
The Parliament of the Commonwealth of Australia

The Blame Game

Report on the inquiry into health funding

House of Representatives
Standing Committee on Health and Ageing

November 2006
Canberra

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Foreword

A common complaint to Members of Parliament is that, when people are unhappy about their health care, both the Commonwealth and the states blame each other for the failings of the health system. While the associated political grandstanding often makes for some good headlines, the blame game does not benefit patients. Patients don't care which level of government manages or pays for their health care — they want reliable access to quality care.

The blame game is a feature of the health system in Australia. The committee considers that an Australian Government led 'national health agenda' is an important part of addressing the blame game.

Addressing the blame game will involve a national approach to developing and funding health care. This will require leadership from the Australian Government, cooperation by the states and a joint commitment to end the blame game. The complexity of health delivery and financing, the rate of development of new health technologies and rising community expectations mean that ongoing reform is needed.

While there is scope for improving the quality and access to health care in Australia, it is important to bear in mind that the health system delivers good outcomes compared to similar overseas countries.

There is no questioning the commitment and dedication of the health workforce in providing high quality health care. Despite the constraints that financing arrangements can impose, most of the time health professionals are able to ensure that patients receive the care they need, when they need it. However, access to health care, particularly in regional, rural and remote areas requires sufficient skilled health workers training and working in major cities and in regional areas.

I welcome the Australian Government's recent commitment to address the under investment in training places for medical and other health professionals over the past 15 to 20 years. However, attention now needs to be given to ensuring that there are sufficient clinical training opportunities in both the public and private sectors for rising numbers of health trainees.

The committee received considerable evidence about Australian Health Care Agreement funding for public hospitals. These agreements expire on 30 June 2008 and governments are considering options for reform. The committee supports some divergence from the current funding model to remove barriers to health reform and more closely link funding with national policy standards and accountability for quality health care. Public hospital funding arrangements should also give closer attention to the health care needs of people living in regional and rural areas.

One key objective of the inquiry was to allow for a transparent engagement with organisations and individuals outside government about their ideas on health funding. The inquiry overlapped with a review by the Council of Australian Governments (COAG), which by its nature, does not provide opportunities for wide consultation with health professionals or the community. The committee is pleased that many of these concerns have been addressed.

The committee received 159 submissions, held 18 public hearings, made 9 site inspections and received approximately 28 private briefings. I would like to thank those who put so much time and effort into their submissions and travelled long distances to appear at public hearings and assist the committee.

It was particularly pleasing to receive submissions and hear evidence from the governments of the ACT, Victoria, Northern Territory, Western Australia and South Australia. Unfortunately, other state governments, some of whom voiced opinions in the media, did not choose to make a direct contribution to the inquiry.

During the course of the inquiry, there were significant problems in the Queensland health system, including allegations of misconduct by 'Dr Death' in Bundaberg Hospital. It is clear that there needs to be significant reform within Queensland Health to ensure that there is no repeat of the horrors allegedly allowed to be practised by Dr Patel. The Queensland Minister for Health did not take up my offer to conduct a swift and open inquiry into further claims of misconduct in August 2006 at Mackay Base Hospital.

Finally, I would like especially to thank the Deputy Chair, Jill Hall MP, and all the members of the committee, including the early involvement of Malcolm Turnbull MP. The committee's enthusiasm for developing health reforms was shown by the hard work and determination to hear evidence and make site inspections around Australia. The committee secretariat work was diligent and sustained, and the committee thanks all those staff involved.

Hon Alex Somlyay MP
Chair



Membership of the Committee

Chair Hon Alex Somlyay MP

Deputy Chair Ms Jill Hall MP

Members Hon Alan Cadman MP

 Mrs Justine Elliot MP

 Mrs Kay Elson MP

 Hon Warren Entsch MP (from 9/2/06)

 Mr Steve Georganas MP

 Mr Michael Johnson MP

 Ms Catherine King MP

 Mr Malcolm Turnbull MP (until 9/2/06)

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Terms of reference

The House of Representatives Standing Committee on Health and Ageing has reviewed the 2003-2004 annual reports of the Department of Health and Ageing and the Private Health Insurance Administration Council and resolved to conduct an inquiry.

The Committee shall inquire into and report on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

- a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;
- b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;
- c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;
- d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in the various levels of government; and
- e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.



List of abbreviations

| | |
|--------|--|
| ACHS | Australian Council on Health Care Standards |
| ACSQHC | Australian Council for Safety and Quality in Health Care |
| AHCA | Australian Health Care Agreement |
| AHMC | Australian Health Ministers' Conference |
| AIHW | Australian Institute of Health and Welfare |
| AMA | Australian Medical Association |
| COAG | Council of Australian Governments |
| COPD | Chronic Obstructive Pulmonary Disease |
| FAGs | Financial Assistance Grants |
| FBT | Fringe Benefits Tax |
| GDP | Gross Domestic Product |
| GPs | General Practitioners |
| GST | Goods and Services Tax |
| HACC | Home and Community Care |
| HPPA | Hospital Purchaser Provider Agreement |
| IMVS | Institute of Medical and Veterinary Science |

| | |
|--------|---|
| MBCC | Medicare Benefits Consultative Committee |
| MBS | Medicare Benefits Schedule |
| MOU | Memorandum of Understanding |
| MPS | Multi-Purpose Services |
| MS | Multiple Sclerosis |
| MSAs | Medical Savings Accounts |
| MSAC | Medical Services Advisory Committee |
| OECD | Organisation for Economic Co-operation and Development |
| PBS | Pharmaceutical Benefits Scheme |
| PEI | Patient Episode Initiation |
| PHIAC | Private Health Insurance Administration Council |
| PHI | Private Health Insurance |
| PHOFA | Public Health Outcome Funding Agreement |
| RPBS | Repatriation Pharmaceutical Benefits Scheme |
| SPGPPS | Strategic Planning Group for Private Psychiatric Services |
| SPPs | Specific Purpose Payments |
| VMO | Visiting Medical Officer |



List of recommendations

3. A national health agenda

Recommendation 1

The Australian, state and territory governments develop and adopt a national health agenda. The national agenda should identify policy and funding principles and initiatives to:

- rationalise the roles and responsibilities of governments, including their funding responsibilities, based on the most cost-effective service delivery arrangements irrespective of governments' historical roles and responsibilities;
- improve the long term sustainability of the health system as a whole;
- support the best and most appropriate clinical care in the most cost effective setting;
- support affordable access to best practice care;
- rectify structural and allocative inefficiencies of the whole health system, as it currently operates;
- give a clear articulation of the standards of service that the community can expect;
- redress inequities in service quality and access; and
- provide a reporting framework on the performance of health service providers and governments. (*para 3.52*)

Recommendation 2

As a matter of priority, the Department of Health and Ageing undertake the actions specified in the July 2006 Council of Australian Governments' response to the Productivity Commission's health workforce inquiry to:

- improve the efficiency and transparency of existing mechanisms to assess changes to the Medicare benefits schedule; and
- strengthen links between the Medical Services Advisory Committee and the Medicare Benefits Consultative Committee.
(para 3.107)

Recommendation 3

The Australian Government should supplement state and territory funding for public dental services so that reasonable access standards for appropriate services are maintained, particularly for disadvantaged groups. This should be linked to the achievement of specific service outcomes. *(para 3.119)*

4. Funding a sustainable health workforce

Recommendation 4

The Department of Health and Ageing take a lead role to better coordinate the existing jurisdiction-based recruitment of overseas trained health professionals by the Commonwealth and state and territory governments. *(para 4.53)*

Recommendation 5

The Australian Government implement a strategy for Australia to:

- be self sufficient by 2021 in producing adequate numbers of health profession graduates to meet projected demand;
- provide the necessary funding to expand the training system to accommodate the required number of students; and
- consider using the AusAID budget to expand medical training to further assist developing countries. *(para 4.59)*

Recommendation 6

The Minister for Science, Education and Training ensure that agreements about health workforce allocation and funding between the Department of Education, Science and Training and universities allow for supplementary funding by the Department of Health and Ageing to:

- provide support to universities to attract and retain key academic staff; and
- ensure appropriate clinical training opportunities for medical and other health workforce students. *(para 4.71)*

Recommendation 7

The Australian Government develop explicit purchasing agreements for clinical training with public health care providers. The purchasing agreement would cover:

- funding levels — adequate to support existing and planned levels of training in both metropolitan and regional locations;
- specified outcomes — including the quantity and quality of training conducted; and
- performance measures — allowing timely assessment of progress in meeting obligations. *(para 4.82)*

Recommendation 8

The Australian Government take advantage of expanding opportunities for private sector health providers to conduct clinical training and, where appropriate, enter into purchasing arrangements to fund this training. *(para 4.94)*

Recommendation 9

The Australian Government ensure that the new national health professions' accreditation body's decisions about changes in models of care arising from task substitution are also reflected in funding arrangements. *(para 4.108)*

Recommendation 10

The Australian Government amend the *Fringe Benefits Tax Assessment Act 1986* so that:

- local governments operating aged care facilities are able to qualify for fringe benefits tax exemptions granted to public benevolent institutions for employees involved in the aged care facility; and
- fringe benefits exemptions applying to public employers delivering health services in hospital-based settings also apply to public employers providing health services in other settings. (*para 4.123*)

5. Rural and regional health services

Recommendation 11

The Minister for Health and Ageing, in consultation with state and territory health ministers and as part of the national health agenda (see recommendation no. 1), develop standards for the delivery of health services in regional, rural and remote areas. (*para 5.41*)

6. Local government

Recommendation 12

The Minister for Local Government, Territories and Roads give priority to the development of processes and guidelines to assist Australian Government agencies implement the principles of the Inter-Governmental Agreement on Local Government, as announced by the Australian Government on 6 September 2006. (*para 6.34*)

7. Public hospital services

Recommendation 13

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government either:

- vary its funding arrangements so that the ‘utilisation growth factor’ can rise or fall in response to the actual level of services provided on the basis of clinical need; or
- define the number of services that it will fund, in a way that is consistent with its funding and indexation formulae. (*para 7.33*)

Recommendation 14

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government ensure that indexation arrangements reflect actual cost increases discounted by an appropriate efficiency dividend. *(para 7.34)*

Recommendation 15

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government should define the standards that states must meet to satisfy the principle of equitable access to public hospital services, particularly in relation to people living in rural and regional areas. *(para 7.43)*

Recommendation 16

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government consider dividing funds into separate streams through which it can:

- provide general revenue assistance to the states as a supplement to the Goods and Services Tax (GST) pool; and
- make specific purpose payments to the states to support its policy objectives in relation to public hospital services and health system reform. These payments:
 - ⇒ should be linked to outcomes and performance standards; and
 - ⇒ should not be absorbed into the GST pool. *(para 7.49)*

Recommendation 17

The Australian Government should make specific purpose payments to the states and territories for the provision of public hospital services subject to horizontal fiscal equalisation using the Commonwealth Grants Commission's 'inclusion' method rather than by being absorbed into the Goods and Services Tax (GST) pool. This would require amendments to the *A New Tax System (Commonwealth –State Financial Arrangements) Act 1999*. *(para 7.53)*

Recommendation 18

The Australian Government should ensure that the terms and conditions associated with future public hospital arrangements do not lock-in historical Commonwealth-state service provision models. Future arrangements should:

- support the movement of services between Commonwealth and state funded programs where this leads to better quality or more cost effective care; and
- allow post hoc adjustments to Commonwealth-state funding arrangements if necessary. *(para 7.59)*

Recommendation 19

The Australian Government consider extension of Medicare Benefits Schedule funding, or substitute grant funding, to public outpatient and emergency department services. *(para 7.65)*

8. Private health

Recommendation 20

The Australian Government introduce an outcomes-based assessment process that:

- examines the clinical benefits of new prostheses prior to their widespread use in Australia; and
- reviews the effectiveness of prostheses currently in use. *(para 8.49)*

Recommendation 21

The Australian Government amend private health insurance legislation to require that a single coordinating doctor be required to obtain informed financial consent from a patient in relation to all treating health professionals in all but the most exceptional circumstances (such as emergencies). The patient should consent in advance to the cost of the full range of services provided by all health professionals involved in the patient's care. *(para 8.68)*

Recommendation 22

The Australian Government, in conjunction with the Australian Medical Association, establish guidelines for private hospitals and health funds that discourage medical professionals and private hospitals providing specific advice to their patients about transfer private health insurance funds and/or products. *(para 8.79)*

Recommendation 23

The Department of Health and Ageing undertake further research to examine how medical savings accounts could be introduced within the Australian health financing system as a health savings and insurance vehicle. *(para 8.98)*

9. Improving accountability

Recommendation 24

The Australian Government, in conjunction with the states and territories, give priority to undertaking research to develop mechanisms to make waiting lists for public hospital elective surgery fairer. *(para 9.15)*

Recommendation 25

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government provide incentives for the states and territories to report in a consistent manner on patient waiting times for access to specialists in outpatient clinics. *(para 9.20)*

Recommendation 26

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government require all public hospitals to:

- be accredited by the Australian Council on Healthcare Standards (or an equivalent accreditation agency); and
- publish their accreditation reports within three months of being completed. *(para 9.38)*

Recommendation 27

The Australian Government prohibit the payment of private health insurance benefits for hospital services unless the relevant hospital:

- is accredited by the Australian Council on Healthcare Standards (or an equivalent accreditation agency); and
- publishes their accreditation reports within three months of being completed. *(para 9.39)*

Recommendation 28

The Australian Government require all state and territory governments to regularly publish reports on sentinel events occurring in their public hospitals. *(para 9.47)*

Recommendation 29

The Australian Government support the development of hospital and clinician-based performance information systems to better inform patients about the competence of health care providers and strengthen accountability of health professionals and health service providers. Reporting systems should allow, where appropriate, for performance information to be qualified to reflect differences in the type of patients being treated. (*para 9.54*)

Introduction

...when we are talking about what is world class...when we are overseas and get sick, where do we want to be? Almost without exception people want to come to Australia... (home). So whilst I think we are actually very harsh on our own health service...in fact, it stacks up against just about any health service in the world.¹

...Australia does not need to spend more money on health. We should be spending it much more effectively and efficiently than we do. I often say that treasurers and treasury departments should be the allies in forcing reform. Reform is needed. We do need to get better value for money.²

- 1.1 The Australian health system delivers many health outcomes of which we should be proud. Highly skilled and motivated health professionals working in both community and hospital settings are generally able to provide the health care that we need, when we need it.
- 1.2 Population ageing, including the ageing medical workforce, advances in medical technology and an increasing demand for medical services are all contributing to the rising cost of health care to the Australian economy.

1 Green D, Australian Healthcare Alliance, transcript, 26 May 2006, p 50.

2 Menadue J, transcript, 21 July 2006, p 26.

- 1.3 Health workforce shortages significantly affect access to health services for some members of the community, such as rural, regional and indigenous people. Despite recent increases in training opportunities at universities, it will be around 10 years before additional numbers of doctors, nurses and other allied health professionals will contribute fully to the operation of the health system.
- 1.4 Changes to health funding arrangements are required to provide incentives for healthcare service providers to deliver more appropriate care and take advantage of the different methods of treatment resulting from rapid changes in technology. Changes are also required to develop a health workforce that can sustain teaching and learning over the long term, in the private and public sectors.
- 1.5 While many participants³ to the committee's inquiry suggested the need to increase expenditures in some areas, such as specific population groups and in regional and remote areas, there was not universal support for the need to increase funding overall in the short term.
- 1.6 The concern was for equity and access to health services, regardless of where they live.
- 1.7 Debate over health funding arrangements is inevitably tied to issues relating to Australia's federal system. Different funding models for public and private health that change the roles and responsibilities of different levels of government have been discussed by governments at various times.
- 1.8 The committee considers that significant momentum is gathering within the community to address the fragmented Commonwealth-state responsibilities for health financing and service delivery. Several different funding models, including the Commonwealth assuming full responsibility as a purchaser of health care services, warrant serious consideration by governments to determine if these funding models can deliver better health care than current arrangements. Consumers do not care which level of government pays – only what services are provided.

3 See for example, Australia Dental Association, sub 28, p 1; Rural Doctors Association of Australia, sub 31, p 2; Sprogis A, Hunter Urban Division of General Practice, transcript, 20 July 2006, p 53; Australian Division of General Practice, sub 15, p 3; Enteral Industry Group, sub 119, p 2.

