ACHR

AUSTRALIAN CENTRE FOR HEALTH RESEARCH

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REPORT INTO THE OPERATION

AND

FUTURE OF

THE AUSTRALIAN HEALTHCARE AGREEMENTS

AND

THE FUNDING OF PUBLIC HOSPITALS

Special Note: The objective of the Australian Centre For Health Research Limited (ACHR) is to undertake activities aimed at improving the provision of health and ageing services in Australia. To this end, the ACHR commissions independent research on topics of importance in health and ageing, in order to stimulate further exploration of areas of shared concern. The presentation of factual matters, and the ideas and conclusions expressed in the independent research reflect the views of the author of that research, and do not necessarily represent all of the views of ACHR or its individual officers.

ACKNOWLEDGEMENTS

In preparing this report a large number of people, who are either part of or associated with the Australian and international health sectors, have been prepared to provide information, data and comment.

In particular, we acknowledge the contribution of senior officials in a number of federal and States' departments within Australia, the U.K, New Zealand and Canada who spent a considerable amount of time and effort in locating data and providing information. As a number of the Australian officials, are or will be, involved with the Australian Healthcare Agreement (AHCA) negotiations, or will be preparing advice for other parts of government that have an interest in the outcomes of those negotiations, the data, information and comment was provided on the strict understanding that it was on a non attributable basis.

We also had discussions with former federal and States' Health Ministers, Treasurers and several Ministers from portfolios that have an interest in the outcome of the negotiations of the AHCAs. The former Ministers came from both major political parties.

A similar approach was adopted with the private hospital and private health insurance sectors. A large number of people across the private hospitals and the health insurance companies willingly assisted us by providing information and comment.

Likewise, with individual hospitals and universities we consulted senior academics and healthcare practitioners involved in teaching, delivery of clinical services, hospital administration and healthcare in general.

In all cases, time was a constraint and, in some cases, senior officials at both a federal and a State level were reluctant about providing data that might be published prior to official release.

It is relevant to comment that none of the former Ministers nor the overwhelming majority of the officials consulted believe that the process associated with the negotiation of the AHCAs, and the management of the Agreements during their period of operation, deliver the most effective outcomes and moreover, their view is that the Agreements are not likely to deal with the enormous challenges that face the health sector over the next 25 years.

We also acknowledge members of the ACHR Board who peer reviewed the draft report. They were candid in their commentary and that was appreciated. At no stage has there been any attempt to intervene in the preparation and writing of the report or the recommendations that have been made as a result of our investigations. The Hon. Neil Batt A.O., the Executive Director of the ACHR has been very supportive during the course of the preparation of this report.

At the end of the report is a detailed bibliography of much of the published source material that was either used or consulted.

K.P. Baxter
Chairman
TFG International Pty Ltd

Sydney
29 February 2008

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AUSTRALIAN CENTRE FOR HEALTH RESEARCH

REPORT INTO THE OPERATION AND FUTURE OF THE AUSTRALIAN HEALTHCARE AGREEMENTS

EXECUTIVE SUMMARY

The arrangements between the federal government **(federal government)** and the State and Territory Governments **(States)** for the funding of public hospitals in Australia are set out in what are known as Australian Healthcare Agreements (**AHCA**s). The AHCAs formalise an arrangement where the federal government contributes funding to the States for running public hospitals.

Public hospitals are an important part of the overall Australian health sector. There has been and there continues to be serious problems with individual public hospitals and the administrative and financial systems that support them. However, all the available data suggests that public hospitals, which are a large part of the Australian health system, provide a consistently high standard of preventative and curative healthcare relative to other countries belonging to the Organisation for Economic Cooperation and Development **(OECD)**.

The cost of maintaining the health system at its current high standard is becoming prohibitive. This will continue to be the case. In short, if there is not major structural change, Australia will not be able to afford a health system at the current standard.

This problem is, in part, due to our ageing population and the exponentially increasing demands for capital and recurrent funding by the health system.

Health is but one of the many competing budgetary outlays. Health simply cannot consume a greater and greater percentage of recurrent and capital budget outlays.

The obvious answer to this dilemma is that structural change and a change of approach is required - now.

In brief, one of the most essential contributions required is to place a far greater emphasis on personal lifestyle and wellbeing (preventative care), and keeping people out of hospitals.

Preventative healthcare is an admirable primary objective, but for a wide variety of reasons there will be a continuing demand for acute, sub-acute and chronic healthcare institutions and the services they provide.

Under the principle of universal access, which underpins the Australian health system, public hospitals will continue to play a very important part, not only for patient care but also for training medical professionals and hospital administrators, as well as for medical research. In the last mentioned role, public hospitals have a continuing relationship with universities and sections of the private sector that are involved with health and play an important role in medical research.

This Report is aimed at encouraging serious debate about how best the AHCAs, or their successors, can contribute positively to continuing to promote healthy lifestyles, to delivering the high standards of healthcare, and to training medical professionals consistent with the Nation's capacity and willingness to provide funding.

In this respect, the Report contains 18 recommendations as follows:

1. **That there should be a continuing public education campaign by the federal government to explain to Australians the costs associated with funding the health system, and the revenues, either from levies and/or taxes and fees that will be needed to fund it;**
2. **That as a short to medium term goal, the federal government takes full responsibility for funding public hospital services. It further recommends that the funding be provided to Area Health Services and that those bodies account directly to the federal government for their performance;**
3. **That deficiencies in data collection, collation and analysis re public hospital performance, must be addressed in the forthcoming AHCA negotiations. In addition, it must be made clear why particular data is being collected.**

   Establishing the parameters for the introduction of a comprehensive data-collection mechanism on individual patient health should also be addressed during the negotiations;

4. **That the federal government provide specific purpose grants to the States to bring their IT systems and analytical processes up to a standard that enables all States' systems to collect consistent data for analysis and publication in the short run, and seeks specific recommendations from the National Health & Hospitals Commission (NH&HC) about rectifying medium to long term IT and MI systems;**
5. **That the federal government and the States should take note of the recommendations of the report prepared by Insight Economics Deloitte entitled 'Evaluating health outcomes in Australia's healthcare system – A Scoping Study of potential methods and new approaches', dated June 2007;**

6. **That as a means of relieving pressure on Casualty/Emergency wards, and to enable non-acute cases to receive more timely attention, encouragement for the establishment of extended hours, bulk-billing G.P clinics close to public hospitals should be provided in the AHCAs.**

   Where clinics are not able to be established within the hospital precinct, financial incentives, possibly in the form of enhanced amortisation and depreciation rates, should be provided.

   G.Ps who staff these clinics should be reimbursed by Medicare for the services they provide at an enhanced rate;

7. **That the AHCAs should require the federal and State governments to promote, by legislation if necessary, a range of measures addressing public health problems in the community. In this way, governments reinforce their dual role in health of encouraging a healthy Nation as much as treating those who are unwell;**

8. **That the AHCAs should reinforce the message about the provision of generic drugs as a means of keeping control over costs involved with the Pharmaceutical Benefits Scheme (PBS). This should involve performance measures to hold a set range of bulk purchases of drugs, prostheses etc, and to maximise the use of bulk buying to reduce costs;**

9. **That the 2008-2013 AHCAs should provide for:**

   (i) Data to be collected on the costs of, and activities undertaken by, all bureaucracies administering health services, and the agreement upon benchmarks for the extent of these bureaucracies with one of the performance criteria being that overhead administration costs have to be lower than a predetermined proportion of total public hospital expenditure;

   (ii) Allocation of the 'overheads' involved in the various levels of bureaucracy, which vary quite considerably between the States, in the hospital system;

   (iii) 'Whole-of-life-of-asset' costing for both individual hospitals and the public hospital system in each State;

   (iv) Disclosure of actual and contingent liabilities that exist for every public hospital in the country and for the health systems in each of the States;

   (v) Development of risk management and risk mitigation plans for the public hospital system and for each hospital in the system; and

   (vi) Transparent reporting of performance;

10. **That the 2008-2013 AHCAs should:**

    (i) Require each State to establish and maintain an up-to-date asset register of all public hospitals and directly related property assets, with priority being given to major public hospital assets;

    (ii) Require each State to undertake an audit of the usage and state of repair of all public hospital assets and directly related property assets; and

(iii) **Consider providing incentives to the States to ensure all public hospitals are put into an appropriate state of repair within a defined period. In some individual cases, for clinical and financial reasons, it might be preferable to close a hospital and build a new one;**

11. **That to improve public hospital services in the short, medium and long term, the following initiatives should be undertaken, with an appropriate starting point being to include them in negotiations for the 2008-2013 AHCAs:**

    (i) **Increase remuneration of doctors and other health professionals in Casualty/Emergency wards, as well as that of G.Ps staffing 'co-located' or 'super clinics', which provide for substantial out-of-hours services;**

    (ii) **Free up the issuing of Provider Numbers as part of increasing the overall supply of doctors;**

    (iii) **Continue to admit adequately trained overseas doctors in to Australia and allow inclusion to the Medicare Provider Number system;**

    (iv) **Concomitantly, in conjunction with the universities, increase the number of undergraduate admissions to medical schools and to allied health professionals training courses; and**

    (v) **Ensure that merit is the only criterion for admission to specialist colleges and address the issues which cause high dropout rates from these colleges;**

12. **That the remuneration of medical practitioners and allied health professionals be considered and, if necessary, remuneration levels be increased with performance criteria introduced. While not an issue which is central to the renegotiation of the AHCAs, it is an issue that will significantly influence the ability of hospital operators to reduce pressures on the public hospitals system, especially in Casualty/Emergency wards. It should therefore be raised in the discussion surrounding the renegotiation of the AHCAs and the funding of public hospitals (as well as in relation to private health insurance premiums);**

13. **That the AHCAs should clarify the lines of responsibility and accountability for funding of public hospitals and healthcare programs and, where obvious market failures appear, they should be dealt with by improving the ability of hospitals to maximise the utilisation of beds at the marginal cost;**

14. **That in the event the AHCAs continue over the next 10 years, part of the funding arrangements should include providing incentives to move sub-acute, chronic and geriatric care patients into facilities suitable for their conditions, thereby freeing up beds and practitioners for acute care in public hospitals, and for the Federal government to assume responsibility for aged care;**

15. **That the dual responsibilities for public hospital funding should be eliminated. In the event where they are not, specific measures to accurately identify and control cost shifting should be introduced, however they should not be seen as an end on their own, but rather as a part of overall improvements in the data collection system by the federal**

government and the States. Any initiatives introduced should also bear in mind that the primary objective of the health system is improved patient care;

16. **That all levels of government should encourage the introduction of further flexibility in setting the level of private health insurance premiums. In particular, the introduction of premium rebates or bonuses for healthy lifestyles should be encouraged. This should be promoted as a part of the fundamental goal of encouraging the population to take responsibility for their own wellbeing.**

17. **That high priority should be given to introducing a simple system which informs all patients about the costs of health services provided to them.**

18. **That in the event that the NH&HC does not extend beyond mid 2009 when it presents its final plan to the federal government, serious consideration should be given to the establishment of a National Foundation for Strategic Health Policy Research, which was presented to the former government in April 2006 but rejected.**

PREFACE

This Report on the possible policy and funding changes to be considered by the federal government and the States when renegotiating the 2008-2013 AHCAs was initiated and funded by the Australian Centre for Health Research **(ACHR)**.

Two of TFG International Pty Ltd's Directors have been involved with negotiating previous AHCAs with the federal government on behalf of the States, and other Directors have had relevant experience.

In undertaking the research, the ACHR placed no preconditions in relation to the conclusions that might be reached. The objective was to analyse and assess the performance of previous AHCAs and make recommendations in relation to improvements that might be made to the forthcoming AHCAs and to the implementation of those improvements.

The terms of reference provided by the ACHR were:

1. To examine the degree of duplication between the federal government and the States in the provision and funding of health services, cost shifting between the States and the federal government, and between recurrent and capital expenditure within the States;
2. To examine the capacity of future generations to afford to fund healthcare at the current or higher standards;
3. To assess the appropriateness of the current structure of the federal government and States funding arrangements (AHCAs);
4. To assess the possible replacements or modifications to the current AHCAs;
5. To assess the process of measuring performance and renegotiating the AHCAs to assess if they are the most effective way to fund public hospitals;
6. To assess the possibility of introducing incentives to make positive changes to the public hospital system;
7. To determine whether there are models or lessons that can be drawn from international experiences that would enable Australia to improve performance and restrain cost increases; and
8. To assess the factions in the healthcare sector and Government that would mitigate against reform.

Following the federal election in November 2007 and the subsequent change of government, the entire health system has become the subject of widespread public interest and political activity. In that context, it became desirable to encompass some issues that are outside the

strict terms of reference but have relevance to the main issues of providing equal access and running a successful public hospital system. Thus, parts of the Report stray into other sections of the health system which do not directly involve public hospitals and which themselves require considerable research and analysis.

