Health Care sought $166.3 million over five years when it reported in 1996. It is also only a fraction of the total cost to the health care system of adverse events which has been estimated at $867 million per year. The Committee is concerned that the Council will require increased funding to enable it to fulfil its functions. The Committee also notes the very long time taken for the Government to address the quality agenda. The Taskforce reported in 1996 but the Council was not established until January 2000.

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

- **collecting and publishing data on the performance of health providers in meeting agreed targets for quality improvements across the entire health system;**

- **initiating pilot projects in selected hospitals to investigate the problem of system failures in hospitals. These projects would have a high level of clinician involvement; and**

- **investigating the feasibility of introducing a range of financial incentives throughout the public hospital system to encourage the implementation of quality improvement programs.**

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

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

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

Collection of data on adverse events

7.54 Submissions emphasised the need for common systems for the collection of information about adverse events and incidents in Australia. The Australian Health Insurance Association (AHIA) argued that all hospitals should be required to report incidents to a central incident reporting system.[62]

7.55 Infections and medication errors are the two areas that have been identified as the major contributors to adverse events in several Australian and international reports.[63] Figure 7.1 in this chapter indicates that data on 'hospital acquired infection rates' are not yet completed and there is no mention in the chart of data relating to medication errors.

7.56 In the United States in February this year the US President, Bill Clinton, announced reforms to begin to reduce medication errors:

> I'm calling on the Food and Drug Administration to develop standards to help prevent medical errors caused by drugs that sound similar or packaging that looks similar. In addition, we'll develop new label standards that highlight common drug interactions and dosage errors.
>
> Hospitals that have already taken these steps have eliminated two out of three medication errors. This is very significant. We tend to think all our problems are the result of some complex, high tech glitch. We just want to make sure people can read the prescriptions – two out of three of these errors can be eliminated.[64]

7.57 The United States report *To Err is Human: Building a Safer Health System* recommended:

> a nationwide mandatory reporting system should be established that provides for the collection of standardised information by state governments about adverse events that result in death or serious harm. Reporting should

62 Submission No.55, p.29 (AHIA).

63 Australian Council for Safety and Quality in Health Care, *Safety First*, pp.1-9; The National Academies Institute of Medicine, *To Err is Human: Building a Safer Health System*, Washington D.C., National Academy Press, 2000.

64 U.S. President Bill Clinton, Office of the Press Secretary, The White House, 22 February 2000.

> initially be required of hospitals and eventually be required of other institutional and ambulatory care delivery settings.[65]

7.58 A comprehensive system of data collection on adverse events enables the health system to identify and learn from errors:

> Reporting is vital to holding health care systems accountable for delivering quality care, and educating the public about the safety of their health care system. It is critical to uncovering weaknesses, targeting widespread problems, analysing what works and what doesn't, and sharing it with others.[66]

7.59 The Committee highlights the urgency for the infection and medication error framework indicators to be completed noting that they are necessary to inform the development of national strategies to address these quality issues. The Committee believes that there should be mandatory reporting of both medication errors and hospital acquired infection rates and that these data should be made public.

7.60 There are a number of systems and methods in place at present to collect information about incidents and adverse events. These include the systematic audits of registers of death and selected complications associated with particular procedures or treatments and the Australian Incident Monitoring System (AIMS). AIMS is an incident reporting system operated by the Australian Patient Safety Foundation. It is a voluntary reporting system largely restricted to hospitals in South Australia and the Northern Territory. Data on adverse events are also collected by the Australian Council on Healthcare Standards as part of their surveys of facilities for accreditation purposes.[67] Evidence to the Committee indicated that these ad hoc attempts at data collection could be improved by implementing a system aimed at collecting comprehensive and consistent data across all hospitals nationally.[68]

7.61 The Expert Group argued that systems need to be put in place to support the efficient collection of incidents and adverse events – ‘these systems need to be simple, usable, robust and must not add significant administrative burdens to those involved in their use’.[69]

7.62 Several submissions called for the establishment of a nationally consistent adverse incident reporting scheme.[70] The Expert Group also argued that there was a need for State and Territory Governments, health care organisations and other

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65 The National Academies Institute of Medicine, *To Err is Human,* Executive Summary, p.9.

66 US President Bill Clinton, Office of the Press Secretary, The White House, 22 February 2000.

67 Expert Group report, p.11.

68 Submission No.41, p.36 (Queensland Government).

69 Expert Group report, p.11.

70 Submission No.63, p.42 (AHA, WHA, AAPTC); Submission No.55, p.29 (AHIA); Submission No.72, p.34 (CHF).

agencies involved in collecting data on incidents, adverse events and complaints to agree on common systems for efficient collection and reporting data on adverse events, with the capacity for national analysis of safety and quality trends.[71]

7.63 The Committee notes that the Australian Council for Safety and Quality in Health Care has set as one of its priorities the development of a national reporting system for errors that result in serious injury and death of patients in the health care system.[72] The Committee strongly supports the adoption of a uniform national approach to this problem as both necessary and long overdue.

7.64 The Committee believes that the national statutory authority could play an important role in overcoming the current ad hoc approach and in establishing a national system of data collection and reporting.

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

Pilot projects

7.65 Submissions identified the need for pilot studies with system wide application to find solutions to the system failures which have been identified in the various studies of adverse events both in Australia and overseas.[73] In most studies of hospital systems, some form of system failure, for example, the absence of, or failure to use policy, protocol or plan; inadequate reporting; or inadequate training or supervision of staff is usually judged to be a contributing factor in up to 90 per cent of cases of adverse events.[74]

7.66 Dr Wilson noted that most quality problems in hospitals are not about individuals making mistakes but are due to system failures. He added:

> This is what happens when things do wrong in hospitals. The person in charge of theatre was not there that day; someone else was there who did not know the routine. The theatre team was new. The surgeon was not well or had been up all night. A whole series of events go wrong. It is not just about an individual misbehaving or behaving badly, or very rarely it is. It is mainly a system failure.[75]

7.67 Dr Wilson further stated that:

71 Expert Group report, p.12.

72 ACSQHC, *Press Release*, 18 February 2000.

73 Submission No.40, p.6 (CPMC).

74 QAHCS, p.471.

75 *Committee Hansard,* 21.3.00, pp.318-19 (Dr Wilson). See also Submission No.32, p.2 (Dr Masters).

> Implementing effective quality management that ensures real quality improvement, needs to be done slowly in a small number of facilities with carefully managed and monitored pilot projects. Such projects will require resources and will need to be evaluated to ensure that they are producing value for money.[76]

7.68 CPMC noted that clinician involvement in identifying and implementing solutions is crucial in any reduction in the frequency of adverse events.[77] The Committee notes that the Medical Colleges have indicated to the Department of Health and Aged Care that they are 'willing to take a leadership role in these activities'.[78]

7.69 The Committee believes that the problem of system failures in hospitals needs to be addressed and that pilot projects to investigate this problem should be undertaken by the new statutory authority. The Committee also believes that the connection between system failure in hospitals and cultural change needs to be addressed. The Australian Council for Safety and Quality in Health Care stated that there is a need for creating 'changes in the culture in which health professionals work from one of "judgement and blame" to one of "learning for quality improvement"'.[79] This cultural change will require more than just pilot projects, it will require national leadership to implement findings on a national scale.

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

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

Financial incentives

7.70 Evidence suggested that there is a serious lack of financial incentives throughout the health system that will promote quality of care. CHPE stated that:

> The key issue is the lack of any reward under current payment arrangements for the achievement of high quality care…The full potential of financial levers is not explicitly recognised. In principle, a system committed to

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76 Submission No.6, p.9 (Dr Wilson).

77 Submission No.40, p.6 (CPMC).

78 Submission No.40, p.6 (CPMC).

79 Australian Council for Safety and Quality in Health Care, *Safety First*, p.3.

> quality improvement would embody incentives to achieve this objective at all levels.[80]

7.71 Professor Richardson commented that 'when you change incentives and financial incentives you will actually change behaviour. That behaviour change, usually with a time lag, is followed by some sort of institutional change…there are any number of studies now from any number of countries – primarily, the United States – which illustrate that financial incentives do have a major effect'.[81]

7.72 Dr Wilson stated that:

> There are no drivers at all for quality management in health care. It is continually assumed that, if you have well-trained people, that is enough. It is important, but it is not nearly enough, not in today's world. So that is the next thing: drivers. And they probably have to be financial drivers because they are the most potent.[82]

7.73 A number of options were suggested to address the issue of the lack of financial incentives. In the area of private health insurance, AHIA suggested that the default payment should be linked with quality criteria, that is, hospitals should not automatically be entitled to benefits without meeting some degree of quality assurance, such as the implementation of a recognised quality improvement program.[83] The Australian Private Hospitals Association (APHA) argued that hospitals offering quality services should be rewarded by insurers through financial incentives, in the form of higher benefits.[84]

7.74 CHPE suggested that one option would be to reduce default payments (preferably to zero) for non-participating hospitals. The health insurance funds should be permitted to base their selection of preferred providers on explicit performance indicators of quality and be permitted to publicise what and why they have selected particular providers.[85]

7.75 With regard to public hospitals, Dr Wilson argued that financial drivers need to be applied to hospital boards and management, who should have prime responsibility for quality management and improvement programs. As noted above, he argued that at present there are no incentives for a hospital managers to undertake the steps necessary for 'quality management'. 'Quality management', as discussed previously, is a general term used to describe a range of hospital activity which aims

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80 Submission No.46, pp.22-24 (CHPE). See also Submission No.53, p.5 (Professor Duggan).

81 *Committee Hansard,* 20.11.00, p.783 (Professor Richardson). See also *Committee Hansard,* 20.11.00, p.795 (Dr Braithwaite).

82 *Committee Hansard,* 21.03.00, p.311 (Dr Wilson).

83 Submission No.55, p.29 (AHIA).

84 Submission No.18, p.9 (APHA).

85 Submission No.46, p.24 (CHPE).

to produce a quality mature hospital. It includes activities such as risk management, quality assurance and credentialling of medical staff. Dr Wilson stated that the introduction of financial incentives available to hospital managers who implement a stated range of quality management activities that are verifiable within a certain timeframe, combined with a financial sanction for failing to achieve designated goals, would substantially improve quality and safety in hospitals.[86]

7.76 CHPE also suggested that the use of 'normative DRGs' and other penalties/rewards should be explored. With these, the cost weight per DRG would have a deterrent or reward loading which could reflect under or over used procedures; origin of the patient in an over or under serviced geographic location; the receipt of services from an accredited hospital; and some other quality related activity such as discharge planning and follow-up service.[87]

7.77 In relation to doctors, CHPE argued that accreditation may be linked to a differential fee. This could be extended so that a loading was added to fees when doctors indicated their compliance with broad evidence based guidelines. The extent of their commitment could, potentially, be monitored using routine administrative data.[88]

7.78 The Committee believes that the new statutory body should explore the use of financial levers to encourage improved quality of care in the hospital setting.

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

Accreditation processes

7.79 A number of submissions argued that there should be improved linkages and coordination between the range of current accreditation and quality improvement approaches, in order to minimise duplication and confusion for health service organisations regarding expected standards of care. In the joint submission of the Australian Healthcare Association (AHA), Women's Hospitals Australia (WHA) and the Australian Association of Paediatric Teaching Centres (AAPTC) it was noted that in addition to the Australian Council on Healthcare Standards there are now a number of other accreditation systems involved in the health care sector including those related to community health and aged residential care. A number of other professional accreditation systems also exist through specialists' colleges and health professional organisations.[89]

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86 Submission No.6, pp.8-9 (Dr Wilson).

87 Submission No.46, p.24 (CHPE). See also *Committee Hansard,* 20.11.00, p.785 (Professor Richardson).

88 Submission No.46, p.24 (CHPE).

89 Submission No.63, pp.40-41 (AHA, WHA, AAPTC).

7.80 The Queensland Nurses' Union (QNU) raised the issue of how these separate processes interrelate and whether there is a need for an 'overarching framework' that will facilitate the involvement of all key stakeholders in activities relating to continuous improvement in health – 'we believe that better integration is required to facilitate consistency of approach with respect to these matters'.[90] The Australian College of Health Service Executives (ACHSE) expressed a similar view.[91]

7.81 ACHSE argued for the establishment of an accreditation authority for all health services. The authority would need to be independent of the funding authority and ensure that there was effective stakeholder and consumer involvement.[92] AHA, however, arguing against the creation of a national accreditation body stated that:

> I think accreditation is part of the overall process of managing risk and improving quality. I do not think it is the total answer to quality and safety so I do not necessarily think a national accrediting body could take responsibility for quality. However, I think an authority that has responsibility for safety and quality could certainly have a look at the plethora of accrediting bodies that are in place at the present time.[93]

7.82 AHA, WHA & AAPTC argued that the Commonwealth and State Governments should collaborate in the establishment of a national accreditation process for all types of health care facilities.[94]

7.83 Submissions also noted that accreditation currently focuses on quality control 'processes', that is, it has a strong input focus. The Australian Nursing Federation (ANF) argued that to strengthen its capacity to bring about significant reductions in the frequency of adverse events, accreditation criteria 'must be comprehensively linked to the achievement of desired health outcomes'.[95] AHA also stated that accreditation systems should move beyond the inputs, processes and simple indicators of the quality of products to an approach that is multidisciplinary in its focus to better reflect the nature of contemporary, best practice care delivery systems.[96]

7.84 Some submissions also argued that there was a need for more consistent national standards to underpin quality improvement and accreditation approaches. Professor Don Hindle of the School of Health Services Management at the University of NSW advocated the 'adoption of national standards for quality of care and outcome measurement'.[97] AHA, WHA & AAPTC stated that the proliferation of different

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90 Submission No.16, p.18 (QNU).

91 Submission No.62, p.5 (ACHSE).

92 Submission No.62, p.5 (ACHSE).

93 *Committee Hansard,* 11.11.99, p.111 (AHA).

94 Submission No.63, p.41 (AHA, WHA, AAPTC).

95 Submission No.39, p.8 (ANF).

96 Submission No.63, p.41 (AHA).

97 Submission No.22, p.5 (Professor Hindle).

standards for the same type of facilities, and of different ways of measuring the same features in multiple settings is a major concern of the Associations.[98] The Expert Group noted that a first step should be to facilitate discussion and debate about the underlying quality standards that should be key elements of all quality improvement approaches.[99]

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

Education and training in quality improvement

7.85 Submissions argued that the education and training available for health professionals and administrators at all levels in quality improvement needed to be improved. ACHSE argued that:

> greater emphasis and investment in education and training in the philosophy and techniques of quality and safety are required for managers and all health professionals. This will enable improved approaches to be established effectively and new accountabilities to be met.[100]

7.86 The Australian Association of Surgeons (AAS) argued that while formal quality improvement programs may decrease the frequency of adverse events educational activities are usually more cost effective.[101] The Doctors Reform Society (DRS) also argued that quality improvement programs should be an integral part of the on-going education of all medical practitioners.[102]

7.87 The Expert Group considered that there would be benefits from the development of core quality management aspects to be incorporated in all educational training provided to all health professionals, whether they are being trained for clinical or administrative roles. The Group also argued that there needs to be a national effort to improve the education and training of health providers in safety and quality matters and agreement on the curricula for continuous quality improvement for inclusion in all undergraduate, postgraduate and continuing education and training.[103]

7.88 The Committee notes that the Australian Council for Safety and Quality in Health Care has identified as a priority area the establishment of undergraduate and postgraduate programs to educate health professionals about safe practice and quality

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98 Submission No.63, p.41 (AHA, WHA, AAPTC).

99 Expert Group report, p.14.

100 Submission No.62, p.4 (ACHSE).

101 Submission No.86, p.4 (AAS).

102 Submission No.20, p.19 (DRS). See also Submission No.60, p.30 (SA Government).

103 Expert Group report, p.17.

improvement.[104] The Committee supports this initiative noting the concerns expressed in evidence about the need for improvements in the education and training of health professionals in the areas of safety and quality.

Encouraging best clinical practice

7.89 Evidence to the inquiry called for the uptake of evidence-based health care and the further development and implementation of best practice guidelines.[105] 'Evidence-based health care' is an approach to health care based on a systematic review of scientific data. 'Best practice' in the health sector refers to the highest standards of performance in delivering safe, high quality care, as determined on the basis of available evidence and by comparison among health care providers.[106]

7.90 The National Health and Medical Research Council (NHMRC) stated that there has been an increasing move towards developing clinical best practice guidelines.[107] 'Clinical practice guidelines' are systematically developed statements to assist providers and users of health services to make decisions about appropriate health care for specific circumstances. The purpose of best practice guidelines is to improve the quality of health care, to reduce the use of unnecessary, ineffective services or harmful interventions and to ensure that care is cost effective. The NHMRC has been primarily responsible for the development and implementation of clinical practice guidelines to assist health care providers implement research into practice. There is also an increasing trend for other expert bodies and the learned Colleges and professional associations to develop clinical practice guidelines for endorsement by the NHMRC. Most States have also invested in clinical effectiveness units to promote evidence-based healthcare and to link research with local practice.[108]

7.91 NHMRC noted that with the development of evidence-based medicine, guidelines are becoming one of the critical links between the best available evidence and good clinical practice.[109] The guidelines are intended to be a distillation of current evidence and opinion on best practice. Clinical practice guidelines are sometimes referred to as clinical pathways, protocols and practice policies, although these differ from clinical practice guidelines in that they are often much more prescriptive and not always based on evidence.[110]

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104 ACSQHC, *Press Release*, 18.2.00.