Setting the context

- 1.9 There are many areas of Australia's health system that deliver world-class outcomes for patients. Advocates of the need for change point to a range of adverse outcomes for some population groups, such as Indigenous Australians and people suffering from mental illnesses, as well as biases towards treating 'illness' rather than promoting 'wellness'.
- 1.10 Many submissions to the inquiry highlighted some of the poor outcomes for mental health patients from the Australian health system. The committee largely deferred the mental health aspects of health funding to the Senate Select Committee on Mental Health, which conducted an inquiry during 2005 and 2006.⁴
- 1.11 The committee welcomes the commitment of \$1.8 billion of new Commonwealth funding to improve mental health services in the community.⁵ The committee encourages the states to meet their funding and service delivery commitments under the *National Action Plan on Mental Health 2006 – 2011*, developed as part of the Council of Australian Governments' process. Some states have already made a commitment.
- 1.12 During the course of the inquiry there has been significant discussion within government about reforming health funding and service delivery arrangements. The former secretary of the Department of Health and Aged Care, Mr Andrew Podger, headed a taskforce commissioned by the Prime Minister to examine how to improve the delivery of health services.⁶ The taskforce report was not publicly released. Further consideration has also been given to health funding by the Council of Australian Governments, which involved discussions between senior bureaucrats primarily behind closed doors.
- 1.13 The committee considers that undertaking this inquiry in parallel with these discussions between governments has provided for a transparent engagement with organisations and individuals outside government about their ideas on health funding.

4 Senate Select Committee on Mental Health 2006, *A national approach to mental health — from crisis to community*, First report, March.

5 Hon Tony Abbott MP, Minister for Health, media release, *Commonwealth commitment to mental health services*, 5 April 2006.

6 Hon John Howard MP, Prime Minister of Australia, media release, *Appointment of secretaries*, 22 October 2004.

- 1.14 Partly as a response to discussions between governments and evidence to the committee, the Commonwealth has announced significant health policy changes and additional funding to address some issues (box 1.1).

Box 1.1 Significant health care related reforms and initiatives, 2005–2006

Mental health services — Following the February 2006 Council of Australian Governments (COAG) meeting, the Commonwealth announced that \$1.8 billion in new funds for mental health services, with a commitment of around \$500 million in the fifth year and ongoing, for the five-year action plan that is being developed.⁷ As part of the package, the Commonwealth announced several new items would be added to the medicare benefits schedule from November 2006 to support better access to psychiatrists, psychologists and GPs.⁸

Improvements to private health insurance products to broaden coverage to out of hospital services — From April 2007, health funds will be able to offer products that cover a broader range of health care services that do not require admission to hospital but which are part of an episode of hospital care or substitute for or prevent hospitalisation.⁹

COAG response to health workforce issues — In response to a research report by the Productivity Commission into Australia's health workforce, the Commonwealth has announced an additional 600 medical places.¹⁰ Additional places for nursing have also been announced.¹¹ Broader health workforce reforms include the establishment of national registration and accreditation bodies for health professions, the development of an agreement with the states for the allocation of places for university based education and training of health professionals within each jurisdiction and the prospect of limited practitioner delegation arrangements to increase task flexibility.¹²

Enhanced primary care services — several 2005-06 and 2006-07 budget initiatives have strengthened the capacity of primary health care, including general practitioners providing coordinated care for chronically ill patients, incentives for earlier intervention in selected at-risk groups and wider bulk billing and after-hours GP access.¹³

7 Hon John Howard MP, Prime Minister of Australia, media release, *Better mental health services for Australia*, 5 April 2006.

8 Hon Christopher Pyne MP, Parliamentary Secretary to the Minister for Health and Ageing, media release, *Better access to mental health services*, 9 October 2006.

9 Department of Health and Ageing, sub 143, p 5.

10 Hon John Howard MP, Prime Minister of Australia, media release, *More doctors and nurses for the health system*, 8 April 2006; media release, *More doctors, nurses and allied health professionals for Australia's health system*, 13 July 2006.

11 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Developing the health workforce to meet community needs*, 9 May 2006.

12 Council of Australian Governments, *Communique*, 14 July 2006.

13 See for example, Hon Tony Abbott MP, Minister for Health and Ageing, media release, *GPs benefit from Budget*, 11 May 2005; media release, *New Medicare item for Indigenous health, refugees and palliative care*, 1 May 2006; media release, *Government expands Medicare*

- 1.15 The committee generally welcomes these changes, which should lead to measurable improvements in access to health care services and health outcomes for many members of the community. Where relevant, the committee has taken account of these significant changes in making its recommendations for future health financing arrangements.
- 1.16 Overwhelmingly, inquiry participants noted the significant impact on access to health services resulting from shortages in skilled health care workers. Part of the shortage of health professionals is likely to be due to an under-investment in training places over the past 15–20 years. Health funding arrangements can also contribute to a mal-distribution of health professionals, less opportunity for quality training in public hospitals and a reduced capacity for older experienced health professionals to train the next generation of health workers — primarily because of the increased work demands and insufficient professionals.
- 1.17 There is a need for the Commonwealth to engage with the states¹⁴ about longer term reform of health funding arrangements. The committee proposes a national health agenda to guide future reform and improve the long term sustainability of the health system.
- 1.18 Some see the renegotiation of the next five-year Australian Health Care Agreements (AHCAs) as the best opportunity to develop and implement meaningful health reform. However, in conjunction with the AHCAs, the committee considers that a separate process via a national health agenda is more likely to produce positive results.

Conduct of the inquiry

- 1.19 On 16 March 2005, the committee resolved to conduct an inquiry into health funding. The inquiry was launched on the same day, with the chair of the committee issuing a media release calling for public submissions.¹⁵ Advertisements calling for submissions were placed in *The Australian* in March 2006 and letters were sent to individuals and

for chronically ill, 9 June 2005; media release, *After-hours GPs: Improving access for families and local communities*, 23 May 2006; media release, *Government expands Medicare for the chronically ill*, 9 June 2005.

14 In this report, references to 'states' or 'each state' includes the territories.

15 Hon Alex Somlyay MP, media release, *Somlyay launches new inquiry into health funding*, 16 March 2005.

peak bodies, including state and territory governments inviting them to make a submission to the inquiry.

- 1.20 A total of 159 submissions were received (see appendix A) and 59 exhibits were accepted as evidence to the inquiry (see appendix B). Submissions were received from all states and territories from groups and individuals residing in metropolitan and regional areas.
- 1.21 Five state governments made submissions — ACT, Victoria, Northern Territory, Western Australia and South Australia. The committee welcomed the contributions from these governments and was disappointed that the remaining governments have not contributed to the inquiry. The NSW and Queensland governments indicated to the committee that they were providing input to health reform through the Council of Australian Governments (COAG) process and declined to provide submissions to the inquiry or appear at public hearings.
- 1.22 During the course of the inquiry, there was considerable media coverage about problems in the Queensland public hospital system. The Queensland government eventually established a Commission of Inquiry in 2005 into allegations about the care of patients at Bundaberg Hospital.
- 1.23 To further involve the community in the inquiry, the committee held 18 public hearings in almost all states and territories between 30 May 2005 and 4 September 2006 (see appendix C). Some 9 site inspections were held by the committee, including the viewing of pathology laboratories, an IVF clinic, a midwife-led birthing centre and the national ‘Critical Care and Trauma Response Centre’ at Royal Darwin Hospital.
- 1.24 Copies of the transcripts of the public hearings are available from the committee’s website.¹⁶
- 1.25 The committee also received 28 private briefings from various Commonwealth agencies, individuals and academics working in relevant fields. During the course of the inquiry, committee members also attended a number of public health conferences and briefings.

16 House of Representatives Standing Committee on Health and Ageing, www.aph.gov.au/house/committee/haa/index.htm; PO Box 6021, Parliament House, Canberra, ACT, 2600.

Scope and structure of the report

- 1.26 The terms of reference for the inquiry are broad. The committee has generally focussed on high-level structural health funding issues rather than addressing the issues at a program by program level.
- 1.27 While the report structure is loosely aligned around the terms of reference, the committee has developed a number of key themes from the evidence that run across different parts of this report:
- the health system is complex. Any change to funding arrangements needs to take a holistic approach because of the mutually dependent and complementary nature of different parts of the health (and education) system in delivering health services;
 - funding for health needs to be re-oriented to support a system that focuses on ‘wellness’ rather than illness — this applies to both public and private funding sources;
 - the private sector is an important part of the health system and its interactions with the public sector can be crucial to providing quality care. It needs to be better integrated to take advantage of the things that it does well, and for the skills and experience of its employees to be better used;
 - traditional health funding arrangements do not support the health (and education) system delivering a health workforce that will be sustainable into the future. More explicit attention as to how governments fund the training and education of the health workforce, the delivery of training in universities, and in the public and private hospital system is warranted.
 - the community’s knowledge and understanding about the Australian health system needs to be improved to clarify expectations about rising private health insurance premiums, out-of-pocket costs and waiting times for treatment.
- 1.28 A brief introduction to the complexity of health funding and service delivery arrangements is presented in chapter 2, together with evidence of how Australia’s health care system compares favourably with overseas equivalent. Some of the shortcomings of funding and service delivery arrangements are also discussed.
- 1.29 In chapter 3, the committee outlines the need to develop a national health agenda to guide future reform and clarify objectives for

Australia's health system. Options for radical and incremental reform are discussed.

- 1.30 The importance of the health workforce to deliver high quality health care is the focus of chapter 4. The effects of health funding arrangements on the equitable provision of services and the need for urgent attention to be given by the Commonwealth and the states to providing clinical experience for the rising number of health workforce trainees are examined.
- 1.31 Chapter 5 discusses options for restructuring health funding arrangements to take account of the disadvantages experienced in rural and remote areas.
- 1.32 In chapter 6, the committee acknowledges the often under recognised contribution local governments make to the provision of health care services.
- 1.33 For many people, public hospitals are the cornerstone of the health system. Funding and service delivery arrangements are the focus of chapter 7, which examines a range of options that the Commonwealth should consider in future agreements with the states for joint funding of public hospital services.
- 1.34 In chapter 8, the committee examines the important contribution that the private sector makes to the health system. The importance of recent reforms to private health insurance arrangements are discussed and further options for reform are also canvassed.
- 1.35 Accountability for the provision of health services is weakened by shared funding arrangements for many parts of Australia's health system. Chapter 9 examines how the community's understanding about the complexity and costs of the health system can be improved and the need to better inform the community about the quality of services provided by medical professionals.

Overview

..... what I've described as the dogs breakfast of divided responsibilities which bedevils our health system or our health systems. As many of you who have been in public, private and other health institutions would know, it's possible on a moment by moment, hour by hour basis to shift from federally funded but privately delivered services to federal and state funded but publicly delivered services to federally funded but state delivered services to federally subsidised and also privately funded services.¹

- 2.1 This chapter provides important background to the responsibilities of different levels of government for health care and the structure of health funding and service delivery arrangements. On the whole, health outcomes compare favourably to similar overseas countries. However, rising costs of health care and a funding structure that can create incentives for governments to shift costs to others can compromise the ability of public and private health care providers to offer the care that patients require.

Roles and responsibilities

- 2.2 The Australian health system is complex. Three levels of government and the private sector have significant roles in raising funds,
-

1 Hon Tony Abbott MP, Speech to the Centre for Independent Studies policy makers forum, 20 September 2006, viewed on 24 October 2006 at www.cis.org.au/Events/policymakers/tony_lecture/Abbott_lecture_06.pdf.

allocating resources, regulating and delivering health services. In many cases these roles overlap. As a result, decisions by one government (or private sector health provider) can impact on other parties.

- 2.3 Patients do not always see, or care about this complexity, or which level of government pays for their health care.
- 2.4 State governments have primary responsibility under current arrangements for health services, including most acute and psychiatric hospital services. At federation, the only explicit Commonwealth power in relation to health was quarantine matters. In 1946, a constitutional amendment allowed the Commonwealth to provide pharmaceutical, sickness and hospital benefits and medical and dental services, without altering the powers of the states in this regard. The constitution also allows the Commonwealth to provide financial assistance to any state on any terms and conditions that the Parliament deems appropriate.²
- 2.5 Consequently, responsibility for parts of the health system is shared between the Commonwealth and state governments. Inquiry participants sometimes viewed this shared responsibility differently, with the Department of Health and Ageing emphasising ‘complementary’ responsibilities and a ‘partnership’ between the Commonwealth and state governments.³
- 2.6 The Western Australian Government noted that although there were areas where states have maintained major responsibility, the Commonwealth exercised a substantial degree of ‘control’ over policy and funding through its use of conditional grants.⁴
- 2.7 Notwithstanding the sometimes shared role, the Commonwealth has assumed the leading role to provide universal and affordable access to high quality medical, pharmaceutical and hospital services through Medicare and the pharmaceutical benefits scheme. It also has clear responsibility for some population groups using the health system — including funding for residential aged care services and community care and war veterans.⁵
- 2.8 The Department of Health and Ageing noted that the Commonwealth provides a ‘leadership’ role in areas of national policy significance,

2 See Section 51 (xxiiiA) and Section 96 of the *Commonwealth of Australia Constitution Act*.

3 Department of Health and Ageing, sub 43, p 6.

4 Western Australian Government, sub 124, p 3.

5 Department of Health and Ageing, sub 43, p 6.

including protecting the overall health and safety of the population, improving access to health services by the Aboriginal and Torres Strait Islander population, guiding national research and evaluation, trialling innovative service delivery approaches and coordinating information management.⁶

2.9 State governments are the main providers of publicly provided health services including:

- public hospital services;
- mental health programs;
- home and community care;
- child, adolescent and family health services;
- women's health programs;
- public health services; and
- inspection, licensing and monitoring of premises, institutions and personnel.⁷

2.10 The Commonwealth has important responsibilities for the development and training of the health workforce through the funding and allocation of university places and medical school facilities and setting criteria for overseas trained medical professionals to work in Australia. State governments partly share the responsibility for development and training through their provision of clinical training places in public hospitals and their funding and regulation of vocational training. The responsibility of different levels of government for workforce training and development is examined in more detail in chapter 4.

2.11 Local government does not have a legislated or constitutional role in the health system.⁸ However, many local governments are involved in delivering health services such as immunisation programs and aged care services and providing infrastructure to service providers.⁹

6 Department of Health and Ageing, sub 43, p 6.

7 Western Australian Government, sub 124, p 3.

8 Local Government Association of NSW and Shires Association of NSW, sub 18, p 5.

9 Western Australian Local Government Association, sub 34, pp 4–5; Local Government Association of NSW and Shires Association of NSW, sub 18, p 5; Australian Local Government Association, sub 36, pp 4–9.

- 2.12 Local government also has a role in the provision of ‘public health-type’ services such as water and air pollution abatement, food quality standards enforcement and the provision of recreation and leisure facilities.¹⁰ The role of local governments in delivering health services is examined in more detail in chapter 6.
- 2.13 There are areas of the health system, such as dental care, where the Commonwealth and state governments do not agree on where the responsibility for funding and delivery lies.¹¹
- 2.14 In the case of dental care, the long waiting lists for public dental services and evidence of declining oral health in the population¹² indicate that disagreements between governments over funding responsibility are leading to poor health outcomes for some Australians.

Funding health care

- 2.15 Total expenditure on health goods and services in 2004-05 was estimated at \$87.3 billion, an average of \$4,319 per person. Of this, 94.1 per cent was for recurrent expenditure and 5.9 per cent was for capital formation and capital consumption. Average expenditure per person varies across states, ranging from \$4,047 in Tasmania to \$4,834 in the Northern Territory.¹³

10 Australian Local Government Association, sub 36, pp 4–9.

11 Australian Dental Association, sub 28, p 9; Western Australian Government, sub 124, p 3; Department of Health and Ageing, sub 43, pp 6–7.

12 Spencer J, ‘Narrowing the inequality gap in oral health and dental care in Australia’, Australian Health Policy Institute (2004), The University of Sydney, Commissioned paper series, pp 5–8; Australian Dental Association, sub 28, p 18.

13 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), pp 9, 16 and 18.

2.16 Per capita, the cost of the Australian system compares favourably with other developed countries (table 2.1).

Table 2.1 Health expenditure per person, Australia and other selected OECD countries, current prices, 1993 to 2003^(a) (\$)

| Year (a) | Australia | Canada | France | Japan | NZ | UK | USA | Avg (b) |
|----------|-----------|--------|--------|-------|-------|-------|-------|---------|
| 1993 | 2,052 | 2,699 | 2,517 | 1,829 | 1,494 | 1,651 | 4,498 | 2,409 |
| 1998 | 2,695 | 3,009 | 2,929 | 2,283 | 1,898 | 2,066 | 5,368 | 2,886 |
| 2003 | 3,855 | 4,054 | 3,919 | n.a. | 2,546 | n.a. | 7,607 | 4,035 |

Notes: (a) Estimated health expenditure according to the International Classification of Health Accounts excludes expenditure on health research. Expenditures converted to Australian dollar values using GPD purchasing power parities. (b) Average of 27 countries (excluding Japan and UK) weighted by population or GDP.