During the course of this Report's preparation, both major political parties went down the track of proposing direct intervention with State owned and run public hospitals.

The new Labor **(ALP)** Government has already announced that it plans major changes to the current system of Specific Purpose Payments **(SPPs)** to the States. In relation to health and public hospitals in particular, it has said it is prepared to make a one-off grant to secure prompt action in the area of waiting lists for components of elective surgery. The amount allocated is $150 million spread over all the States and, while it is obviously a positive first step, it is very small in the overall scheme of things. It will set performance criteria for the States public hospital systems and, if those criteria are not met, will actively intervene.

The details of the new arrangements are still to be worked out between the federal government and the States. While there is a stated high degree of cooperation between the two tiers of government, there may well be serious and prolonged debate about the details of any new system - it will be a case of the 'devil is in the detail'. If this happens, the federal Government may consider the option of either a 12 month extension of the 2003-2008 AHCAs, or their abandonment and replacement with a new funding structure.

This Report concludes that there are major changes needed if the standards of Australian healthcare are to be maintained at amongst the best in the world and at the same time providing affordable access to all Australian taxpayers.

The Australian government's expenditure on public health, public hospitals and a range of related programs has steadily climbed to 7.3% of Gross Domestic Product **(GDP)** and is estimated in the federal government Treasury's intergenerational statements to climb steadily over the next two decades. The OECD has reached similar conclusions.

Additionally, with an ageing population and the demand by the community to maintain high standards of healthcare, the overall cost of government and private sector spending on healthcare could reach over 20% of GDP by 2025. This reinforces the point that unless major

changes are made or alternative means of funding are found, Australians will not be able to afford the system as it is at present – it will simply be unaffordable.

This Report reaches a view based on history that it is politically and administratively unlikely that the States' governments would agree to totally dismembering the current AHCAs. However, there is a wide range of matters that urgently need serious consideration by governments, patients and healthcare professionals. This Report deals with some of those matters and offers options for change and improvement.

The health sector has accumulated vast tomes of literature and commentary on what is wrong with the system and what needs to be done. Vested interests in parts of the health sector have staunchly resisted change and it would be naïve to believe that these attitudes will change quickly.

The new ALP government, prior to the federal election, specifically raised the issue of major changes in the health sector and thus it could be justifiably argued that it has a mandate for change. There is a public perception that the federal government will move quickly to 'fix the health system' – whatever that might mean.

The States have recognised that there are serious deficiencies in the administration of their health bureaucracies and public hospitals that need to be rectified. Hopefully this will be done on the basis of sensible long term policy decisions, not just asking the federal government for more dollops of money and hoping that ad-hoc, short term measures will fix long term problems. History has amply demonstrated that this is not the case.

An objective of this Report is to encourage greater debate about the funding of public hospitals and related services. It also aims to elicit more independent analysis as to the best ways in which to provide an Australian healthcare system that is world class, sustainable and will not be an unaffordable burden on future generations.

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1. SETTING THE SCENE

1.1 General

The current AHCAs expire on 30 June 2008. Before then, in the normal course of events, there will be negotiations between the federal government and the States regarding the terms and conditions of the AHCAs for the period from 1 July 2008 to 30 June 2013. Since the change in federal government, there have been discussions between the federal and States' Health Ministers. The implication is that there will be new Agreements for 2008-2013 but no formal announcement has been reached as yet.

Two relevant things have occurred since:

- An announcement was made about the allocation of $150 million by the federal government to the States to help reduce waiting lists for elective surgery; and

- On 20 December 2007, a meeting of the Council of Australian Governments **(COAG)** took place. The COAG Communiqué refers to the established National Health and Hospitals Reform Commission, which is to provide "advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term," and goes on to say that "by April 2008, the Commission will provide advice on the framework for the next AHCAs[1]."

On this basis it would appear likely that there will be 2008-2013 AHCAs.

1.2 What the Agreements are about

The AHCAs provide that the federal government will contribute to the cost of States' public hospital services in accordance with a formula spelt out in the Agreements. In return for this contribution, the States take responsibility for the provision of public hospital services to eligible persons and agree to contribute, from their own sources, matching funding such that the cumulative rate of growth of funding by the States at least matches the cumulative rate of growth of funding provided by the federal government. The States are required to report to the federal government on their financial contributions.

[1]Council of Australian Government's Communiqué – 20 December 2007

The States are also required to provide performance information against agreed indicators set out in the Agreements. This includes data on public and private hospital utilisation, including data on all items in the admitted patient care national minimum data set, elective surgery waiting times and emergency department waiting times. If such information is not provided, or if the States do not provide matching funding, the Agreements contain provisions that enable the federal government to withhold funding.

There is an AHCA between the federal government and each State. There are core provisions in each Agreement and in each case there are some particular provisions dealing with special circumstances (eg Torres Strait Islander and Papua New Guinea **(PNG)** access to the Queensland health system).

There has always been vigorous debate between the federal government and the States before the terms of prior AHCAs have been finalised. This is no less likely to occur this round, notwithstanding the fact that the federal government and all the States are controlled by the ALP and that the federal government has announced a new co-operative, consultative approach to Federal government-States relationships.

1.3 2003-2008 AHCAs

The 2003-2008 AHCAs were the third round of such Agreements.

The principal objective of the 2003-2008 AHCAs was to secure access for the community to public hospitals, based on the following principles[2]:

(i) eligible persons are to be given the choice to receive health and emergency services free of charge as public patients of the kind that are currently provided by public hospitals,

(ii) access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate time, and

(iii) arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of geographic location.

Other objectives of the 2003-2008 AHCAs were to:

[2] Clause 13 : Agreed Principles, 1998-2003 Australian Healthcare Agreement

(i) improve the transparency of the federal government's and the States' financial contributions to public hospital services,

(ii) improve the quality and timeliness of information available to the public to enable the performance of public hospital services to be assessed,

(iii) improve the focus of public hospital services on safety, quality and improved patient outcomes, and

(iv) improve the efficiency and effectiveness of public hospital services.

Further objectives included an improved focus on mental health services, the transition from hospital to home project, and improvement of the provision of palliative care services.

1.4 What should be the fundamental objectives of the 2008-2013 AHCAs?

The major objectives of the federal government and the States when renegotiating the AHCAs should be:

(i) to maintain the health and wellbeing of all Australians,

(ii) to provide equal access to all Australians to a high standard health system in the event of curative care being required; and

(iii) to regard the health system as an integrated whole and not in its component parts. Thus there should be an ability to move seamlessly through all stages of the health system.

Our view is that major changes are required in the funding and operation of the Australian health system. There also needs to be far greater encouragement for individuals to accept more responsibility for the level of their personal wellbeing.

While some commentators are suggesting that there should be a 'greenfields' approach to renegotiating the 2008-2013 AHCAs, this is unlikely to be practicable. Any changes are likely to be made within the framework of the current system and are likely to be incremental. This is, at least in part, because of the limited institutional capacity to make massive changes without simultaneously causing major disruption to services.

The Agreements are likely to be renegotiated early in the first term of the new federal government and they are likely to incorporate the government's election commitments. The

COAG Communiqué of 20 December 2007 identifies these commitments and lays down three stages of action.

The first is the "federal government/State Implementation Plans" to be delivered to the March 2008 COAG meeting, which will cover:

(i) tackling elective surgery waiting times;

(ii) investing in aged care, especially in transition care;

(iii) investing in public dental programs;

(iv) preventative healthcare;

(v) G.P. 'super clinics'.

The second is that "by April 2008, the National Health and Hospitals Reform Commission **(Commission)** will provide advice on the framework for the next AHCAs, including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of healthcare."

The third is that "by June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system, addressing the need to:

(i) reduce inefficiencies generated by cost shifting, blame-shifting and buck-passing;

(ii) better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;

(iii) bring a greater focus on prevention to the health system;

(iv) better integrate acute services and aged care services, and improve the transition between hospital and aged care;

(v) improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;

(vi) improve the provision of health services in rural areas;

(vii) improve Indigenous health outcomes; and

(viii) provide a well qualified and sustainable health workforce into the future."

This Report considers that the key objectives of the 2008-2013 AHCAs should be:

(i) to implement programs whose outcomes will maintain the wellbeing of all Australians and diminish the need for them to enter the hospital system,

(ii) to devise and implement other policies which will relieve pressure on the public hospital system by keeping people out of hospitals,

(iii) to acknowledge the budgetary pressures involved with funding the health system and establish measures which will address these pressures,

(iv) to devise a system of funding which sends clear signals about the costs of providing hospital care and ensures that patients and funders get value for money,

(v) to recognise the role of private healthcare and leverage it to relieve the pressures on the public hospital system,

(vi) to support policies and options which will encourage individuals to take greater responsibility for their own health,

(vii) to improve the collection, analysis and review of data, thereby enabling the performance of the health system to be monitored effectively and for there to be prompt, accurate responses to changing demands for programs and services,

(viii) if the life of the recently established **NH&HC** is only two years (i.e. to mid 2009 when it delivers its final report), the federal government should seriously consider supporting and contributing funds to an independent, highly credible research institute whose prime objective is to encourage and promote high level policy research into the future of the health sector and the funding of health services over the next 50 years.

This recommendation has a precedent in the Australian Strategic Policy Institute which is a non-partisan policy institute. Its aim is to help Australians understand the critical strategic choices that Australians will face in the future and to help the governments make better decisions in relation to Defence.

As governments spending on health exceeds that of spending on Defence, there is a strong argument for a similar policy institute; and

(ix) to ensure the system of data collection, analysis and review is consistent between the federal government and the States.

2. THE HEALTH BUDGET

2.1 The present

The cost of healthcare is increasing. Government (federal and State) spending as a proportion of the GDP is shown in the tables[3] below.

(i) Public health sector:-

Year	GDP
1966	2.1%
1976	4.7%
1986	5.2%
1995	5.3%
2000	6.0%
2004	6.4%

(ii) Combined public and private health sectors:-

Year	GDP
1966	4.2%
1976	7.0%
1986	7.4%
1995	8.0%
2000	8.8%
2004	9.5%

[3] OECD Health Data 2007
It should be noted that in spite of the large volume of statistics and other data about the federal and States' Governments spending on health and hospitals and other parts of the health sector, much of it is extrapolated from official and other statistics. Similarly with data from other countries and comparative benchmarking figures prepared by bodies such as the OECD and our conclusion is that there is no set of figures that is absolutely correct and that consistent, comparable figures are not easily verified. However, from the vast array of figures, it is clear that the trend in governments and private sector spending on hospitals and in the health sector is increasing as a proportion of GDP.

A comparison of statistics released by the OECD leads to the conclusion that the health spend by Australia's government is within acceptable parameters for an OECD member country. However, the spend by governments does not tell the full story.

While many stakeholders incur costs directly, a significant proportion of total costs are met by those other than the recipients of the services. The composition of overall percentage of Australia's GDP spent on health is explained below.

2.1.1 *Costs incurred directly by patients*

These are costs in addition to any funding provided by the federal and/or States' Governments.

- Costs incurred on:

  (i) The PBS – where PBS does not provide the full cost of pharmaceutical products and the patient picks up the difference in cost.

  (ii) Medicare and related arrangements, private health insurance costs and doctors' fees:

  – The increasing 'gap' (where doctors do not bulk bill) between the cost of a G.P./specialist visit and the Medicare contribution. Statistics show that, nationally 76.6% of services are bulk billed while in New South Wales 82.4% of services are bulk-billed.

  – The cost of private health cover, which is increasing at a rate faster than the rate of inflation.

  – The cost of allied medical services and diagnostics.

- Taxation and related measures, including:-

  (i) The Medicare levy, which is imposed at a fixed percentage (1.5%) of taxable income, is met generally by taxpayers whose taxable incomes exceed $17,005 (1 January 2007 figure),

  (ii) The Medicare surcharge, which is imposed, where no private health insurance is held, at the rate of 1.0% of taxable income and is payable beyond thresholds which have not changed since it was introduced. The basic thresholds are taxable incomes

of $50,000 for a single person and $100,000 for the combined taxable incomes of a taxpayer and his/her spouse,

(iii) The thresholds for the Medicare safety net and the income tax rebate for medical expenses, which have increased over time, thereby increasing the cost to the patient.

Although the absolute amounts collected by the levies are increasing as taxable incomes increase, the combination of the Medicare levy and the tax surcharge go nowhere near meeting the federal government's financial funding of healthcare.

2.1.2 *Government incurred costs*

Government incurred costs are incurred mainly, but not entirely, at the federal level They include:

(i) contributions to the costs of running public hospitals via the AHCAs;

(ii) Medicare reimbursements (these are rising – although not at the rate of general inflation and certainly not at the rate of health sector inflation, which is rising at a rate higher than the Consumer Price Index **(CPI)**);

(iii) the PBS;

(iv) the private health insurance rebate;

(v) the Medicare safety net and the income tax rebate; and

(vi) the bureaucracies at federal, State and local government levels via appropriations.