105 Submission No.45, p.31 (RACP, HIC, ACA); *Committee Hansard,* 21.3.00, pp.336-37 (Professor Hindle).

106 Expert Group report, p.47.

107 NHMRC, *A guide to the development, implementation and evaluation of clinical practice guidelines*, 1999, p.9.

108 Expert Group report, p.7; Rubin, G *et al*, 'Getting new evidence into medicine', *Medical Journal of Australia*, Vol.172, 21 February 2000, p.182.

109 NHMRC report, p.9.

110 NHMRC report, p.9.

7.92 Quality assurance and quality improvement activities have a complementary and reciprocal relationship with clinical practice guidelines. Quality assurance activities encourage the implementation of guidelines, and guidelines are a crucial component of quality assurance activities. Continuous clinical practice improvement aims to improve the quality of care by bringing together research on variation of cost, access, quality and standardised care. It requires a knowledge of processes and systems, human behaviour and an approach to continuous learning.[111]

7.93 During the inquiry witnesses discussed aspects of these approaches. For instance, RACP supported the development and implementation of clinical practice guidelines and evidence-based medicine. RACP stated that it is currently undertaking the Commonwealth-funded Clinical Support Systems Project (CSSP), an initiative which focuses on the measurement and improvement of clinical care through the implementation of clinical support systems. Such systems include clinical practice guidelines, clinical pathways, consumer pathways and information technology for clinical decision support and measurement of health outcomes. It is an approach that links clinical practice improvement directly to medical evidence and aims to improve the efficiency and quality of health care provision.[112]

7.94 Professor Hindle advocated the clinical pathways approach. A clinical pathway is a document which describes the usual way of providing multidisciplinary clinical care for a particular type of patient, and allows for annotation of deviations from the norm for the purpose of continuous evaluation and improvement. He agued that good clinical teams in Australia and overseas are increasingly using clinical pathways.[113] He argued that:

> Good clinicians want to work in teams. They want to specify how they will work together…so it is sensible to write down the protocol for what they will normally do. They are making these changes around Australia as we speak because they recognise that it will help them allocate their scarce resources–they won't waste resources on that patient when they are better spent on another of their patients. They will improve quality of care and outcomes by avoiding duplication of care or missing out on care and so on.[114]

7.95 Professor Hindle argued that evidence from around the world shows that clinical pathways improve quality of care and reduce costs because the team works better, thus avoiding omission, duplication and other errors. He suggested that the main barriers to the use of clinical pathways are that some clinicians are reluctant to

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111 NHMRC report, p.39.

112 Submission No.45, pp.31-32 (RACP, HIC, ACA). See also *Committee Hansard,* 21.3.00, pp.378,380 (RACP).

113 Submission No.22, Additional Information, 12.4.00, pp.36, 40 (Professor Hindle).

114 *Committee Hansard,* 21.3.00, pp.336-7 (Professor Hindle).

work in a team, or are concerned to avoid anyone else being aware of, and consequently in a position to criticise, their clinical practice.[115]

7.96 The Expert Group argued that existing efforts to promote evidence-based practice through such groups as the learned Colleges and NHMRC should continue to be supported by all jurisdictions, Colleges and other relevant groups, and that this work should form part of an overall national action plan for safety and quality enhancement. The Expert Group considered that the focus on evidence-based care should also be underpinned by a commitment to continuous quality improvement in clinical practice. The Group also argued that national action should continue to be taken to research, develop and encourage implementation of evidence-based practice, including use of clinical practice guidelines and quality improvement tools that reduce unexplained variation and improve aspects of quality across the continuum of care.[116]

7.97 Some evidence indicated that the development of clinical practice guidelines by the Colleges has been relatively slow. Professor Richardson indicated that while a number of the Colleges are investigating evidence based medicine the pace of reform is ‘leisurely’ in relation to the importance of the issue.[117] The Menadue report into the NSW health system also commented on the slow development of clinical practice guidelines by most of the Colleges, with some notable exceptions.[118] The Committee is concerned at this development and encourages the learned Colleges to further facilitate the development of clinical practice guidelines.

7.98 NHMRC also stated that there needs to be greater attention given to implementation and evaluation of guidelines once they have been developed. NHMRC noted that many of those involved in producing guidelines have become frustrated by the lack of implementation. Further, health care professionals’ acceptance of clinical practice guidelines has to some extent been marred by concern that the guidelines represent ‘cookbook’ medicine.[119] One study suggested that there were marked variations in the uptake of evidence-based methods among different practitioners in different fields of medicine – the fields that have a higher reliance on technology, such as neonatology, appear to adopt evidence-based practice styles more readily.[120]

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115 Submission No.22, Additional Information, 12.4.00, pp.36,40 (Professor Hindle).

116 Expert Group report, p.8.

117 Submission No. 46, Additional Information, 15.3.00 (CHPE). See also *Committee Hansard,* 20.11.00, p.784 (Professor Richardson).

118 NSW Health Council, *A Better Health System for NSW*, (Chairman: Mr John Menadue), March 2000, p.69.

119 NHMRC report, p.12.

120 Rubin, G *et al*, ‘Getting new evidence into medicine’, *Medical Journal of Australia*, Vol.172, 21 February 2000, p.182. See also Phillips, P *et al*, ‘Evidence for evidence-based medicine at the coalface’, *Medical Journal of Australia*, Vol.172, 20 March 2000, pp.259-260.

7.99 The Committee notes the proposed establishment of the National Institute of Clinical Studies. As noted previously, the role of the Institute is to promote best clinical practice throughout the public and private health sectors and encourage behavioural change by the medical profession. The Committee notes that the Institute was due to begin operations in January 2000.[121] The Committee is disappointed at the delay in the establishment of the Institute given its potential importance in promoting best clinical practice.

7.100 The Committee notes that several witnesses stressed the importance of the Institute in addressing the issue of best practice medicine. Professor Donald Cameron representing the RACP stated that the Institute will be 'looking at outcomes – clinically significant outcomes, not the sort of thing that has happened in the past like some satisfaction surveys which usually ask if the doctor was polite and nice and so on'.[122] Professor Peter Phelan representing the CPMC stated that the Institute would assist in promoting best clinical practice:

> There are considerable variations in medical interventions across the community…they occur because there is not good evidence on which these interventions are based, so doctors use their own experience. We have not been able to provide them with information to allow them to make more informed judgements. I think the initiative to establish a national institute of clinical studies may well start to provide that sort of information to doctors which can make them more informed.[123]

7.101 The Committee supports the further development and implementation of evidence-based medicine and of clinical practice guidelines. The Committee believes that a firm commitment to evidence-based medicine will promote best practice and improve the quality of health care.

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

Consumer participation in quality improvement

7.102 Evidence to the Committee from consumer organisations highlighted the need to improve consumer participation in the development of quality improvement programs and the health system generally. Mr McCallum representing the Consumers' Health Forum of Australia (CHF) stated that there was a need to:

> …strengthen individual consumers and communities to think more about the care they need, to make better choices about the care they access and to

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121 Submission No.38, p.48 (DHAC).

122 *Committee Hansard,* 21.3.00, p.381 (Professor Cameron).

123 *Committee Hansard,* 23.3.00, p.500 (Professor Phelan).

> become partners with the health system. It worries me that we will craft solutions that will not involve the consumers and communities who might have solutions for us in this.[124]

7.103 The CHF outlined a number of requirements that they see as essential to any quality improvement program to reduce adverse events. CHF argued that consumers should:

- have access to their own medical records – 'medical records are still one of the most important sources of information for consumers trying to make sense of an adverse event';
- have access to effective information to help consumers understand their treatment options;
- have access to effective complaints mechanisms;
- be informed when a mistake has been made or an accident occurred as a result of the failure of the system, or of a medical practitioner; and
- participate in all levels of the health system.[125]

7.104 RACP, HIC & ACA also argued that to promote a high quality public hospital system there needs to be investment in better systems to promote 'consumer-oriented care'. This includes attention to best practice, clinical practice supports and protocols, the measurement and analysis of variations in practice and health outcomes measures.[126]

7.105 The Expert Group argued that national action should continue to be taken to research, develop and disseminate methods to enable better consumer participation in health care service delivery, planning, monitoring and evaluation at all levels, including strategies to improve the quality and accessibility of consumer health information.[127]

7.106 DHAC stated that the Commonwealth is working with consumer organisations, health service providers and State/Territory Governments to increase consumer participation in the planning, delivery and evaluation of health care. As noted previously, the Consumer Focus Collaboration aims to improve the accountability and responsiveness of the health care system to consumers.[128] The

124 *Committee Hansard,* 20.11.00, p.765 (CHF).

125 Submission No.72, p.34 (CHF).

126 Submission No.45, p.14 (RACP, HIC, ACA). See also Submission No.7, p.4-5 (Health Consumers' Council WA).

127 Expert Group report, p.7. See also Submission No.26, p.4 (Medical Consumers Association of NSW); Submission No.4, p.2 (Hunter Urban Network for Consumers of Healthcare).

128 Submission No.38, p.54 (DHAC).

Collaboration is overseeing some 14 projects funded through the Commonwealth. These projects include:

- Consumer and Provider Partnerships in Health project – the aim of the project is to document the most effective approaches available for teaching and learning the skills needed for effective communication between health care consumers and providers. The consultant undertaking the project will analyse the issue of education and training in health care to promote active consumer involvement in health system planning delivery and monitoring and evaluation.
- Project to support nurses to involve consumers in their own health care – the ANF and the Royal College of Nursing Australia have been funded for a project to develop strategies to support nurses in involving consumers in health care planning and delivery. A similar project involving the AMA and the CPMC is undertaking a project to work with medical practitioners to support their efforts to involve consumers in their health care.
- Structural and Cultural Marginalisation in Health Care project – the aim of the project is to identify ways that health services have involved or sought feedback from groups of consumers who have been excluded from existing processes due to structural or cultural barriers.
- Toolkit for consumer participation – the aim of the project is to provide a practical toolkit of approaches and strategies to assist service providers and consumers to achieve effective consumer participation in the planning, delivery and monitoring of health services.[129]

7.107 Many of these projects are close to finalisation but there is only one published report available to date on these projects. The results of individual projects are to be made available to the National Resource Centre for Consumer Participation. As noted previously, the Commonwealth has funded the National Resource Centre for three years. It is being established to assist health service providers to improve their strategies for involving consumers in the development of services and will act as a clearinghouse for information on methods and models of community participation in health care.[130]

7.108 At the State level, in NSW the Menadue report argued that action was needed in that State to improve consumer involvement in decisions about health care. The report argued that there needed to be increased consumer access to information. The report recommended that NSW Health establish a 24-hour Health Call Centre with full coverage across the State; and that a health care Internet site be established to provide

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129 http://nrccph.latrobe.edu.au/aboutus.htm

130 Submission No.38, p.54 (DHAC).

information which supports the advice available through the Health Call Centre. The NSW Government subsequently accepted these recommendations.[131]

7.109 The Menadue report also called for expanded opportunities for local communities to participate in decisions about the type and location of health services. The report proposed that formal structures for ongoing community participation be established in each Area Health Service. In addition, the report argued that there should be greater involvement of consumer representatives in identifying health priorities at the State level through the establishment of a State-wide Consumer and Community Representative Forum to provide advice on planning, policy development and resource allocation at the State level.[132] The NSW Government announced that it will establish a Statewide consumer forum to provide input to decision-making on policy and resource allocation. [133]

Report cards

7.110 Some submissions argued that 'report cards' on hospitals and medical practitioners should be published so consumers can make informed choices concerning their treatment options. The Health Consumers' Council WA argued that hospital report cards 'would ensure greater knowledge of and confidence in our public hospital system. Data should be collected and analysed to support the report card concept'.[134] CHF also argued that consumers need more information on risks, benefits and options for treatment from their health care providers as a basis for decision making. CHF stated that reliable, independent information from sources other than the medical professional administering the treatment is also needed.[135]

7.111 The medical profession generally opposed the publication of league tables or report cards arguing that they are not reliable indicators of performance or best practice.[136] AMA argued that there are considerable difficulties in interpreting data based on report cards:

> …the more competent, senior experienced surgeons are likely to see the more difficult end of the spectrum and, amongst them, their death rates may be higher because, for instance, they may be operating, especially in a tertiary hospital, on patients that a surgeon at a peripheral hospital would not touch. That is really the problem about report cards on both hospitals and individual doctors.[137]

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131 NSW Government, *Working as a Team – the Way Forward,* p.4.

132 Menadue report, pp.73-76.

133 NSW Government, *Working as a Team – the Way Forward*, p.4.

134 Submission No.7, p.4 (Health Consumers' Council WA).

135 Submission No.72, pp.29-30 (CHF).

136 Submission No.47, p.39 (AMA); Submission No.27, pp.4-7 (AMA -Victoria).

137 *Committee Hansard,* 11.11.99, p.94 (AMA).

7.112 AMA (Victoria) argued that current data collections and risk adjustment tools are poorly developed and inadequate for the publication of comparative performance indicators for hospitals and individual medical practitioners.[138]

7.113 The Committee questioned the AMA concerning the current situation where a GP refers patients to a specialist about which the patient as a consumer probably has little knowledge as to his or her medical competence and therefore is not in a good position to make an informed judgement concerning the surgeon. Dr Sandra Hacker, former Vice President of the AMA conceded that the current situation is 'not particularly' satisfactory.[139] Dr David Brand, former President of the AMA, added that 'I would agree that the public has a right to know, but it has a right to know about information where it can compare – if you are going to compare apples with apples you have got to be comparing apples with apples. That is something that is very difficult to do'.[140]

7.114 The Committee believes that consumers should have access to information on the relative performance of hospitals and the performance of individual providers so that they can make informed choices about their treatment options. The Committee is not convinced by the arguments advanced by the medical profession that because data are supposedly inadequate for the dissemination of reliable comparative performance indicators for hospitals and medical practitioners it therefore should not be made available. The Committee believes that this is more an argument for improving upon the current data than for not providing such information to consumers.

Conclusion

7.115 The Committee believes that there needs to be greater consumer involvement in the health system generally, including the provision of health information to consumers and consumer participation in health care service delivery and planning. The Committee commends the initiatives at the Commonwealth and State level to encourage consumer participation in the health system. The Committee further believes that measures that encourage consumer involvement in the health area need to be encouraged and expanded.

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

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138 Submission No.27, p.7 (AMA -Victoria).

139 *Committee Hansard,* 11.11.99, p.95 (AMA).

140 *Committee Hansard,* 11.11.99, p.95 (AMA).

Performance measurement

7.116 Submissions argued that there needs to be greater priority given to the development of performance indicators and health outcome measures.[141] CHPE stated that:

> There is a need for the establishment of national performance indicators for public hospitals and associated services, including inpatient, outpatient and emergency department services. These performance indicators could be used for comparative purposes across institutions relating to efficiency, clinical outcomes and quality.[142]

7.117 DHAC indicated that data about quality of care and health outcomes are piecemeal at present – 'different parts of the hospital systems collect a great range of data…However the data is often haphazardly collected and there is little analysis of anything but information relating to financial requirements. The use of data to improve performance in the clinical area is at a very low level while data for system-wide analysis is unreliable and poorly articulated and collected'.[143]

7.118 The Expert Group argued that rigorous and reliable indicators for the measurement of safety and quality performance are required at all levels of the health system and that joint funding and support for national research and development of performance information and indicators for health care quality are critical to continued efforts in this area. The Expert Group argued for the development of a national framework for performance management and reporting for all health services.[144]

National health sector performance measures

7.119 In 1994 the National Health Ministers' Benchmarking Working Group was established to coordinate and report on the development of national health sector performance indicators and benchmarks. In August 1999 the Australian Health Ministers established the National Health Performance Committee (replacing the National Health Ministers' Benchmarking Working Group). The Committee, which has similar objectives to the previous Committee, aims to develop and maintain a national performance measurement framework for the health system, to support benchmarking for health system improvement and to provide information on national health system performance.

7.120 The new Committee will have a broader focus covering the whole of the health sector, including community health, general practice and public health. The membership of the Committee includes representation from each State and Territory

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141 Submission No.45, p.14 (RACP, HIC, ACA); Submission No.63, p.42 (AHA, WHA, AAPTC).

142 Submission No.46, p.21 (CHPE).

143 Submission No.38, p.45 (DHAC).

144 Expert Group report, p.13.

and the Commonwealth together with representatives from other national bodies such as the NHMRC and the Australian Institute of Health and Welfare (AIHW).[145]

7.121 A number of other groups are working in the area of performance measurement and related activities. These include the Australian Council on Healthcare Standards, Australian Institute of Health and Welfare, individual health authorities, universities and other government authorities.