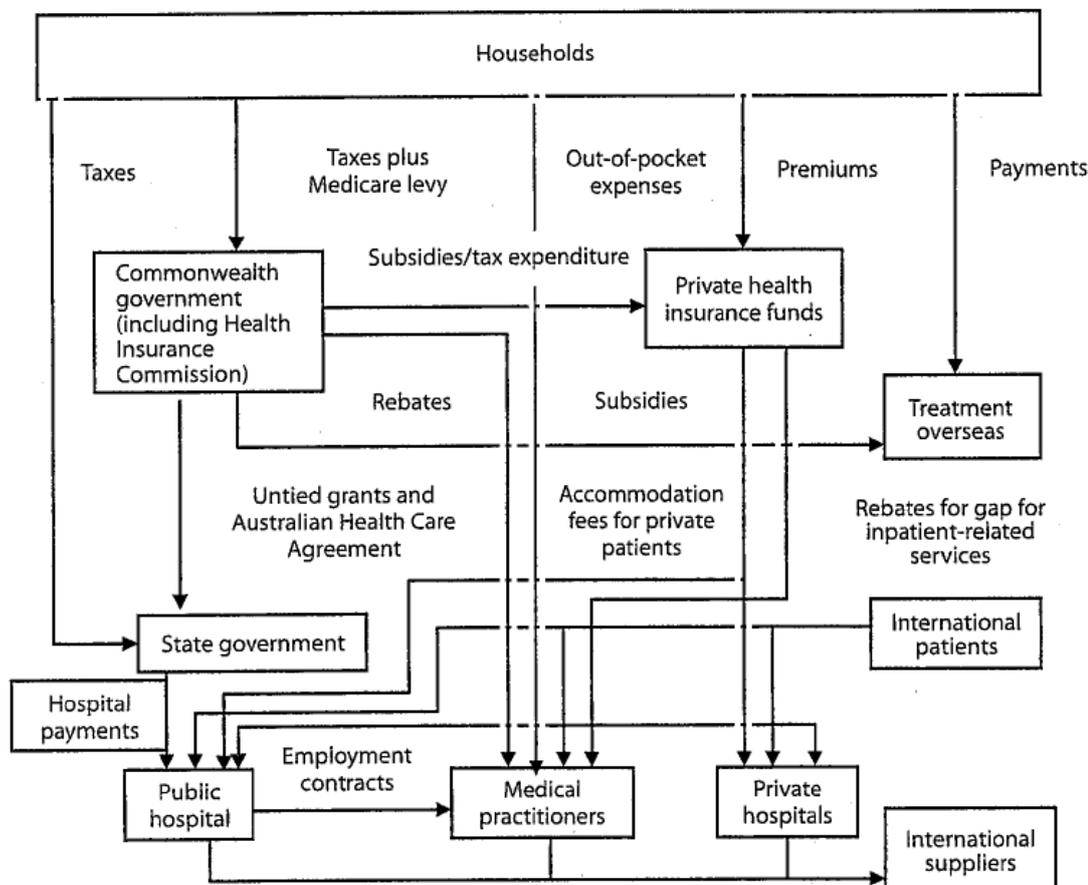
Source Australian Institute of Health and Welfare, *Australia's health 2006 (2006)*, p 299.

2.17 Direct funding of health care is complemented by significant expenditure in other areas, including funding of higher education and training and foregone tax revenue from exemptions provided to health care providers by different levels of government. These indirect health expenditures are discussed in chapter 4.

2.18 Health funding arrangements in Australia involve a complex flow of funds between taxpayers, patients, private health insurance funds, public and private service providers and different levels of government (see figure 2.1).

2.19 There has been a greater emphasis towards consumers of health care contributing to their health care in the form of higher out of pocket expenses (see below).

Figure 2.1 Funding flows for hospital and medical services



Source Adapted from Duckett S, *The Australian Health Care System* (2004), p 75.

2.20 Health spending features significantly in the taxing and spending decisions of governments — accounting for around 15 per cent of total Commonwealth general government revenue and 24 per cent of total state government revenue in 2004-05.¹⁴

2.21 Commonwealth expenditure on health is largely raised through general taxation. Of the Commonwealth's \$35.7 billion in health expenditure in 2004-05, around \$6.1 billion (17.1 per cent) was raised from the Medicare levy and surcharge.¹⁵ Despite perceptions that revenue raised by the Medicare levy and surcharge is automatically allocated (hypothecated) to support the health system, all money raised by the levy and surcharge is paid into consolidated revenue. In

14 Australian Bureau of Statistics, *Government Finance Statistics, 2004-05* (2006), Cat No 5512.0, pp 10 and 40.

15 Parliamentary Library, Bills Digest, 'Tax Laws Amendment (Medicare Levy and Medicare Levy Surcharge) Bill 2006', p 2; Australian Institute of Health and Welfare, *Health expenditure Australia 2003-04* (2005), p 18.

- 2003-04, the levy and surcharge accounted for around 3.2 per cent of total Commonwealth taxation revenue.¹⁶
- 2.22 The Commonwealth makes a significant contribution to state government health expenditure through specific purpose grant payments that are tied to the delivery of health services. In 2005-06, the Commonwealth provided \$9.2 billion to the states in specific purpose grants, with the majority (90.3 per cent) relating to payments under the Australian Health Care Agreements.¹⁷
- 2.23 The specific purpose payments from the Commonwealth typically comprise around 30 per cent of state government health-related expenditure.¹⁸ Most of the remaining expenditure is financed through state general taxation revenues, including their share of goods and services tax collections, which totalled \$36.8 billion in 2005-06.¹⁹
- 2.24 There are some instances where specific state government taxes, such as those on gambling revenue or tobacco taxes, are hypothecated for health-related purposes.²⁰ For example, in Victoria, tax revenue from gaming machines raised of around \$1 billion is transferred to a trust fund that contributes approximately one-eighth of the Victorian Government's health-related expenditure in 2005-06.²¹
- 2.25 In total, the Australian and state governments make a significant contribution to health expenditure, accounting for 45.6 per cent and 22.6 per cent of health expenditure respectively in 2004-05.²²
- 2.26 Non-government sources also make an important contribution to health funding, accounting for around \$27.7 billion (32 per cent) of overall health expenditure in 2004-05.²³ Around \$18.5 billion
-

16 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 434.

17 The Treasury, *Federal Financial Relations 2006-07*, Budget Paper No. 3 (2006), pp 47-48.

18 The Treasury, *Final Budget Outcome 2003-04* (2004), p 59; Australian Bureau of Statistics, *Government Finance Statistics Australia 2004-05* (2006), Cat No. 5512.0, p 40.

19 The Treasury, *Federal Financial Relations 2006-07*, Budget Paper No. 3 (2006), p 5.

20 For a summary of gambling-related taxes that are used for health-related purposes, see Department of Health and Aged Care, *Gambling: is it a health hazard?* (1999), Occasional Papers, New Series No. 2, April; Moodie A, Victorian Health Promotion Foundation (VicHealth), transcript, 28 June 2005, p 49.

21 Victorian Department of Treasury and Finance, *Statement of Finances 2006-07*, Budget Paper No. 4 (2006), p 174; Victorian Department of Human Services, Victorian Budget 2006-07 Information Kit, 30 May 2006, viewed on 15 August 2006 at www.dhs.vic.gov.au/budget/downloads/budget_07.pdf.

22 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 23.

23 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 23.

(59.7 per cent) of non-government funding for health goods and services is from out-of-pocket payments by individuals, who either meet the full cost of a service or good or share funding with third-party payers—for example, private health insurance funds or the Commonwealth through income tax offsets. The remaining share of non-government sources are contributed by individuals via private health insurance funds (20.5 per cent) and other sources such as workers' compensation schemes.²⁴

Funding and expenditure trends

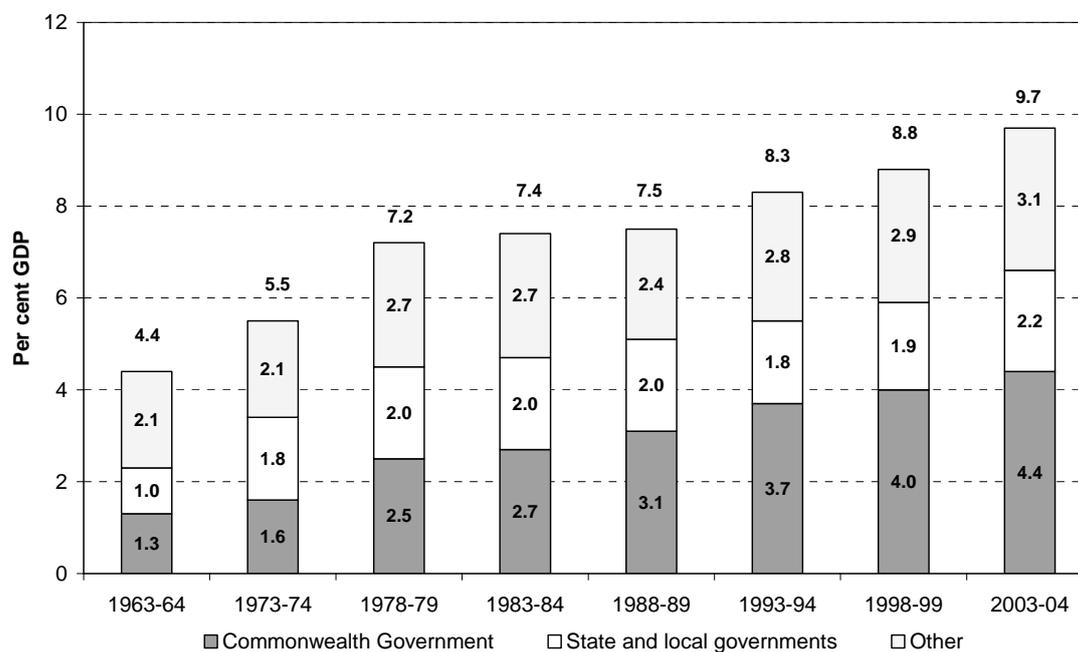
- 2.27 Total health expenditure in 2004-05 increased by \$8.2 billion over the previous year. This is an increase of 10.3 per cent, or 5.9 per cent after allowing for inflation. Over the period 1994-95 to 2004-05, the average annual growth was 8.3 per cent, or 5.3 per cent after allowing for inflation.²⁵
- 2.28 The proportion of total health expenditure sourced from the Commonwealth government, state and local governments, and the non-government sector has been fairly stable since 1998-99, at around 46 per cent, 23 per cent and 31 percent respectively.²⁶
- 2.29 While some sources of health funding are rising more rapidly than others, over the longer term the Commonwealth and state governments and the non-government sector have all contributed to the overall increase in health expenditure relative to the growth in the economy over the past 40 years (figure 2.2).

24 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 38.

25 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 9.

26 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 23.

Figure 2.2 Total health expenditure and GDP, current prices, by source of funds, 1963-64 to 2003-04



Note Other includes individual out-of-pocket, PHI and other non-government (eg: workers' compensation)

Source Australian Institute of Health and Welfare, Health expenditure database, viewed on 20 September 2006 at www.aihw.gov.au/expenditure/datacubes/index.cfm.

2.30 The increase in state government expenditure has not been uniform, with some jurisdictions increasing their contribution to health funding for some types of health services at a faster rate than others. In the case of public hospital funding, the increase in average annual health expenditure per person over the six years to 2004-05 by the states ranged from 3.6 per cent in Tasmania to 8.3 per cent in the Northern Territory (figure 2.3).²⁷

27 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 291.

Figure 2.3 State and territory government recurrent expenditure per person, weighted Australian population, 2004-05 and 1998-99

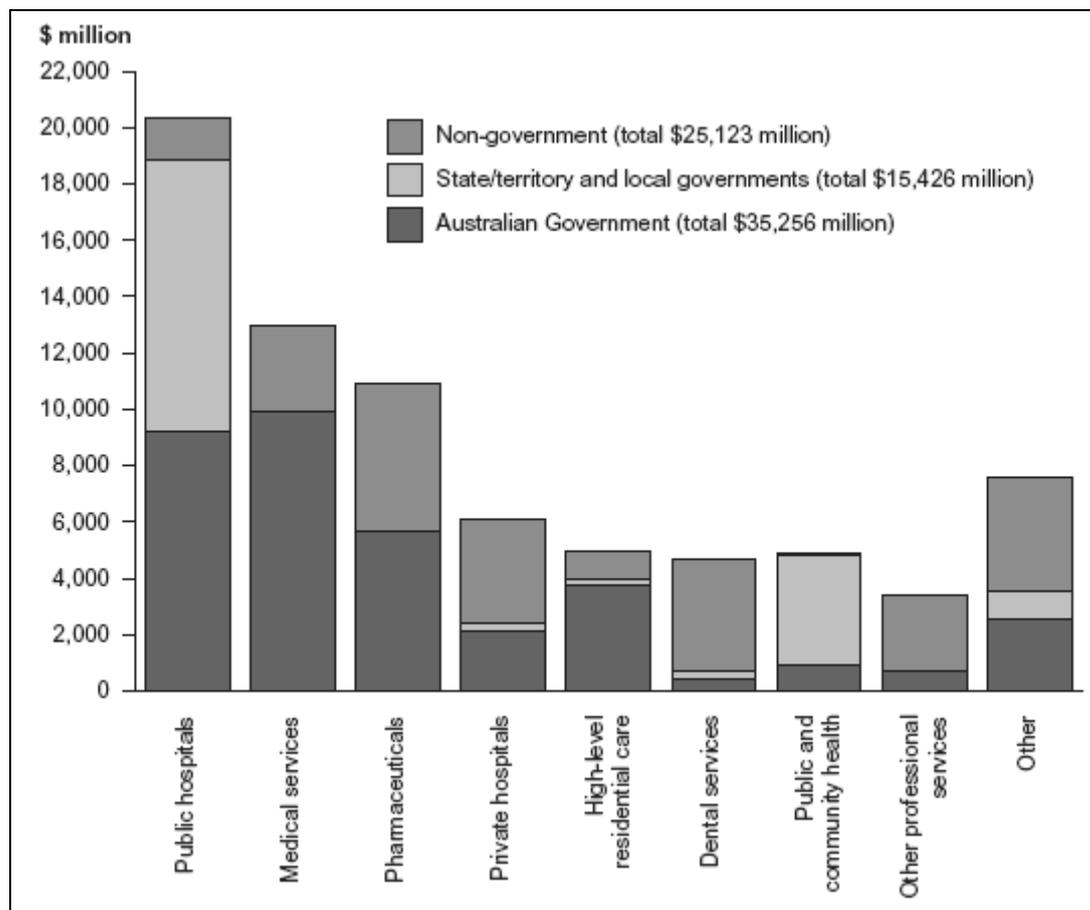
| Rank | | 2004-05 (\$) | 1998-99 (\$) | |
|-------|------------------------------|--------------|--------------|---|
| 1 | Northern Territory | 1355 | 774 | 1 |
| 2 | Australian Capital Territory | 862 | 569 | 2 |
| 3 | Western Australia | 826 | 527 | 4 |
| 4 | Tasmania | 696 | 543 | 3 |
| 5 | New South Wales | 615 | 427 | 5 |
| 6 | Victoria | 555 | 328 | 7 |
| 7 | South Australia | 554 | 353 | 6 |
| 8 | Queensland | 479 | 319 | 8 |
| Total | | 600 | 393 | |

Source Department of Health and Ageing, *The state of our public hospitals, June 2006 Report (2006)*, p 13.

2.31 The relative importance of the funder for different health services varies according to the type of health service (see figure 2.4). In general terms:

- funding for public hospital services is shared by the Commonwealth and state governments;
- private hospital services are largely funded from non-government sources, although the Commonwealth subsidises in-hospital medical costs through the Medicare Benefits Schedule (MBS) and through private health insurance rebates;
- the Commonwealth is the most important source of funds for high-level residential aged care, medical services and health research;
- state governments provide most of the funding for community health programs and public health services; and
- funding for pharmaceuticals is shared between the Commonwealth and non-government sources, and the states in relation to public inpatient services.

Figure 2.4 Recurrent health expenditure by health area and source of funds, current prices, 2003-04



Source Australian Institute of Health and Welfare, *Australia's health 2006 (2006)*, p 302.

2.32 The major agreements and funding arrangements that determine sources of funding for different health services are described in box 2.1. It is important to note that where an episode of care involves patients moving between different areas of health care — such as from a public hospital to a community care setting or residential aged care — the relative contribution to care by governments and individuals can also change.