2.1.3 Indirect costs

Indirect costs, which can be justifiably included in the overall percentage of GDP spent on health, include the costs of professional indemnity insurance incurred by medical practitioners and the costs of training future doctors and other health professionals in universities and colleges.

2.2 The future

Given Australia's ageing population and other factors, Australia's health bill as a percentage of GDP is certain to continually increase. As noted, it has risen as a percentage of GDP from

8.0% in 1995 to 9.5% in 2005. This compares with an OECD weighted average increase from 7.5% (1995) to 11.1% (2005).

The recent federal government Budgets[4] have specifically referred to the impact of ageing. The federal government estimates that by 2046-2047, federal government spending alone will be 7.3% of GDP. Expenditure by the States on health is about half that of the federal government, while expenditure by the private sector is about equal to the combined expenditure of governments. This means that, based on present trends, overall health spending by the public and private sectors by 2046-2047 will be about 20-21% of GDP.

A wide range of academic and professional papers have projected the financial and operational consequences of an ageing population and most reach the view that the current costs of health services cannot be maintained at the current proportions of GDP without major changes.

A logical conclusion from these trends is that in the medium to long term there will need to be greater integration between public and private hospital's acute care services and aged care and related ancillary services.

There are, however, other reasons why the country's health spend will continue to increase. Market pressures on remuneration for health sector professionals and employees, higher costs for a wide range of modern technology in the health sector, higher costs of educating and training medical professionals and allied health professionals, together with community expectations about the range and standards of healthcare, all dictate that as a proportion of GDP, healthcare costs, without significant change, will continue to rise.

One of the issues that must be confronted is whether the voting public will accept that a rising percentage of GDP will have to be spent on healthcare, and the likely reactions of the federal and States' governments. It is our view that the Australian community would never accept governments saying that they should accept a lower level of healthcare. It would, in our view, be politically suicidal for a federal or State government to propose that because of funding constraints, voters should accept a drop in the range and standard of health services.

[4] See Federal government Budget p.49 2007 Intergenerational Statement

Increasing the percentage of general tax revenue (noting that the Medicare levy and Medicare levy surcharge fund only a small part of the overall health budget) applied to the provision of healthcare services would potentially increase pressure on the federal government to:

(i) reduce the rate of increase of payments to the States for hospitals; or

(ii) increase taxation, possibly by increasing the Medicare levy/surcharge, to meet increasing health costs; or

(iii) shift allocations away from other sectors; or

(iv) spend more on preventative health programs; or

(v) further encourage the expansion of a user pays system and the increased take up of private health insurance; or

(vi) a combination of all of the above.

In the case of (iv), increased expenditure should result in medium to long term reductions in overall expenditure.

2.3 What do we get for our expenditure?

While international comparisons are fraught with incompatible data, available evidence shows that the Australian health system delivers a satisfactory overall health outcome. Statistics about life expectancies, infant mortality (with the notable exception of indigenous infant mortality), deaths from cancer and from cardiovascular disease, all suggest that the Australian health system delivers a result that is in the top quartile of performance of OECD countries.

In light of recent controversies about the performance, or lack of it, in parts of the hospital system, it should be pointed out that in a system as large as the Australian health sector it is highly likely that there will be institutions and individuals whose performance is below acceptable benchmarks.

3. OUR PUBLIC HOSPITALS

3.1 Relevant features of Australia's public hospitals

A snap-shot of Australia's public hospitals provides the following picture:

(i) They treat 61% of all patients and 90% of emergencies;

(ii) Emergency or casualty[5] services are provided at no cost to the patient, including where the patient has private health cover;

(iii) Privately insured patients who use the public system in non-emergencies (including to undergo surgery) often do not disclose the fact that they have private health insurance and are therefore treated without charge. It is the choice of the patient whether they are treated as a privately insured patient or as a public patient. Where they are treated as a privately insured patient, the public hospital is able to claim from the private health fund. This is consistent with the fundamental principle that a privately insured patient is able to receive treatment, free of charge, in a public hospital;

(iv) In regional and rural areas, public hospital facilities may be used by privately insured patients because private hospitals are not available;

(v) Public hospitals periodically receive bad publicity because of "queues" for elective surgery and the time it takes to receive treatment in emergency wards. The recent cases at Royal North Shore Hospital in Sydney are examples;

(vi) The reduction of waiting lists has been the subject of promises made in State election campaigns and the newly elected federal government has committed $150 million to reduce the "queues" in public hospitals for elective surgery of patients who have not received treatment within a clinically appropriate period. The focus is to be on elective surgery with the highest morbidity risk;

(vii) Over the last decade, waiting lists have been 'managed' in an attempt to maximise bed occupancy in individual hospitals, as well as to deal with budget cuts and reductions in bed numbers;

(viii) There is a shortage of skilled health professionals, especially nurses. In some cases, the shortage of nurses, especially trained theatre nurses, can be a greater constraint than the shortage of doctors in providing the acute care services, which are the primary function of the public hospitals;

[5] Note: The definition of 'casualty' and 'emergency' varies between the States. The terms are interchangeable and refer to the first stage of a person's presentation at a hospital for assessment and possible admission.

(ix) Australia's geography makes it difficult to provide in remote areas the breadth of services at the standards that apply in cities and major regional areas;

(x) Public hospitals often have ageing infrastructure, which lead to inefficiencies. In some instances, public hospitals in some States have been reported as not meeting Occupational Health and Safety Regulations or Fire Regulations or both;

(xi) Public hospitals are open 24 hours a day, 365 days a year, however wards or beds will be 'closed' during periods of low demand;

(xii) Most major public hospitals in capital cities are concentrated relatively close to the city centre. This results from them having been built many decades ago and, in some cases, at the end of the 19th Century. Vested interests work to ensure that these hospitals retain their pre-eminence and their close-to-city location. On a per capita basis, the outer suburbs of major cities are usually less well-catered for by major public hospitals. In some cases, the provision of public hospital services in outer metropolitan areas is more lightly spread than in major regional centres;

(xiii) There appears to be an increasing utilisation of beds by patients suffering from sub-acute conditions, particularly those that afflict the ageing. This reduces the number of beds available for acute care patients. This is in part a result of the impact of an ageing population. Moreover, there has been a failure by successive federal governments to make adequate provision for aged care facilities and services. Moving sub-acute care patients into more appropriate facilities would relieve the pressures on public hospitals. The new federal government has announced that COAG will be considering the arrangements for care of the aged and ageing.

3.2 Funding of Public Hospitals

3.2.1 *General*

Funding of public hospitals comes from three main sources - the federal government, the State governments, and non-government sources. Overall in 2005-2006 the expenditures were:

	$Million
Federal Government	10,105
State Governments	12,361

Non-government	1,943
	24,409

In 2005-2006, expenditure by the federal government via the AHCAs amounted to $8.3 billion, while expenditure by the States under the AHCAs amounted to an estimated $10.1 billion.

The non-government revenue sources include payments from private health insurance funds for privately insured patients treated in public hospitals, a relatively small amount of funding from research institutions and universities, payments from medical professionals who use public hospitals for teaching and/or research, and payments from doctors who have rooms in the hospitals.

3.2.2 *AHCA funding*

The method by which funding was provided by the federal government under the 2003-2008 AHCAs involved grants made under an established formula that took account of matters considered by the federal government Grants Commission in allocating GST revenue to the States. The federal government's expenditure (actual or budgeted) for 2004-2005 to 2007-2008 is set out in the table below[6]:-

	$ Million
2004-2005 (actual)	8,000
2005-2006 (actual)	8,300
2006-2007 (budgeted)	8,800
2007-2008 (budgeted)	9,300

Once allocated to the States, it is the States that determine the way in which funding is spent, subject to generally adhering to the fundamental principles of the AHCAs. Payments made by the federal government under the AHCAs are notionally block grants, but in reality they are specifically for public hospitals (and as such, could be treated as SPPs) and the federal government has a contingent prospect of enforcing sanctions and exercising control if the funds are not spent in accordance with the Agreements (see below). Federal Treasurer, the Hon. Wayne Swan, has not indicated if the funding provided under the current AHCAs will

[6] 'Australian Health & Ageing System: The Concise Factbook' – Australian Government, Department of Health and Ageing, October 2007

be part of the overall announced review of SPPs, although statements that have been made indicate health funding will be one of the areas that will be one of the major areas for review.

Under the current AHCAs, if additional funding is required it is generally the States who have to make the additional contributions. While in 2000, the States and the federal government contributed to the funding of public hospitals on roughly a 50:50 basis, by 2005 the ratio was 55% by the States to 45% by the federal government. During this period, the number of admissions to public hospitals grew by 400,000. (Numbers dealt with may actually have been higher because in many instances people presenting at Casualty/Emergency wards are not admitted and records of attendance are not always kept.)

While the percentage supplied by the federal government specifically under the AHCAs has slipped, the overall reimbursements of GST revenue to the States has increased. Also, over the period since 1975 when the federal government started direct public hospital funding, the proportions committed by the federal and States governments has fluctuated.

As adjunct Prof. John Deeble noted[7], "The federal government share was invariably higher at the beginning of the agreement period, lowest at the end, even under the 1988-93 agreements when the federal government significantly underestimated needs. Though slightly lower at the end of the period than at the beginning, it averaged almost 50% throughout".

There are several reasons for the States having to provide additional funds:

(i) the increasing cost of modern medical equipment;

(ii) wage increases to nurses and other hospital staff at above the annual inflation rate without the increases necessarily being related to productivity gains. At a time when the economy is running at (or near) full employment and paramedical and hospital staff are in short supply, maintaining tight control over wages and associated costs is difficult. It is a problem exacerbated by the fact that other OECD countries are experiencing the same pressures and are competing in an international market for nurses; and

[7] 'Funding the Essentials' : the Australian Healthcare Agreements 2003-2008, Australian Health Review [Vo. 25: No. 6] 2002

(iii) the States have also incurred increased costs on additional administrative staff and new IT systems. Over the last decade, it would appear that even on a conservative estimate, over $2 billion has been spent on IT systems throughout the Australian health sector without delivering any real improvements in fundamental comprehensive performance data or standards of service delivery.

4. FUTURE FUNDING ALTERNATIVES

4.1 General

The recently elected federal government has indicated that in response to the well documented problems in the health system, it is prepared to intervene more directly in hospital funding and administration and accept increasing responsibility for healthcare costs. It has announced that it will be determining performance criteria to be met by the States. If they are not met within two years the federal government will intervene directly and take control.

It is also likely that the federal government will increasingly pick up the responsibility for funding areas of the current health system such as aged care, where the current responsibilities and accountabilities are unclear.

With the improvement of transport and the consolidation of hospital groups (public and private) in major regional centres, state borders are becoming increasingly irrelevant. There is a logical argument for a national approach to ensure consistency, especially in operational standards, data collection and financial management throughout Australia.

As a general statement, it is our view that the rationale for allocating monies to the States for further disbursement is disappearing and it would be more effective if the federal government directly funded the public hospital system and introduced consistent performance standards across the country.

This proposition is not likely to be embraced in its entirety at the forthcoming renegotiation of the AHCAs, it should, however, be seen as a medium to long term goal and an initial step towards achieving it should be an aim of these negotiations. Moves in this direction will improve the long term sustainability of the Australian health system.

4.2 Alternative funding mechanisms

This Report concludes that there are good reasons for the federal government to eventually assume greater responsibility for the funding of health and hospital services. If this approach is adopted there would seem to be no need for future AHCAs. However, it is necessary to consider the following matters if we are to determine the entity best able to deliver health services in the future.

4.2.1 *The entity or body best able to deliver the services*

We have considered three options:

(1) federal government funding of public hospitals through payments to the States; or

(2) federal government funding of public hospitals through payments to Area Health Services (AHS) (or similar arrangements) reporting to the federal government; or

(3) federal government funding of public hospitals through direct payment to individual hospitals.

The advantages and disadvantages for each of these alternatives are set out below.

4.2.1.1 *Funding through payments to the States*

Advantages

(i) Public hospitals services delivered by the States are good by international standards with individual hospitals exceptions – therefore why change?

(ii) Funding methods known; and

(iii) Fewer administrative changes would be needed

Disadvantages

(i) Compartmentalises the health system - in that the States would look at hospitals rather than the health system as a whole - and militates against a national health system

(ii) Effectively retains State borders

(iii) Makes it more difficult to collect data on individual hospital performance

(iv) The possibility of sanctions for non-performance would remain - not exercised to date by the federal government under existing AHCAs – why would this change?