7.122 The terms ‘performance indicators’ and ‘benchmarking’ are often used interchangeably even though they deal with different but related concepts. A ‘performance indicator’ is a measure that quantifies the level of performance for a particular aspect of health service provision and allows comparison between service providers, modes of service provision or both. ‘Benchmarking’ can be defined as the continuous process of measuring products, services and practices against the best available in the relevant area. The process examines attributes of performance (indicators) in comparing individual units or organisations against standards (benchmarks) that are considered attainable and desirable. The process by which data are collected and collated can be defined as the process of performance measurement. The Benchmarking Working Group has essentially focussed on the development of performance indicators and the process of performance measurement. [146]

7.123 The Working Group’s 1999 report provides details of a framework of performance indicators for public hospitals with an emphasis on those indicators of most relevance in gaining a ‘holistic’ view of the performance of the public hospital sector.

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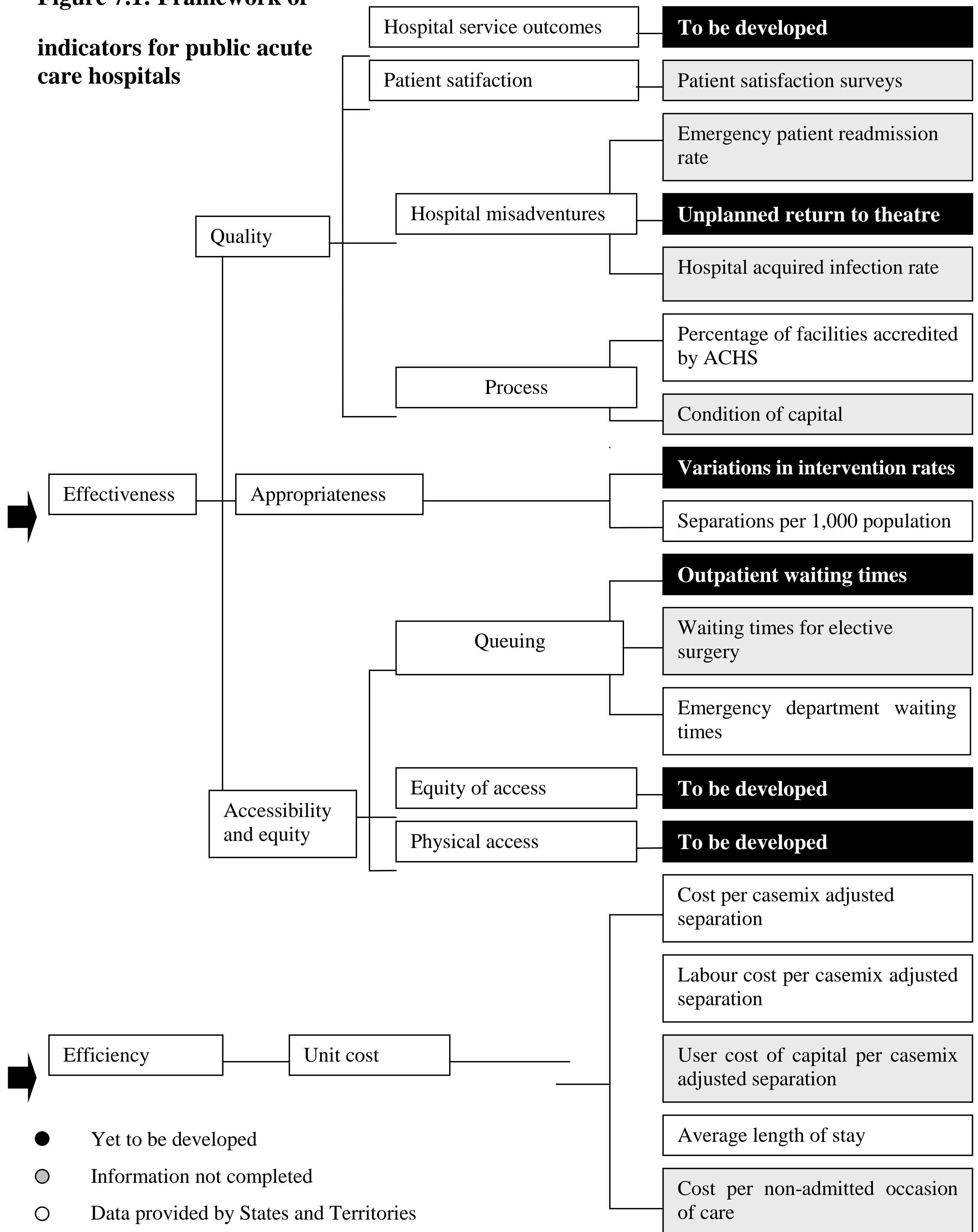
145 Submission No.38, p.44 (DHAC).

146 National Health Ministers’ Benchmarking Working Group, *Third National Report on Health Sector Performance Indicators*, June 1999, pp.6, 72.

Figure 7.1: Framework of indicators for public acute care hospitals



Source: National Health Ministers' Benchmarking Working Group, *Third National Report on Health Sector Performance Indicators,* June 1999, p.7.

7.124 As indicated in the table while some performance indicators are provided by the States and Territories a significant number of indicators have yet to be developed or the information is incomplete. The report notes that comprehensive data that can fully investigate the two dimensions of 'effectiveness' and 'efficiency' are 'not yet available. Available data for reporting against the indicators…are, therefore, limited to a subset of the framework'.[147]

7.125 The Queensland Nurses Union (QNU), referring to the above table, stated that while the data give some indicators for public acute care hospitals they are far from complete:

> …when you look at the indicators you see that they state that hospital service outcomes are to be developed. Under quality outcomes and hospital misadventures, you see there is no development of anything for unplanned return to theatre. We are not assessing the number of patients who are discharged who need to be returned to theatre. In terms of appropriateness of health care, there is no assessment of variations in intervention rates. …If you look at queuing, there is some work being done on outpatient waiting times but it is not fully developed. If you look at accessibility and equity, you see that equity of access is still to be developed. Physical access is still to be developed. **A heck of a lot of indicators which would tell you whether the system is working are not even developed yet**.[148]

7.126 The Working Group's report noted that several barriers existed in further development of national benchmarking including the complexity of some of the measurement issues; the lack of coordination across jurisdictions; and the time required to establish and implement national data standards. The report argued that 'the establishment and implementation of national data standards, which are imperative for national benchmarking, will continue to be a slow and difficult process'.[149]

7.127 The Committee believes that a much more concerted effort should be made to develop performance indicators in the health sector, especially given that a national working group has been established since 1994 with the specific aim of developing national performance indicators for the health sector. The Committee believes that the slow progress to date in the development of national benchmarking points to the need for the establishment of an independent statutory body to drive reforms in the area of quality improvement. It is clear that the current system is too slow and that a new approach is needed.

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147 Benchmarking report, p.27. See also National Health Performance Committee, *Fourth National Report on Health Sector Performance Indicators*, July 2000, pp.57-62.

148 *Committee Hansard,* 22.3.00, pp.438-39 (QNU).

149 Benchmarking report, p.66. See also National Health Performance Committee, *Fourth National Report*, p.2.

Performance measures – State level

7.128 In the States a range of activities have been initiated in developing and implementing performance measures. As noted earlier in the chapter, in NSW the Government has developed a performance measurement framework for Area Health Services that encompass indicators such as effectiveness, efficiency, safety and access.[150] The Menadue report also recommended that comparative data for all NSW hospitals, on factors such as admission rates, readmission rates, mortality rates and surgical intervention rates for the major planned surgical procedures, should be included on the NSW Health information website within 12 months.[151] The NSW Government subsequently announced that health data and information on treatments will be included on the NSW Health internet site.[152] In Victoria, the Government will require the Department of Human Services to publish a series of performance indicators by July 2001 to assess quality of care in public hospitals.[153]

Performance measures – AHCAs

7.129 The AHCAs also commits the Commonwealth and States to work together to develop and refine performance indicators and to publish information on performance against the indicators to demonstrate whether overall funding is contributing to better health outcomes. The objective in publishing this information is to enable the Commonwealth and the States to compare performance within the acute health sector in order to stimulate improvement in service performance and health outcomes; improve national and State acute health development; and facilitate best practice service delivery.[154]

7.130 A report on progress towards the development of performance indicators will be included in the first AHCA annual report due to be published in December 2000.[155]

Conclusion

7.131 The Committee believes that there needs to be a coordinated effort by the Commonwealth and States to develop a framework of indicators for the public hospital sector so that a comprehensive set of performance indicators is available across all States for comparative purposes.

7.132 The Committee notes that the National Health Performance Committee is working in this area but that progress has been relatively slow with several key indicators for public acute care hospitals yet to be developed. The Committee also

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150 Submission No.79, p.23 (NSW Government).

151 Menadue report, p.72.

152 NSW Government, *Working as a Team – the Way Forward,* p.4.

153 Victorian Minister for Health, *Media Release*, 16 May 2000.

154 Submission No.38, pp.41-42 (DHAC).

155 Submission No.38, pp.42, 51 (DHAC).

notes that the States are also developing performance measures and that the implementation of the AHCAs also provides for reporting against a range of the performance indicators developed jointly by the Commonwealth and the States. As noted in this chapter, the first report is yet to be released some 2½ years after the Agreements commenced. The Committee believes that the delay in the release of data on comprehensive performance indicators, as provided for under the AHCAs, is unsatisfactory and their release should be a matter of high priority. The Committee also believes that there needs to be a high degree of co-ordination between the various bodies at the Commonwealth and State level in order to avoid duplication in the collection of data and in the development of performance indicators.

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

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

Conclusions – strengthening the commitment to quality

7.133 Evidence received by the Committee suggests that while the quality of care in public hospitals is generally of a high standard, more attention needs to be given to quality improvement programs to reduce the frequency of adverse events and improve the overall quality of care.

7.134 Patient safety clearly must be an essential element of health care quality and accorded the highest priority, notwithstanding the fact that all healthcare interventions have some potential for risk. As noted previously, the Quality in Australian Health Care Study showed that 16.6 per cent of hospital admissions in 1992 were associated with an adverse event and that at least half of the adverse events were judged to be preventable. The extent of adverse events identified in this study and others clearly requires a concerted national effort to address safety and quality issues in the hospital setting.

7.135 While there have been numerous efforts at the Commonwealth, State and hospital level in relation to quality improvement in hospitals, evidence to the Committee indicated that much of the effort to date has been largely ad hoc and unsystematic. The Committee believes that a commitment to further quality improvement requires concerted national leadership by the Commonwealth and a firm commitment by the Commonwealth and the States and other key stakeholders to work together to improve the quality of health care services.

7.136 The Committee believes that the recent establishment of the Australian Council for Safety and Quality in Health Care has the potential to provide the necessary national focus on safety and quality issues and to promote a systematic

approach to these issues in the health care system. The Committee believes that the Council must be proactive in pursuing a reform agenda and be adequately resourced to address key areas of concern, and to provide essential national leadership and coordination.

7.137 The Committee has identified a number of key areas for reform. These areas include:

- the establishment of a national statutory authority with responsibility for overseeing the quality programs;
- the establishment of pilot projects to find solution to system failures identified in various studies of adverse events;
- establishment of a system of financial incentives throughout the health system to promote quality of care;
- improved linkages and coordination between the range of current accreditation and quality improvement approaches;
- improved education and training for health professionals and administrators in quality improvement;
- measures to encourage best clinical practice;
- greater consumer participation in quality improvement programs; and
- development of performance indicators and health outcome measures.

7.138 The Committee believes that a systematic and multifaceted approach to safety and quality issues and active national leadership together with the fostering of an effective partnership with State Governments and other key stakeholders will promote an environment where quality and safety issues are paramount, and that patients and the community generally can be assured that the quality of care received in public hospitals meets the highest standards.

CHAPTER 8

ADEQUACY OF DATA COLLECTION AND ANALYSIS

Introduction

8.1 Term of reference (h) of this inquiry requires the Committee to assess:

> 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.

8.2 About 40 per cent of submissions commented on this term of reference and of these, the vast majority believed that current procedures for the collection and analysis of data relating to public hospital services are generally inadequate. The most commonly identified deficiency was gaps in the types of data collected. These gaps included data on health outcomes, effectiveness and cost-effectiveness of services, quality and adverse events, allied health and community care. The views of participants support the comment made by the Committee in its First Report, that 'one of the central difficulties for this inquiry has been the lack of available data upon which to base decisions'.[1]

8.3 A view was expressed in many submissions that data collection to date has tended to focus on costs and payment systems at the expense of other areas. Other problems raised in submissions highlighted deficiencies in the data which is currently collected. These included a lack of standardised methodology across various jurisdictions and, related to this, an inability to link data sets. It is possible to argue that two key reasons underlying the inadequacies of data collection on particular aspects of public hospital services are the fragmented nature of Australia's health system and a wide-spread under-investment in appropriate information systems in public hospitals.

8.4 Notwithstanding the shortcomings identified in evidence, the Committee also received other evidence indicating that improvements were either underway or planned in several areas of data collection and analysis. The Commonwealth Department of Health and Aged Care's (DHAC) submission[2] included a useful overview of data collections, as well as current and future initiatives in this area and pointed also to aspects of data collection where shortcomings are evident.

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1 Senate Community Affairs References Committee, *First Report: public hospital funding and options for reform*, July 2000, p.65.

2 Submission No.38, pp.40-45 (Department of Health and Aged Care).

National structural aspects of health data collection

8.5 In 1993, the National Health Information Agreement was signed between the Commonwealth, State and Territory health authorities, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare. The agreement, which took effect from 1 July 1993, established 'cooperative processes and structures to facilitate and coordinate activities to improve, maintain and share national health information'.[3] The agreement was renewed in 1998 for a further 5 years.

8.6 The National Health Information Management Group (NHIMG) was established to oversee the implementation of the agreement. The NHIMG comprises senior representatives of the signatories to the agreement. The National Health Data Committee is a standing committee of the NHIMG and is responsible for the assessment of data definitions proposed for inclusion in the *National Health Data Dictionary*. The *National Health Data Dictionary* is designed to make health data collections more efficient and to improve the comparability of data across the health sector. The Dictionary (now in its 8th revision) 'is the authoritative source of health data definitions used in Australia where national consistency is required'.[4]

8.7 Data on health services, including public hospitals, is collected by the Commonwealth 'for the purposes of policy analysis and development'.[5] DHAC advised that the content and refinement of these data collections, which are often derived from State health services, are agreed between the Commonwealth and the States/Territories. The associated technical and definitional work is undertaken by reference to the NHIMG. The three main data collections are the Hospital Morbidity (Casemix) Database[6]; hospital and other performance measures collected under the Australian Health Care Agreements (AHCAs); and the National Health Performance Committee[7] (NHPC) process, which was endorsed by Health Ministers in April 1999.[8]

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3 Australian Institute of Health and Welfare and Australian Health Ministers' Advisory Council, *National Health Information Development Plan*, Canberra, AGPS, 1995, p.11.

4 National Health Data Committee, *National Health Data Dictionary*, version 8, Canberra, Australian Institute of Health and Welfare, 1999, p.xvii.

5 Submission No.38, p.40 (DHAC).

6 The National Hospital Morbidity (Casemix) Database contains about 33 million de-identified records, each of which consists of a mix of demographic items (such as age and sex), administrative items (such as insurance status) and clinical items (such as diagnoses and procedures). The database contains data on public and private hospital activity since 1991-92. The database and annual reports on hospital morbidity can be found at this web address: http://www.health.gov.au/casemix/nhmdb1.htm

7 The National Health Performance Committee has replaced the former National Health Ministers Benchmarking Working Group, which produced three reports on benchmarking and performance measurement in the health sector. These reports are available at this web address: http://www.health.gov.au/hsdd/nhpq/pubs/pquality.htm The National Health Performance Committee will have a broad focus across the whole health sector, including community health, general practice and public health (Submission No.38, p.44, DHAC).

8 Submission No.38, p.40 (DHAC).

8.8 DHAC's submission noted that hospital and other health performance measures data are collected under the provisions of Schedule C of the AHCAs, which commits the Commonwealth and the States and Territories to work together to develop and refine performance indicators in the following areas:

- public hospital activity levels and costs;
- waiting times for access to public hospital services;
- indicators of Aboriginal and Torres Strait Islander health;
- indicators of integration of care processes;
- indicators of access to primary care;
- measures of quality of care, including patient satisfaction;
- indicators of effort in medical and nurse training, and medical and health research;
- mental health reform indicators; and
- indicators of access to and quality of palliative care services.

The Australian Health Ministers Advisory Council (AHMAC) has agreed to the development of an annual report which should enable a comparison of the States and Territories against a range of acute sector performance indicators. In agreeing to the production of these annual reports, AHMAC noted that release will be subject to Ministerial approval. The first annual report, covering the first year of the AHCAs (1998-99) is expected to be published in December 2000.[9]

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

Key data collections and reports

8.9 A wide range of data on public hospital services are currently collected, analysed and reported upon. Links are provided below to reports available online, as appropriate.[10]

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9 Submission No.38, p.42 (DHAC).