Box 2.1 Key health system funding arrangements and programs

Medicare benefits schedule (MBS) — a ‘list’ of medical services and selected optometry and dental services specifying the level of benefits paid for private medical services by the Commonwealth. Annual expenditure on the MBS is uncapped and depends on the number of services provided. In 2004-05, MBS expenditure was around \$9.9 billion for more than 236 million services — an average of 11.6 services per resident at an average cost of \$487.69.²⁸

Pharmaceutical benefits scheme (PBS) — provides for the supply of listed pharmaceutical products to eligible people at subsidised rates. Annual expenditure on the PBS is uncapped, and depends on depending on the quantity of different pharmaceutical products dispensed to patients. In 2004-05 expenditure on the PBS was around \$5.5 billion for 170 million services — an average of 8.33 services per resident at an average cost of \$268.30 per resident. A similar Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidies to entitled veterans.²⁹ In 2004-05, RPBS expenditure was around \$274 million for 15.7 million services.³⁰

Australian Health Care Agreements (AHCAs) — commit the Commonwealth to formula based grants to the states as a contribution to the cost of provision of public hospital services. In return, the states are required to provide equitable access to services, free of charge (with limited exceptions) based on clinical need and within a clinically appropriate period. Over the five years of the current agreement (2003–2008), state governments will receive an estimated \$42 billion from the Commonwealth, with \$7.95 billion provided in 2004-05.³¹ The 2003–2008 Agreements require each state to increase funding for public hospitals to at least match the rate of growth of Commonwealth funding over the same period.

Private health insurance rebate — individuals taking out eligible private health insurance policies are entitled to a reimbursement or discount of 30 per cent (or 35 per cent for those aged 65-69 years and 40 per cent for people aged 70 years and over) on the cost of private health insurance. In 2003-04, the cost of the rebate was around \$2.5 billion.³²

Public Health Outcomes Funding Agreement — Agreements between the Commonwealth and state governments to provide funding for a range of public health programs. Expenditure

28 Medicare Australia, Annual Report 2004-05 Statistical Tables, Medicare statistical tables, 3, 4, 13 and 14, viewed on 15 July 2006 at www.medicareaustralia.gov.au/about/about_us/annual_report/04-05/statistics.htm.

29 References to the PBS in this report can generally be taken to include the RPBS.

30 Medicare Australia, Annual Report 2004-05 Statistical Tables, Pharmaceutical and Repatriation Pharmaceutical Benefits Scheme statistical tables 1, 2, 4, 5, 13 and 14, viewed on 16 October 2006 at www.medicareaustralia.gov.au/about/about_us/annual_report/04_05/statistics.htm.

31 Department of Health and Ageing, *The State of our public hospitals, June 2006 report* (2006), p 12.

32 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 310.

by the Commonwealth over the five-year agreements covering the period 2004-05 to 2008-09 is \$812 million (adjusted annually for indexation).³³

Residential aged care — the Commonwealth has primary responsibility for the funding of residential aged care places. In 2003-04, the Commonwealth spent \$5.2 billion on residential aged care (including contributions to veterans).³⁴

Veterans' health services — eligible veterans, war widows and widowers are entitled to health services funded by the Department of Veterans Affairs. Expenditure by the department in 2004-05 was around \$4.1 billion, or an average of \$12,400 per eligible person.³⁵

2.33 The Commonwealth has also entered into arrangements with peak industry groups to manage selected areas of expenditures within its MBS and PBS programs. These include co-operative strategies which promote affordability of services for patients, including pharmaceuticals, diagnostic imaging and pathology services (box 2.2). The agreements for radiology and pathology include provisions that allow for expenditure adjustments for demonstrable and measurable instances of cost shifting between the public and private sectors.³⁶

33 Department of Health and Ageing, Public Health Outcome Funding Agreements (PHOFAs), viewed on 27 July 2006 at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-about-phofa-phofa.htm.

34 Department of Health and Ageing, Australian Health and Ageing System - The Concise Factbook - April 2006, viewed on 30 June 2006 at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-statistics-april2006-table5.

35 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 293.

36 Department of Health and Ageing, *Radiology Quality and Outlays Memorandum of Understanding (MOU) between the Commonwealth of Australia and The Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association 1 July 2003 to 30 June 2008* (2003), clause 5.8; Department of Health and Ageing, *Radiology Quality and Outlays Memorandum of Understanding (MOU) between the Commonwealth of Australia and The Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association 1 July 2003 to 30 June 2008* (2003), clause 5.7.

Box 2.2 Selected expenditure management arrangements

Pathology Quality and Outlays Memorandum of Understanding (MOU) — an agreement between the Commonwealth, the Australian Association of Pathology Practices, the Royal College of Pathologists and the National Coalition of Public Pathology to promote access to quality, affordable pathology services and manage government outlays relating to MBS pathology services. The current MOU covers the period 2004-05 to 2008-09 and applies to more than \$8 billion of pathology services.³⁷

Radiology Quality and Outlays MOU — an agreement between the Commonwealth of Australia and The Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association to promote access to quality, affordable radiology services. The current MOU covers the period 2003-04 to 2007-08 and applies to more than \$5.7 billion of radiology services.³⁸

Fourth Community Pharmacy Agreement — an agreement between the Commonwealth and the Pharmacy Guild of Australia that sets out the remuneration pharmacists will receive for dispensing PBS medicines. The agreement covers the period 1 December 2005 and to 30 June 2010 and provides for \$11.1 billion in payments for the dispensing and supply of PBS medicines.³⁹

The rising cost of health care

2.34 All levels of governments are concerned about the rising costs of health care, which is projected to consume a significant and increasing proportion of the economy's future resources. A number of factors contribute to rising prices for health services and the growth in demand for health services.⁴⁰

37 Department of Health and Ageing, *Pathology Quality and Outlays Memorandum of Understanding between the Australian Government and the Australian Association of Pathology Practices and the Royal College of Pathologists and the National Coalition of Public Pathology, 1 July 2004 to 30 June 2009* (2004).

38 Department of Health and Ageing, *Radiology Quality and Outlays Memorandum of Understanding (MOU) between the Commonwealth of Australia and The Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association 1 July 2003 to 30 June 2008* (2003).

39 Department of Health and Ageing, *The Fourth Community Pharmacy Agreement between the Commonwealth of Australia and the Pharmacy Guild of Australia* (2005).

40 Australian Health Services Alliance, sub 5, p 2; Australian Health Insurance Association, sub 16, pp 16–19; ACT Government, sub 65 p 3; Macquarie Health Corporation, sub 55, p 5; Local Government Association of NSW and Shires Association of NSW, sub 18, p 4; Caboolture Shire Council (Qld), sub 103, p 3.

- 2.35 The committee noted a range of recent projections of future health costs in Australia, most of which forecast a doubling of government expenditure on health as a proportion of GDP over the next 40 years.⁴¹
- 2.36 It is important that governments continue to take action to address the drivers of rising demand on the health system as well as make changes that can improve health system efficiency. Such action should not be delayed and should be seen a long term investment. In many cases, such as preventing chronic conditions and supporting more flexible use of the health workforce, costs may actually increase in the short term but targeted investments must be made to secure a sustainable health system in the long term.
- 2.37 The Australian Institute of Health and Welfare reported that ‘excess health inflation’, the difference between the rate of change in the price of health services and the general inflation rate, has averaged 0.8 per cent over the 10 years to 2003-04.⁴²
- 2.38 Some of the explanations for the cost pressures experienced in the health system provided to the committee included:
- technology — newer methods of treatment, including pharmaceuticals, are more expensive than previous treatments. As these more expensive technologies are introduced, the cost of care rises;⁴³
 - increasing utilisation — higher expectations about what medical care can achieve, rising incomes and the greater availability of new treatment technologies have increased the community’s demand for health services;⁴⁴ and
 - workforce shortages — changes in the gender composition of the health workforce, a lack of skilled professionals, competition between the public and private sectors and a reduction in the hours

41 The Treasury, *Intergenerational Report 2002-03*, Budget Paper No. 5 (2002), p. 39; Productivity Commission, *Economic implications of an ageing Australia* (2005), p 169; OECD, ‘Projecting OECD health and long-term care expenditures: What are the main drivers?’ (2006), Economics Department Working Papers No. 477, p 31; Office of Financial Management, *NSW Long-Term Fiscal Pressures Report 2006-07*, Budget Paper No. 6 (2006), p 4-2; Western Australian Government, sub 124, p 2.

42 Australian Institute of Health and Welfare, *Australia’s health 2006* (2006), p 289.

43 Health Insurance Restricted Membership Association of Australia, sub 6, p 3; Australian Health Insurance Association, sub 16, p 32; MBF Australia Limited, sub 19, p 18; Medical Industry Association of Australia, sub 61, p 9; Australian Health Care Association, sub 62, p 7.

44 Australian Private Hospitals Association, sub 24, p 3; Harrison B, Australian Health Services Alliance, transcript, 23 August 2005, p 3.

worked by medical staff as the workforce ages have allowed practitioners to reduce the hours they work without significantly affecting their income.⁴⁵

- 2.39 In addition to increases in the price of health services, the quantity of health services delivered in many parts of the health system has increased significantly in recent years. Areas that had experienced increases in demand include public and private hospital admissions, the use of Medicare funded medical services and pharmaceutical prescriptions (table 2.2). Several submissions also pointed to increased pressures at public hospital emergency departments.⁴⁶

Table 2.2 Use of selected medical and pharmaceutical services, 1996-97 to 2003-04

| Service | 1996-97 | 2003-04 | Change (per cent) |
|---|---------|---------|----------------------|
| Public hospital separations (per 1,000 population) | 195.8 | 207.7 | 6.1 |
| Private hospital separations (per 1,000 population) | 108.4 | 130.9 | 20.8 |
| Medicare services (per 1,000 population) | 1,063 | 1,087 | 2.3 |
| Pharmaceutical benefits scheme prescriptions (per capita) | 6.7 | 8.2 | 22.4 |

Source Medicare Australia, *Statistics*, viewed on 25 August 2006 at www.medicareaustralia.gov.au/about/media/statistics.htm; Australian Institute of Health and Welfare, *Australia's health 2006 (2006)*, p 362, *Australia's health 2002 (2002)*, p 282; Department of Health and Ageing, correspondence received 5 September 2006.

- 2.40 Although rising health costs are a concern to governments, inquiry participants also pointed to the economic and social benefits of higher health expenditures.⁴⁷ The Medical Industry Association of Australia noted:

In the broadest sense, medical technology has been responsible for significant reductions in mortality, morbidity (including disability) and improvements in quality of life in all age groups. In particular, many medical devices have reduced the use of some drugs, reduced hospital admissions

45 Australian Health Insurance Association, sub 16, p 10; Fisher L, Private Hospitals Association of Queensland, transcript, 7 April 2006, p 68; Warden R, NT Department of Health and Community Services, transcript, 23 August 2006, p 6.

46 City of Darebin (Vic), sub 32, p 2; ACT Government, sub 64, p 5; Western Australian Government, sub 124, p 8.

47 Australian Association of Pathology Practices, sub 38, p 5; Medicines Australia, sub 42, p 4.

and length of stay and allowed individuals to function normally. As a result, this has reduced the indirect costs for care of patients and the healthcare system.⁴⁸

- 2.41 It is important that health funding arrangements do not restrict unnecessarily the introduction of new technologies and procedures that provide significant benefits to patients or the economy.
- 2.42 While governments are generally more exposed to rising health care costs than individuals, the committee also noted concerns from several inquiry participants of the rising costs of health care, which were usually experienced in the form of higher co-payments, out-of-pocket costs and rising private health insurance premiums.⁴⁹ An individual told the committee that:

I am getting to the stage now, because of the income that I get from my allocated pension plus my Centrelink pension, where I do not know whether I am going to be able to afford to be in a private health fund for much longer. The only reason I am staying in it for as long as I can is in case I get sick again.⁵⁰

Cost shifting

- 2.43 Cost shifting occurs when service delivery is arranged so that responsibility for services can be transferred to another program funded by another party, without the agreement of the other party.⁵¹
- 2.44 The complexity of funding and delivery arrangements and the division of responsibilities between the Commonwealth and state governments provides opportunities and incentives for the costs of health care to be shifted from one level of government to another, including local government.⁵² Issues of cost shifting are also raised when governments shift the cost of treatments to patients for services

48 Medical Industry Association of Australia, sub 61, p 5.

49 Professor Stephen Leeder, sub 3, p 3; Australian Dental Association, sub 28, p 2; ACT Government, sub 64, p 3; Health Group Strategies, sub 116, p 11; Catholic Health Australia, sub 35, p 27.

50 Brown D, transcript, 20 July 2006, p 41.

51 Ross, B et al, *Health financing in Australia: the objectives and players* (1999), Occasional Papers: Health financing series volume 1, Department of Health and Aged Care, p 37.

52 Western Australian Government, sub 124, p 7.

that have previously attracted no charge or increase the level of patient co-payments.⁵³

- 2.45 In an environment of rapidly rising health costs, there may be significant incentives for health providers to engage in activities that shift the costs of health care to another party.
- 2.46 Cost shifting can occur at the boundaries of different parts of the health system, such as between general practice and hospitals, general practice and aged care and aged care and hospitals.⁵⁴
- 2.47 There can also be claims of cost shifting at a broader level, with state governments arguing that the Commonwealth Government's removal of incentives for GPs to bulk bill patients after hours leading to an increase in the pressure of GP-type patients presenting at public hospital emergency departments.⁵⁵
- 2.48 Many local governments also noted that the issue of cost shifting was also relevant to them.⁵⁶The City of West Torrens told the committee that costs were sometimes shifted to local governments over time when grant funding for a specific program expired:
- While funding may be provided by state or federal governments for project based initiatives, it is often only seed funding whose subsequent termination places considerable pressure on our ability to provide long-term comprehensive programs.⁵⁷
- 2.49 While 'cost shifting' is almost always used as a pejorative term, it is not necessarily a symptom of inappropriate behaviour. A distinction should be made between situations where the transfer of costs from one party to another is the purpose of the change in service delivery arrangements, or is a consequence of changes in clinical practice. The substitution of a new drug therapy for surgery, for example, shifts costs from the states to the Commonwealth but should reduce overall costs and/or improve outcomes.

53 Medicines Australia, sub 42, p 11; Government of Victoria, sub 67, p 6.

54 Royal Australian College of General Practitioners, sub 19, p 3; Catholic Health Australia, sub 35, p 9.

55 Western Australian Government, sub 124, p 8; ACT Government, sub 64, p 3; Victorian Government, sub 67, p 3.

56 Dubbo City Council (NSW), sub 4, p 1; Bankstown City Council (NSW), sub 13, pp 2–3; Local Government Association of NSW and Shires Association of NSW, sub 18, p 11.; Western Australian Local Government Association, sub 34, p 8.; City of Mandurah (WA), sub 46, p 3.

57 Trainer J, City of West Torrens (SA), transcript, 2 May 2006, p 35.

- 2.50 Opportunities for cost shifting also dilute government accountability for health outcomes. The chair of the committee noted that blame shifting did not offer a solution to some members of the community:

I quote the example of Mrs Smith who comes to me because she needs a hip replacement and has to wait five years and she is 80. I write to [the Minister for Health], and he writes back to me and says: 'Look, it's a state matter. I can't help her.' Then I write to the state minister, and he writes back and says, 'The Commonwealth doesn't give us enough money.' She gets two letters from the health ministers, but she does not get her hip replacement. This is ridiculous.⁵⁸

- 2.51 Cost shifting is examined in more detail in chapter 3.

Private health

- 2.52 The delivery of health services outside public hospitals is dominated by fee-for-service arrangements with private health providers such as general practitioners, allied health professionals, pathologists, dentists and pharmacists.
- 2.53 The public and private health systems are increasingly interdependent — sometimes sharing the same workforce and facilities. Often the delivery of quality health care over a patient's episode of care requires coordination between public and private health providers working in laboratories, hospitals and general practitioner and allied health professional clinics.
- 2.54 Health funding arrangements need to reflect this interdependence and facilitate the cooperation and coordination required to achieve seamless delivery of health care across the continuum of care.
- 2.55 For this inquiry, the committee has concentrated on the part of the private health sector comprising the private health insurance industry and private hospitals. In 2004-05, there were almost 2.8 million separations in private hospitals, with total revenue of more than \$6.6 billion.⁵⁹ In the same period private health insurance funds insured more than 8.8 million people, collecting more than \$8.6 billion

58 Hon Alex Somlyay MP, transcript, 29 March 2006, pp 2–3.

59 A separation is the formal process by which a hospital records the completion of a treatment and/or care for an admitted patient (Australian Bureau of Statistics, *Private Hospitals Australia* (2006), Cat No. 4390.0, p 9).

in premiums and paying more than \$7.6 billion in benefits to members.⁶⁰

- 2.56 Health funds operate in an environment where products, prices, registration and the financial and prudential aspects are regulated.⁶¹ Key government agencies involved in private health insurance regulation include:
- Department of Health and Ageing — assessing annual premium increases requested by funds;
 - Private Health Insurance Administration Council — regulating the financial and prudential aspects of the industry, disseminating financial and statistical data and information to inform consumer choice; and
 - Private Health Insurance Industry Ombudsman — resolving complaints about private health insurance and an umpire in dispute resolution at all levels within the private health insurance industry.
- 2.57 Contracting between health insurance funds and private hospitals underpins the delivery of health services to privately insured patients in private hospitals. Private hospitals and private day hospital facilities receive hospital benefits from health funds through either a hospital purchaser provider agreement (contract) that they have negotiated with the fund or, where a contract does not exist, the Commonwealth determined default benefit. Health funds are required to cover all eligible members that receive hospital treatment even where the fund does not have a contract with the hospital.⁶²
- 2.58 Contracting arrangements between health funds and private hospitals are a commercial matter for the parties. The Australian Private Hospitals Association highlighted the often fractious nature of these negotiations and the sometimes adverse impact on patients when contracts ceased.⁶³
- 2.59 The committee has examined private hospitals and private health insurance arrangements in more detail in chapter 8.