(v) Continues possibility of conflict between two levels of government – federal and State

(vi) Entrenches existing vested interests opposed to changes

(vii) Continues duplication of responsibilities between the federal government and the States

4.2.1.2 *Funding through payments to AHS on annual or triennium or longer period*

Advantages

(i) Eliminates the role of the States

(ii) Eliminates a tier of bureaucracy where AHS already exist (eg in New South Wales)

(iii) Closer linkage between the funder and patients

(iv) Enables greater community involvement with governance

(v) Establishes a basis for provision of regional health services not constrained by State borders

(vi) Retains existing teaching and other hospitals in existence

(vii) Does not preclude continued ownership of hospital sites by the States

(viii) Possibility of greater co-operation with private sector hospital and aged care facilities due to the AHS operating over a smaller geographic area

(ix) Easier to establish national health system

(x) Enables transition to a national healthcare system

(xi) Removes the involvement of State politics from public hospital services delivery and lessens marginal seat syndrome with federal seats

Disadvantages

(i) Need to create AHS where they do not exists

(ii) Transition arrangements could be administratively cumbersome

(iii) Federal government likely to adjust GST or other payments to the States to compensate for assuming funding responsibilities

(iv) Shifts further financial control to Canberra

4.2.1.3 *Funding through direct payments to individual hospitals*

Advantages

(i) Reduces significant bureaucracy at State level

(ii) Complements pursuit of overall national system

(iii) Enables the federal government to co-ordinate hospital acute care with aged, sub-acute, geriatric and ancillary care not covered by current AHCAs

(iv) Enables introduction of individual hospital performance indicators

(v) Provides better patient information about hospital performance

(vi) Possibility of better co-operation with private hospitals

(vii) Does not preclude continued State ownership of hospital land and buildings

Disadvantages

(i) Funders-administrators more geographically remote from service deliverers

(ii) Substantial shift to the federal government of State public servants involved in administration and service delivery

(iii) Cultural differences

(iv) Massive transitional task

Although it will be strongly resisted by some of the States, our conclusion is that taking into account the future directions of the structure, funding and operation of the public hospital system (and associated services), the most effective action would be for the federal government to takeover responsibility for the funding of public hospitals and for that funding to be distributed directly through AHS or their equivalent.

4.2.2 *More radical medium to long term options*

One method could involve paying an amount equal to a scheduled Medicare payment for every service provided in a public hospital. To the extent that these payments were inadequate, further funding would be provided either by way of general block grants or targeted payments.

Ultimately, it could also be a transition to a composite method of funding that introduces effective competition between public and private hospitals by having a specific amount of

funding that is provided by the federal government and 'travels' with the patient, regardless of whether the patient is admitted to a public or private hospital.

Such a system may also address rigidities arising in the system from the G.P/specialist being the 'customer' of the hospital. Under this proposal the 'patient' would be the customer, or at least would have a greater involvement with the delivery of their own healthcare. It is quite likely that a change of this kind would elicit strong resistance from elements of the medical profession because it could also result in a shift of power from parts of the medical profession to the funders of the services and the patient.

There are many administrative issues that arise from a change of this type and would have to be fully addressed before it was adopted. It is not suggested that it is a matter that is likely to be addressed at the 2008-2013 AHCA negotiations. However it is a model that should be closely considered in the future, particularly in the context of the reforms which would occur as the federal government takes greater responsibility for the funding responsibilities for the health system.

4.3 The funding dilemma

The Australian federal system creates complexity in funding for hospital based health services. The federal government collects the tax revenues, including the Medicare levy and the surcharge, from which it funds Medicare, the States and other aspects of the health system. Public hospitals receive a significant proportion of these payments and, as a result, the public patient at no stage is in a conventional customer relationship where the service is actually paid for by the recipient. At best, it is a notional transaction.

It is conceivable that many users of the public health system believe that the services are 'free'.

In terms of government social policy, the current system has the distinct disadvantage of not providing any clear signals about the 'cost' of a service. It is also likely that where a service is provided 'free of charge', the recipient does not seriously think about whether or not the service is really required or if it reflects value for money.

The logical conclusion from this proposition is that it reduces and most likely removes the incentive for some individuals to take care of themselves, maintain a healthy lifestyle and minimise the need to visit a G.P, an Emergency Ward or be admitted to hospital.

As will be argued later in this Report, increased spending on effective public health programs is essential. Their efficacy is likely to be greater if price signals are quickly and accurately conveyed to potential users about the costs of providing curative healthcare and diminishing the concept that curative healthcare is 'free'.

One way is to try to develop a system which sends clear signals to users of the services, but does not impose onerous burdens on the disadvantaged. It is essential to at least partially 'empower' the users of G.Ps and public hospitals so that they have a concept of the 'cost of service'.

Recommendation 1
We recommend that there should be a continuing public education campaign by the federal government to explain to Australians the costs associated with funding the health system, and the revenues, either from levies and/or taxes and fees, that will be needed to fund it.

4.3.1 *The federal government funding of public hospitals*

The federal government would provide funds to either the AHS (or their equivalent) and the AHS would account directly to the federal government. The hospitals may continue to be owned by the States and employees continue to be employed under State or federal government awards or arrangements.

In transitional arrangements for States where there are no area or regional health services, the funds would pass through State health departments while area or regional health services are being established (it should be a condition from the federal government that a timetable is set for transfer of functions).

If the federal government and States accept that personal wellbeing is a key priority and that people should be encouraged to stay out of hospitals, the greater transparency of pricing of services, and sending cost signals in conjunction with publishing overall costs, will help achieve that objective.

Recommendation 2
This Report recommends that as a short to medium term goal, the federal government takes full responsibility for funding public hospital services. It further recommends that the funding be provided to AHS and that those bodies account directly to the federal government for their performance.

5. DATA COLLECTION

5.1 The consequences of inadequate data

Comprehensive, accurate data is required for two main reasons. The first relates to the patient – data as to their use of the various elements of the health system is needed if a full picture of their individual health is to be drawn, thereby ensuring as far as possible that they receive appropriate treatment. The second relates to having a full picture of the services provided by public hospitals and their areas of greatest need.

The data and information available is inconsistent, patchy and not readily comparable on a State by State basis. In some cases, both macro and micro data has been found to be unreliable and inconsistent with what is actually happening. In some instances the data obtained has a low degree of reliability. In Australia, data collection and analysis is complicated by the federal system, although attempts have been and continue to be made to collect and compile nationally consistent data.

5.2 Patient data

One benchmark of the health data collection and compilation systems in relation to patient data is that operated by the Japanese - where a single patient identifier code covers an individual in any transaction in the health, hospital and pharmaceuticals part of their life. It also enables more accurate progressive tracking to the Japanese health system, regardless of where patients present themselves. The newly established **NH&HC** should seriously examine the implementation of the Japanese system or something similar.

In Australia, privacy issues, especially vis-à-vis doctor/patient relationships, have been a contentious issue. However, if a person has to receive hospital or other healthcare and the fundamental objective is to keep the patient alive and well, it will be essential to have this information. Thus, there may be a need to compromise in this area.

Progress is being made with e-Health[8] in Australia, but the effectiveness of any electronic health records system depends upon the quality and modernity of the basic data used and the establishment of an 'identifier'.

[8] e-Health is a "national electronic health records system to improve safety for patients and increase efficiency for healthcare providers by developing the capacity for health providers, with their patients' consent, to communicate safely with each other electronically about patients and their health" – 'e-Health newsletter', June 2006, Australian Government, Department of Health and Ageing

5.3 Hospital data

In each of the States, large sums have been spent on IT and data systems to collect information on the services provided by public hospitals and, except for in Victoria, have not produced the results that would have been expected from such a level of expenditure. The estimated spend over the last decade by the States on IT and data collection systems is considerably in excess of A$2 billion.

The federal government has also spent large sums on IT for data collection on the performance of the healthcare system. These funds have been spent to improve the ability to assess the performance of hospitals, medical practitioners and preventative healthcare programs – but the outcomes have not been satisfactory.

The paucity of consistent up-to-date data suggests that much of the IT expenditure has largely been wasted. This view is strengthened by the decision of two States, Western Australia and New South Wales, to substantially overhaul existing IT systems.

The public expects governments to be able to monitor the 'health of the Nation' and to ensure that relevant funding and actions are put in place to further improve the Nation's health. This can only be done if the government has timely, up-to-date and appropriate information.

There is already a mass of data from bodies such as the Australian Institute of Health and Welfare. Much of the data is useful and "vital to understanding the characteristics of Australia's health system".[9] However the data available does not enable a simple, up-to-date comparison of performance within Australia's public hospital system, and comparison with the performance of private hospitals.

At the very least, for reasons related to the prompt and effective allocation of resources, the federal government and the States should collect and analyse individual hospital performance data. The data collected and its analysis should be published. It should be noted that the federal Health Minister is insisting on this as a precaution for providing conditional federal funding.

Accurate performance data would enable policy makers, politicians and media analysts to make considered judgments as to whether or not the highly publicised problems at some New South

[9] Source: 'Health Expenditure Australia' 2005-2006 – The Australian Institute of Health & Welfare

Wales and Queensland hospitals reflect a small number of particular cases due to individuals' poor judgment or bad management of a particular hospital, or are endemic in the system as a whole.

Such data would also enable the federal government, the States, and any other organisation funding hospitals or patients to make informed judgments about the performance of hospitals and the people running them. Some of the private health insurers maintain comprehensive data on the performance of private hospitals and the practitioners and support staff in them.

In the short term it will lead to embarrassment for some hospitals, health bureaucracies and Ministers – this is happening now in a more dramatic and unhelpful way without data being available publicly. In the medium to long term, if it results in improved performance, the political embarrassment will diminish.

Recommendation 3

This Report recommends that deficiencies in data collection, collation and analysis re public hospital performance must be addressed in the forthcoming AHCA negotiations. In addition, it must be made clear why particular data is being collected.

Establishing the parameters for the introduction of a comprehensive data-collection mechanism on patient health should also be addressed at the upcoming AHCA negotiations.

5.4 The present situation under AHCAs re data collection

For a State to qualify for the full level of funding contemplated under the 2003-2008 AHCAs, it is required to meet performance reporting requirements (as well as adhering to the principles of the Agreements including the provision of matching funding).

These performance reporting requirements are set out in detail in clause 6 of schedule C to the 2003-2008 AHCAs. Failure to meet them can, by application of the terms of the Agreements, result in funding for the following year being partially withheld.

Notwithstanding the fact that some of the States have not been able to comply with their obligations re data collection, it is our understanding that the sanction of partially withholding future funds has not been applied by the federal government under the 2003-2008 AHCAs or previous Agreements.

Because the federal government has not exercised the sanctions, no discipline has been put into the current arrangements - a State that did not comply was confident that it would not be penalised. The non-imposition of sanctions for non-compliance was also a disincentive to States who either complied or were attempting to comply.

5.4.1 *Sanctions – the difficulty*

There are undoubtedly many well-founded reasons for not applying the sanctions. It is difficult to envisage the circumstances in which funding would be reduced or withheld by the application of sanctions - politically, it would be very difficult to do.

The adverse political repercussions flowing from the federal government exercising sanctions at a macro level on the States, or at a micro level on an individual hospital, is such that there will not be the political will to penalise an entire system or individual hospital for not meeting the requirements spelt out in an AHCA. This is amply demonstrated by the continuing problems that have arisen over the last decade in some of the States who have not provided agreed data to the federal government, and by the obvious lack of performance of some of the prominent public hospitals in New South Wales and Queensland.

It is our understanding that the federal health bureaucracy, knowing full well the deficiencies of the sanctions, has not strongly advised successive federal Health Ministers to enforce the penalty regime, nor have they strongly recommended a move to an alternative system which would encourage compliance with the data collection and other performance requirements of the AHCAs. It is possible that individual Ministers have discouraged such advice.

It is our view, based on the specific examples of the AHCAs and other areas of federal-State relations, that punitive sanctions are very blunt instruments that do not work. It can be argued that it would not be in the public interest for sanctions to be applied.

5.5 The alternatives to sanctions

Our proposition is that sanctions of the kind in the current Agreements are unlikely to be enforced and alternatives need to be explored. Set out below are possibilities for the Agreements commencing in 2008 or for any funding arrangements that replace those Agreements.

5.5.1 *Incentives rather than sanctions*

The federal government has signalled already that it wants to move away from sanctions and move to a performance based incentive system. The replacement of sanctions/penalties with incentives to encourage innovation and efficiency and the provision of relevant, accurate and timely data would be a positive step.

This might involve the provision of a minimum guaranteed level of funding to an individual State, with the possibility of extra funding being provided following compliance with the requirements under the National Minimum Data Sets **(NMDS)**. The rules could be included in the 2008-2013 AHCAs.

Incentives are almost invariably easier to implement than penalties and may encourage States to spend and manage more effectively to put in place the data collection mechanisms to enable compliance with the NMDS, as well as other operational and financial performance criteria. It could also lead to greater transparency in disclosure of State and individual hospital performance.