10 A comprehensive listing of websites and online reports relevant to public and private hospitals is available from this Parliamentary Library Electronic Brief: http://www.aph.gov.au/library/intguide/SP/hospitals.htm

Australian Institute of Health and Welfare

8.10 The key agency which collects, collates, analyses and reports on hospital-related data is the Australian Institute of Health and Welfare (AIHW). Examples of relevant AIHW reports include:

- a comprehensive collection of data on public and private hospitals in Australia, including the number of hospitals and available beds, staffing, workload, costings and patient profiles, together with trends over the last six years can be found in the annual Australian Hospital Statistics;
- expenditure on public and private hospitals by the Commonwealth and each State and Territory government as well as the non-government sector is reported in the Health Expenditure Bulletin;
- comparisons of hospital-related data (public and private) between metropolitan and rural and remote areas can be found in Health in Rural and Remote Australia;
- international comparisons are included in the report International Health: how Australia compares;
- a comprehensive overview of public and private hospital-related data together with commentary and analysis can be found in the biennial Australia's Health;
- the latest available national data on waiting times for elective surgery in public hospitals is reported periodically by the AIHW; and
- detailed workforce data for both public and private hospitals is available in the annual reports on the medical labour force and the nursing labour force.

Australian Medical Workforce Advisory Committee

8.11 The AIHW also works with the Australian Medical Workforce Advisory Committee (AMWAC) which has produced a range of reports, including benchmarks for the Australian medical workforce and Australia's current and future requirements in individual medical specialities. AMWAC was established in the mid-1990s by the Australian Health Ministers' Advisory Council to advise on national medical workforce matters.

Australian Bureau of Statistics

8.12 The Australian Bureau of Statistics produces several collections of data which are relevant to the hospital sector. These include regular surveys such as Private Hospitals Australia (full text not available online) and occasional papers, including Hospital Statistics, Aboriginal and Torres Strait Islander Australians.

Productivity Commission

8.13 The Productivity Commission, in its role as the Secretariat for the Steering Committee for the Review of Commonwealth/State Service Provision, issues an

annual report which compares the performance of governments across several important areas of responsibility, including public hospitals. The Productivity Commission also issued a research paper on private hospitals in Australia in December 1999. This paper provides a detailed profile of the private hospital industry, an analysis of the sector's financial performance, explains the regulatory and legislative framework within which the industry operates and assesses the degree of competition in the private hospital market and the drivers of demand for private hospital services. This report is discussed in more detail in chapter 6.

Shortcomings in data collection and analysis

8.14 While these and other collections of data are valuable and useful, they are limited by a lack of focus on the outcomes of the services provided. Thus, while data exists on the costs and occasions of services, little is known about the outcomes, value or usefulness of the services. For example, in his submission, Professor Hindle stated that 'we currently know a little about costs and virtually nothing about value'.[11] In addition, the South Australian Government identified the need to collect and analyse data beyond the acute sector, stating that 'there is an overemphasis on hospital based services and insufficient attention to community and public health'.[12]

8.15 DHAC's submission also outlined several limitations of current data collection and analysis:

> different parts of the hospital systems collect a great range of data, for example, data relating to organisational and clinical performance and services delivered to consumers. However, the data is often haphazardly collected and there is little analysis of anything but information relating directly to financial requirements.[13]

8.16 This view was supported by the Consumers' Health Forum (CHF) which provided a consumer perspective on the adequacy of data collection and analysis. Commenting on data collection in general, the CHF stated that the overall view of consumers was that 'inadequate data is available for them to really ascertain good information on many of the key issues of concern to consumers'.[14] The Queensland Government commented that accessing data was often the biggest challenge, arguing that 'there is so much data around the place that it is hard to work out what you need, what you do not, where you keep it and how you access it'.[15]

8.17 The danger of collecting data for its own sake was raised by several participants in the inquiry. For example, the Northern Territory Shadow Minister for

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11 Submission No.22, p.5 (Professor Don Hindle).

12 Submission No.60, p.28 (South Australian Government).

13 Submission No.38, p.45 (DHAC).

14 Submission No.72, p.29 (Consumers' Health Forum).

15 *Committee Hansard*, 22.3.00, p.479 (Queensland Government).

Health argued that data collection can be an imposition in small jurisdictions such as the Northern Territory and that there should be 'an emphasis on data collection and analysis that provides appropriate and useful information to improve health comes, rather than data for data's sake'.[16] In a similar vein, the South Australian Government argued that data collection should not be a 'significant burden on hospitals' and that increased data collection would need to 'consider the benefits as well as the costs of collection'.[17]

8.18 A link between the level of resources available to public hospitals and their capacity to collect data was raised by some participants. For example, in their joint submission, the Royal Australasian College of Physicians (RACP), the Health Issues Centre and the Australian Consumers' Association (ACA) linked the issue of public hospital staff being required to increase activity without a commensurate increase in resources, with limits on the time available for clinicians to collect data.[18] Similarly, the Australian College of Health Service Executives (ACHSE) argued that:

> the tension between initiatives to drive down administrative costs and creating funding initiatives to improve data/information management of clinical processes is ongoing.[19]

8.19 A different perspective was offered by the National Rural Health Alliance (NRHA) which was concerned that the collection and availability of data on rural health and well-being required a more consistent and streamlined approach than currently is the case and argued that Australia does not make full use of the data which is collected at present. The NRHA commented that:

> it is not so much a need for new data collections or series as the need to use existing series better, in particular by cross-matching existing data and freeing up information from some collections. Among other things this would help planning for health and well-being across all levels of government and at regional levels.[20]

8.20 The view that Australia is not making full use of the available data was advanced also by the Centre for Health Program Evaluation (CHPE). CHPE's Professor Richardson argued that:

> we do in Australia have an extraordinarily good database by world standards, but we do not use it. Through the linkage of records we could

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16 Submission No.78, p.4 (Northern Territory Shadow Minister for Health).

17 Submission No.60, p.27 (South Australian Government).

18 Submission No.45, p.30 (Royal Australasian College of Physicians, Health Issues Centre and Australian Consumers', Association).

19 Submission No.62, p.4 (Australian College of Health Service Executives).

20 Submission No.66, p.28 (National Rural Health Alliance).

> make an enormous impact onto this pool of ignorance about the effectiveness of different services.[21]

Data on allied health services

8.21 Allied health services encompass a wide range of services, such as pharmacy and physiotherapy, that usually are not part of an acute episode but which are, however, essential elements in a patient's treatment and rehabilitation. Evidence was received that identified shortcomings in data collection and analysis in the broad area of allied health services as being due principally to a focus on the acute episode at the expense of the continuum of services provided to patients.

8.22 Hence, evidence to the inquiry indicated a lack of systematic reporting of public hospital allied health services. The Society of Hospital Pharmacists of Australia (SHPA) noted in its submission that 'the standardisation of data collection in relation to hospital pharmacy services and utilisation of pharmaceuticals is a major issue'.[22] A key reason for this lack of standardisation was identified by the SHPA who told the Committee that 'the IT infrastructure is not consistently in place across the country'.[23] In a similar vein, the National Allied Health Casemix Committee (NAHCC) gave evidence that system-wide, there is 'a large deficit in IT hardware infrastructure systems', with many allied health staff not having access to personal computers.[24]

8.23 The Australian Physiotherapy Association (APA) argued that the lack of standardisation in data collection inhibited benchmarking in a number of areas 'except within States using the same system, which is a major problem for physiotherapy and other allied health professions'.[25] The APA pointed also to shortcomings in data collection affecting allied health services in rural and remote areas of Australia:

> data collected is, by definition, data necessarily relating to services currently provided. In rural and remote areas where there are often physiotherapy and allied health position vacancies, the dearth of data means that the needs of communities may be overlooked in the planning of services. This can have an impact on the implementation of programs designed and funded to address particular health issues.[26]

8.24 The Queensland Government noted in its submission that data collection and analysis of allied health services had been targeted for improvement. It commented that only data on occasions of service were currently collected in this area and made

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21 *Committee Hansard*, 23.3.00, p.588 (Centre for Health Program Evaluation).

22 Submission No.52, p.7 (Society of Hospital Pharmacists of Australia).

23 *Committee Hansard*, 21.3.00, p.309 (Society of Hospital Pharmacists of Australia).

24 *Committee Hansard*, 23.3.00, p.573 (National Allied Health Casemix Committee).

25 Submission No.61, p.19 (Australian Physiotherapy Association).

26 Submission No.61, p.19 (Australian Physiotherapy Association).

the important point that 'this permits limited analysis of services, and thus limits the ability to generate service improvements'.[27]

8.25 In its submission, DHAC advised that refinements were underway in four areas that 'may improve the collection of data on the provision of allied health services in public hospitals'.[28] The Commonwealth and the States and Territories have agreed to work proceeding on refinements to several indicators:

- agreement has been reached between the parties to expand the admitted patient morbidity data set in order to improve knowledge on the various components of services provided to an admitted patient, including those ancillary to treatment. This may include allied health services, pathology and diagnostic imaging;
- agreement has been reached also to develop a non-admitted patient morbidity data set by 30 June 2003;
- summary data is currently collected by the States and Territories on allied health services provided to non-admitted patients in outpatient clinics. The National Health Data Committee is currently working on a national clinic-based classification for outpatient services to ensure greater national consistency in collecting and reporting data on non-admitted patients; and
- agreement has been reached between the parties to develop measures for waiting times for outpatient services. The development of these measures will proceed following the finalisation of the outpatient classification system.[29]

8.26 DHAC advised also that allied health professional codes have been incorporated into the procedure classification of the *International Classification of Diseases and Related Health Problems Tenth Revision–Auistralian Modification* (ICD-10-AM). This means that it is possible to search the data 'using these codes to obtain information on allied health professional procedures on admitted patients'. However, while these codes are used for analysis at the local level they are not used at the national level.[30]

8.27 Funding was provided by the Commonwealth Government during 1998-99 for a project that aimed to 'develop a set of allied health indicators that will be a starting point for measuring the outcomes of allied health activities'.[31] The project was undertaken by the National Allied Health Casemix Committee (NAHCC), which

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27 Submission No.41, p.34 (Queensland Government).

28 Submission No.38, p.42 (DHAC).

29 Submission No.38, pp.42-3 (DHAC).

30 Submission No.38, p.43 (DHAC).

31 Submission No.38, p.43 (DHAC).

reported in January 2000. The NAHCC also provided evidence to the Committee at which a copy of the report[32] was tabled. The NAHCC advised that:

> we have developed a national activity hierarchy that standardises the way that allied health professionals describe their inputs to the health care system. We have also developed a minimum data set that describes characteristics of the clients and patients that are treated and we are in the process of developing patient focused performance measures or outcome measures for those clients where allied health have a large part to play in their outcomes.[33]

8.28 The NAHCC explained to the Committee how its developmental work in this area would fit with the use of Diagnosis Related Groups (DRGs) which form the basis of casemix-based funding. While a DRG defines an acute episode it is not readily adaptable to include allied health treatments which may be unrelated to the original condition. For example, following acute medical treatment, a patient who has suffered a stroke may require assistance in learning to speak, which would be provided by an allied health practitioner. In this example, the acute episode would be defined by a DRG, while the allied health intervention would be described by a performance indicator developed by the NAHCC. The NAHCC advised that their indicators for allied health would intermesh with the DRGs by describing the allied health intervention, providing a performance measure and measuring the outcome of the intervention.[34]

8.29 The Committee notes the work to date aimed at improving the identification, reporting and measuring of the allied health components of health interventions, and it is aware that work in this area is ongoing, particularly with regard to the development of performance indicators.

Data on waiting times for elective surgery

8.30 Waiting times for elective surgery are used in preference to waiting lists because they are regarded as a ‘better indicator of hospital performance than numbers on waiting lists’.[35] Patients waiting for elective surgery are grouped into the following three categories depending on the severity of their condition and the corresponding necessity for treatment:

- category 1 is the most urgent and contains patients whose admission is considered desirable within 30 days;

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32 Details of the report are as follows: National Allied Health Casemix Committee, *Report on the Development of Allied Health Indicators for Intervention (IFI) and Performance Indicators (PI) and Revisions of Allied Health-sensitive ICD-10-AM codes for inclusion in ICD-10-AM, Edition two*, January 2000.

33 *Committee Hansard*, 23.3.00, p.572 (National Allied Health Casemix Committee).

34 *Committee Hansard*, 23.3.00, p.579 (National Allied Health Casemix Committee).

35 Australian Institute of Health and Welfare, ‘Elective surgery waiting times presented in new report’, *Media Release*, 16 June 2000.

- category 2 includes patients whose admission is considered desirable within 90 days; and
- category 3 includes patients whose admission at 'some time in the future' is regarded as acceptable, although patients waiting more than 12 months are regarded as having an 'extended wait'.[36]

8.31 The AIHW has published three reports to date that present data on waiting times for elective surgery, the latest of which includes data for 1997-98 (released in June 2000). Although improvements are evident in each successive report, their usefulness is limited by a continued lack of standardisation in the way data is collected at the State and Territory level. This lack of standardisation limits any comparison of different jurisdictions and inhibits any knowledge of whether particular jurisdictions have improved their performance over time.

8.32 DHAC's submission indicated that the States and Territories have agreed to provide data in line with the Waiting Times minimum data set. The annual reports under Schedule C of the AHCAs, discussed earlier, are expected to include data on the total number of admissions for elective surgery and the percentage of elective surgery patients admitted within the clinically appropriate time (ie category 1 within 30 days, category 2 within 90 days and category 3 within 12 months).[37] Some States and Territories are now releasing data in relation to waiting times for elective surgery, with some also posting issues of their elective surgery bulletin on departmental websites. An example is the elective surgery bulletin from the South Australian Department of Human Services.

8.33 The CHF provided a slightly different perspective on waiting list/waiting times data. It expressed the view that consumers are wary of data on waiting lists which they regard as being open to manipulation.[38] Commenting further, the CHF argued that 'there is considerable debate about what waiting lists actually show, as studies have illustrated'.[39] CHF also raised the need for data on waiting lists for community care as a means of working towards a more integrated health care system.[40]

8.34 The Committee has been concerned about the generally poor quality of data on waiting times for elective surgery. Some jurisdictions appear to be more advanced than others in making available information on waiting times to their communities, however the Committee is encouraged to learn that all States and Territories have agreed to provide consistent data in this area.

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36 Submission No.38, p.43 (DHAC).

37 Submission No.38, p.43 (DHAC).

38 Submission No.72, p.29 (Consumers' Health Forum).

39 Submission No.72, p.29 (Consumers' Health Forum).

40 Submission No.72, p.31 (Consumers' Health Forum).

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

Data on health outcomes

8.35 This section provides a synthesis and analysis of the evidence received that dealt with data on health outcomes. There is some degree of overlap between measurement and reporting of data on health outcomes and data collection on adverse events and initiatives to improve quality. Issues around adverse events, quality initiatives, benchmarking and performance indicators have been discussed in some depth in Chapter 7 which dealt with the inquiry's term of reference (i) on the effectiveness of quality improvement programs.

8.36 A number of submissions were critical of the lack of data collection and analysis in the area of health outcomes. By and large, submissions were less forthcoming on how health outcomes could be measured. Once appropriate systems are in place, it should be relatively straightforward to collect and analyse data on the inputs, processes and outputs of hospital services because all are tangible, measurable units. However, as was indicated by the earlier discussion in relation to data on allied health services, Australia is still some way from adequately collecting and analysing data on the complete episode of care. It is much harder to define and measure health outcomes. Adequate data collection in this area is obstructed by the difficulty of measuring accurately the outcomes of a great many health interventions.

8.37 Dr O'Connor from the School of Health Services Management at the University of New South Wales outlined for the Committee how health outcomes could be measured:

> …health outcomes measurement means asking the patient. It is not asking the patient, 'Are you satisfied with health services?'; it is asking the patient, 'How do you feel? Can you walk, can you wash the dishes, can you do the shopping?'– all those sorts of very functional things associated with just living life normally.[41]

Dr O'Connor cautioned, however, that while patients can provide an assessment of how they feel and what they can do, 'they cannot tell you why they are not better'.[42]

8.38 The joint submission from the Australian Healthcare Association, Women's Hospitals Australia and the Australian Association of Paediatric Teaching Centres[43] (AHA, WHA and AAPTC) argued that the focus of data collection on standards of

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41 *Committee Hansard*, 21.3.00, p.328 (Dr O'Connor).

42 *Committee Hansard*, 21.3.00, p.328 (Dr O'Connor).