60 Department of Health and Ageing, sub 43, p 23.

61 Department of Health and Ageing, sub 43, p 22.

62 Department of Health and Ageing, sub 43, p 30.

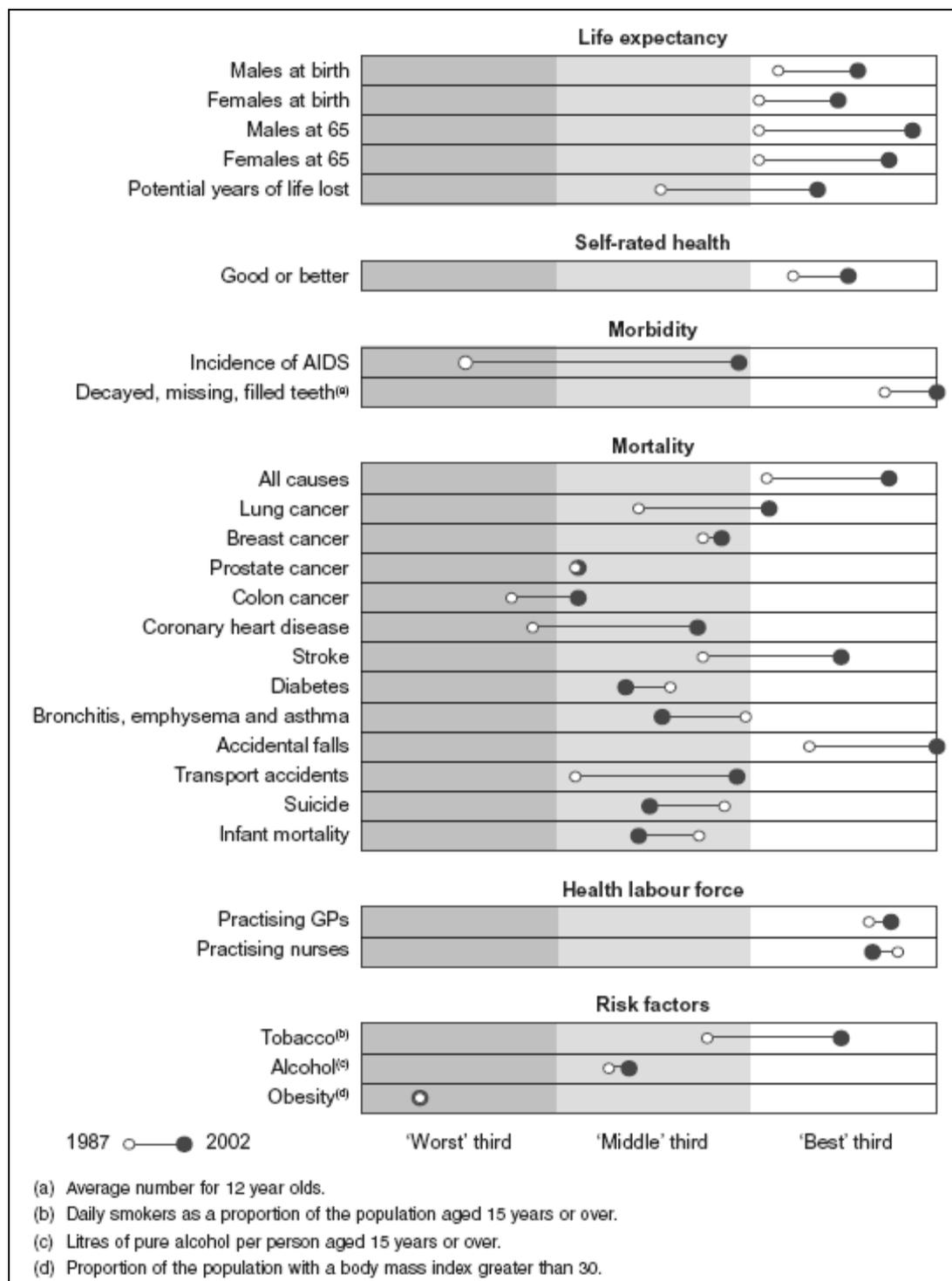
63 Gee C, Australian Private Hospitals Association, transcript, 21 September 2005, p 47; Roff M, Australian Private Hospitals Association, transcript, 23 August 2005, p 15; Toemoe G, Australian Private Hospitals Association, transcript 24 August 2005, p 3.

Health system outcomes

- 2.60 The Australian health system, or parts of it, was amongst the best in the world. Objective measures of health outcomes demonstrate that overall, the standard of health care in Australia is generally better than most developed countries (figure 2.5).
- 2.61 The Australian health system also performs relatively well in terms of access to services and the quality of care:
- relative to Canada, the UK and the US, a higher proportion of Australians see a doctor promptly when they need to, and rate their care as very good or excellent;
 - waiting times for emergency departments are shorter than for the US, Canada and the UK; and
 - waiting times for elective surgery are shorter than for Canada, NZ and the UK.⁶⁴

⁶⁴ Podger A, *Directions for Health Reform in Australia, Presentation to Productivity Commission Roundtable on Productive Reform in a Federal System (2005)*, exhibit 26, p 3.

Figure 2.5 Selected health indicators, Australia's ranking among OECD countries, 1987 and 2002



Source Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 3.

2.62 Despite these successes, inquiry participants nominated a number of areas where health performance can be improved including:

- Indigenous health — life expectancy is around 17 years lower than for other Australians, this gap being bigger than the gap between Indigenous and non-Indigenous peoples in the US, Canada or NZ.⁶⁵ In the Northern Territory, health status of Indigenous people equates to that of non-Aboriginal Territorians who are twenty years older than indigenous people — both in terms of the extent of disease and outcomes;⁶⁶
- rural and remote health — people in rural and remote areas have worse health status overall than people in the major cities and face higher risk factors such as higher rates of smoking.⁶⁷ Standardised mortality data show death rates in Australia increasing with rurality: Australians living in regional, rural and remote areas are 10 per cent more likely to die of all causes than those in major cities, and 50 per cent more likely to do so if they live in very remote areas;⁶⁸
- quality of care in hospitals — the rate of adverse events in hospitals increased from 5.1 per cent of admissions in 2001-02 to 5.5 per cent in 2002-03.⁶⁹ A recent study also found that up to 16 per cent of hospitalised patients would suffer an adverse event, 50 per cent of which were preventable and 10 per cent of which would result in permanent disability or death;⁷⁰
- waiting lists for elective surgery — there has been deterioration in recent years in the proportion of patients waiting longer than is clinically appropriate for elective surgery in all states. Median waiting times for selected elective surgery procedures have also increased in most states;⁷¹
- workforce shortages — shortages were identified in a number of health workforce areas, including general practice,⁷² nursing,⁷³ allied health professionals,⁷⁴ dentists⁷⁵ and pathologists;⁷⁶

65 Podger A, *Directions for Health Reform in Australia, Presentation to Productivity Commission Roundtable on Productive Reform in a Federal System* (2005), exhibit 26, p 3.

66 Northern Territory Government, sub 60, p 4.

67 National Rural Health Alliance, sub 59, p 19.

68 Rural Doctors Association of Australia, sub 31, p 6.

69 Health Group Strategies, sub 116, p 17.

70 Australian Health Insurance Association, sub 16, p 15.

71 Department of Health and Ageing, *The state of our public hospitals, June 2006 report* (2006), pp 27–29.

72 Australian Divisions of General Practice, sub 15, p 3; Australian Medical Association, sub 31, p 16; Rural Doctors Association, sub 31, p 16; Redcliffe-Bribie-Caboolture Division of General Practice (Qld), sub 81, p 5.

- chronic disease management — Australia has a high rate of potentially avoidable hospitalisations for chronic conditions. Increases in the incidence of chronic diseases suggest that there is an underinvestment in preventative health strategies.⁷⁷ Recent research by the Australian Institute of Health and Welfare indicated that the burden of chronic disease falls unevenly across the community, with areas of socio economic disadvantage reporting higher mortality rates and hospitalisation rates than less disadvantaged areas;⁷⁸ and
- lifestyle diseases and children’s health — rising levels of childhood obesity are expected to lead to an increase in the number of young people diagnosed with type 2 diabetes.⁷⁹

2.63 Several inquiry participants also noted that current funding arrangements can work against providing the continuity of care for people with complex conditions⁸⁰ — a situation that is likely to increase as the population ages.⁸¹ The Australian Private Hospitals Association noted that:

[The patient] might see a specialist in private practice in one specialty, Commonwealth funded through Medicare, and then be referred to another specialist in their rooms, Commonwealth funded through Medicare—probably co-payments in both cases. They might need a hospital admission for a surgery—public and private options. Radiotherapy is a doctor’s office service or it might be undergone at a public hospital. In addition—and the cancer patient is a particularly good example—the patient has to

73 Australian Nursing Federation, sub 39, p 4.

74 Australian Healthcare Association, sub 62, p 5

75 Australian Dental Association, sub 28, p 26.

76 Graves D, Royal Australian College of Pathologists, transcript, 5 July 2005, p 2.

77 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, pp 4–5.

78 Australian Institute of Health and Welfare, *Socioeconomic inequalities in cardiovascular disease in Australia: Current picture and trends since 1992* (2006), p 1.

79 Taplin C, M Craig, M Silink and N Howard, ‘The rising incidence of childhood type 1 diabetes in New South Wales, 1990–2002’, *Medical Journal of Australia* (2005), Vol 183, no 5, pp 243–246; Australian Institute of Health and Welfare, *Australia’s young people 2003* (2003), p 167.

80 Royal Australian College of General Practitioners, sub 66, p 8; ACT Government, sub 64, p 2; MBF Australia Limited, sub 29, p 24; Australian Health Insurance Association, sub 16, p 1; Australian Association of Gerontology, sub 53, p 4.

81 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 4.

make a number of choices about what combination of care they are going to subject themselves to.

The system is now not well geared to putting a comprehensive service around that patient as they move between not just public and private but Commonwealth and state funded health care.⁸²

- 2.64 Areas requiring improvement are examined in further detail in subsequent chapters.
- 2.65 The committee considers that while pragmatic and largely incremental changes to health funding arrangements can partly address some of these health concerns in the short term, more fundamental changes to health funding arrangements are required to achieve sustainable improvements in health outcomes.

82 Greenman R, Australian Private Hospitals Association, transcript, 24 August 2005, p 9.

A national health agenda

In a single episode of care, individuals may require services from providers in both the public and private sectors, with funding coming from both public and private sources including Medicare, health funds, or their own pockets. Patients rely on the health care system working seamlessly, that is, on collaboration and cooperation between the different sectors, but the financial and administrative arrangements unfortunately do not always support this. It is vital that reforms focus on building a health system based around the needs of the patient, rather than relying solely on the 'goodwill' and professionalism of practitioners.¹

- 3.1 There are a number of areas where the performance of the health system could be improved by reforming funding arrangements. This chapter discusses the shortcomings of current funding arrangements on the incentives for providing quality care to patients during an episode of care and for population 'wellness' to be addressed at an early stage. The committee sets out a number of different funding models proposed by inquiry participants that aim to address some or all of these shortcomings.
- 3.2 The effects of health funding arrangements on the development of the health workforce, regional, rural and remote health services, and accountability for health service provision and outcomes are separately addressed in chapters 4, 5 and 9 respectively.

¹ Australian Association of Pathology Practices, sub 38, p 9.

- 3.3 The committee has attempted to assess the potential benefits and costs of implementing several proposed funding models. While there appear to be benefits associated with moving to different funding arrangements, the magnitude of benefits is uncertain and there are risks that would need to be managed. There are, however, also risks in leaving funding arrangements unchanged.
- 3.4 Irrespective of the funding model adopted by governments, there is a need for a national health agenda to guide future reform. These changes can be implemented independently and incrementally, or as part of a more radical restructuring of funding arrangements.

Problems with existing funding arrangements

- 3.5 As discussed in chapter 2, current funding arrangements can lead to waste, duplication and cost shifting between jurisdictions. Funding arrangements can reduce the incentives for governments and the population to promote 'wellness' and also reduce opportunities to improve the quality care and continuity of care for patients.

Waste and duplication

- 3.6 One outcome of the division of funding responsibility between the Commonwealth and state governments is administrative duplication of a range of tasks and the 'wasted' resources that are consumed by the health bureaucracy.
- 3.7 The committee noted that a recent review in Queensland, described the Queensland health department as having 'a bureaucratic, mechanistic structure characterised by highly centralised formal authority and hierarchical layers of decision making'.² The committee also received evidence noting that:

... only 20 per cent of the [Queensland Health] Department's employees (totalling some 64,000) are doctors and nurses: for every clinician who actually deals with patients, there are four other employees who have to justify their existence within Queensland Health.³

2 Foster P, Queensland Health Systems Review, Final Report September 2005 (2005), p 68.

3 Anthony Morris QC, sub 72, p 20.

3.8 However, a much higher proportion of the staff employed directly by public hospital are involved with patient care, as illustrated by figure 3.1.

Figure 3.1 Public hospitals – average full time equivalent staff, states and territories, 2004-05

| | Salaried Medical officers | Nurses | Diagnostic and Other Health Professionals | Administrative and Clerical Staff | Personal Care, Domestic and Other Staff | Total |
|-----------|---------------------------|--------|---|-----------------------------------|---|--------|
| NSW | 6698 | 31858 | 10002 | 11700 | 11679 | 71937 |
| Vic | 5557 | 24372 | 11105 | 9104 | 6861 | 56999 |
| Qld | 3787 | 14996 | 3456 | 4162 | 6916 | 33317 |
| WA | 1944 | 8118 | 2238 | 3231 | 3586 | 19117 |
| SA | 1700 | 7908 | 1993 | 2810 | 2047 | 16458 |
| Tas | 442 | 2163 | 423 | 601 | 1060 | 4689 |
| ACT | 373 | 1493 | 409 | 634 | 350 | 3259 |
| NT | 263 | 1030 | 280 | 394 | 545 | 2512 |
| AUSTRALIA | 20764 | 91938 | 29906 | 32636 | 33044 | 208288 |

Source Department of Health and Ageing, *The state of our public hospitals, June 2006 report (2006)*, p 15

3.9 It is difficult to estimate and verify the cost of wasted bureaucratic effort. Various estimates were provided to the committee giving the costs of inefficiencies, ranging from annual savings of \$1.1 billion and up to \$4 billion if potential savings in improving population wellness are taken into account.⁴

3.10 Although the committee has not tested the reliability of these estimates, their order of magnitude suggest that there may be significant resources that can be saved within the existing health budget and be directed to more appropriate areas. With over \$87 billion in health expenditure in 2004-05, including \$2.3 billion in administration costs,⁵ there is significant scope for savings by reducing duplication of service provision and/or administration. A 10 per cent reduction in administrative cost, for example, would save \$230 million.

Cost shifting

3.11 As noted in chapter 2, cost shifting is at least perceived to be a feature of the health system. Cost shifting between governments, and to

4 Rural Doctors Association of Australia, sub 31, p 9; Australian Association of Pathology Practices, sub 38, p 2; Australian Healthcare Association, sub 62, p 6.

5 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05 (2006)*, table A3, p 105.

patients via co-payments, can affect the incentives for providers and patients to access appropriate care options.