5.5.1.1 *The advantages*

On a similar basis to that used under the Competition Policy incentive payment system instituted in the mid 1990s, the 2008-2013 AHCAs could incorporate incentives that result in extra funds flowing to the States as they improve their data collection, analysis and disclosure systems. The States may achieve this by spending more, applying more attention to relevant and up-to-date data collection, along with a range of other operational and financial goals.

5.5.1.2 *The disadvantages*

Experience with performance based systems in both the public and private sectors has been:

(i) realistic performance criteria are not established in the first instance;

(ii) outputs are substituted for outcomes and as a consequence, service levels or relevant data supply are not improved;

(iii) the absence of regular, consistent, rigorous reviews of performance by departments, government agencies, companies or non-government bodies; and

(iv) the lack of adequate skills in organisations in setting and monitoring performance agreements.

In the long term, an incentive system may become politically more difficult for the federal government to apply because in addition to showing up the non-performing States, it would also reward the States that meet the performance standards. The States that are lagging behind will use political means to complain that they are being discriminated against and that the principles of fiscal equalisation are not being observed. In these circumstances, the federal government should have no hesitation in 'naming and shaming' any State that clearly lags behind.

Regardless of the disadvantages of a performance-based incentive system, it is likely to be far more effective than a sanctions/penalty-based system where the sanctions are not enforced and where the federal government actively intervenes during the course of implementation of a program.

5.5.2 *One-off injection of funds*

A transitional option is a one-off injection by the federal government to fund the upgrade of the States' data collection systems as it has done with the provision of $150 million for reducing elective service waiting lists. The federal government and the States, in consultation, would reach an agreement about how much is needed. It may vary from State to State. One way would be to look to the State currently with best practice and fund the upgrade of the other States to that level. This would also be consistent with a number of programs that are in progress in some of the States in the area of e-Health. The role of the National e-Health Transition Authority could be expanded. It is noted that COAG has taken the initiative by calling a tender on e-Health to be run out of the Victorian Health Department.

This approach would have the benefit of forcing to the federal government's timetable the upgrade of data collection and analysis to a level acceptable to the federal government (and agreed to under the AHCAs). Because it would be effected by a one-off specific purpose capital injection, it should not be as politically difficult as enforcing general funding penalties/sanctions or incentives.

This approach would require a commitment from the States to maintain recurrent, future funding to continually modernize the system to sustain its relevance. Some of the States have been notorious in not fulfilling commitments to whole-of-life-of-asset or program funding.

5.5.2.1 *The advantages*

It would not only contribute to consistent data but also reduce costs and assist with patient mobility (eg a patient domiciled in Victoria presenting for treatment in Western Australia).

This alternative would be able to be done within the framework of the current AHCAs and would ensure valuable comparative data is available to the federal government. It should enable better decision making, particularly at the federal level.

5.5.2.2 *The disadvantages*

The poor performance of several key States in this area to-date means that funds would be provided to the States that have not performed. This political difficulty could be overcome by giving the States that have performed a one-off bonus akin to the competition policy incentives that have been shown to work effectively.

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During the time we have been preparing this Report, all of the States have been critical of the federal government's approach to funding the public hospital system. However, privately several of the States complained that at least two States are seriously lagging behind in improving overall health system performance and that they lack the consistent and timely data to make accurate analysis of the problems and informed judgments about the best solutions.

If the federal government regarded the comparable collection data issue as critical to performance and makes a one-off injection of funds to fix IT systems to enable delivery of required data, in the medium to long term incentives and/or sanctions will be needed to ensure the systems are continually upgraded to cope with changes in medical technology and procedures, as well as meeting community expectations. Also, if the federal government assumes responsibility for funding of hospitals it would have to be an assumed precondition that improvement in IT and management information systems is non-negotiable.

The collection of appropriate data on the operation of our public hospital system is an important and continuing priority. The threat of sanctions in the past has not resulted in the needed information being collected. The use of incentives on their own, as an alternative, may not produce the desired change from the States quickly enough. The publication of the data and its analysis would act as an incentive to lift performance.

A considerable body of work had been done in this area. In June 2007, ACHR released a report entitled 'Evaluating health outcomes in Australia's healthcare system'[10]

Recommendation 4

The Report recommends that the federal government provide specific purpose grants to the States to bring their IT systems and analytical processes up to a standard that enables all the States' systems to collect consistent data for analysis and publication in the short term, and seeks specific recommendations from the NH&HC about rectifying medium to long term IT and MI systems.

Recommendation 5

The report recommends that the federal government and the States should take note of the recommendations of the report entitled 'Evaluating health outcomes in Australia's healthcare system'.

6. MATTERS WHICH SHOULD BE INCLUDED IN THE AHCA NEGOTIATIONS

The federal Treasurer, supported by the Prime Minister, has announced an extensive, major overhaul of funding arrangements by the States. This may cause the federal government to decide to extend the current AHCAs by a year while a comprehensive review is undertaken. If such an approach is taken it is likely to result in superior funding arrangements, better performance by public hospitals and create an environment for major positive changes - it would be a preferred course of action.

The observations which follow are therefore made on the basis that the federal government and the States agree to proceed with the renegotiation of the AHCAs in their current form in general accordance with the timetable dictated by the expiry of the 2003-2008 AHCAs.

The matters which should be considered in the AHCA negotiations include:

[10] 'Evaluating health outcomes in Australia's healthcare system – A scoping Study of potential methods and new approaches', prepared by Insight Economics Deloitte, June 2007

6.1 Relieving pressure on Casualty/Emergency services

6.1.1 *Background*

The primary objective of the 2003-2008 AHCAs is that, "all eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind that are currently provided by hospitals". Moreover, "access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate time". The question of "clinical need and within a clinically appropriate time" has been the major issue associated with large metropolitan hospitals such as Royal North Shore in New South Wales.

The Agreements also provide that "if it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital."

The problems associated with availability of timely services at Casualty/Emergency wards of public hospitals rank as one of the major sources of complaint about the public hospital system. The logistics associated with and the cost of providing these services is also a significant reason for the increasing budgetary pressures imposed by the public hospital system. An expectation has built up in parts of the community that Casualty/Emergency departments should be continuously staffed to cope with peak demands.

With some exceptions, public hospital Casualty/Emergency wards throughout Australia deal with trauma and high level acute cases just as well as anywhere else in the world. These are unplanned events and can be variable. One night a Casualty/Emergency ward may have few cases presenting and the following night a very large number. It is extremely difficult to maintain a continuing supply of healthcare professionals to meet peak demand and to do so involves having staff on call or having high spare capacity. It is unrealistic to expect that Casualty/Emergency departments will be staffed to meet peak demand.

Both uninsured and insured patients present themselves for assessment, treatment and possibly admission at Casualty/Emergency wards – especially at night and over weekends. In many cases there is an expectation that these facilities and staff should provide a standard of service equivalent to a proficient General Practice and with a high degree of timeliness.

For a whole series of reasons, many in the Australian community have come to regard Casualty/Emergency as a substitute for visiting a G.P. This is in spite of the fact that a substantial number of General Practices bulk bill for their services and some practices are open for extended hours.

A detailed examination and explanation of why this has happened is outside the scope of this Report, however it would be desirable if the Casualty/Emergency wards were freed-up to treat trauma and high level acute cases, and co-located G.P clinics were to meet the demand for non-trauma and non-acute cases. This would significantly reduce the pressures on public hospitals. It would also moderate the demands of individual hospitals and the States' governments for additional funding – demands which often arise out of highly publicised Casualty/Emergency problems.

6.1.2 *Co-located G.P clinics – 'super clinics'*

To relieve pressure on the Casualty/Emergency wards of public hospitals and to enable non-acute cases to receive more timely attention, the expansion of extended hour bulk-billing G.P clinics ('super clinics') close to public hospitals should be encouraged and given a high priority.

At a minimum, this would enable public hospitals to provide information about alternative service providers and, particularly at times of high traffic, would be expected to result in many non-acute cases being treated in such clinics. It may also develop a course of conduct where attending such clinics becomes regarded as the normal approach.

There is anecdotal evidence, especially from large regional and rural centres, that where a public hospital is located close to general practices and/or a private hospital, an informal arrangement exists for privately insured, non-trauma cases to be sent to the general practice by the triage nurse and then, if required, admitted to the private hospital.

The cost of services provided by such clinics could be met through Medicare and drugs prescribed by such clinics would not be supplied free as they sometimes are in public hospital emergency wards. This separation may help diminish an area where it is claimed there is cost shifting from the public hospital system to the federal government funded PBS.

Doctors and other health professionals who staff these 'super clinics' should, for after hours services, be reimbursed by Medicare at an increased out-of-hours rate, and this should

encourage the establishment of these clinics and encourage them to stay open longer hours and in some cases 24 hours a day, seven days a week.

6.1.2.1 *The advantages*

The proposed 'super clinics' would provide the following benefits:

(i) Casualty/Emergency wards would be able to better deal with trauma and acute cases because of the referral of non-emergencies to the 'super clinics';

(ii) Non-acute cases would receive appropriate timely treatment at the 'super clinics';

(iii) While the 'super clinics' would be funded by the federal government via Medicare payments, their establishment should not suffer from the accusation by the States of cost shifting, but rather be seen as a welcome addition to the means by which health services are delivered, particularly after-hours;

(iv) They would have the political advantage of reducing the attention paid to Casualty/Emergency wards, and rather focus the attention on the core functions of the public hospital, which are the surgical operations and diagnosis and treatment of acute non-surgical cases;

(v) One flow on advantage may be that private hospitals may be more willing to provide Emergency services. To date, with a small number of exceptions, private hospitals have been reluctant to establish and operate Casualty/Emergency wards or an equivalent. However, with a change in the financial incentives and the availability of adequately trained G.Ps and medical support staff, private hospital owners may be willing to establish Emergency wards either within existing hospitals or adjacent to them.

6.1.2.2 *The disadvantages*

(i) In the short term, they could drain doctors from single doctor practices in small communities;

(ii) They could hasten the development of large corporate practices or clinics, which some sections of the medical profession see as a disadvantage; and

(iii) They will compete for the supply of doctors, paramedical and support staff and thus put further upward pressure on medical services costs.

6.1.2.3 *Where would they be located?*

The buildings the clinics occupy could be:

(i) Within a public hospital precinct but with a separate entrance and a specified area allocated to it that could be leased from the specific hospital or the State; or

(ii) Attached to an adjacent privately owned hospital; or

(iii) Separately located close to the public hospital in a stand-alone building and, in cases where public and private hospitals abut, adjacent to both.

6.1.2.4 *Benchmarks*

Benchmarks for the establishment of 'super clinics' should be determined and monitored. The collection of data from them should be part of a 'national medical performance' data system.

6.1.2.5 *Staffing*

A fundamental question will be the availability of an adequate supply of G.Ps. While this issue does not fall squarely within the AHCAs, a continuing shortage of doctors and a reluctance by successive federal governments to issue an increased amount of 'provider numbers' for doctors has contributed to the overall problems of the health system, including those which relate to public hospitals.

Likewise, the supply of nurses is also a constraint in the provision of hospital services and, as has been amply demonstrated in most OECD countries, there is no 'quick fix' to increasing the supply of adequately trained nurses.

The shortage of doctors will not be solved quickly. The lead time for training a doctor is about seven to ten years from commencing medical training to the issue of a practice certificate. An increase in the number of doctors will contribute to reducing the pressures on public hospitals and is therefore a matter which should be considered by Ministers for Health if and when they negotiate the 2008-2013 and subsequent Agreements. (See below for further comment on this issue).

To encourage available G.Ps to staff these 'super clinics', consideration should be given to their level of remuneration and particularly the rate of reimbursement they receive from Medicare. Differential rates for out-of-hours work is common in many areas of activity in the Australian

community and there is no reason in principle why the same policies and practices should not apply to medical practitioners.

6.1.2.6 *Other measures/incentives*

In the short to medium term, accelerated depreciation or other concessions (including grants) for the establishment and operation of co-located clinics adjacent to or close to public hospitals, which should include encouraging existing private hospitals to provide such facilities, could be provided.

The solution to the problems of delivering the current standards of health services within the framework of providing universal access will have to be pragmatic.

Depending upon the level of demand, there may have to be service agreements between the co-located clinic and the adjacent hospital about the after hours provision of services such as pathology, radiology and other diagnostic services. Likewise, during peak times the agreement may work in the other direction with the public hospital 'buying' diagnostic services from the co-located clinic.

The federal government may consider making one-off grants to a State where the construction of a co-located clinic will be on State owned land and could even be owned by the State and leased back to a group of G.Ps. The payment to the State would enable the project to be fast tracked. This would be in a limited number of sites where a clinic would be close to a public hospital that has demonstrated a consistent, high level of demand to casualy and emergency services.