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

care and quality 'remain substantially focussed on processes and inputs rather than outcomes of care'.[44] The South Australian Salaried Medical Officers Association (SASMOA) made the important point that outcome measures need to be relevant and useful. The Association argued that once relevant and useful measures of health outcomes were in place 'you would then change practice' and 'we would be in a position to work out what models we should be practising in health care'.[45]

8.39 Several participants pointed to the lack of systematic collection of data on clinical processes. For example, the submission from DHAC encapsulated succinctly the limitations of data collection in this area:

> the use of data to improve performance in the clinical area is at a very low level while data for system-wide analysis is unreliable and poorly articulated and collected.[46]

8.40 The Australian Healthcare Association (AHA) told the Committee that more information was required on the performance of the various players such as governments, hospitals and health authorities: 'the notion of a national report card on health, on hospitals, on insurance funds, on practitioners, I believe is something we need to get far more aggressive about'.[47] The Committee believes that this is a strong argument for the role of an authority for overseeing quality programs in creating a more transparent system and holding all the players accountable for their performance.

8.41 Under-investment in appropriate information technology in public hospitals was raised by the NAHCC as an issue in relation to data on health outcomes. It commented that there is a 'lack of available information technology infrastructure to collect and analyse activity that relates to patient outcome information'. This in turn limits the capacity of allied health professionals 'to operate within a paradigm of evidence-based practice which we all strive to do'.[48]

8.42 The Queensland Government, however, argued in its submission that some progress was being made in the collection, reporting and analysis of data on health outcomes. For example, it is spending $1.6 million over four years to implement a program called *Health Outcomes Measurement and Feedback Processes for National Health Priority Areas*, drawing on funding available under the National Health Development Fund[49] of the Australian Health Care Agreements (AHCAs). The

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44 Submission No.63, p.38 (AHA, WHA, AAPTC).

45 *Committee Hansard*, 23.2.00, p.195 (South Australian Salaried Medical Officers Association).

46 Submission No. 38, p.45 (DHAC).

47 *Committee Hansard*, 11.11.99, p.108 (Australian Healthcare Association).

48 *Committee Hansard*, 23.3.00, p.573 (National Allied Health Casemix Committee).

49 The National Health Development Fund has been established under the AHCAs to fund 'projects that improve: patient outcomes; efficiency and effectiveness, or reduce the demand for public hospital services; and integration of care between public hospital services and broader health and community care services'. Approximately $253 million is available through the fund over the five years of the AHCAs (Submission No.38, p.7, DHAC).

Queensland Government anticipates that this program will 'increase the cost effectiveness of health service delivery'. The objective of the program is to develop processes that will:

> provide information on quality-of-care to clinicians and policy-makers and enable measurement of health outcomes across the continuum of care including primary prevention, treatment, secondary prevention and rehabilitation.[50]

Patient satisfaction

8.43 Allied to this area of health outcomes is data on patient satisfaction. Many public hospitals make an effort to gain feedback from patients on their hospital stay, however sometimes the forms/surveys are not designed in such a way as to ensure that genuine, detailed feedback is obtained. For example, patient satisfaction surveys that require only a Yes/No answer may not always permit the patient to reveal the full details of the hospital experience. The CHF commented that although some consumers valued hospital patient satisfaction surveys, 'the information most of them currently provide on the experiences of patients is extremely limited'.[51]

8.44 The CHF argued that for hospitals to gain meaningful feedback, consumers should be involved in the design of survey forms and could also assist in developing ways of administering the surveys. To illustrate the importance of community consultation in this area, the CHF provided an example of a large scale 'Healthy Communities Survey' of 25 000 people in Tasmania, the usefulness of which was limited by its design. The CHF commented that:

> the survey required respondents to be able to write and answer complex questions. This automatically excluded those with low literacy or no English, vision impairment or other disability such that they could not complete a form. Data collection techniques must be inclusive or it will not adequately represent the population being surveyed.[52]

8.45 A 'real world' example of a survey of patient feedback can be found in the 1997-98 annual report of the Western Australian Metropolitan Health Service Board. The Board surveyed 2565 patients in 1998, achieving a 48 per cent response rate. The survey found that the most important issue for patients was 'care, respect and treatment as a person', followed by 'availability of staff'. Also important to patients was 'continuity before, during and after care'.[53]

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50 Submission No.41, p.34 (Queensland Government).

51 Submission No.72, p.31 (CHF).

52 Submission No.72, pp.30-31 (CHF).

53 Metropolitan Health Service Board, *Annual Report 1997-98*, Perth, 1998, pp.106-109.

8.46 Surveys of patient satisfaction face a challenge in providing useful data on health outcomes. Dr O'Connor told the Committee that the role played by the medical practitioner in deciding the extent to which a patient receives services meant that:

> the consumer does not know whether health services are adequate or not. If you ask people whether they are satisfied with health services, it is usually 70 out of 100–70 per cent are satisfied. That is a figure which you have found for years and years.[54]

Data on quality of care and standards of care

8.47 Issues around data on quality of care was discussed in Chapter 7 which dealt with the inquiry's term of reference (i) on the effectiveness of quality improvement programs. DHAC advised in its submission that the following priority areas are under consideration for development and reporting of national quality of care indicators:

- patient satisfaction;
- patient complaints;
- services accreditation; and
- patient safety.

Any performance information that is developed in this area is expected to be reported in the annual reports under Schedule C of the Australian Health Care Agreements, which was discussed earlier.[55]

8.48 The Australian College of Midwives Inc–Victorian Branch (ACMV) was concerned that current collections of data in relation to maternity services tend to focus on throughput rather than quality of care issues. In particular, elements that the ACMV regards as essential aspects of midwifery care such as telephone counselling, developmental work and education 'are not considered key indicators for measuring service provision' in regard to outpatient maternity services.[56]

8.49 Data on standards of care appears to be sparse. For example, in its submission, DHAC stated that 'there is little information at a national level that relates to standards of care'.[57] DHAC offered the following definition of standard of care:

> the level of conduct used to assess healthcare, particularly medical practitioners conduct for the purposes of determining its adequacy or especially, liability in negligence law or malpractice suits.[58]

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54 *Committee Hansard*, 21.3.00, p.327 (Dr O'Connor).

55 Submission No.38, p.44 (DHAC).

56 Submission No.75, p.10 (Australian College of Midwives Inc–Victorian Branch).

57 Submission No.38, p.44 (DHAC).

8.50 DHAC advised that the only general measure of standards of care that is currently reported is adherence to accreditation standards (issues around accreditation have been discussed in Chapter 7 on the effectiveness of quality improvement programs).

Information technology, quality of care and data collection

8.51 Discussion earlier in this chapter indicated that the use of IT systems in public hospitals had been driven largely by financial and cost data considerations. This section examines information technology in greater detail and discusses, in particular, individual patient identifiers and electronic health records. Evidence was received during the inquiry that indicated there was potential to increase quality of care by, for example, reducing the incidence of adverse events, through the introduction of unique patient identifiers and electronic health records. It is anticipated that data collection and analysis will be enhanced also through these developments.

8.52 Evidence to the Committee indicated that there needs to be greater priority given to the development of information technology (IT) in the health care system. DHAC confirmed that at present IT is being developed throughout the health system in an uncoordinated way and that without action these independent investments will be largely wasted.[59]

8.53 AHA, WHA & AAPTC commented on the lack of investment in information technology:

> Healthcare…has focussed its investment more on the progressive application and transfer of new diagnostic and treatment methodologies than it has on the management of information necessary to assess its performance, understand its client base and improve its clinical management.[60]

8.54 Barwon Health also noted that 'the shortfall is not so much capturing of the data, but the development of integrated management systems with software development focusing on supporting management decision making'.[61]

8.55 Submissions also argued that there needed to be greater financial resources devoted to IT in the public hospital sector. For example, the Committee of Presidents of Medical Colleges (CPMC) stated that:

> the level of information technology hardware and software in Australian hospitals is approximately equivalent to where Australian banks were 20

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58 Boyce, *et al*, *Quality and Outcome Indicators for Acute Healthcare Services*, 1997, quoted in Submission No.38, p.44 (DHAC).

59 Submission No.38, p.54 (DHAC).

60 Submission No.63, p.37 (AHA, WHA, AAPTC).

61 Submission No.37, p.5 (Barwon Health). See also Submission No.45, p.31 (RACP, HIC, ACA).

> years ago. Without major investment, Australian hospitals will not have the information systems to reduce the incidence of adverse events and enhance quality, to produce reliable information on the full range of hospital activities and to allow proper management of waiting lists.[62]

8.56 CPMC stated that in Victoria alone an investment of at least $100 million is required to purchase reasonably satisfactory systems. Across Australia, the figure is likely to be in excess of $500 million.[63]

8.57 The National Expert Advisory Group on Safety and Quality in Australian Health Care (the Expert Group) stated that the development of IT for health, and in particular data communication, represents 'a tremendous opportunity to break down some of the barriers between health services both within and across jurisdictions. The opportunity exists to ensure that full information about a patient is available within the Australian health care system wherever it is appropriate and needed'.[64]

8.58 The adoption of IT advances by the Australian health care system has been fragmented and slow.[65] Currently there is no single record that contains a person's health history. There is no computerised network to link GPs, hospitals and other health care providers, and consumers have little or no access to their medical records.[66]

8.59 The National Health Information Management Advisory Council (NHIMAC) was established in 1999 to provide a nationally coordinated approach to improving health information management through the greater uptake of online technologies and to achieve national coordination among the Commonwealth and the States to reduce unnecessary duplication in the area of information technology. The Council will advise Health Ministers on options to promote a nationally uniform approach to information management within the health sector.

8.60 Two specific areas where improving IT to support service delivery as well as data collection and analysis were highlighted in the development of a unique patient identifier and electronic health records for patients. These are discussed below.

Unique patient identifier

8.61 Evidence to the Committee indicated that there would be advantages if there was a unique patient identifier that could be used across the various elements of the health care system.[67] At present individual health consumers are identified by name,

62 Submission No.40, p.1 (CPMC).

63 Submission No.40, p.1 (CPMC).

64 Expert Group report, p.16.

65 *Committee Hansard,* 23.3.00, p.544 (ACHSE); *Committee Hansard,* 23.3.00, p.499 (Professor Phelan).

66 NSW Health Council, *A Better Health System for NSW*, March 2000 (Chairman: Mr John Menadue), p.23.

67 *Committee Hansard,* 23.3.00, p.499 (Professor Phelan).

address and date of birth when their health records are forwarded to another health provider. This system is not always reliable and there is the potential for adverse patient outcomes if transfer of clinical information such as prescription data or medical history is not accompanied by a foolproof system of patient identification.[68] The advantages of a unique patient identifier are that:

- it would improve the safety and quality of health care of the individual patient. It would allow access, with patient permission, to information held by hospitals, the Health Insurance Commission on services provided by private medical practitioners, drugs prescribed under the PBS, and potentially, information held by other health care providers. It would ensure that an attending doctor could have access to information on what drugs had been previously prescribed and identify previous medical interventions;
- it would help prevent the repeat performance of various tests that were previously undertaken by another medical practitioner;
- it would allow patients to be tracked, in a de-identified way, across the health care system and also allow data to be linked with other administrative data sets. In this way information on longer-term outcomes of medical interventions could be obtained which is important in determining their effectiveness; and
- the availability of a unique patient identifier would encourage the development of an electronic medical record containing crucial medical information about a patient that could be made available to a health care provider whose access was authorised by the patient.[69]

8.62 A number of factors inhibiting the development of a unique patient identifier and its use were also identified in evidence. These included:

- the lack of agreement between the Commonwealth, States, private health insurers, private providers of health care services and consumers on the desirability of having a unique patient identifier;
- the form a unique patient identifier would take – the Medicare number could be adapted as the unique identifier as the Health Insurance Commission holds a unique Personal Identification Number for each individual enrolled in the Medicare system;
- a ruling by the Privacy Commissioner prohibiting the linkage of Medicare and the PBS data. The Privacy Commissioner's determination was that there must be no linkage of data sets held by different government agencies;
- while public hospitals in some States record a patient's Medicare number at the time of attendance to determine his or her eligibility for free care under

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68 NHIMAC report, p.27.

69 Submission No.40, Additional Information, 24.3.00 (CPMC).

Medicare, this is mainly for inpatient care and is not universal, particularly for attendances at outpatients and accident and emergency departments even in those States who record the Medicare number; and

- the only private health care services reported to the Health Insurance Commission are those that attract a Medicare Benefit – effectively those provided by a medical practitioner or an optometrist. Admission to a private hospital is identified only through information provided on a Medicare claim for a rebate for billed medical services.[70]

8.63 Community concerns about privacy issues are often cited in relation to the introduction of a unique patient identifier. The NHIMAC stated that the use of a personal health identifier is a sensitive issue that has been addressed by the Privacy Commissioner in the *National Principles for the Fair Handling of Personal Information.* The Council noted that within this framework, strict guidelines would need to be legislated before a patient identification system could be implemented – 'the extent to which health consumers will agree to the use of a health identifier, will depend critically upon their understanding of, and trust in, its use'.[71] The Council stated that further work on the use of a personal health identifier should be guided by the following:

- a health identifier should be created primarily for patient safety and quality reasons, allowing certainty of identification and transfer of information with patient consent; and
- a health identifier should be fully transparent and remain in the hands of the health consumer.[72]

8.64 CPMC also noted that the community could be better assured that access to information would be in their control by the use of available technology such as a combination of a pin number and a card similar to a credit card. Patients could also indicate different levels of access according to the needs of providers – thus providing for restricted access to certain sensitive information. CPMC stated that the privacy issues around a unique patient identifier have been discussed with the Privacy Commissioner and he was 'very receptive' to the arguments put by the College.[73]

8.65 At the national level, the NHIMAC referred the issue of patient identification as part of a wider reference on the development of electronic health records and a health information network to the National Electronic Health Records Taskforce, a subcommittee of the Council. The Taskforce reported recently to Health Ministers at their 31 July 2000 meeting. Health Ministers welcomed the recommendations of the report and agreed to pursue the development of HealthConnect, a national health

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70 Submission No.40, Additional Information, 24.3.00 (CPMC).

71 NHIMAC report, p.28.

72 NHIMAC report, p.28.

73 Submission No.40, Additional Information, 24.3.00 (CPMC).

information network.[74] This is discussed below, in the section dealing with electronic health records.

8.66 With regard to patient identifiers, the Taskforce recommended the:

> establishment of a national health identifier to be used only in the health sector under strict privacy protocols and which is implemented concurrently with HINA. Similarly, providers and facilities/locations need to be reliably identified to eliminate any uncertainty about who was involved in an episode of care and where that care was provided.[75]

8.67 Legislation introduced into Parliament on 6 September 2000 by the Minister for Health and Aged Care, Dr Wooldridge, proposes to use the Medicare Card number as a means of establishing the eligibility of patients for pharmaceuticals dispensed under the Pharmaceutical Benefits Scheme (PBS). The National Health Amendment (Improved Monitoring of Entitlements to Pharmaceutical Benefits) Bill 2000 proposes a three stage implementation, the final stage of which provides that there will be no payment by the Commonwealth to a pharmacist for a prescription without a Medicare number.[76]

8.68 Privacy issues associated with the use of a personal health identifier are discussed below, in the section dealing with the broader issue of privacy and electronic health records.

8.69 At the State level, in NSW the report of the NSW Health Council (Menadue report) recommended that a unique patient identifier be developed and that it be trialed in at least two Area Health Services in that State. The report argued that it should be developed in consultation with the consumer organisations and clinicians. The report also argued that the Commonwealth Government and the Health Insurance Commission must be closely involved 'as there is little point in a Unique Patient Identifier being confined to State-administered services unless the number can be used when accessing GP services'.[77] Some jurisdictions have already adopted their own unique identifiers – for example, the ACT and the Northern Territory.

8.70 The Committee supports the development of a unique patient identifier and believes that its introduction needs to be accompanied by strong privacy safeguards. The Committee notes the recommendation of the National Electronic Health Records

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74 Minister for Health and Aged Care, 'Health Ministers give green light to national health information network', *Media Release*, 31 July 2000.

75 National Electronic Health Records Taskforce, *A Health Information Network for Australia: report to Health Ministers*, Canberra, Commonwealth Department of Health and Aged Care, 2000. HINA means Health Information Network Australia, the Taskforce's working title for a national health information network. The announcement by Health Ministers giving their support to the development of such a network noted that the network is to be called HealthConnect.

76 House of representatives, *Debates*, 6 September 2000, p.18223.

77 NSW Health Council report, p.25.

Taskforce and the statement by Health Ministers welcoming the Taskforce's recommendations for the creation of a national electronic health network, including the establishment of a unique patient identifier.

Electronic health records

8.71 Currently the majority of health care records exist as discrete paper-based records held in a variety of different locations, resulting in a fragmented picture of an individual's health history. They cross traditional and non-traditional health care sectors, and health and related community support services. The information contained within them varies and problems often arise about the quality and appropriateness of the content of the current records.[78]

8.72 There is increasing recognition across the health sector of the potential benefits of electronic health records in improving efficiency, safety and quality of care over paper-based systems. An electronic health record is a single, complete patient record of all health care information which relates to an individual. It records all information about treatments that an individual has received – including hospital admissions – and diagnostic information such as test results.