3.12 Numerous examples of alleged cost shifting were provided to the committee, including:

- states shifting costs to consumers and the Commonwealth through public hospitals ‘encouraging’ patients to elect to be private patients,⁶
- cost shifting to the states by diverting after-hours patients from general practice to emergency departments;⁷
- cost shifting to the states when nursing home type patients occupy public hospital beds rather than being accommodated in a residential aged care setting;⁸ and
- states shifting costs to the Commonwealth and patients when public hospital patients are sent to have pathology and radiology undertaken either in private practice clinics at the public hospital or sent to general practitioners (GPs) to have the request ordered privately by the GP.⁹

3.13 The shifting of costs from one party to another was seen by the Department of Health and Ageing as a matter of some debate:

Part of the very nature of ‘cost-shifting’ is that one person’s cost-shifting is another person’s good management. So to actually draw a line around a particular piece of money and say, ‘This is a cost that has been shifted,’ would in fact be subject, in itself, to quite a degree of debate, ambiguity and alleged subjectivity. To try and quantify cost-shifting, you are probably trying to quantify something that is, in itself, fairly vaguely defined.¹⁰

3.14 In most cases clinicians working in the health system are able to navigate patients through services with different funding arrangements without affecting the quality of care. The Royal Australian College of General Practitioners told the committee that:

6 Australian Health Insurance Association, sub 16, p 25.

7 Australian College for Emergency Medicine, sub 17, p 1.

8 Australian Association of Gerontology, sub 53, p 3.

9 Australian Nursing Federation, sub 39, p 11; Australian Medical Association (Queensland), sub 104, p 13.

10 Davies P, Department of Health and Ageing, transcript, 30 May 2005, p 16.

As a general practitioner, I do not particularly think about whether the service that I am referring my patient to is funded by the Commonwealth or by the state. I think about the best service to assist that person whose care I am responsible for.

We are gatekeepers for our patients to the rest of the health sector. We are advocates for our patients. We will become aware of certain parts of the health system where it is easier for patients to get appointments, and they may be the ones we will use. Or we will become aware of services which provide what we may regard as a higher quality care or a safer care, and that is where we will focus. So the issue of cost shifting does not really come into the minds of many general practitioners.¹¹

- 3.15 Where cost shifting is not driven by appropriate clinical practice, it imposes significant system-wide effects that can result in:
- waste and duplication — management time is used to creatively find short-term funding solutions rather than concentrating on improving the efficiency and effectiveness of service delivery and replication of some tasks at different levels of government;¹²
 - a reduction in the overall efficiency of the health system — the incentives in funding arrangements may not ensure that care is appropriate throughout the full episode of care, resulting in hospital re-admissions and the prevention of potentially avoidable hospitalisations;¹³
 - distorted market signals to private sector providers that result in inappropriate investment in medical technology and ‘unfair’ competition between the public and private sectors;¹⁴ and
 - over-servicing, where three investigations are done when one would be appropriate, or over-investigations are undertaken (by

11 Kidd M, Royal Australian College of General Practitioners, transcript, 5 July 2005, p 52.

12 Roff M, Australian Private Hospitals Association, transcript, 23 August 2005, p 66; Toemoe G, St Luke’s Hospital, transcript, 24 August 2005, p 23; Australian Health Care Association, sub 62, p 4; Macquarie Health Corporation, sub 55, p 4;

13 Local Government Association of NSW and Shires Association of NSW, sub 18, p 9; Australian Association of Gerontology, sub 53, p 3; Dr Ross Cartmill, sub 107, p 3; Enteral Industry Group, sub 119, p 17; Western Australian Government, sub 124, p 23; Australian Health Insurance Association, sub 16, p 9.

14 Australian Diagnostic Imaging Association, sub 21, p 2; Australian Medical Association (Queensland), sub 104, p 13.

private doctors working in private hospitals) – not a ‘fair go for all’;¹⁵ or Department of Veterans’ Affairs (DVA) turnover in private hospitals is 25 per cent of procedures with veterans being only 1.3 per cent of the population.¹⁶

The ‘blame game’

- 3.16 The ‘blame game’ between different levels of government over the level of funding and responsibilities can undermine the functioning of political accountability for government actions.¹⁷ Mr Menadue noted that:

I think all the evidence is clear that we must resolve this problem to ensure integrated care and the avoidance of cost and blame shifting. Both federal and state governments have a vested interest in the present system. They can blame each other. The solution to this requires political action. It is not one for managers.¹⁸

- 3.17 It is important that clinicians’ decisions about a patient’s health care are based on providing high quality health care rather than funding outcomes for individual providers. When non-clinical considerations drive decisions about how and where care is provided, then funding arrangements that create this pressure should be revised.

Promoting wellness

- 3.18 Hospitals are the most expensive component of the health system, but most interaction with the system occurs outside of institutional settings.¹⁹ Primary care in a community setting also offers more opportunities to promote wellness.
- 3.19 Primary health care involves treatment in the community by a range of health professionals including, general practitioners, allied health

15 Ralls J, Doctors Reform Society of Western Australia, transcript, 24 August 2006, pp 21 and 24; Armitage M, Australian Health Insurance Association, transcript, 4 September 2006, pp 29–30.

16 Bartlett R, Department of Veterans’ Affairs, transcript, 4 September 2006, pp 15 and 29.

17 Australian Health Care Association, sub 62, p 11; Australian Doctors’ Fund, sub 78, p 6; Goulston K, Hospital Reform Group, transcript, 29 March 2006, p 2; Singer A, Australasian College for Emergency Medicine, transcript, 28 June 2005, p 42; Mackender D, Hospital Reform Group, transcript, 26 May 2006, p 9.

18 Menadue J, ‘Principles and Priorities for Health Care Policy Development’ (2005), address to L21 Health and Aged Care Forum, Sydney 22–23 November, exhibit 35, p 5.

19 Duckett S, *The Australian Health Care System* (2004), p 206.

- workers, and pharmacists. Primary health care shares the complexity of funding arrangements for other parts of the healthcare system, including multiple government and private funders and providers.
- 3.20 Current health funding arrangements have an inherent bias towards ‘treating’ illness rather than preventing illness (or promoting ‘wellness’).²⁰ This bias is partly due to incentives in the Commonwealth funded Medicare benefits schedule (MBS) for practitioners to treat conditions rather than averting potential illnesses or hospitalisations. A stark example of this bias was provided by the National Rural Health Alliance, who noted that the amputation of a diabetic foot is reimbursed under the MBS whereas preventative treatment by a podiatrist is not.²¹
- 3.21 The committee acknowledges, however, that in recent years the Commonwealth has made significant changes to extend services covered by the MBS to strengthen the capacity of primary health care to promote wellness and continuity of care. Services covered include general practitioners providing coordinated care for chronically ill patients and incentives for earlier intervention in selected at risk groups.²²
- 3.22 Public health programs cover activities designed to benefit the population and includes activities that emphasise prevention, protection and health promotion as distinct from treatment.²³ Public health expenditure by Australian governments was estimated to be around \$1.3 billion in 2003-04, of which \$657 million was funded by the Commonwealth and \$609 million by the states.²⁴ Public health

20 Redcliffe-Bribie-Caboolture Division of General Practice, sub 81; Menadue J, Health Sector Reform Part 2: Primary Care and Wellbeing, exhibit 40; Health Group Strategies, sub 116; Australian Healthcare Reform Alliance, sub 127; Parkes H, Department of Health (South Australia), transcript, 2 May 2006; Meikle R, Australian Diagnostic Imaging Association, transcript, 26 May 2006; Victorian Health Promotion Foundation, sub 8, p 1; Professor Lesley Barclay and Dr Suzanne Belton, Charles Darwin University, sub 76, p 1.

21 National Rural Health Alliance, sub 59, p 7.

22 See for example, Hon Tony Abbott MP, Minister for Health and Ageing, media releases, *GPs benefit from Budget*, 11 May 2005; *New Medicare item for Indigenous health, refugees and palliative care*, 1 May 2006; *Government expands Medicare for chronically ill*, 9 June 2005; *Government expands Medicare for the chronically ill*, 9 June 2005; *Promoting health throughout life*, 9 May 2006.

23 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 475.

24 Australian Institute of Health and Welfare, *National public health expenditure report 2001-02 to 2003-04* (2006), p 4.

expenditure as a share of total recurrent health expenditure has remained largely unchanged at around 1.7 per cent since 1999-00.²⁵

3.23 There is increasing evidence supporting the need to improve both the community's access to primary health care services and the incentives for medical practitioners to provide better prevention-based health care services. It is also clear that there are significant benefits in investing in preventative and early detection measures for a range of chronic conditions to avoid the future significant costs of hospital treatment (box 3.1).

3.24 The need for additional efforts to be made in primary and public health is also highlighted by the potential costs of not addressing the rising incidence of obesity and diabetes, especially among children. Health Group Strategies noted that:

Despite six reports since the 1997 report by [the National Health and Medical Research Council], the absence of funded, targeted national policies for obesity prevention in adults and children is another sign of national complacency....

- overall, during the 20-year period to 2004, the percentage of overweight males and females rose 17.5 per cent and 18 per cent, respectively
- about 60 per cent of the Australian adult population is now overweight or obese, and the International Obesity Task Force estimates that by 2025, 1 in every 3 adults in Australia will be obese.
- adult obesity is rising at 1 per cent per year, and over 60 per cent of overweight and obese adults in the ABS 2004-05 National Health Survey considered themselves to be at a healthy weight
- healthcare expenditures associated with the downstream effects of obesity - which means large shares of the costs of treating seven major chronic disorders - are rising at about 2 per cent per year. Much of that care is in hospitals only because we refuse to think about policy solutions upstream.²⁶

25 Australian Institute of Health and Welfare, *National public health expenditure report 2001-02 to 2003-04* (2006), p 8.

26 Health Group Strategies, sub 116, pp 23-24.

Box 3.1 Investing in prevention and early detection

Kidney health — Chronic kidney disease is a common, under-recognized, progressive, preventable and treatable condition. Over the last 25 years, while the Australian population has grown less than 40 per cent, the numbers of Australians being treated with dialysis or a kidney transplant has grown by more than 400 per cent. Early diagnosis through screening followed by appropriate treatment can reduce the rate of kidney failure, strokes and other problems by up to 50 per cent. A recent study of the best practice rules by which general practitioners are funded to care for diabetics require foot checks, eye checks and eight other checks— but no check on the function of the kidneys.²⁷

Osteoporosis— a skeletal disorder characterised by compromised bone strength predisposing a person to an increased risk of fracture. In 2001, 2 million people had osteoporosis. Direct costs are estimated to be \$1.9 billion per annum (concentrated in hospitals and nursing homes) with indirect annual costs of around \$5.6 billion (including lost earnings and carers). In 2002, someone was admitted to a hospital with a osteoporotic fracture every 8.1 minutes — this will rise to one every 3.7 minutes by 2021 if no preventative action is taken. While there are a range of medications under the pharmaceutical benefits scheme to treat osteoporosis, the Medicare benefits schedule does not subsidise a bone density test for at risk patients, delaying access to early diagnosis and treatment.²⁸

Chronic Obstructive Pulmonary Disease (COPD) — Chronic bronchitis and emphysema are common long-term lung diseases that cause shortness of breath. COPD is Australia's fourth biggest killer, estimated to cost Australian taxpayers \$800-900 million each year. Approximately 75 per cent of those with COPD do not know they have it and therefore are not taking the critical steps to manage their condition. COPD is a burden on Medicare through the cost impact of inefficient and delayed diagnosis, which in turn is shifted as a burden to state hospitals that provide for longer bed stays when patients require hospitalisation—which could have been prevented if simple rehabilitation treatments and early diagnosis were more widely available.²⁹

Multiple Sclerosis (MS) —MS is a chronic, often disabling disease that randomly attacks the central nervous system. The largest direct cost is the provision of informal care, with the loss of productivity associated with MS of individuals and their carers also a significant issue. Although MS is a long term chronic condition, there is clear benefit to early intervention and health self management programs to ease the disease burden, which stands at the value of \$1.3 billion per year.³⁰

27 Kidney Health Australia, media release, *Silent killer! Silent governments!*, 7 August 2006.

28 Osteoporosis Australia, *Osteoporosis in Australia: A presentation to the House Standing Committee on Health, September 6 2006*, exhibit 56.

29 Australian Lung Foundation, sub 112; Darbishire W, Australian Lung Foundation, transcript, 21 July 2006, pp 13–25.

30 MS Australia, sub 130.

- 3.25 As noted in chapter 2, the Treasurer's *Intergenerational Report 2002-03* highlights the need for governments to take strategic action to address the drivers of rising demand for health services. Supporting wellness in the population should be an underlying principle for such strategic action.
- 3.26 The submission made to the inquiry by the Australian Breastfeeding Association illustrates the kind of action that the committee believes should be assessed.³¹ The Association presented evidence that breastfeeding rates in Australia are well below levels recommended by the National Health and Medical Research Council and that increasing the rates would reduce the prevalence of a range of health problems including asthma, diabetes, gastroenteritis and respiratory infections. Prima facie, development and implementation of an action plan to increase the breastfeeding rates would be good long term investment that should be supported by governments.
- 3.27 In 2007, the committee will examine the health benefits of breastfeeding.

High quality and safe health care

- 3.28 There are significant economic and social costs associated with poor quality health care. Health funding arrangements need to provide the right incentives for health providers to deliver high quality and safe medical care to the community.³²
- 3.29 There is evidence to suggest that the safety and quality of health care in Australia can be improved:
- the reported medical error rates in public and private hospitals in 2003-04 are 5.4 per cent and 3.6 per cent, respectively. The extended treatment of patients affected by these errors increases private health fund pay-outs and public hospital costs by at least these percentages;³³
 - hospital-acquired infections are estimated to generate an annual cost of in the range of \$460-\$895 million;³⁴

31 Australian Breastfeeding Association, subs 153 and 159.

32 Australian Institute of Medical Scientists, sub 12, p 1; Rural Doctors Association of Australia, sub 31, p 21; Australian Association of Pathology Practices, sub 38, p 8.

33 Health Group Strategies, sub 116, p 25.

34 Health Group Strategies, sub 116, p 25.

- patients, including the elderly are discharged from public hospitals early, leading to unnecessary readmissions;³⁵ and
 - health care for sicker patients — a recent cross national survey of sicker adults in six countries noted that 1 in 4 of the sickest patients interviewed in Australia was not accessing needed care, with access barriers partly caused by co-payments. These sick patients are also trying to warn us that we need to respond to the low rankings on relating to patient safety, effectiveness of care, efficiency of care and timeliness of care.³⁶
- 3.30 While there are already a range of institutional structures and funding mechanisms that focus on improving the quality of health care,³⁷ there are clearly opportunities for improvements to be made.

Continuity of care

- 3.31 Continuity of care is increasing in importance as a result of an ageing population and the rising incidence of chronic and complex conditions.³⁸ Health funding arrangements need to support continuity of care across multiple public and private service providers.
- 3.32 Changes in the types of care required to support Australia's population are related to success during the twentieth century in reducing mortality rates for children and middle-aged people in particular (figure 3.2).

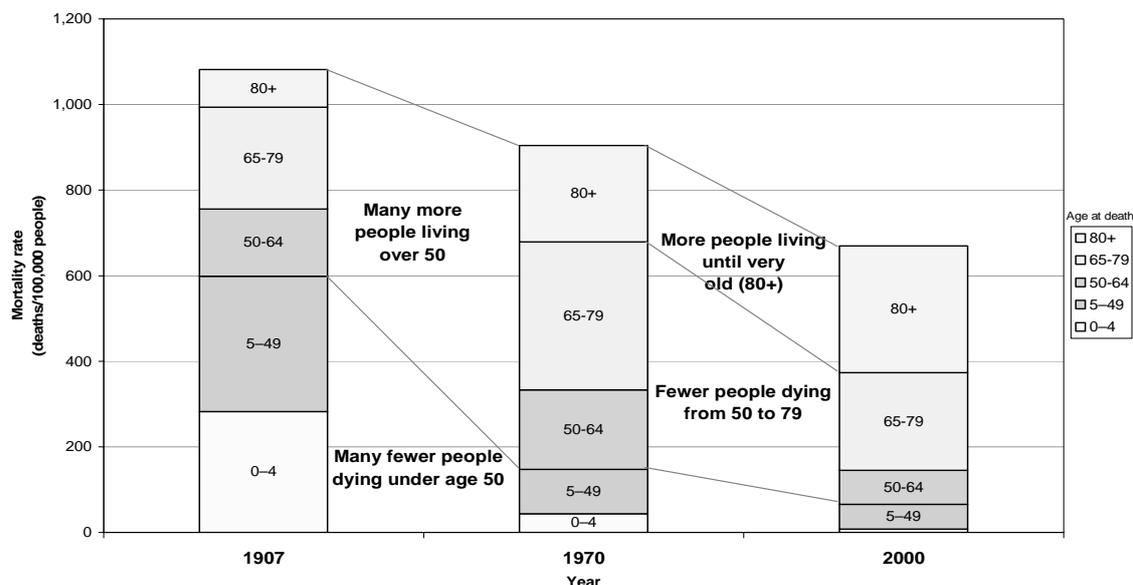
35 Dr Ross Cartmill, sub 107, p 3.

36 Health Group Strategies, sub 116, pp 10–11.

37 Department of Health and Ageing, sub 43, p 16.

38 Royal Australian College of General Practitioners, sub 66, p 8; ACT Government, sub 64, p 2; MBF Australia Limited, sub 29, p 24; Australian Health Insurance Association, sub 16, p 1; Australian Association of Gerontology, sub 53, p 4.