Recommendation 6

The Report recommends that as a means of relieving pressure on Casualty/Emergency wards and to enable non-acute cases to receive more timely attention, encouragement for the establishment of extended hours, bulk-billing G.P clinics close to public hospitals should be provided in the AHCAs.

Where the clinics are not able to be established within the hospital precinct, financial incentives, possibly in the form of enhanced amortisation and depreciation rates should be provided.

G.Ps who staff these clinics should be reimbursed by Medicare for the services they provide at an enhanced rate.

6.2 Specific measures that promote healthy lifestyles

It is clear that too many patients are receiving treatment for preventable/avoidable lifestyle related diseases. The combined costs of treating Australia's ageing population and patients with lifestyle diseases is fast placing an unacceptable cost-strain on the health budget. Therefore, a concerted effort by all stakeholders is required to improve the health of the Nation. These efforts should gradually reduce the numbers of patients in hospitals and free up resources. Governments must promote such measures that aim to reduce the number of patients presenting at public hospital Casualty/Emergency wards for treatment and/or subsequent admission to hospital. These measures will also reduce the overall demands on the total health system, including G.Ps, pharmacies etc.

Governments, both federal and State, must continue to mount vigorous awareness campaigns against lifestyle diseases. Australia has an excellent record in addressing diseases resulting from things such as smoking, excessive drinking, not exercising and obesity as well as HIV AIDS. This must continue.

While a number of actions could be taken by the federal government alone to promote better health, there are areas which can be addressed via the AHCAs. For example, the Agreements could make it a requirement that the States:

(i) Mount campaigns emphasising the importance of a good diet;

(ii) Introduce laws which further restrict the public places where smoking is permitted;

(iii) Legislate that cigarettes are not displayed for sale in retail outlets (eg petrol stations and supermarkets) – that is, they are only to be sold from under the counter;

(iv) Mandate the inclusion in school curricula of physical activity for all primary and secondary school children/teenagers. Such a requirement would encourage school age children to adopt healthy, active lifestyles, which would lead to a

reduction in diseases in later life that result from a sedentary lifestyle. Such diseases include diabetes, many cancers, arthritis and cardio-vascular diseases;

(v) Provide incentives to school tuck shops to provide healthy foods and limit the sale of food and drink that contribute to diabetes, obesity, etc;

(vi) Increase the amount of education about the virtues of vaccinating your children and, through a range of educational and counselling programs, aim to maximise the number of young children who are vaccinated. If it were not for the concern about individual rights, there is a strong long term health related argument for mandating vaccinations of all young people; and

(vii) Provide greater information and counselling in maternity wards for mothers with new babies about the importance of diet.

In time, these measures and many others of a similar nature will positively impact on the health budget, surgery waiting lists and the overall health of the Nation. Governments' programs should promote self management and encourage people to take greater responsibility for their own health and understand the risks of not taking action.

Recommendation 7

This Report recommends that the AHCAs should contain specific requirements that the federal and the State governments promote, by legislation if necessary, a range of measures addressing public health problems in the community. In this way, governments reinforce their dual role in health of encouraging a healthy Nation as much as treating those who are unwell.

6.3 Generic Drugs

The federal government has initiated a program where pharmacists are encouraged to draw patients' attention to generic drugs that will perform as well as an identical branded product.

Additionally, the purchasing and management of inventory that includes drafts etc, to a major logistics issue for public (and private) hospitals.

Recommendation 8

The Report recommends that the AHCAs should reinforce the message about the provision of generic drugs as a means of keeping control over costs involved with the PBS. This should

include performance measures to hold a set range of bulk purchases of drugs, prostheses etc, and to maximise the use of bulk buying to reduce costs

6.4 Accounting for Assets and Overhead costs/administration

An issue resulting in budgetary strains, which has not been adequately addressed in past AHCA negotiations, is the failure of some States to deal with the capital funding of public hospitals and their associated assets on a whole-of-life accruals basis. This has led to a failure to regularly and publicly disclose actual and contingent liabilities of individual hospitals and the public hospital system as a whole. In some cases, the cost of capital is not accounted for in relation to public hospitals.

Critics of the accrual accounting system being applied in the government sector claim it is necessary only to have cash accounting to match the annual appropriation process. However this ignores the important fact that the public hospital system (as with other parts of the States' infrastructure based services) is absolutely dependent on very expensive assets such as hospital buildings and modern medical equipment. These assets have a life beyond each year's annual appropriations for recurrent expenses, which should be accounted for. Also, with the rapid advance of modern medical technology, obsolescence is a far greater issue.

Under the current government accounting guidelines, the treatment of expenses should be consistent and thus comparable. Unfortunately, most of the States do not have credible and consistent systems for allocation of overhead costs.

Another accounting related issue arises from the fact that the federal government and the States all have Departments of Health. In all cases, they rank amongst the larger departments in each of the public services. At a state level, a significant part of the 'health bureaucracy' is involved with hospital administration and overseeing public hospitals. The structure of the States' health bureaucracies vary quite considerably. This makes direct and accurate performance comparisons difficult. It is also clear that there is no relationship between the size of health bureaucracies at federal and State levels and health outcomes.

An incentive could be put into the new funding arrangements where, as part of the performance criteria, overhead administration costs have to be lower than a predetermined proportion of total public hospital expenditure. Depending upon the structure of each State's

health bureaucracy, this could be done on a whole of State, by AHS, or on an individual hospital basis.

Recommendation 9

The Report recommends that the 2008-2013 AHCAs should provide for:

(i) data to be collected on the costs of and activities undertaken by all bureaucracies administering health services, and an agreement upon benchmarks for the extent of these bureaucracies, with one of the performance criteria being that overhead administration costs have to be lower than a predetermined proportion of total hospital expenditure;

(ii) allocation of the 'overheads' involved in the various levels of bureaucracy (which vary quite considerably between the States) to the hospital system;

(vii) 'whole-of-life-of-asset' costing for both individual hospitals and the public hospital system in each State;

(viii) disclosure of actual and contingent liabilities that exist for every public hospital in the country and for the health systems in each of the States;

(ix) development of risk management and risk mitigation plans for the public hospital system and for each hospital in the system; and

(x) transparent reporting of performance.

Only by agreeing to these measures will it be possible to determine the real cost of providing health services, the extent of duplication of activities, and to agree on benchmarks for the future streamlining of the health bureaucracies. As pointed out elsewhere in this Report, it is essential that the basis for collecting the data from each State, its analysis and the report periods should ensure that an accurate comparison can be made.

These recommendations are consistent with the recently stated approach by the federal Treasurer re changing the structure of SPPs, and the provision of overall funding to the States.

6.5 Property and Hospital Assets Audit

As a fundamental preliminary step to enable governments to understand what assets there are in the public hospital system and what it really costs them, an audit of all hospital real estate should be undertaken to determine what exists and how it is currently utilised. This information could be used to reassign usage (eg conversion to aged care facilities). This may enable the transfer of aged patients with chronic illnesses currently using beds that, as a

priority, should be used for acute cases in public hospitals. Urgent attention needs to be paid to aged care accommodation so that there is sensitive handling of sub-acute aged patients who need a high level of personal care. In preparing this Report, numerous cases were cited where aged care patients who are no longer in the acute category are occupying acute care beds in public hospitals.

The audit should form the basis for developing a continuous and reliable asset register, which must include data regarding the state of repair of the hospitals.

Recommendation 10
The Report recommends that the 2008-2013 AHCAs should:

(i) require each State to establish an up-to-date asset register of all public hospital and directly related property assets with priority being given to major public hospital assets;

(ii) require each State to undertake an audit of the usage and state of repair of all public hospitals and directly related property assets; and

(iii) consider providing incentives to the States to ensure all public hospitals are put into an appropriate state of repair within a defined period. In some individual cases it might be preferable for clinical and financial reasons to close a hospital and build a new one.

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In dealing with the real and perceived problems of the public hospital system and the services it provides, it is difficult to separate reality from the emotional issues associated with individual cases at public hospitals or the services that precede people being admitted to public hospitals.

It is also difficult to separate fundamental causes and effects that influence the strengths and weaknesses of the total Australian Health System, of which public hospitals are an important but not the only part.

One basic element running throughout the entire system is that the total available funds from the governments' sources are insufficient to pay for all aspects of the health system as it is currently structured. Rationing and ensuring best value for money spent is inevitable and

unless there is either a change in the funding priorities of governments, an increase in taxation, increased fees for services, or a combination thereof, that rationing will continue and the severity of it will increase.

Good personal health should be everyone's objective, and access to the wide range of services that enable such result is regarded as the right of all Australians. However it is not a 'free good' - it all comes at a cost funded personally. For example, through good diet and healthy lifestyle, private health insurance, private payments for services and the taxation levy by the federal government, appropriation of revenue to the Medicare system and the States public hospitals and health programs, and through the States through allocation of tax revenues.

In spite of the importance to individuals and governments that Australians are as healthy as possible, there are limits to the individual's and governments' willingness and ability to pay for health and related services vis-à-vis other expenditure decisions.

As abstruse and arcane as it may seem to be, financial and value for money aspects and the management of Australia's health system are very important. They must be taken into account when dealing with the claims and counterclaims of the many vested interest groups in the health sector.

One of the objectives of any future AHCA, or any other funding arrangement that is introduced, should be not only to ensure that there is access to the public hospital system for those who really need it, but that there is 'value for money' and an acceptance that some of the services might be better and more efficiently provided elsewhere.

Inevitably, this brings the Report to an aspect of the Australian Health System that is fundamental to current and future performance – the availability and remuneration of healthcare professionals.

7 HEALTHCARE PROFESSIONALS

7.1 Supply

Delivery of public hospital services is dependent upon a wide range of people - from highly qualified medical specialists to garbage disposal staff. Those that are in contact with the public for the delivery of the clinical services are doctors, specialists, nurses and allied health professionals such as physiotherapists, dieticians etc.

The overwhelming evidence is that the supply of doctors, nurses and allied health professionals is an increasingly significant factor in the ability to provide public hospital services and the alternatives that may be available.

On the basis of the empirical data available, the shortage of healthcare professionals will become more pronounced over the next five to seven years. It will be even more pronounced if the federal government, supported by the various groups of health professionals, takes no action in the very near future regarding the availability of these professionals.

The issue of supply and demand for healthcare professionals is a complex matter with substantial lags in the system responsible for the provision of doctors and allied health professional services. There is no 'quick fix' to what has been, and will continue to be, a major problem both in Australia and Internationally. The adequacy of the supply and training of doctors is a matter of public debate in all OECD countries, as is the supply of nurses, who are as fundamental to the public hospital system as doctors.

The provision of additional funds to public hospitals by governments does not necessarily bring with it an improvement in services, if for no other reason than that there is not a surplus of suitably qualified doctors and appropriately trained nurses immediately available to staff Casualty/Emergency wards and other parts of the hospitals. So, if it is accepted that there is a shortage of suitably qualified doctors and nurses, what are some solutions in the short, medium and long term?

The level of payments to 'interns' and 'registrars' in public hospitals are set by State governments in the nature of an 'Award'. An increase in the levels of remuneration might attract some G.Ps to return to hospitals and become what would amount to 'permanent registrars' – a system that operates overseas but the numbers are unlikely to be large. Currently, a number of doctors' positions in public (and private) hospitals are being provided by locum services. While it is a useful stop-gap solution, it does not deal with the medium to long term demands.

Overseas trained doctors have increasingly been used and, in spite of some isolated cases of adverse publicity, will continue to be recruited to meet demands for services in hospitals and general practice. It should be noted that there has been a long term flow of doctors, nurses and

other health professionals across between Australia and New Zealand. As the standards of education and training in both countries are identical, further cooperation between the two countries in training doctors and healthcare professionals should be considered by the NH&HC as a medium term issue.

7.2 Provider numbers

A key policy issue, over which the federal government has total control, is the issue to doctors of 'provider numbers', which enable patients to claim on Medicare and for the doctor concerned to bulk bill. Provider numbers are not required by doctors working in public hospitals.

Associated with that policy issue is the interrelated question of the extent and effectiveness of public health campaigns, which over the medium to long term should theoretically stabilise the demand for doctors and allied health professionals in public hospitals. However in the short term (five to seven years), the supply side will continue to be a major issue.

To overcome the shortage problem, overseas trained doctors have been given access to 'provider numbers'. In addition, the States have been vigorously recruiting overseas for nurses. However it is clear that any solution involves more than just freeing-up the issuing of 'provider numbers' or recruiting nurses from overseas.

While the whole issue of the demand for doctors and healthcare professionals is outside the scope of this study, governments, both federal and State, will have to urgently find a solution to the numbers of doctors, triage nurses and support staff in public hospitals if they are serious about improving the level of service.

7.3 Remuneration – working environment

An important issue is the remuneration levels and working conditions of doctors and other health professionals. Doctors, nurses and allied health professionals work in an international market. They can move freely across national boundaries and doctors from most OECD counties will be regarded as being acceptable for work in other OECD and less developed countries. These are doctors who are truly 'san frontieres' - many of those who graduate from Australian universities may never practice in Australia, while others, for a variety of reasons, will move in and out of the Australian medical workforce.