8.73 NHIMAC stated that:

> Access to the appropriate information at the time of care delivery is central to good clinical decision-making – practitioners and consumers need the right information at the right time. The greater focus of health care policy on providing a "seamless delivery of care", particularly for the frail aged, the chronically ill and those with complex care needs has highlighted the need to improve information exchange between different types of services and providers.[79]

8.74 A number of advantages to both patients and health care providers have been identified with electronic health records:

- clinicians will have all the relevant information before them to diagnose a patient and provide treatment or organise a referral to another clinician;
- where patients are referred to another clinician relevant information can be transferred electronically if the patient consents;
- the onus will no longer be on the patient to retain and recall vital and often complex diagnostic information and advice; and

78 NHIMAC report, p.52.

79 NHIMAC report, p.52.

- when a patient's doctor arranges tests, the results can be transferred electronically to other relevant providers, thus avoiding the inconvenience and cost of having tests repeated.[80]

8.75 The use of an electronic health record is widely regarded as a high priority in health care reforms in the United Kingdom, Canada, the USA and the Scandinavian countries.[81] The National Health Service in the UK has now commenced developing a national system of lifetime electronic health records.[82]

8.76 NHIMAC established a sub-committee, the National Electronic Health Records Taskforce, in November 1999 to develop a framework for electronic health records in Australia. The Taskforce comprised representatives of DHAC, the Health Insurance Commission, the States and Territories and clinicians. The Taskforce consulted widely with stakeholders to identify the form and key components of an electronic health records system for Australia; and other matters that need to be considered to enable electronic health records to operate, such as issues concerning record linkage, security and coding.[83]

8.77 The Taskforce submitted its report on the development of an electronic health records system for Australia to Health Ministers in July 2000. Rather than the creation of a single electronic health record system, the Taskforce recommended the development of a national information network that 'can evolve from work already being undertaken by the many stakeholders in the health sector'.[84] Health Ministers welcomed the recommendations of the Taskforce and gave their approval for the development of HealthConnect, a national health information network. HealthConnect will provide for the creation and storage of electronic health records together with other health information.[85] However, as this proposal is unfunded the Committee recommends that the Commonwealth and the States commit the necessary resources to implement the changes (see recommendation at the end of the chapter). Privacy issues around electronic health records are discussed in a later section of this chapter.

8.78 At their July 2000 meeting, Health Ministers also supported, in principle, a proposal to develop a system of electronic medication records, to be called the Better Medication Management System (BMMS). Announcing the support of Health Ministers for the proposal, the Commonwealth Minister for Health and Aged Care, Dr Wooldridge, said that:

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80 NSW Health Council report, p.24.

81 NSW Health Council report, pp.23-24, 27.

82 NHIMAC report, p.53.

83 NHIMAC report, pp.56-57.

84 National Electronic Health Records Taskforce report, p.vi.

85 Minister for Health and Aged Care, 'Health Ministers give green light to national health information network', *Media Release*, 31 July 2000.

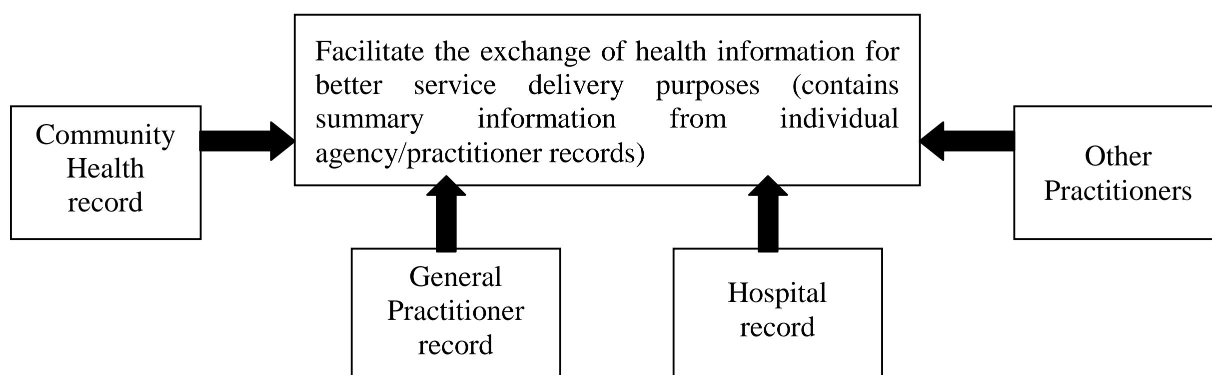
> the Better Medication Management System (BMMS) is a way to bring together currently fragmented medication record systems by using information technology to link patients, doctors, pharmacists and hospitals.[86]

The Minister's statement also noted that participation in the proposed BMMS will be voluntary for all parties and will offer consumers access for the first time to their own medication record. It is understood that the Medicare Card number will be used as the unique patient identifier for the BMMS.

8.79 This unique patient identifier is being developed without clear rules for collecting data on Medicare numbers or how they will be matched against other health insurance data. The Federal Government is creating one unique patient identifier to check a patient's eligibility for the PBS and plans to create another identifier to allow doctors, pharmacists and patients to access medication records as part of the BMMS. Australians are going to have multiple unique patient identifier numbers without first establishing a national health privacy regime. The uncertainty about multiple unique patient identifiers and their operation should not continue, as it could seriously harm public confidence in the Health Insurance Commission's data management system and set back the adoption of electronic records in the health sector.

8.80 The proposed framework of electronic health records is illustrated in the diagram below.

Figure 8.1: Proposed framework of electronic health records



Source: NHIMAC, *Health Online: A Health Information Action Plan for Australia,* November 1999 p.57.

8.81 NHIMAC stated that there will not be one record system but multiple record systems. This is because the information needs, and therefore the level and type of detail required for service delivery, vary across health care settings and among health care providers. It is envisaged that the health records system will contain several discrete components – perhaps a standard health record that could be used by GPs,

86 Minister for Health and Aged Care, 'Electronic medication records a boon for consumer safety–Health Ministers', *Media Release*, 31 July 2000.

one for hospitals etc. The Council noted that where there are multiple record systems, it is 'essential' for common elements to be agreed in order to achieve a high level of compatibility. The interchange of information between electronic record systems is expected to take place in a distributed data network. Data would reside essentially where it is collected, rather than a single, centralised repository of health records. Sub-sets of these records would be brought together for purposes of exchanging relevant clinical information.[87]

8.82 NHIMAC emphasised that it was imperative in the area of data linking that there be consistency of approach across Commonwealth, State and Territory jurisdictions and in different forms of care – in the public and private sectors, and in the acute and community care settings.[88]

8.83 At the State level there have also been moves advocating the introduction of electronic health records. The Menadue report into the NSW health services recommended that within two years NSW should be in a position to introduce electronic health records. The report argued that the introduction of electronic health records would dramatically improve the quality of care within the hospital system and reduce the number of medical errors.[89]

8.84 The Menadue report noted that the electronic health record will have the following features:

- it will be accessible to the individual consumer and their providers, regardless of the location and with the appropriate attention to privacy and security safeguards;
- the individual will need to give consent about the type of information made available, and the transfer of information between providers;
- the record will contain clinical records, advice, specialist referrals, pharmacy details, diagnostic tests and results;
- the record will be able to provide GPs, specialists, public and private hospitals, community health centres, and other health providers with access to relevant information about the individual's medical history with the patient's consent;
- it will be linked to clinical protocols and clinical pathways and assist the health care provider in clinical decision making; and
- an information system based on the electronic health record will allow the collection of data that can be used to measure the quality and performance of

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87 NHIMAC report, pp.53, 56.

88 NHIMAC report, p.53.

89 NSW Health Council report, p.23.

health care provision, and to assist the consumer in making informed health choices.[90]

8.85 The report argued that that there should be a staged approach to the development of an electronic health record allowing for the involvement of consumers, clinicians and relevant privacy bodies. The strategy should identify the types of information to be recorded, and specify privacy and confidentiality standards and should establish a timetable for a number of steps which are essential to introduce an electronic health record. These include the development of a unique patient identifier, improved links between patient management systems and improving clinical care systems. The report noted that the introduction of an electronic health record should commence with, and be evaluated through, a number of demonstration projects.[91]

Privacy and security considerations

8.86 The Committee acknowledges that a system of electronic health records, as with the introduction of a unique patient identifier, cannot be introduced until satisfactory arrangements are in place to ensure privacy and security considerations are protected. The Committee believes that a strong privacy regime is an essential precondition to ensure public acceptance of electronic health records.

8.87 NHIMAC also stated that it was important to ensure that health consumers are confident that the privacy of their personal records is protected. The Council noted that this is particularly an issue in the health sector 'where people are often at their most vulnerable and powerless, where information is often particularly sensitive and personal, and where inappropriate disclosure and use of personal information can have a devastating effect on people's lives and circumstances'.[92]

8.88 One commentator noted that while electronic health records are increasingly seen as a way to achieve quality and continuity in treatment:

> such systems run the risk of foundering in the wake of community concerns…Successful implementation of proposals for electronic record systems must learn from such experiences and demonstrate keen attention to delivering information useful to both citizens and clinicians, while ensuring privacy protection and promoting public accountability for secondary use of personal information.[93]

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90 NSW Health Council report, p.24.

91 NSW Health Council report, p.25.

92 NHIMAC report, p.20.

93 Carter M, 'Integrated electronic health records and patient privacy: possible benefits but real dangers', *Medical Journal of Australia*, Vol. 172, 2000, p.28. See also Mount C *et al.*, 'An integrated electronic health record and information system for Australia?', *Medical Journal of Australia*, Vol.172, 2000, pp.25-27.

8.89 NHIMAC stated that governments, industry and many health service providers are increasingly interested to see national arrangements established to provide a nationally consistent approach across jurisdictions in relation to privacy issues.[94] In this regard, the Privacy Amendment (Private Sector) Bill 2000 was introduced into the House of Representatives on 12 April 2000. The Bill proposes to amend the *Privacy Act 1988* to establish a national scheme, through codes of practice adopted by private sector organisations and the National Privacy principles, for the appropriate collection, holding, use, disclosure and transfer of personal information, including health information, by private sector organisations. The proposed legislation will extend the national privacy regime to cover the private sector.

8.90 A House of Representatives report on the Bill noted, however, that a considerable number of submissions from consumer groups argued that health information should be removed from the Bill. Submissions representing this view argued that the Bill does not provide appropriate rights to privacy in respect of health information and access to health records. The main reasons for arguing this were that the regime established by the Bill will led to the creation of inconsistent standards governing privacy rights in the public and private sectors; that access rights contained in the Bill enabling individuals to access their own health information are inadequate; and that the health sector is so different from other sectors that any attempt to incorporate it within the general framework of the Bill is misguided.[95]

8.91 In relation to security considerations, NHIMAC stated that moving to an electronic environment for these communications demands a high degree of confidence that the information will be transferred securely and that the identity of the parties is not in dispute.[96] As noted previously, the exchange of information across the health sector generally involves the transfer of highly personal and sensitive information.

8.92 The Health Insurance Commission is currently working on a project to develop methods to ensure that the transfer of health information will be secure. It is envisaged that for security purposes, health professionals will need to be issued with digital certificates – a form of smart card – as part of the provider registration process. Under the project, the Commission is working with security specialists to investigate the use of this technology to authenticate the identity of the sender of electronic documents and to ensure the integrity of transmitted information.[97]

8.93 The Health Insurance Commission is also looking into the feasibility of operating a registration authority that would provide a security vetting function and issue digital certificates. This it is argued will provide for privacy and security

94 NHIMAC report, p.21.

95 See House of Representatives Standing Committee on Legal and Constitutional Affairs, *Advisory Report on the Privacy Amendment (Private Sector) Bill 2000*, June 2000, pp.65-66.

96 NHIMAC report, p.22.

97 NHIMAC report, pp.22-23.

safeguards to be built into the online services to ensure that only authorised people will have access to electronic health information and information.[98]

8.94 Announcing their support for the development of HealthConnect, a national health information network, Health Ministers stated at their July 2000 meeting that they had agreed to protect people's privacy through the following provisions:

- individuals must freely agree to participate in the network in the first place and on an ongoing basis;
- an individual's information must only be used in a health care context;
- people must have access to their own information and must be able to control who can see their information;
- a stringent security framework must be in place wherever health information is collected, stored or exchanged, including audit trails and review mechanisms built into the network to track who has accessed information; and
- provisions must be in place to ensure, among other things, penalties for people who misuse the information.[99]

8.95 As discussed earlier, the Minister for Health and Aged Care has introduced the National Health Amendment (Improved Monitoring of Entitlements to Pharmaceutical Benefits) Bill 2000 into Parliament. The AMA has expressed its concern about the Bill's proposal to use the Medicare Card number as a means of establishing patient eligibility for pharmaceutical benefits. The AMA is particularly concerned that an appropriate privacy regime will not be in place prior to the introduction of this new scheme and that the Medicare Card number is proposed also to be used as a patient identifier for the BMMS:

> we have serious concerns about this proposal and we are calling for urgent, overarching health privacy legislation to prevent any transfer of Medicare numbers onto other databases, including the government's BMMS.[100]

8.96 However, in his Second Reading speech on the Bill, Dr Wooldridge argued that:

> implementation of the proposed arrangements will be founded on the well-established privacy principles under the *National Health Act 1953*. The national health amendment bill not only maintains current levels of privacy. It extends protections under the National Health Act to cover all aspects of

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98 NHIMAC report, pp.22-25.

99 Minister for Health and Aged Care, 'Health Ministers give green light to national health information network', *Media Release*, 31 July 2000.

100 Australian Medical Association, 'AMA warns: Medicare numbers the new "Australia Card"', *Media Release*, 13 September 2000.

the use of the Medicare number, and other identifying data, for the purposes of pharmaceutical benefits entitlement monitoring.[101]

Conclusion

8.97 The Committee believes that the development and implementation of nationally consistent electronic health records can improve the safety and quality of health services. The Committee notes the decision of Health Ministers to support the development of HealthConnect, a national health information network, which will provide for the creation and storage of electronic health records. It notes also the measures to protect privacy which have been agreed by Health Ministers. The Committee supports these developments and, in the light of evidence presented to the inquiry, anticipates that benefits will flow from the early implementation, with appropriate safeguards, of HealthConnect.

8.98 Evidence discussed in this chapter has painted a mixed picture of Australia's current position in relation to data collection and management. In some areas, notably financial and cost data as well as data on patients treated in hospitals, systems are well advanced and data is now being collected and reported in a relatively timely manner. On the other hand, national data on such areas as waiting times for elective surgery and health outcomes is patchy and in some cases underdeveloped. However, there are signs that frameworks are being established which should lead to greater consistency in data collection in the different jurisdictions.

8.99 Adequate resourcing of public hospitals is clearly important here. Evidence received indicated that, at times, some public hospital staff feel that there is tension between their time available for patient care and the time required for data collection. Evidence to this inquiry indicates that Australia knows little about the effectiveness of its spending on public hospitals. Greater transparency of funding by each jurisdiction together with the development of meaningful indicators of performance and outcomes should enable increased knowledge in this area over time.

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

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

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101 House of Representatives, *Debates*, 6.9.00, p.18223.

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

Senator the Hon Rosemary Crowley
Chair

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.

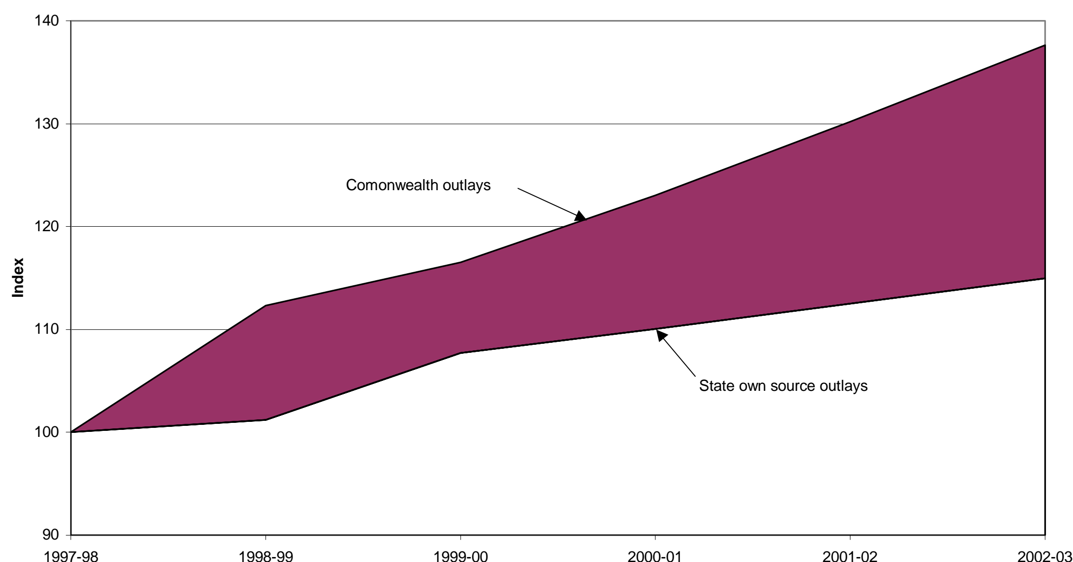
Adequacy of State and Territory funding

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.