Figure 3.2 Changes in mortality rates, 1907 to 2000



Source Podger A, *Inaugural Menzies Health Policy Lecture* : 3 March 2006, exhibit 27, p 4.

3.33 The Australian Health Insurance Association noted that current funding arrangements do not provide any responsibility for providers for health outcomes:

The concept of a continuum of care is undermined by the fact that there are different people paying for different stages of the process. Why does that matter? I think it matters for one reason and one reason only, and that is that with a mixture of different payers no-one has really got a concern about what the outcome is for the patient.³⁹

3.34 Inquiry participants raised a number of areas where funding arrangements can affect the continuity of care, including the transition between hospitals and residential or community aged care and mental health services.⁴⁰ The Australian Health Care Reform Alliance stated that:

... whenever our patients move from general practice into hospitals, when they cross a boundary in our health care system if you like, from a community hospital, private to public, inefficiencies travel with them. Often their medical details, their personal health information, does not travel with

39 Schneider R, Australian Health Insurance Association, transcript, 23 August 2006, p 50.

40 ACT Government, sub 64, p 7; The Royal Australian College of General Practitioners, sub 64, p 8; Department of Veterans' Affairs, sub 74, p 10; Caboolture Shire Council (Qld), sub 103, p 11.

them. Often tests that have been carried out in the community are duplicated when people arrive in hospital. Expensive investigations may be duplicated. People may be discharged back into our care without relevant important information being transferred. Therefore, we may see people who subsequently get sick again because they have not had the proper follow-up which they required after discharge, and they manage to go back into hospital again. So the inefficiencies run across the system.⁴¹

- 3.35 The Australian Association of Pathology Practices emphasised the importance of coordination between service providers, noting that:

Coordination between general practices, other community-based services, secondary care and hospitals is haphazard, and largely reliant on individual relationships among providers and services. Coordination of care must be supported by comprehensive information and communications technology and management systems that provide all health practitioners and care givers with access to accurate and timely information about an individual's treatment.⁴²

- 3.36 The committee was provided with a number of examples of locally-based arrangements aimed at improving communication between hospitals and general practitioners and other allied health professionals, primarily led by Divisions of General Practice.⁴³ Primarily based on facilitating improved communication, it is clear that better use of information technology is likely to underpin efforts to share patient information across providers.

Funding silos

- 3.37 The complexity of having multiple health funders and multiple health programs was seen by some inquiry participants as creating funding 'silos', within which funders assess the costs and benefits of programs without considering the potential effects on other programs or service

41 Kidd M, Australian Health Care Reform Alliance, transcript, 21 July 2006, p 45.

42 Australian Association of Pathology Practices, sub 38, p 8.

43 Australian Divisions of General Practice, sub 15, pp 3–4.

providers. This can be the case even when programs delivered by the same level of government are involved.⁴⁴

3.38 Some examples of the impact of funding silos on the delivery of health care raised by participants included:

- expenditure on pharmaceuticals, particularly newer, high technology pharmaceuticals, can be demonstrated in many instances to be accompanied by substantial and real cost-offsets within other areas of the health system;⁴⁵
- pharmaceutical benefits scheme (PBS) funding for medicines to treat or prevent fractures associated with osteoporosis but no MBS items allowing access to screening for bone density in the target population;⁴⁶
- greater investment on preventative dental care can improve individual health outcomes and avoid significant hospital expenditure;⁴⁷ and
- supporting health care with appropriate community-based social services, such as home visits for mothers with identified shortfall in their parenting skills, to improve health and education outcomes.⁴⁸

3.39 It is important to acknowledge that there will inevitably be some management of funds within specific areas. The Hospital Reform Group noted that:

I am always nervous using the word 'silo' to start with. As soon as you break anything up into a manageable unit, it runs the risk of becoming a silo. You can go down the clinical line and say it has been siloed. You can go across sites and say they have siloed. You can go across professions and say they have siloed. Unless you can come up with a matrix which says 'by clinical requirement, the professions, sites and bureaucrats come together with a way of managing clients', the silos will exist no matter what.⁴⁹

44 Australian Private Hospitals Association, sub 27, p 7; Australian Health Care Association, sub 127, p 30; The Australian Psychological Society, sub 136, p 7; Australian Diagnostic Imaging Association, sub 21, p 4; Australian Nursing Federation, sub 39, p 14; Harvey D, Australian Council of Social Service, transcript, 21 September 2005, p 72.

45 Medicines Australia, sub 42, p 3.

46 Osteoporosis Australia, transcript, 6 September 2006.

47 Australian Dental Association, sub 28, p 11.

48 Parkes H, Department of Health (SA), transcript, 7 April 2006, pp 18–19.

49 Stevenson K, Hospital Reform Group, transcript, 26 May 2006, p 7.

- 3.40 Notwithstanding these realities, it is especially important for health funding decisions at a broad level to be able to acknowledge the costs and benefits of different types of health interventions across the whole health system as well as over an individual's lifetime.

A national health agenda

- 3.41 Previous sections of this chapter have identified problems relating to waste and duplication, cost shifting, a bias to treatment of illness rather than supporting wellness, and concerns about safety and quality and continuity of care. A comprehensive national approach to addressing these problems is needed. **This requires leadership by the Commonwealth, cooperation by the states and a joint commitment to end the blame game.**
- 3.42 A multitude of national level 'strategies', 'plans' and 'frameworks' have been adopted by the Commonwealth and state governments. These guide policy makers in setting health priorities, allocating funding and providing feedback on the performance of different parts of the health system (box 3.2). Many states have also developed their own range of policy documents that guide health funding and service delivery.⁵⁰
- 3.43 These national policy frameworks play an important role in focusing and coordinating Commonwealth and state efforts in particular subject areas. However, almost by definition, they can not address system wide issues such as the balance between resources allocated to prevention or early detection of disease versus treatment of injury and disease, or the structural changes necessary to minimise expensive institution based care.

50 See for example, Department of Premier and Cabinet (Victoria), *Growing Victoria Together: A vision for Victoria to 2010 and beyond* (undated); Department of Health (NSW), *NSW Tobacco Action Plan 2005-2009*, November 2005; Queensland Health, *Action Plan: Building a better health service for Queensland*, October 2005; Department of Health (ACT), *ACT Mental Health Strategy and Action Plan 2003-2008*, September 2006.

Box 3.2 Selected national health strategies, frameworks and programs

'Healthy Horizons: Outlook 2003–2007' — a national health framework for rural, regional and remote Australians. Developed by Commonwealth, state health ministers in 2003, the framework provides a banner under which governments develop strategies and allocate resources to improve the health and well-being of people in rural, regional and remote Australia.⁵¹

'Report on Government Services' — an annual report commissioned by the Council of Australian Governments to provide information on the efficiency and effectiveness of government services (including health) on a state by state basis.⁵²

'National Chronic Disease Strategy' — provides an overarching framework, endorsed by the Australian National Health Ministers' Conference, of national direction for improving chronic disease prevention and care across Australia. Five supporting national service improvement frameworks have been developed for asthma, cancer, diabetes, heart, stroke and vascular disease, osteoarthritis, rheumatoid arthritis and osteoporosis.⁵³

'National Health Workforce Strategic Framework' — endorsed by the Australian National Health Ministers' Conference in 2004 is designed to guide national health workforce policy and planning and Australia's investment in its health workforce throughout the decade.⁵⁴

3.44 A number of inquiry participants noted the absence of a high-level national agenda to guide health policy and funding.⁵⁵ A national health agenda may lead to major reforms but can also guide incremental reforms if there is general agreement about how the health system needs to change over time. Dr Scotton told the committee:

I think there is some value in knowing where you would like to be, even if that is some sort of measuring rod when things come up to determine which step is a step forward and which

51 National Rural Health Alliance, *Health Horizons Outlook 2003–2007*, viewed on 21 September 2006 at www.ruralhealth.org.au/nrhpublic/publicdocs/hh/03_hh0307rep.pdf.

52 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2006* (2006), Productivity Commission.

53 National Health Priority Action Council, *National Chronic Disease Strategy* (2006), Department of Health and Ageing, Canberra.

54 Australian Health Ministers' Conference, *National Health Workforce Strategic Framework* (2004).

55 Webb R, Department of Health (SA), transcript, 2 May 2006, p 32; Australian Healthcare Association, sub 62, pp 9–10; Australian Nursing Federation, sub 39, p 9; Clout T, Hunter New England Health, transcript, 20 July 2006, p 18; Australian Medical Association, sub 30, p 16.

one is a step back. We do have potentially in the longer term a very serious problem with health costs going to 15 per cent or 18 per cent of GDP. It is a good idea to think well ahead of what you might do to put some sort of brake on that, because there may well come a time when the rising demand for resources for health care may start to impinge on other areas of great value to our society.⁵⁶

- 3.45 The committee considers that the Commonwealth needs to provide leadership on setting a national health agenda, in consultation with the states. When fully developed, the national agenda should result in:
- policy and funding principles to underpin the long term sustainability of a health system that provides affordable access to best practice care;
 - identification of elements of structural and allocative inefficiency in the health system as a whole;
 - a clearer articulation about the standards of service that the community can expect to receive including desired population health outcomes, the extent to which rationing is acceptable within the public system and the quality of care that people are entitled to receive;
 - strategies to integrate the private sector within the health system to improve continuity of care between the public and private sectors; and
 - a framework for reporting on performance of health service providers and governments.
- 3.46 The national health agenda could establish a basis for major structural reform or could guide incremental reforms.
- 3.47 As part of addressing the long-term health impact of emerging health concerns the committee considers that the national health agenda also needs to be linked to broader public health strategies. In the case of addressing the rising incidence of childhood obesity and diabetes, which is being examined by a ministerial taskforce,⁵⁷ the agenda should integrate with action taken in schools and in the marketing of food.

56 Scotton R, transcript, 21 July 2006, p 52.

57 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Tackling obesity head-on*, 19 July 2006.

- 3.48 Several participants suggested that a set of ‘principles’ should be used to assess whether proposed reforms are consistent with a reform path.⁵⁸ Other participants also noted that reform could be guided by a range of intergovernmental bodies including COAG, health ministers or a newly established national ‘commission’.⁵⁹
- 3.49 The committee believes that health ministers should drive reform but governments need to endorse and support the underlying principles and objectives.
- 3.50 If the pressures foreshadowed by the Intergenerational report⁶⁰ are to be ameliorated, any policy changes that can reduce the long term demand for services or reduce the long term costs of care need to be identified and implemented. As the benefits of some initiatives, such as tackling the prevalence health risk factors, may not be apparent for many years, action should be initiated as soon as possible.
- 3.51 The community has made it clear that it expects the Commonwealth and states to stop blaming each other for shortcomings in the health system. The committee agrees and recommends accordingly.

58 Australian Health Care Association, sub 62, pp 7–8; Australian Nursing Federation, sub 39, p 6; City of Darebin (Vic), sub 32, p 3.

59 Health Group Strategies, sub 116, p 14; City of Darebin (Vic), sub 32, p 4; Local Government Association of NSW and Shires Association of NSW, sub 18, p 10; Australian Medical Association, sub 30, p 10; Podger A, transcript, 31 May 2006, p 10.

60 The Treasury, *Intergenerational Report 2002-03*, Budget Paper No. 5 (2002).

Recommendation 1

- 3.52 **The Australian, state and territory governments develop and adopt a national health agenda. The national agenda should identify policy and funding principles and initiatives to:**
- **rationalise the roles and responsibilities of governments, including their funding responsibilities, based on the most cost-effective service delivery arrangements irrespective of governments' historical roles and responsibilities;**
 - **improve the long term sustainability of the health system as a whole;**
 - **support the best and most appropriate clinical care in the most cost effective setting;**
 - **support affordable access to best practice care;**
 - **rectify structural and allocative inefficiencies of the whole health system, as it currently operates;**
 - **give a clear articulation of the standards of service that the community can expect;**
 - **redress inequities in service quality and access; and**
 - **provide a reporting framework on the performance of health service providers and governments.**
- 3.53 The adoption of a national health agenda will require a clear commitment of political will by all levels of government. Difficult as this commitment may be to achieve, the community has made it clear that it expects nothing less.
- 3.54 A national health agenda should also guide debate about changing health funding arrangements. While there are several alternate funding models that could be used to achieve the national agenda, the committee considers that a high-level commitment to a national agenda is likely to lead to an improved debate about how health funding arrangements should be structured.

Radical reform: possible models

- 3.55 Inquiry participants nominated a range of different funding models that would, to varying degrees, change the structure of current health funding arrangements. While some funding models could be structured around current service delivery arrangements, most of the proposed models also require changes to governance and service delivery arrangements.
- 3.56 Many of the suggested models are not new. In 2000, the Senate's Community Affairs Committee considered a number of different reform models as part of its inquiry into public hospital funding.⁶¹
- 3.57 One common theme to these proposed models is that they incorporate — to varying extents — a broad pooling of funds from the current 'silos', such as the Australian Health Care Agreements and Commonwealth funded programs such as the PBS and the MBS.
- 3.58 Some commentators argue that fund pooling is more likely to promote better continuity of care, a stronger emphasis on primary health care and public health and reduce incentives for cost shifting. This is largely due to increased flexibility in the allocation of funds across existing program areas and incentives for fund holders to provide for the long-term health needs of the enrolled community.⁶² Mr Podger noted that:
- Perhaps the most significant contribution to inefficiency in our system today however, is not the lack of technical efficiency within particular functional areas such as hospitals or residential aged care or general practice, but allocative inefficiency where the balance of funding between functional areas is not giving best value, and the inability to shift resources between the functional areas at local or regional levels and to link care services to individuals across program boundaries is reducing the effectiveness of the system.⁶³
- 3.59 Some differences between the proposed fund pooling models include the extent that the private sector is incorporated into service delivery

61 Senate Community Affairs Committee, *Healing our hospitals: A report on public hospital funding* (2000).

62 Fitzgerald V, 'Health reform in the federal context', *Productive reform in a federal system* (2006), Productivity Commission, p 120.

63 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 7.

arrangements and governance arrangements for distributing funds and monitoring service delivery.

- 3.60 Mr Podger summarised four main options for reforming Commonwealth/state funding arrangements:
- ONE: the states to have full responsibility for purchasing all health and aged care services;
 - TWO: the Commonwealth to take full financial responsibility for the system, as both funder and purchaser;
 - THREE: the Commonwealth and the states to pool their funds, with regional purchasers having responsibility across the full range of health and aged care services; and
 - FOUR: the Scotton model, or ‘managed competition’ model, with total Commonwealth and state moneys to be available for channelling through private health insurance funds by way of ‘vouchers’ equal to each individual’s risk-rated premium which the individual may pass to the fund of their choice, the fund then having full responsibility as funder/purchaser of all their health and aged care services.⁶⁴
- 3.61 These four models, or variants of these models, were raised by inquiry participants as providing a possible solution to overcome some of the deficiencies of current funding arrangements.⁶⁵ Mr Podger noted:
- The main differences between different reformers is about what is the best model for a single funder, what is the best role for private funding and private health insurance, and whether we should be pursuing incremental or systemic reform.⁶⁶
- 3.62 The other main option for health funding is to maintain existing arrangements. A number of ways that current arrangements could be left in place but improved are discussed later in this chapter.

64 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 9.

65 Australian Healthcare Association, sub 62, pp 8–11; Scotton R, transcript, 21 July 2006, pp 50–57; Menadue J, transcript, 21 July 2006, pp 29–30; Municipal Association of Victoria, sub 33, p 3; Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 2; Australian Association of Gerontology, sub 53, pp 3–4; Australian Council of Social Service, sub 25, p 1.

66 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 12.

1. States — full responsibility

- 3.63 In Canada, responsibility for health is devolved to the provinces within a federal system.⁶⁷ Although giving states full responsibility for the delivery of health services may result in the loss of a ‘national’ health system, states could be required to meet national principles requiring universal access to services and regular performance measurement.⁶⁸
- 3.64 The states could also choose whether to have lower level regional purchasers of services, and might agree to cooperate or seek economies of scale through delegated Commonwealth management of certain parts of the system. For example, listing and pricing drugs and medical services, managing the blood supply and regulating private health insurance.⁶⁹

2. Commonwealth — full financial responsibility

- 3.65 A detailed model for the Commonwealth having full responsibility for funding and purchasing health care has recently been developed by Mr Andrew Podger.⁷⁰ One of the features of the model proposed by Mr Podger is the separation of funding and purchasing and a regional approach to service provision (figure 3.3).⁷¹

67 OECD 2001, *Consulting on health policy in Canada*, viewed on 24 October 2006 at www.oecd.org/dataoecd/53/43/2536423.pdf.

