Report into the operation and future of the Australian Health Care Agreements and the funding of public hospitals

Prepared by

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REPORT INTO THE OPERATION

AND

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THE AUSTRALIAN HEALTHCARE

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AND

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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.**