Similar other professions, there is a broad spectrum of gross and net incomes across the entire medical profession - there will be examples where individuals earn very high incomes. As with any other profession, the majority of practitioners will be earning incomes in the medium range. In the case of G.Ps and specialists, fees are influenced very largely by the level of Medicare reimbursements. Where bulk billing does not operate, there will be an additional charge or 'gap' payable by the patient.

Clearly there is considerable concern expressed by the federal and States' treasuries that any increase in Medicare reimbursements specifically, or doctors' charges more generally, will have inflationary and flow-on effects not only on health insurance premiums but to the wider economy.

The reality is that, as with most professions or vocations, the level of remuneration will be a major influence where someone works, how much they do and for how long they work. Doctors are no different and if Australians want to maintain an adequate and continuous supply of doctors and healthcare professionals, remuneration will have to move with the international market 'prices' for the profession.

Part of the solution will be to increase remuneration but simultaneously to reduce the demand for high cost healthcare professional services. Ways of doing this is greater emphasis on preventative healthcare programs promoting healthy lifestyles, greater operational efficiencies in hospitals when people need clinical procedures, and enabling lower cost healthcare professionals to deal with sub-acute patients in areas such as aged care.

We accept that the levels of remuneration for doctors is a highly contentious issue, but if it is not addressed on a consistent, continuing basis it will only create greater 'peaks' and 'troughs' in the supply of adequately trained doctors over the long term.

This is an important area well beyond the negotiation of the AHCAs and the funding of public hospitals, and has been discussed widely in other flora and literature.

In 2006, the Productivity Commission published a report[11] into the medical workforce and related matters. The report makes a valuable contribution to this vexed issue and, where practical, its recommendations should be adopted.

Some published information suggests that up to 40% of general practices are not financially viable and many single G.P practices earn less than $100,000 net a year, however it is difficult to verify these figures. If they are current, it is a little surprising that the applications for admissions to medical schools exceed available places. It suggests that remuneration levels within the medical profession are 'skewed', or that in some cases, non-financial motives often provide the incentive or satisfaction for working in areas of medical services that remunerate at low levels. This is another area where there needs to be consistent, reliable Australian wide data.

7.4 Other issues

The issue of professional indemnity insurance **(PII)** should also be reviewed. As it currently stands, it may discourage doctors from remaining in the system on a part-time basis. An option is to more effectively cap litigation payouts (there are precedents in other professions, for example accountants and auditors). The previous federal government attempted to deal with the cost of PII by placing a cap on the premiums payable by practitioners and for the government to fund additional payments in some high risk areas. However limited evidence suggests doctors, especially older (and more experienced) ones, are discouraged by the PII premiums from remaining in part-time practice. However, it needs to be stated that it is difficult to obtain credible data about how much of a disincentive the current PII arrangements really are.

Specific issues facing female doctors should also be addressed. Women are increasingly a large part of general practice and, albeit slowly, are becoming a larger proportion of specialist divisions. Incentives need to be found to enable female doctors with families to continue to provide services.

The question of doctors' remuneration and conditions is long standing. In this respect, it is instructive to read the Hon. Richard Crossman's accounts of the then UK Health Ministers continuing dilemmas with doctors' remunerations[12].

[11] 'Australia's Health Workforce' – Product Commission Research Report, 22 December 2005

Recommendation 11

This Report recommends that to improve public hospital services in the short, medium and long term, the following initiatives should be undertaken and an appropriate starting point would be to include them in negotiations for the 2008-2013 AHCAs:

(i) Increase remuneration of doctors and other health professionals in Casualty/Emergency wards as well as that of G.Ps staffing 'co-located' or 'super clinics' that provide substantial out-of-hours services;

(ii) Free up the issuing of Provider Numbers as part of increasing the overall supply of doctors;

(iii) Continue to admit adequately trained overseas doctors into Australia and to the Medicare provider number system;

(iv) Concomitantly, in conjunction with the universities, increase the number of undergraduate admissions to medical schools and to allied health professionals training courses; and

(v) Ensure that merit is the only criterion for admission to specialist colleges and address the issues which cause high dropout rates from these colleges.

Recommendation 12

This Report recommends that the remuneration of medical practitioners and allied health professionals be considered and, if necessary, remuneration levels be increased with performance criteria introduced. While not an issue that is central to the renegotiation of the AHCAs, it is an issue that will significantly influence the ability of hospital operators to reduce pressures on the public hospitals system, especially in Casualty/Emergency wards. It should therefore be raised in the discussion surrounding the renegotiation of the AHCAs and the funding of public hospitals (as well as in relation to private health insurance premiums).

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[12] See Vol. III 'The Diaries of a Cabinet Minister' – Secretary of State for Social Services 1968-70, Richard Crossman, Hamish Hamilton 1977.

8. COST SHIFTING

8.1 General

In addressing this term of reference, the initial observation was that the extent of cost shifting between the federal and State governments involved very large sums of money and was a major impediment to the successful operation of the Australian health system.

On further examination, there was very little credible, up-to-date data to accurately assess the amount of money involved in the areas where 'ost shifting is possible or does occur.

A number of States' officials advised that over the last 15 years they had been asked to quantify the value of cost shifting between the federal and State governments, but had not been able to do so with any degree of accuracy.

The areas where some cost shifting takes place, is where patients attending Casualty/Emergency wards are assessed in a public hospital and given a prescription to take to an external pharmacist. Instead of the drugs being supplied by the public hospital at the cost of the State (a proportion of which cost is shared by the federal government) the cost is born by the PBS (a federally funded program).

In other areas, sub-acute patients may be held in public hospitals instead of being transferred into aged care or other external facilities that are not funded by the State (again shared with the federal government).

There are also situations where patients may be dismissed from a public hospital on a Friday to be readmitted on a Monday (a cost saving measure by the hospital) and, if medical treatment is required, a G.P may become involved and the cost is met by Medicare and in some cases, the patient will pay for the 'gap' if the G.P does not bulk bill.

There are also instances where patients may move between public and private hospitals and the costs can move (in both ways) between the federal and State governments.

Our analysis suggests that the perception of the extent of the cost shifting is greater than the reality. While it is not possible to put a precise dollar value on cost shifting between the tiers of government, it is our conclusion that it could be large in absolute terms - that is, anywhere

between $300 million to $500 million annually, but that it is not of a material order in the context of overall government expenditure on the health system, which is A$60 billion[13].

What did arise as a result of the investigation is that there are two fundamental issues:

(i) the overhead costs associated with dual responsibilities for funding and the administration of public hospitals; and

(ii) 'market failure' where hospital administrators (often supported by clinicians) try to deal sensibly to ensure that facilities (beds, operating facilities, other healthcare professional staff) are available. This occurs where public and private hospitals are co-located or where sub-acute patients can be moved between hospitals without adverse affects.

There are sound economic and operational reasons why both public and private hospitals should marginally cost available beds to maximise utilisation rates of both beds and support staff.

So long as dual responsibility continues for the funding of public hospitals, largely unproductive debates about cost shifting will continue.

It is our view that putting mechanisms in place to make cost shifting practices more difficult to implement, or easier to track down, may, within the current AHCA framework, introduce unwarranted complexities without necessarily delivering a substantial saving. It is our further view that activities which are seen as involving (and do, in fact, involve) cost shifting are often activities that result in the overall health and hospital system operating more effectively - that is, 'side deals' can get around a particular problem within a State or between a public hospital and other parts of the health system.

While the dual funding arrangements continue, there will be the possibility for cost shifting and the probability of governments at different levels raising cost shifting in debate regarding the overall system as a justification for the levels of their contributions, or to substantiate

[13]DOHA - Concise Factbook October 2007

claims for additional funding from the federal government or for the federal government to claim that funding in some areas should be reduced by the estimate value of cost shifting.

There are dual responsibilities between the federal and the States' health bureaucracies. Frequently medical practitioners and actual service deliverers claim that unclear lines of responsibility and accountability cause delays in and add costs to patient service delivery. Federal government monitoring of a program may in effect be equivalent to exercising control over the delivery of the program in a State.

If cost shifting is a major concern, it would be preferable to see the establishment of an open, transparent market that would allow public and private hospitals and chronic care facilities to trade in a way that would always ensure that unused beds are being offered to hospitals and chronic care facilities at a marginal cost.

8.2 Identified areas of cost shifting

8.2.1 *Transfers between public and private hospitals*

Limited evidence suggests that there is an informal 'market' in beds between public and private hospitals. The operation of such a 'market' is potentially inconsistent with the spirit of the current AHCAs. Where a privately insured patient, who may not have declared at the time of presenting to a Casualty/Emergency ward that he/she was privately insured, is occupying a bed in a public hospital, it may constitute as cost shifting. Although it is the right of everyone to access the public hospital system, if a private patient who is capable of being treated in a private hospital occupies a public hospital bed it is a form of cost shifting. The initial evidence is that the practice is not prevalent, but in terms of public policy it would seem to encourage arrangements between public and private hospitals that enable greater utilisation of facilities.

A subsidiary issue, which is not entirely unrelated, concerning the availability of beds in public hospitals is the practice where some specialists operating in public hospitals have a tacit understanding with the hospital, which includes having a continuing 'entitlement' to a number of beds for that doctor's patients. This is linked closely to the utilisation of operating theatres. Such practice could create a situation which, on the one hand, ensures availability of operating theatres and associated beds for trauma and acute cases, but on the other hand, if not managed by a hospital's administration, could reduce the availability of beds and the flexibility of their allocation to other doctors' patients. It may also be a means by which public

hospitals attract top specialists and surgeons. It may have minor cost shifting implications, but more significantly it raises the question of who is the 'customer' of a public hospital – the patient, the doctor, the State, or the private health sector?

In any debate about cost shifting, clarifying and delineating clearly the lines of responsibility and accountability are far more important, operationally, financially and politically, than a convoluted argument about cost shifting.

Recommendation 13

This Report recommends that the AHCAs should clarify the lines of responsibility and accountability for funding of public hospitals and healthcare programs and, where obvious market failures appear, should be dealt with by improving the ability of hospitals to maximise the utilisation of beds at the marginal cost.

8.2.2 *Costs of chronic care*

The expanding aged population requires special purpose accommodation and will continue to require it. Major public hospitals deal with trauma and acute cases, but not sub-acute or chronic care. Sub-acute and chronic care is associated significantly with older people, yet many of these people occupy public hospital beds. Aged care is a federal government responsibility and there is insufficient infrastructure to meet the current level of demand.

The maladies and problems associated with ageing will increase exponentially, placing demands on society in general. If no action is taken by the federal government, this will impose costs and blockages on the rapid increase of patients through public hospitals. Evidence suggests, especially in rural and regional hospitals, that a substantial number of acute care beds are being occupied by aged and ageing patients.

Aged people are occupying public hospital beds on a long term basis, which limits the capacity of public hospitals to provide trauma and acute care services to the public. The problem becomes greater in outer metropolitan areas and country towns.

In terms of the current funding arrangements and cost shifting, it means the States are sharing what should be a federal government cost. In the future this is an area where, with proper planning and greater private sector involvement, sub-acute, chronic and geriatric care could be provided outside the public hospital system and in fact, outside the hospital system altogether.

Recommendation 14

This Report recommends that in the event the AHCAs continue over the next 10 years, part of the funding arrangements should include providing incentives to move sub-acute, chronic and geriatric care patients into facilities suitable for their conditions and free up beds and practitioners for acute care in public hospitals, and for the federal government to assume responsibility for aged care.

8.2.3 *Influences on demand for public hospital services*

The increasing cost of going to a G.P who does not bulk bill may cause patients to go to their local hospital for treatment that is more appropriately provided by a G.P. This use of public hospitals may also be exacerbated at weekends, given that many G.Ps do not operate on an after hours basis and, if contacted after hours, direct patients to their local hospital. In this situation, the States share the costs that would be a federal government cost if the service provided by G.P private health cover does not defray these costs since they are precluded from doing so by legislation. The extent of inter-government cost shifting in this area is limited.

Another point is that if the triage nurse or doctor prescribes drugs and sends the patient to a local pharmacist, the cost will be shifted to the federally funded PBS. On the other hand, if the patient is admitted briefly, drugs are made available from a hospital dispensary, and the State will probably share the cost. As pointed out previously, there is no real means of quantifying this element of cost shifting.

8.2.4 *Establishment of 'super clinics'*

The establishment of extended hour 'super clinics' close to public hospitals, as recommended earlier in this Report, may lead to patients receiving treatment in the clinic, especially where the medical problem is minor. The clinic may or may not bulk bill. Regardless of what the practice might be, all or part of the cost will be met under the current Medicare arrangements.