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	%
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%.

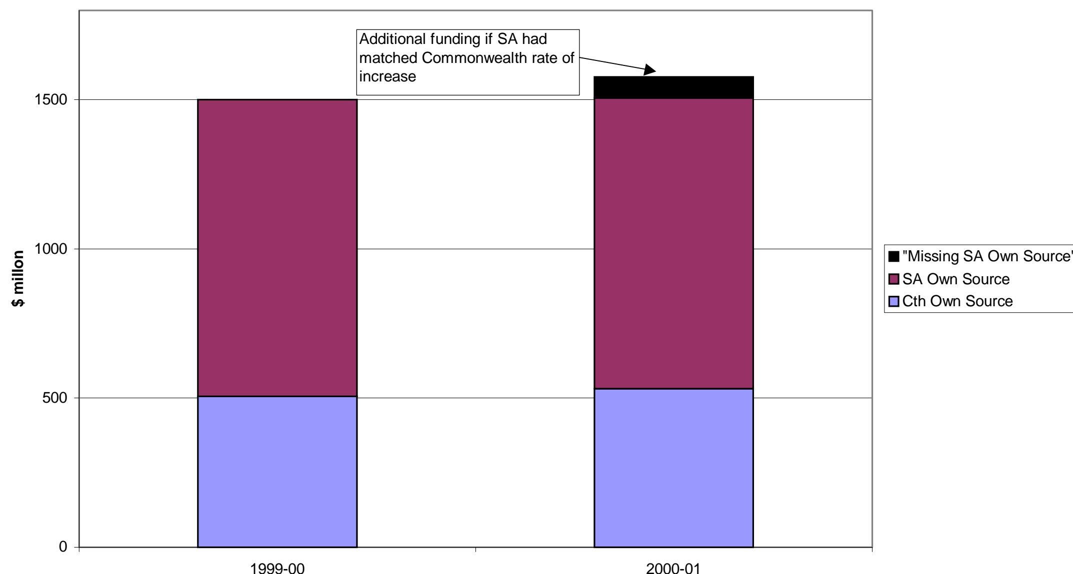
South Australian Public Hospital Funding

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	%
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 <u>recommend</u> 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.

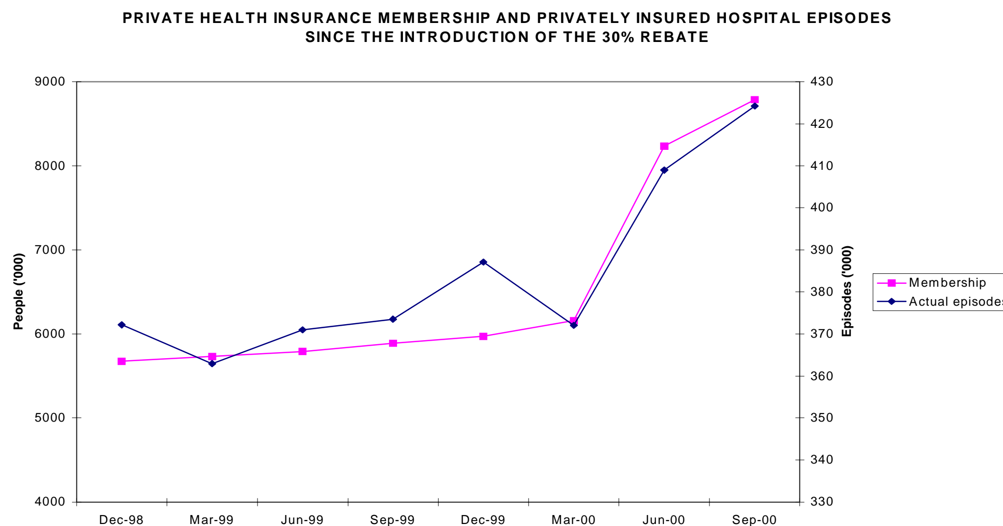
The Opposition Report claims that there is no evidence of a direct link between private health insurance membership and demand for public hospital services.

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)

DEMOCRATS SUPPLEMENTARY REPORT

The Democrats endorse the recommendations of the Final Report. Specifically, the Democrats support the development of better funding mechanisms for public hospitals and other public health services. Submissions provided to the Committee and evidence from witnesses emphasised the need to see hospital services as one part of the broader public health system which includes general practice, aged care, allied health and home and community care (HACC) services.

The Democrats believe that there is overwhelming evidence that the current funding arrangements for health and community services do not maximise either efficiency or health outcomes.

The major problems identified by the Committee within the health and community service sector include:

- a lack of coordination between different sectors of the health system
- cost-shifting and buck-passing between federal and state governments
- an inefficient use of resources across the health system
- geographical inequities in access to health services
- unequal imposition of health care costs on people on low incomes and people with chronic illnesses.

The Committee heard evidence from a number of witness confirming that the current funding and structural arrangements for health and community services cause significant wastage throughout these sectors. Different levels of Government and different vertically structured health programs have a financial incentive to shift responsibility for providing appropriate care elsewhere to save their own costs. This results in the misdirection and inappropriate use of health care resources and costs the community millions of dollars a year.

The Democrats believe that there has been insufficient research conducted into the many ways in which resources in the health sector are wasted through duplication of function, cost-shifting and inappropriate use. However, the Committee was provided with some important examples of where the costs of these practices are clearly considerable, for example, the use of acute care beds for nursing home type patients.

The Democrats are concerned that current health funding arrangements work against adopting a more preventive approach to health. Under the current system neither hospitals or, in many cases GP's, have an incentive to focus on preventive health or health promotion. Apart from some specific programs, such as payments to increase vaccination rates in GP's rooms, payment structures within the health system are linked to throughput and not to cost effective, quality or preventive care.

The Democrats recommend that an alternative model of health funding and service delivery be trialed for a period of three to four years.

The aims of this funding model are as follows:

- High quality care
- Integrated care across health, aged and community care sectors
- Increased consumer input into funding and service delivery decisions
- Focus on most appropriate care and health outcomes, regardless of funding source
- Cost effective care, regardless of level of government funding
- Flexible enough to respond to different populations priorities and needs
- A reduction in adverse events and unnecessary hospital admissions
- An increased focus on prevention and quality of care.

The key to this model is to have a single funder for all health and community services. This model involves a pooling of all health and community care funding from Commonwealth and State/Territory Governments.

A single funder has the advantage of increased purchasing power and would eliminate the incentives for cost-shifting and duplication of administration. It would also be a more powerful negotiator with interest groups within the health system, such as doctors.

The pooled funding would be allocated on a regional basis to a number of discrete regions throughout Australia. Provision would be made for rural and remote regions where health care costs are higher. Regions would have control over the allocation of funding within their areas. The Commonwealth would set minimum standards of service delivery for specific areas of health care, ie acute care, drug and alcohol services and physiotherapy.

Within these guidelines regions would be able to determine priorities for funding for their population. Within parameters set by the Commonwealth, regions would determine any co-payments required for health services and how these are levied. The States would monitor the quality of care and health outcomes, providing data to the Commonwealth. The Commonwealth would collect data on health service provision and health status of the general population and specific population groups.

The Democrats believe that pooling of funding allows more flexibility and greater coordination between services. A regional funding structure would allow regions to respond to priorities within their populations. This model would also encourage increased consumer participation into health funding and the organisation of health services at a local level. It would facilitate a preventive approach to health care which will save health costs in the long run.

The current incentives for cost-shifting and buck-passing would be removed, as regions would benefit from providing more efficient and cost-effective care. It would also remove the need for negotiations on the Medicare agreements and the constant arguments between State and Federal Governments over health funding.

The Democrats recommend that two trials of the integrated health funding model be established and recommend the ACT and the Hunter Valley region as sites for the trials.

Senator Meg Lees
Leader of the Australian Democrats

APPENDIX 1

LIST OF PUBLIC SUBMISSIONS, TABLED DOCUMENTS, SUPPLEMENTARY INFORMATION AND OTHER WRITTEN MATERIAL AUTHORISED FOR PUBLICATION BY THE COMMITTEE

1 Dr Michael Rose (QLD)
2 Dr Russell Broadbent (QLD)
3 Mr G R Neely (VIC)
4 Hunter Urban Network for Consumers of Healthcare (NSW)
5 Cancer Foundation of Western Australia (WA)
6 Dr Lionel Wilson - Qual-med Pty Ltd (NSW)
7 Health Consumers' Council WA (Inc) (WA)
8 National Seniors Association (QLD)
9 Professor Don Roberton, Professor of Paediatrics, University of Adelaide (SA)
10 Association of Independent Retirees Inc (VIC)
11 Doctors' Reform Society of Western Australia (WA)
12 Deafness Association of the Northern Territory (NT)
13 Dr James E Breheny (VIC)
14 National Health and Medical Research Council (NHMRC) (ACT)
15 Merck Sharp & Dohme (Australia) Pty Ltd (NSW)
16 Queensland Nurses' Union (QLD)

Supplementary information

- Queensland Health submission to the Two Year Review of Aged Care Reforms, provided 15.3.00

Tabled at public hearing 22.3.00

- Valuing Nurses, QNU Submission to the Ministerial Taskforce on Recruitment and Retention, June 1999

17 Public Hospitals, Health & Medicare Alliance of Queensland (QLD)
18 Australian Private Hospitals Association Limited (ACT)
19 Professor Richard W Harper (VIC)
20 Doctors Reform Society (QLD)
21 Midwifery Practice & Research Centre (NSW)
22 Professor Don Hindle, School of Health Services Management, UNSW (NSW)

Supplementary information

- Additional information following the hearing 21 March 2000 dated 12.4.00

23 National Allied Health Casemix Committee (VIC)

Tabled at public hearing 23.3.00

- Report on the Development of Allied Health Indicators for Intervention and Performance Indicators

24 Dr Steven Doherty (NSW)

25 Dr Robert Dowsett (NSW)

26 Medical Consumers Association of NSW (NSW)

27 Australian Medical Association (Victoria) (VIC)

28 Royal Australasian College of Surgeons (VIC)

29 Private Health Insurance Administration Council (PHIAC) (ACT)

30 Ms Margaret Mauro (NSW)

31 Aged and Community Services Australia (VIC)

32 Dr Geoff Masters (WA)

33 Queensland Ex-Service Round Table (QLD)

34 Darwin Community Legal Service (NT)

35 The Speech Pathology Association of Australia (VIC)

36 Australasian Faculty of Rehabilitation Medicine (NSW)

37 Barwon Health (VIC)

Supplementary information

- Reponse to questions from hearing 23 March 2000, dated 12.4.00

38 Commonwealth Department of Health and Aged Care (ACT)

Tabled at public hearing 11.11.99

- Changes to DHAC submission
- States Graph – Submission to Senate Community Affairs Legislation Committee
- Printout of presentation slides.

Supplementary information

- Response to questions from hearing 11 November 1999, dated 17.1.00
- Response to questions from hearing 11 November 1999, dated 11.2.00
- Response to questions from hearing 11 November 1999, dated 17.5.00
- Additional information concerning Australian Health Care Agreements, dated 16.6.00

39 Australian Nursing Federation (VIC)

40 Committee of Presidents of Medical Colleges (VIC)

Supplementary information

- Additional information following the hearing 23 March 2000 dated 24.3.00
- Additional information following the hearing 23 March 2000 dated 8.5.00

41 Queensland Government (QLD)

Supplementary information

- Additional information following the hearing 11 November 1999 dated 10.12.99
- Response to questions from hearing 22 March 2000, dated 26.5.00
- Additional information concerning cost shifting dated 19.7.00

- Health Service Integration in Queensland: Position Statement: June 2000

42 Dr Paul Cunningham

43 Dr Bryan Walpole (TAS)

44 Mayne Nickless Limited (NSW)

45 Royal Australasian College of Physicians
Health Issues Centre
Australian Consumers' Association (NSW)

Supplementary information

- Additional information on the Clinical Support Systems Project, dated 14.6.00

46 Centre for Health Program Evaluation (VIC)

Supplementary information

- Information expanding on issues raised in submission, dated 15.3.00
- Copy of overheads used at hearing on 23.3.00
- Private health insurance initiatives, dated 15.8.00
- Statistics from CGC: 1998 Update; Dissection of Health Expenditure and Revenue Hospital Services
- How we are to Prioritise Possible Reforms
- Regional Single Fundholder Model

47 Australian Medical Association (ACT)

48 Swan Health Service – Primary Health Management Team (WA)

49 Monash University – Faculty of Medicine (VIC)

50 Dr John Deeble (ACT)

51 South Australian Salaried Medical Officers Association (SA)

52 The Society of Hospital Pharmacists of Australia (VIC)

Tabled at public hearing 21.3.00

- Selection of Articles from Pharmacotherapy, AJH-SP, Pharmacoeconomics

Supplementary information

- Response to questions from hearing 21 March 2000, dated 19.4.00
- Comments re pharmaceutical funding, dated 17.8.00

53 Associate Professor John Duggan (NSW)

54 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (VIC)

55 Australian Health Insurance Association Ltd (ACT)

Tabled at public hearing 11.11.99

- Tables: Utilisation and Bed Day Costs; Hospital Bed Days per 1000 People Covered; Total Annual Benefits Paid

Supplementary information

- Response to questions from hearing 11 November 1999, dated 18.11.99
- Private health insurance and the public hospital system, dated 17.8.00

56 Catholic Health Australia (ACT)

Supplementary information

- Response to questions from hearing 11 April 2000, dated 19.4.00

57 Australian Salaried Medical Officers Federation (ACT Branch) (ACT)

58 Australian College of Midwives Inc – SA Branch (SA)

Tabled at public hearing 23.2.00

- Graphs relating to health expenditure

59 NSW Therapeutic Assessment Group Inc (NSW)

Tabled at public hearing 21.3.00

- Indicators for Drug & Therapeutics Committees, NSW TAG, January 1997
- Manual of Indicators for drug use in Australian hospitals, NSW TAG, April 1998

Supplementary information

- Workforce Planning Study, Hospital Pharmacists in NSW (prepared for the Pharmacy Board of NSW July 1999)
- Pharmacy Workforce in NSW - Strategies for change (prepared by NSW Health Department Pharmacy Monitoring and Review Committee, August 1999)
- Editorial from the American Journal of Health-System Pharmacy, February 2000
- Additional information, dated 28.11.00 and TAGNET Bulletin No.5, August 2000

60 South Australian Government (SA)

Tabled at public hearing 23.2.00

- AHCAs Indexation arrangements – comparison of Commonwealth funding to states/territories

Supplementary information

- Additional information and responses to questions on notice following the hearing 23 February 2000, dated 30.6.00

61 Australian Physiotherapy Association (VIC)

62 Australian College of Health Service Executives (NSW)

63 Australian Healthcare Association
Women's Hospitals Australia
Australian Association of Paediatric Teaching Centres (ACT)

Supplementary information

- Additional information dated 3.4.00

64 Australian Midwifery Action Project (AMAP) (NSW)

65 Australian Nursing Federation (SA Branch) (SA)

Tabled at public hearing 23.2.00

- Additional information

Supplementary information

- Response to questions from hearing 23 February 2000, dated 28.3.00

66 National Rural Health Alliance (ACT)

Tabled at public hearing 11.11.99

- Healthy Horizons
- Balancing Health Imperatives with Broader Rural Issues, H. Morton

- Fringe Benefits Tax and Rural Health, NRHA
- FBT Reforms – Impact on the Health Care Industry, AHA
- Regional Health summit – Extracts from Final Report

67 Tasmanian Government (TAS)

68 The NSW Midwives Association (NSW)

69 Northern Territory Government (NT)

Supplementary information

- Response to questions from hearing 24 February 2000, dated 28.3.00
- Additional information concerning hospital funding in the NT, dated 14.6.00

70 Medical Benefits Fund of Australia Limited (NSW)

71 Mr John Gill (VIC)

72 Consumers' Health Forum of Australia Inc (ACT)

73 Dr John Vinen (NSW)

74 Walcha Council (NSW)

75 Australian College of Midwives Incorporated – Victorian Branch (VIC)

76 The Royal Australian and New Zealand College of Radiologists – Faculty of Radiation Oncology (NSW)

77 Miss B Cobble (VIC)

78 Mr Paul Henderson MLA – Shadow Health Minister for the Northern Territory (NT)

79 New South Wales Government (NSW)

Tabled at public hearing 21.3.00

- A Review of NSW Health, Report to the NSW Treasurer and the Minister for Health, Independent Pricing and Regulatory Tribunal, November 1998
- Hospital Data Analysis Consultancy, Final Report, October 1999
- Copy of letter Minister for Health (NSW) to Minister for Health and Aged Care (Cth), undated

Supplementary information

- Response to questions from hearing 21 March 2000, dated 21.7.00

80 Mr Les Park (WA)

81 Queensland Greens (QLD)

82 Mr Andrew Lockwood-Penney (VIC)

83 Dr J M Wynne (QLD)

84 National Aboriginal Cummunity Controlled Health Organisation (ACT)

85 Metropolitan Hospital Advocacy Committee (NSW)

86 Australian Association of Surgeons (NSW)

87 National Council of Women of Australia (VIC)

88 Australian Nursing Federation (Victorian Branch) (VIC)

89 Australian Medical Association (Northern Territory Branch) (NT)

90 Dr Eddie Price (NSW)
91 Dental Health Services Victoria (VIC)
92 Ms Amber Bramble (NSW)
93 Professor John Zalcberg (VIC)

Additional Information

ACT Minister for Health and Community Care, Mr Michael Moore MLA

- Activity Report – Financial Year 1997-98, 1998-99
- ACT Department of Health and Community Care – Annual Reports 1996-97, 1997-98
- Chart on cost weighted separations for ACT Public Hospitals – 1996-1999
- Data on Public Acute Care Hospitals, provided for the Productivity Commission 2000 Report on Government Service Provision

Supplementary information

- Response to questions from hearing 11 April 2000, dated 15.7.00

Australian Nursing Federation (Northern Territory Branch) – Nurse salary comparative data across Australia, dated 24.2.00

Centre for Clinical Effectiveness, Monash Medical Centre – Information on the Centre, evidence-based medicine and examples of Evidence Centre Reports, dated 4 May 2000

Health Department of Western Australia – Answers to questions on notice following hearing on 25 February 2000 dated 24.3.00

Victorian Minister for Health, The Hon John Thwaites MP

- Copy of overheads used at hearing on 23.3.00
- Response to questions on notice from hearing 23 March 2000, dated 26.6.00

Commissioned Report

Centre for Health Economics Research and Evaluation (CHERE) Progress Report, dated April 2000 and Final Report, dated June 2000.