If there is a gap between the fee charged and the Medicare rebate, it will be the patient that picks up the extra cost. If the total costs incurred by a patient in any one year exceed the tax rebate threshold, part of the cost will be shifted to the federal government via the income tax system.

The extent of the realignment of costs being met by different levels of governments as a result of establishing 'super clinics' is unlikely to be large relative to the total cost of the health system to Governments, and the efficiencies delivered by reducing the pressures on public hospital Casualty/Emergency wards should deliver significant savings and improved standards of care to acute care patients.

Recommendation 15

This Report recommends that the dual responsibilities for public hospital funding should be eliminated. In the event that they are not, there should be specific measures to accurately identify and control cost shifting, but they should not be seen as an end on their own, but rather as a part of overall improvements in the data collection system by the federal and State governments. Any initiatives introduced should also bear in mind that the primary objective of the health system is improved patient care.

9. PRIVATE HEALTH INSURANCE

The costs of private health cover incurred by the community are substantial. They reflect the high cost of modern healthcare and are increasing at a far faster rate than inflation. There is some level of competition, but largely the funds are in lock-step because of the regulatory regime within in which they work. The universal rebate is costly to the federal government but is fairer than providing relief through tax deductions, as it makes the cost the same to all participants.

The new Prime Minister and his government have recognised this by making a firm commitment to retain the universal rebate. This will enshrine private health insurance and private hospitals in the Australian healthcare system. In light of the medium term projections about the pressures on the provision and costs of healthcare, sole reliance on the public hospital system is not possible or realistic.

Private health insurance provides flexibility and choice and is an option taken up by a substantial percentage of Australians (44%) because they want certainty about the availability and standard of healthcare.

There may be a case for the AHCAs to encourage greater competition between public and private hospitals (including not for profit institutions that currently enjoy a special tax status vis-à-vis privately owned hospitals run by corporations or profit based companies) and to enable

private health insurers to structure their schemes and premiums so as to encourage healthy lifestyles to keep people out of hospitals.

There are individual issues that influence particular groups within Australian society as to whether or not and when they take out private health insurance. One area that would have an impact on the health system would be for insurance premiums to reflect the extent to which the insured maintains good health and personal wellbeing (eg a modified 'no claims' bonus).

While this would modify the concept of community rating that has been, and remains, a fundamental element of the Australian system, it could be an effective incentive for individuals to take the initiative and look after their health. Such measures have been introduced in the UK in the form of reduced premiums for regular walkers/joggers/cyclists. As an example, a usual insurance premium of A$4,830 became a premium of A$980 by the insured person complying with a supervised exercise regime. These measures have been welcomed and supported by the UK Government as an effective means of fighting obesity. This example shows what can be achieved in what is a "win" for all participants – the insured, the insurer and the Government. It is acknowledged that the UK environment, with regards to private health insurance, is different from that operating in Australia.

A major issues associated with moving in this direction will be the capacity of the private health insurance sector to pay.

Recommendation 16

This Report recommends that all levels of government should encourage the introduction of further flexibility in setting the level of private health insurance premiums. In particular, the introduction of premium rebates or bonuses for healthy lifestyles should be encouraged. This should be promoted as part of the fundamental goal of encouraging the population to take responsibility for their own wellbeing.

10. ACHIEVING CHANGE

10.1 General

One of the obstacles to implementing the reforms and changes recommended in this Report is the large number of highly educated, articulate interest groups that are an integral part of the total health system.

The parties involved in the current health system are:

(i) The people

(ii) Groups with special needs – (eg indigenous groups)

(iii) Governments – federal and State

(iv) Government departments – Treasury, Health, Aged Care, Department of Veteran Affairs (**DVA**)

(v) Hospitals – public and private (including not-for-profit)

(vi) Medicare

(vii) Private health insurance organisations

(viii) Doctors – G.Ps and Specialists

(ix) Nurses

(x) Other health professionals

(xi) Unions and professional organisations

(xii) Universities and other training organisations

(xiii) 'Colleges' within the overall medical profession

(xiv) Health research bodies

(xv) Medical insurers

(xvi) The PBS

(xvii) The Therapeutic Goods Administration (TGA)

Amongst the 17 separate groups are a series of sub-groups.

The issue is to assess where the process of reform should start. That is, which are the more significant of the above groups, and how are the various interest groups within the system motivated to best meet the Australian community's real health needs?

10.2 Who is the Customer? How are patients made aware of healthcare costs?

One of the current key features of the system, especially the public hospital system, is that the patient, including the person who is a potential patient and who needs to be kept well and out

of hospital, is not the 'customer'. At no stage is a public patient required to sign a 'payment authorisation', nor do they receive an itemised statement of what a visit or treatment has cost.

In only two instances in the process is the patient treated as the customer:

1. Dealing with a G.P or specialist. However if the G.P bulk bills, the 'customer' does not actually pay the bill or sign a payment authorisation; and

2. As the buyer of private health insurance.

This can best be demonstrated by what happens to public patients, and it is useful to understand the details of the processes:

(a) A person attends a casualty ward, where they are initially seen by a triage nurse who either applies an immediate low-level remedy or gets a registrar to see the patient. The registrar (who is an employee of the State) may either treat the patient and send them away or admit the person. If admitted, depending upon the nature of the problem, the patient will be seen by a specialist of one kind or another who will then determine what happens; or

(b) A person sees a local G.P, a problem is diagnosed and the G.P then refers the patient on to a specialist, who in turn decides what action needs to be taken. The patient, if not privately insured, is admitted to a public hospital. Presumably the specialist 'shops' around to find which hospital might have a bed, or if they know that a bed is available at one of the public hospitals where they have an entitlement to operate, arrangements will be made to admit that patient. It will be the specialist that makes contact with the hospital.

This may not seem an important point, however one of the major long term problems is making individual Australians aware about the real and increasing costs of healthcare. As mentioned earlier in this Report, there is a view that curative healthcare is a 'free good'. In our view, sending clear signals about costs and the 'value for money' measured by the user as well as the funder, provides an important incentive to improve lifestyle with a view to keeping out of the health system.

Accurate performance assessment of a hospital by a lay person is very difficult. However, many doctors report that patients have trawled the Internet to find out about their illness, the treatments that are available and commentary about the performance of the hospital to which they might be admitted. This information is not necessarily reliable. Thus, transparent, reliable information about public hospital performance should be available.

Where the patient is not the 'customer' or direct purchaser of the services, the only real incentive to take an interest in what is happening is the desire to feel better or stay alive.

In effect, the State (mainly represented by Medicare) and the private health insurers are the surrogate customers, and through their oversight they attempt to maximise service delivery standards and ensure value for money. In the case of the public hospital system, the convoluted and at times conflicted relationships between the patient, the medical professionals and the hospital administration may mean that although the patient's expectations are not met, there is little ability for redress. This is because the payment agency is removed from the patient, the doctor and the hospital.

Private health insurers increasingly see themselves involved in quality assurance within hospitals as a means of trying to assure patients they are getting value for money as well as containing cost.

There is evidence that private health insurers are the 'advocates' for patients in dealing with hospitals and they try to contain cost increases.

If there is no competition between doctors and hospitals and the patient has no choice, there is no direct community to hospital pressure to improve performance (short of crisis situations that have arisen with individual doctors and public hospitals in Queensland and New South Wales in the last two years).

Recommendation 17

The Report recommends that high priority should be given to introducing a simple system which informs all patients about the costs of health services provided to them.

10.3 Payment for services – a radical suggestion

Empowering the patient can be achieved by a substantial part of the payment to the hospital being made by the patient. The literature contains a number of proposals for funding to

'travel' with the patient, rather than being made by appropriations and grants to the States and/or individual hospitals. Having funding 'travel' with the patient would also increase the ability of patients to choose, which in turn would increase competition and is likely to make the level and quality of services more transparent. The federal government could provide patients with an 'entitlement' to buy an amount of hospital accommodation and treatment from G.Ps and specialists.

The proposal is radical and requires further investigation into its administrative possibility, but warrants a detailed investigation into systems of patient tracking and funding that operate elsewhere. It is being floated because it will be criticised and in some instances point blank rejected by some of the many parties in the health sector. It will illustrate that no matter how governments might try to develop and implement new policies for improving the health and wellbeing of Australians by providing access to high standard healthcare and hospital services and maintaining control over costs, it will be strenuously opposed by articulate and politically influential groups within the sector.

It has ever been thus – the memoirs of various Australian and UK politicians have recorded the battles with the health sector over reform and remuneration. The Rt. Hon. Barbara Castle regarded dealing with the self interests of the health sector as far more difficult than dealing with some of the toughest trade unions and employers over industrial disputes.

Part of the reason for this is that a very large percentage of the population do not have a reasonable understanding of the system and the costs of the services.

The personally sensitive nature of health matters, and the understandable reluctance of politicians to take on health sector interests, has limited the ability to achieve institutional change and elevated throwing huge sums of money at the problem as being the preferred solution.

Sections of the medical profession have demonstrated that they are as adept as militant trade unionists in intimidating governments into either little or no reform, or retaining the status quo. In fairness, other sections of the profession have been strong advocates of reform.

The interest groups within the sector are long established and entrenched. They have survived numerous changes in government, and this situation will not change quickly.

However as two separate federal government Budget papers have stated in their intergenerational reports, Australia will not be able to afford the current high standards of healthcare in the future if the costs continue to escalate exponentially, which will occur if change is not implemented.

Our assessment is that one of the reasons the reforms have not occurred is that sections of the vested interest groups have been able to play off the federal government against the States' Governments as well as one State playing off another State, for example, over health professionals' remuneration. The most recent case of nurses' remuneration in Tasmania (November 2007) is but one example.

Both the major political parties impliedly recognised this in the run up to the 2007 federal election by promising greater federal government involvement and funding. Importantly, one of the resulting effects has been to make the additional funding dependent on performance against benchmarks set by the federal government.

There should be a continuing public education campaign by the federal government to explain to Australians the costs associated with funding the health system and revenues, either from levies and/or taxes that will be needed to fund the system, and the necessity to secure changes. One of the ways of achieving this is to make patients, and the community in general, more aware of the cost of services they access, both by being made personally aware of the costs and by way of public education campaigns in relation to payment by the federal and States' governments.

While it is possible that a majority of the States' governments will resist taking a first stand on serious, medium to long term health sector reform on a national basis, our view is that for the federal government to have effective control is more desirable than the current situation.

The recently elected federal government has indicated that it will intervene more directly in hospital funding and administration, and accept increasing responsibility for healthcare costs and programs.

It is also becoming obvious that state borders are becoming increasingly irrelevant, a pattern which is expected to continue. In some highly specialised areas where the cost of modern medical equipment is very high and the intellectual skills required for their operation is limited

to a small number of people, it is possible that in the future patients will have to travel to another capital city or major regional centre hospital for some procedures. In our view, in light of the limited resources in Australia this practice should not be discouraged. If patients are more widely aware of the costs of such procedures it may help them to understand why such action is needed.

As a general statement, it is our view that the rationale for allocating monies to the States for further disbursement is disappearing, and it would probably be more effective if the federal government directly funded AHS or public hospitals and simultaneously introduced consistent meaningful performance standards across the country. While this proposal may not be included in the negotiations for the 2008-2013 AHCAs it should be considered at the very least by the recently established COAG working party on health.

The working party will hopefully recommend that COAG accepts this approach and that the next AHCAs, if they are to be established for 2008-2013, should not be constructed in a way which precludes reform during their lifetime. Preferably, they should be structured in a way that allows the federal government to progressively, and in an orderly way, take over public hospital funding as well as simultaneously placing greater emphasis on public health programs that keep people out of hospitals.

The history of AHCAs has been a little like major wars, in that there is great activity for a short time with all sides strenuously pursuing and protecting their vested interests. Once the Agreements have been signed there has been no real incentive provided by the terms of the AHCAs for significant reforms and improvements to be picked up, implemented and pursued during the lifetime of any one agreement.

Maintaining and improving the standards of healthcare does not come in neat, tidy discrete five year packages. If the federal and State Governments decide to proceed with the AHCAs for 2008-2013, they should be Agreements which will encourage Australians to improve the management of their own lifestyles, allow the funding arrangements to evolve to meet the demands of the public hospital sector, as well as ensuring that Australia becomes self sufficient in the supply of doctors and healthcare professionals. As a result of the review by the NH&HC and the implementation of the federal government's policies in relation to funding key areas of activity such as health, it should ensure that the system evolves in a way that maintains high

standards of healthcare, but that the cost of doing so is clearly understood and there is a capacity to pay for maintaining those standards.

Recommendation 18

That in the event that the National Health & Hospitals Commission (NH&HC) does not extend beyond mid 2009 when it presents its final plan to the federal government, serious consideration should be given to the establishment of a National Foundation for Strategic Health Policy Research which was presented to the former government in April 2006, but rejected.

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Sydney, February 2008

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