Campaign Mail and Petitions

The Committee received 6,739 letters, postcards and Emails from all States and Territories expressing support for Medicare and the public health system. The breakdown between each State and Territory was as follows:

New South Wales – 1167
Queensland – 3101
South Australia – 1176
Tasmania – 64
Victoria – 821
Western Australia – 45
Australian Capital Territory – 222
Northern Territory – 117
No Identification – 26
Not supporting Medicare - 1

The text of this correspondence read as follows:

Dear Senator Crowley,

I am writing to you in your position as Chair of the current Senate Inquiry into Public Hospital Funding to inform you of my wholehearted support for Medicare and our public health system.

Medicare is fair - it is a system in which access to health care is based on need and not ability to pay. I don't want to see our Australian health system become an unjust two-tiered system like the USA.

I believe all Australians must be able to access quality health care - this is a basic human right. The fairest, most efficient and easiest way to do this is through our taxation system and Medicare.

Please ensure that your Inquiry listens to the views of the majority of Australians who support Medicare and our public health system. We want to see this system extended so that health services to all Australians are improved.

The Committee notes that 6 petitions expressing similar sentiments have been presented to the Senate with 12,448 signatories

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS AND ROUNDTABLE DISCUSSIONS

Thursday, 11 November 1999 at 9.20 am, Senate Committee Room 2S3, Parliament House

Department of Health and Aged Care

Ms Lynelle Briggs, First Assistant Secretary, Portfolio Strategies Division
Mr Charles Maskell-Knight, Assistant Secretary, Financing and Analysis Branch
Mr Peter Broadhead, Assistant Secretary, Acute and Coordinated Care Branch
Ms Jenny Thomas, Assistant Secretary, National Health Priorities and Quality Branch

Australian Institute of Health and Welfare

Dr Richard Madden, Director
Mr John Goss, Unit Head, Health and Welfare Expenditure
Ms Jenny Hargraves, Unit Head, Patient Morbidity and Services

Queensland Government

Dr David Filby, Deputy Director-General, Policy and Outcomes, Queensland Health
Dr Martin Therkelsen, Principal Analyst, Health Funding and Systems Development Unit

Australian Medical Association

Dr David Brand, President
Mr John O'Dea, Director, Medical Practice Department

Australian Healthcare Association (AHA), Women's Hospitals Australia (WHA) & the Australian Association of Paediatric Teaching Centres (AAPTC)

Mr Mark Cormack, National Director, AHA
Mr John Smith, President, AHA
Ms Anne Cahill, National Director, WHA and AAPTC
Professor Les White, President, AAPTC

National Rural Health Alliance

Mr Gordon Gregory, Executive Director
Ms Judith Adams, Member of Council

Australian Health Insurance Association

Mr Russell Schneider, Chief Executive

Wednesday, 23 February 2000 at 9.10 am, Reception Room, Ground Floor, The Samuel Way Building, Women's and Children's Hospital, North Adelaide

Professor D M Roberton
McGregor Reid Professor of Paediatrics, University of Adelaide

South Australian Government

The Hon Dean Brown MP, Minister for Human Services
Ms Christine Charles, Chief Executive, Department of Human Services
Mr Jim Davidson, Executive Director, Strategic Planning and Policy Division, Department of Human Services

Australian Nursing Federation – SA Branch

Ms Lee Thomas, Assistant to the Secretary
Ms Gail Gago, State Secretary
Dr Paul Chapman, University of Adelaide
Mrs Alexa Jamieson, Work Site Representative
Ms Lillian Margellos, Work Site Representative
Ms Susan McKechnie, Work Site Representative
Ms Jayne Williams, Work Site Representative

South Australian Salaried Medical Officers Association

Dr John Norman, President
Associate Professor Peter Marshall, Member
Dr David Fenwick, Member
Mr Michael Grimes, Senior Industrial Officer

Australian College of Midwives – SA Branch

Ms Elizabeth Wood, State President
Ms Jen Byrne, Vice President
Ms Chris Cornwell, Secretary
Ms Nicky Leap, Political Co-ordinator

Thursday, 24 February 2000 at 9.45 am, Litchfield Room, Parliament House, Darwin

Australian Nursing Federation (NT Branch)

Mr Paul Nieuwenhoven, NT Branch Secretary

Australian Medical Association (NT Branch)

Dr Paul Bauert, President
Ms Robyn Cahill, Executive Director

Deafness Association of the Northern Territory

Mrs Mary Salter, AM, President

The Hon Stephen Dunham MLA, Minister for Health, Family & Children's Services

Mr Paul Henderson MLA, Shadow Minister for Health

Friday, 25 February 2000 at 9.00 am, Alpha Seminar Room, F J Clark Lecture Theatre Complex, Sir Charles Gairdner Hospital, Queen Elizabeth II Medical Centre, Nedlands, Perth, Western Australia

Doctors' Reform Society of WA

Dr David Atkinson, President
Dr David Paul, Treasurer

Health Consumers' Council of WA

Ms Michele Kosky, Executive Director
Ms Maxine Drake, Assistant Director

Health Department of Western Australia

Ms Prudence Ford, Executive General Manager, Finance and Infrastructure

Tuesday, 21 March 2000 at 9.10 am, de Lacy Function Room, Ground Floor, St Vincent's Hospital, Darlinghurst, Sydney

The Society of Hospital Pharmacists of Australia

Ms Helen Dowling, Federal President
Ms Penny Thornton, Counsellor

NSW Therapeutic Assessment Group

Professor Richard Day, Executive Member and Immediate Past President
Ms Karen Kaye, Executive Officer
Ms Maria Kelly, Deputy Chair

Dr Lionel Wilson, Managing Director, Qual-Med Pty Ltd

Professor Don Hindle, Visiting Professor, University of New South Wales

School of Health Services Management, University of New South Wales

Dr Rod O'Connor, Adjunct Senior Lecturer

NSW Department of Health

Mr Michael Reid, Director-General
Dr Tim Smyth, Deputy Director-General Policy

Royal Australasian College of Physicians

Professor Donald Cameron, President
Mr Craig Patterson, Director, Health Policy

Australian Consumers' Association

Ms Nicola Ballenden, Senior Policy Officer, ACA

Metropolitan Hospitals Advocacy Committee

Dr Louis McGuigan, Member, Sydney Teaching Hospitals Advocacy Group

Wednesday, 22 March 2000 at 9.05 am, Ground Floor Seminar Room, Diamantina House, Princess Alexandra Hospital, Woolloongabba, Brisbane

Doctors Reform Society

Dr Peter Davoren, President
Dr Theo van Lieshout, Vice President
Dr Tracy Schrader, Secretary

Queensland Nurses Union

Ms Gay Hawksworth, Secretary
Ms Beth Mohle, Project Officer
Mr Lex Oliver, Professional Officer

Public Hospitals, Health & Medicare Alliance of Queensland

Ms Grace Grace, Member
Mrs Kathy Kendell, Member

Queensland Government

The Hon Wendy Edmond MLA, Minister for Health
Dr David Filby, Deputy Director-General, Queensland Health

Thursday, 23 March 2000 at 9.05 am, Conference Room No. 4, Ground Floor, Mary Aikenhead Conference Centre, St Vincent's Hospital, Cnr Nicholson and Victoria Sts, Fitzroy, Melbourne

Committee of Presidents of Medical Colleges

Professor Peter Phelan, Immediate Past President

Victorian Government

The Hon John Thwaites MP, Minister for Health
Dr Phyllis Rosendale, Acting Director, Policy Development & Planning Branch, Department of Human Services
Dr Chris Brook, Director, Acute Health, Department of Human Services

Australian Nursing Federation

Ms Jill Iliffe, Federal Secretary
Ms Victoria Gilmore, Federal Professional Officer

Australian Nursing Federation – Victorian Branch

Ms Belinda Morieson, Secretary

Australian College of Health Service Executives

Mrs Mavis Smith, Junior Vice President
Mr James Swinden, Federal Councillor

Barwon Health

Mr Stanley Capp, Chief Executive
Dr John Gallichio, Chief Medical Officer
Mr John Linke, Chief Financial Officer
Ms Jill Linklater, Chief Nursing Officer

National Allied Health Casemix Committee

Mr David Rhodes, Manager
Mr Ian Woodruff, Executive Officer
Mr David Stokes, Psychology Representative

Centre for Health Program Evaluation

Professor Jeff Richardson, Director, Health Economics Unit
Dr Leonie Segal, Deputy Director, Health Economics Unit
Ms Jennifer Watts, Lecturer, Health Economics Unit

Tuesday, 11 April 2000 at 4.05 pm, Senate Committee Room 2S1
Parliament House, Canberra

Professor John Deeble

ACT Government

Mr Michael Moore, MLA, Minister for Health and Community Care
Mr David Butt, Chief Executive
Dr Penny Gregory, Executive Director, Health Outcomes and Service Performance

Catholic Health Australia

Mr Francis Sullivan, Executive Director

Hospitals visited by the Committee during the inquiry:

Monash Medical Centre, Clayton Campus
Princess Alexandra Hospital, Brisbane
Royal Hobart Hospital, Hobart
Sir Charles Gairdner Hospital, Perth
St Vincent's Hospital, Melbourne
St Vincent's Hospital, Sydney
The Prince of Wales Hospital, Sydney
Westmead Hospital, Sydney
Women's and Children's Hospital, Adelaide

Friday, 18 August 2000 at 9.40 am Roundtable Discussion, Senate Committee Room 2S3, Parliament House, Canberra

Mr David Anderson, Manager, Financial Analysis and Purchasing, Acute Health, Department of Human Services, Victoria

Dr Robert Bain, Secretary General, Australian Medical Association

Mr David Borthwick, Deputy Secretary, Commonwealth Department of Health and Aged Care

Dr Chris Brook, Director, Acute Health, Department of Human Services, Victoria

Ms Anne Cahill, National Director, Women's Hospitals Australia and Children's Hospitals Australasia

Ms Christine Charles, Chief Executive, Department of Human Services, South Australia

Mr Mark Cormack, National Director, Australian Healthcare Association

Mr Jim Davidson, Executive Director (Strategic Planning and Policy), Department of Human Services, South Australia

Professor John Deeble

Professor Stephen Duckett, Professor of Health Policy; Dean, Faculty of Health Sciences; and Pro Vice-Chancellor (Health Developments), La Trobe University

Professor John Dwyer, Chairman, Senior Medical Staff Advocacy Committee

Dr David Filby, Deputy Director General, Queensland Health

Mr Ian Forbes, Head of School of Health Services Management, University of New South Wales

Mr Paul Geeves, Manager, Intergovernment Relations Divisional Support Unit, Department of Health and Human Services, Tasmania

Ms Victoria Gilmore, Federal Professional Officer, Australian Nursing Federation

Dr Penny Gregory, Chief Executive, Department of Health and Community Care, Australian Capital Territory

Mr Paul Gross, Director, Institute of Health Economics and Technology Assessment, Australia and France

Professor Jane Hall, Director, Centre for Health Economics Research and Evaluation, University of Sydney

Mr Denis Jones, Assistant Federal Secretary, Australian Nursing Federation

Professor Stephen Leeder., Dean, Faculty of Medicine, University of Sydney

Dr Richard Madden, Director, Australian Institute of Health and Welfare

Mr Andrew Matthews, Federal Councillor, Society of Hospital Pharmacists of Australia

Mr Charles Maskell-Knight, Assistant Secretary, Financing and Analysis Branch, Commonwealth Department of Health and Aged Care

Dr Kerryn Phelps, President, Australian Medical Association

Mr Michael Reid, Director General, New South Wales Health

Mr Russell Schneider, Chief Executive Officer, Australian Health Insurance Association

Dr Leonie Segal, Deputy Director, Health Economics Unit, Monash University

Dr Tim Smyth, Fellow, Australian College of Health Service Executives

Professor Nip Thomson, Professor of Medicine, Head, Central and Eastern Clinical School, Monash University

Professor Les White, President, Children’s Hospitals Australasia

Monday, 20 November 2000 at 10.30 am Roundtable Discussion II, Senate Committee Room 2S3, Parliament House, Canberra

Ms Yvonne Allinson, Executive Director, The Society of Hospital Pharmacists of Australia

Professor Lesley Barclay, Director and Professor, Centre for Family Health and Midwifery, Faculty of Nursing, Midwifery and Health, UTS

Mr Matthew Blackmore, Executive Director, Consumers Health Forum of Australia

Mr David Borthwick, Deputy Secretary, Commonwealth Department of Health and Aged Care

Dr Jeffrey Braithwaite, Director of Graduate Management Programs, University of New South Wales

Dr Christopher Brook, Director, Acute Health, Department of Human Services, Victoria

Mr Mark Cormack, National Director, Australian Healthcare Association

Ms Marita Cowie, Chief Executive Officer, Australian College of Rural and Remote Medicine

Ms Kerrie Cross, Regional Chief Executive Officer, Sisters of Charity Health Service Melbourne, Catholic Health Australia

Mr Jim Davidson, Executive Director, Strategic Planning and Policy Division, Department of Human Services, South Australia

Professor John Deeble

Dr Martin Dooland, Chief Executive, Dental Health Services Victoria

Professor John Dwyer, AO, Professor of Medicine, University of New South Wales and Clinical Director, Prince of Wales Hospital

Associate Professor Judith Dwyer, Representative, Public Health Association of Australia

Dr David Filby, Deputy Director-General, Queensland Health

Mr Gordon Gregory, Executive Director, National Rural Health Alliance

Dr Penny Gregory, Chief Executive, Australian Capital Territory Department of Health and Community Care

Mr Denis Jones, Assistant Federal Secretary, Australian Nursing Federation

Ms Maria Kelly, Representative, Management Committee, New South Wales Therapeutic Assessment Group

Mr William Lawrence, National Director, Australian College of Health Service Executives

Dr Bernd Lorenzen, Vice Chairman, College Council, Royal Australian College of General Practitioners

Dr Richard Madden, Director, Australian Institute of Health and Welfare

Mr Louis McCallum, Chairperson, Consumers Health Forum of Australia Inc

Ms Fiona McKinnon, National President, Australian Physiotherapy Association

Ms Terry Melocco, Representative, Management Committee, New South Wales Therapeutic Assessment Group

Mr Craig Patterson, Director, Health Policy Unit, Royal Australasian College of Physicians

Dr Kerryn Phelps, President, Australian Medical Association

Associate Professor Debora Picone, Deputy Director General - Policy,
New South Wales Department of Health

Professor Jeff Richardson, Professor and Director, Health Economics Unit, Monash University

Professor Don Roberton, Executive, Paediatrics and Child Health Division, Royal Australasian College of Physicians

Mr Russell Schneider, Chief Executive Officer, Australian Health Insurance Association Ltd

Professor Richard Scotton, Honorary Professorial Fellow, Centre for Health Program Evaluation, Faculty of Business and Economics, Monash University

Dr Leonie Segal, Deputy Director, Health Economics Unit, Centre for Health Program Evaluation, Monash University

Professor Peter Smith, Stevenson Professor and Head, Department of Paediatrics, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne

Professor Napier Thomson, Professor of Medicine and Head, Central and Eastern Clinical School, Faculty of Medicine, Nursing and Health Sciences, Monash University

Ms Sally Tracy, Senior Research Midwife, Centre for Family Health and Midwifery, Faculty of Nursing Midwifery and Health, UTS

APPENDIX 3

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