68 Podger A, *Directions of health reform in Australia (2005)*, Productivity Commission,, p 147, exhibit 26.

69 Podger A, *Directions of health reform in Australia (2005)*, Productivity Commission, p 147, exhibit 26.

70 Podger A, transcript, 31 May 2006, p 2.

71 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006 (2006)*, exhibit 27, p 12.

- 3.66 Some of the key features of the model proposed by Mr Podger include:
- the Commonwealth to articulate the policy objectives and the general principles, set the conditions within which health care services would be purchased and provided, and establish the framework for reporting on performance. The policy objectives and principles should include the requirements of equity in terms of geographic access, co-payments, safety nets and acceptable queues etc, and the requirements of value-for-money such as cost effectiveness processes for listing and pricing drugs and health services;
 - a national (or supra-national by including NZ) approach to most areas of health regulation, at least in standards if not in day-to-day administration. This includes regulation aimed at patient safety and consumer protection, including licensing of products and providers (both individuals and organisations such as hospitals and nursing homes), regulation of the private health insurance industry and the setting of food standards;
 - regionally-based purchasing arrangements with around 20-30 regional purchasers having the flexibility to allocate funds according to their most cost effective use to achieve the health objectives for their regional population;
 - budget arrangements to involve a 'soft-capped' total budget based on the population's risk profile, with access to some specific national risk pools where the region cannot be expected to manage the risk on its own. These might cover, for example, the impact of the MBS or PBS safety nets, as well as some very high-cost populations or even some high care episodes. The soft cap would also allow budget over-runs if necessary, where the consequences would be some form of performance review rather than penalising the regional population;
 - provider arrangements would not be substantially changed, with most doctors and other professional health providers continuing to operate as independent private businesses, and hospitals and aged care providers continuing to operate with a degree of independence as private or charitable organisations, or as public institutions with substantial management autonomy. However, over the longer term expected changes would include a strengthening of primary care arrangements; and

- individual Australians will need to participate in the national patient information record system which, through smart-card technology, would allow considerable patient control over the information – to those having access to it and who can add to it or vary it. Over time, such a system also has the potential to enhance patient control over their own care without jeopardising professional influence about effectiveness and cost-effectiveness.⁷²

3. Commonwealth-state — pooled funding

- 3.67 A Commonwealth-state fund pooling model was recently suggested to the Victorian Government as a way of overcoming some of the disadvantages of current funding arrangements. A similar proposal was also discussed as part of COAG deliberations in the mid 1990s.⁷³
- 3.68 Proponents of this pooled model include governance arrangements that would establish a ‘joint health commission’, which would be responsible for resource allocation and facilitate integration of services.⁷⁴ The commission could assume responsibility for a number of existing health-related programs including public hospitals, veterans’ health care, the MBS, PBS and Indigenous health.⁷⁵
- 3.69 The main feature of this proposal is that implementation could be progressed on a jurisdiction by jurisdiction basis and possibly be tailored to suit the different histories and needs of each jurisdiction.⁷⁶
- 3.70 Other features of pooled funding models include:
- shared resource allocation through the purchase of various services from providers (Commonwealth, state and local government and non-government providers) as part of a joint strategic plan;
 - shared performance management to oversee continuous improvement of the health system, monitor progress and establish reform targets including development of standard measurement, benchmarking and patient-centred best practices; and

72 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, pp 11-21.

73 Allen Consulting, *Governments working together: A future for all Australians* in Productivity Commission, *Productive Reform in a Federal System* (2006), p 149.

74 Menadue J, *A coalition of the willing*, exhibit 42, p 2.

75 Menadue J, *A coalition of the willing*, exhibit 42, p 2.

76 Menadue J, *A coalition of the willing*, exhibit 42, p 2.

- representation on the governing (not advisory) commission to include equal commonwealth and state representation and include related agencies (such as Department of Education) and people having knowledge of the private sector.⁷⁷

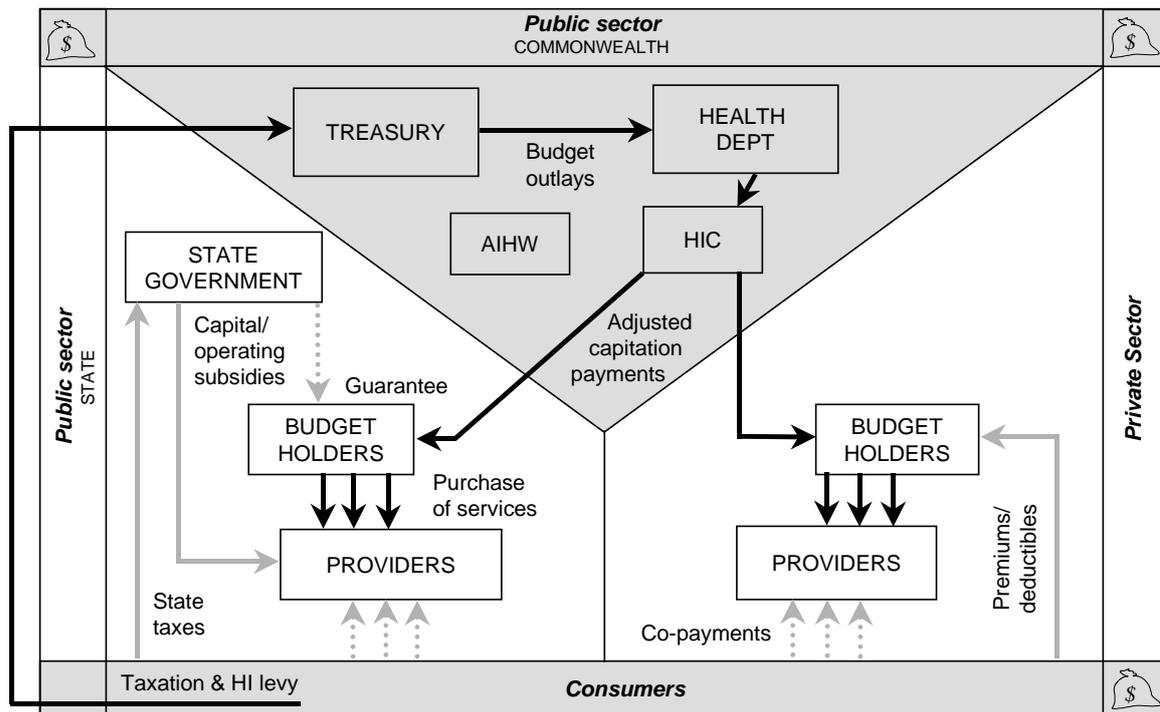
4. Managed competition — Scotton model

- 3.71 The Scotton model involves the use of financial incentives to modify the actions of funders, service providers and consumers in order to improve the efficiency of the delivery of health care, while at the same time, preserving the government's commitment to universal and equitable access to health services.
- 3.72 Developed by Dr Scotton, the model has been the subject of academic discussion for a number of years.⁷⁸ The Scotton model is a form of 'managed competition' model that involves setting up a market oriented structure by separating the financing and insurance/third party payer function from the provision of health care services.
- 3.73 The Scotton model can be outlined in terms of the roles of three participants — Commonwealth government, state governments and private sector — in carrying out the functions of financing, budget holding and service provision. Financial flows under model are outlined in figure 3.4.

⁷⁷ Menadue J, *A coalition of the willing*, exhibit 42, p 2.

⁷⁸ See for example, Productivity Commission, *Managed Competition in Health Care* (2002); Scotton R, 'Managed Competition: issues for Australia', *Australian Health Review* (1995), vol 18, no 1, pp 82–104; Productivity Commission and Melbourne Institute of Applied Economic and Social Research, *Health Policy Roundtable* (2002); Productivity Commission, *Productive Reform in a Federal System* (2006).

Figure 3.4 Managed competition model: financial flows



Note AIHW – Australian Institute of Health and Welfare, HIC – Health Insurance Commission (now Medicare Australia), HI – health insurance.

Source Productivity Commission, *Managed Competition in Health Care* (2002), p 67.

3.74 Dr Scotton told the committee:

... [the model] is based on the Commonwealth taking responsibility for the whole lot but devolving that by a formula which incorporates incentives to efficiency, both in the sense of efficient resource use in the health care sector and market efficiency—doing things in the least cost way—and devolving that responsibility. The Commonwealth takes over but it does not get into the service delivery area at all. It devolves the control over service delivery to others—to a lower level where it can be managed.⁷⁹

3.75 The Scotton model is described as the most radical proposal for funding arrangements, with implementation of the full model broadly involving:

- comprehensive amalgamation of existing health programs;

79 Scotton R, transcript, 21 July 2006, p 53.

- clear and separate roles for Commonwealth and State governments; and
- the substantial integration of private sector funding and service provision into a national program using population-based funding for program delivery.⁸⁰

The case against radical reform

- 3.76 There are a broad range of views on the benefits and risks of adopting more radical proposals for funding reform.

Participants' views on radical reform options

- 3.77 There is not universal support to move to a different funding model.⁸¹ Mr Deeble told the committee that:

I would be very cautious about giving one level of government control over all of it because if it was the Commonwealth I think it may be too far away from the delivery interface to respond to what the real pressures are and it will be run too much by Treasury bureaucrats. At the state level it is run more at the state level, and indeed those who are state members are much more active with their minister on behalf of their constituencies than perhaps at the Commonwealth level.

... there is a responsiveness at the state level which is different to the responsiveness at the federal, and I think it is a good thing that there is some competition between the two levels of government in terms of advocacy for health. The Commonwealth will wish to push the states in a certain direction and the states will wish to do something else. I would be uncomfortable with a completely monolithic system.⁸²

- 3.78 No state government directly indicated to the committee that it would support moves to establish single funder arrangements. However, at

80 Productivity Commission, *Managed Competition in Health Care* (2002), p 5.

81 Australian Medical Association, sub 30, p 28; Deeble J, Australian Health Care Association, transcript, 26 May 2006, p 41.

82 Deeble J, Australian Health Care Association, transcript, 26 May 2006, pp 41-42.

various times, the Queensland, South Australian and New South Wales governments have indicated their support for the Commonwealth to take over the operation of the public hospitals (see chapter 7).⁸³

- 3.79 A major benefit shared by the proposed funding models is that, compared to current arrangements, they potentially offer greater flexibility and integration in service provision and patient-centred funding arrangements. These funding models are also likely to provide the funders of health services with greater incentives to promote wellness through public health and primary health care programs, thereby reducing the pressures that are faced by acute service providers.
- 3.80 Notwithstanding these benefits, the adoption of a different funding model is not likely to solve all of the perceived shortcomings of the Australian health system. Mr Podger noted that:
- One aspect of [the Commonwealth assuming full responsibility] model is that it is trying to superimpose on the system some form of budget holding. I am not talking about an absolute, rigid, cash-limited budget, but this model is premised on a form of budget holding, and the ability for better financial control. There will be, out of that, rationing coming through. But any health system is going to have some rationing, and I think people have got to be realistic about that. It is just trying to get a model of rationing that is most likely still to deliver the best care, and get the best results from the money available.⁸⁴
- 3.81 It was not clear to the committee that there is one model that overwhelmingly offered greater benefits than the others. While it was possible to identify some of the relative disadvantages of each model, the relative advantages of one model over another are more difficult to identify (table 3.1).

83 Karvelis P. and A. Cresswell, 'States ask Canberra to control hospitals', *The Australian*, 2 June 2006, p 6; Sommerfield J, 'Abbott passes health proposal', *Courier Mail*, 27 August 2005, p 8.

84 Podger A, transcript, 31 May 2006, p 12.

Table 3.1 Summary of inquiry participants' comments on proposed funding models

| Model | For | Against |
|--|---|---|
| States – full responsibility | <ul style="list-style-type: none"> • Competitive federalism to encourage innovation and hence greater efficiency and effectiveness. | <ul style="list-style-type: none"> • Against trend towards greater Commonwealth funding and control. • Complex legislative change and a long controversial debate about principles and the extent of flexibility within national framework. • Substantial doubts about the capacity of smaller jurisdictions to provide the full range of health responsibilities. |
| Commonwealth – full financial responsibility | <ul style="list-style-type: none"> • Strengthens political accountability allowing a single minister and department to focus on management and outcomes. • Avoids vertical fiscal imbalance and could allow for local community responsiveness through regional planning and purchasing processes and local provision of services. • Consistent with trend of increasing share of Commonwealth health expenditure. | <ul style="list-style-type: none"> • Would require significant effort and complementary action to take over state staff and facilities and establish new administrative structures which allow for regional and community level flexibility and input, and enabled more sophisticated planning. • Complex renegotiation of GST agreement. • High political risk for Commonwealth minister. |
| Commonwealth-state – pooled funding | <ul style="list-style-type: none"> • Some experience in running successful trials. | <ul style="list-style-type: none"> • Low optimism for agreement and difficulties in negotiating the pools of funds and sharing of risks. • Unrealistic degree of sustained cooperation to implement. • Unhealthy level of bureaucratic control. • Reliance on output and outcome targets is not sufficient. Serious risk of 'game playing' on the data without agreed commitment on the financial inputs. |
| Managed competition – Scotton model | <ul style="list-style-type: none"> • Scope to increase competition amongst funders as well as providers. • Increased choice, of funders and providers, with capacity through private contributions to sign up to the insurance cover the individual would prefer. | <ul style="list-style-type: none"> • Substantial work would be required to calculate the risk-rated premium for each person to use as their voucher. • Likely to have Commonwealth to take full responsibility as a transition to this model. • Uncertain impact of the extra competition given limited capacity of private insurers to manage the levels and costs of the services doctors provide. • Concern about transition to US-style 'managed care'. |

Source Podger A, *Directions for Health Reform in Australia - A Presentation to Productivity Commission Roundtable on Productive Reform in a Federal System, October 2005, exhibit 26*; Productivity Commission, *Managed Competition in Health Care(2002)*; Podger A, *Inaugural Menzies Health Policy Lecture: 3 March 2006 (2006), exhibit 27*; Podger A, *transcript, 31 May 2005*; Menadue J, *transcript, 21 July 2006, pp 26–39*; Scotton R, *transcript, 21 July 2006, pp 50–57*; Australian Health Care Reform Alliance, *transcript, 21 July 2006, pp 47–49*; Australian Health Care Association, *transcript, 26 May 2006, pp 38–55*; Catholic Health Australia, *sub 35, pp 10–11*.

3.82 Mr Podger, a major proponent of the Commonwealth assuming full responsibility, believed that the political environment favoured this approach, noting that:

... the only feasible single-funder option for Australia in the medium term is for the Commonwealth to have full financial responsibility for public funded services. This is not to deny the theoretical attractions of some of the other models. Also, compromise on both sides of politics is needed to develop a coherent and sustainable balance between public and private financing. Getting that balance is almost certainly dependant, in the long term, on having a single government funder.⁸⁵

3.83 Mr Menadue believed that a state-by-state approach to fund pooling was more likely to be achievable than the Commonwealth assuming full responsibility, noting that:

I would favour that model, but I am being a political realist in knowing that it is not likely to happen and that it would be more profitable and successful to go state by state to achieve a result. It may, in the end, produce an outcome such as Andrew Podger has mentioned, but I think that will take some time to achieve.⁸⁶

The case against radical reform: The committee's view

3.84 Overall, the committee considers that the implementation of a model that delegates full responsibility to the states and the Scotton model are less attractive options to pursue.

3.85 It is clear that the full implementation of the 'Commonwealth assuming full financial responsibility' and a 'pooled funding' approach would involve significant up front costs and would require a substantial period to prepare the necessary institutional arrangements. While benefits from either approach can be identified, the magnitude is difficult to determine.

3.86 The committee considers that there is significant benefit in the Commonwealth working with states to develop agreed principles and arrangements to guide health reform over the longer term. Agreed arrangements may cover a range of funding reform options including:

85 Podger A, transcript, 31 May 2006, p 2.

86 Menadue J, transcript, 21 July 2006, p 34.

- the sharing of downstream savings from investing in primary and public health; and
 - making broad adjustments to Commonwealth-state funding after the implementation of more efficient and effective models are care, rather than prior to their implementation as presently occurs.
- 3.87 A commitment to developing new funding arrangements should also provide impetus for further research on the costs and benefits of different funding approaches.
- 3.88 Theoretically, the status quo is also an option but it should not be contemplated. While Australia's health system may be generally good, this report highlights many areas where it can be improved. These problems reduce the quality of health care and increase its cost to patients and governments. These adverse effects will significantly increase in the coming decades due to the pressures created by evolving medical technology, community expectations and an ageing population. Action must not be delayed.

Incremental reform

- 3.89 While the case for more radical restructuring of funding arrangements may need to be further developed, inquiry participants nominated a number of changes that could be made to current arrangements. Some of these changes could be implemented by a single level of government while others require cooperation and coordination between governments.

Strengthening primary health care

- 3.90 There are a number of areas where funding arrangements for primary health care could be changed to provide incentives that encourage the promotion of 'wellness' and for improved support for the chronically ill and frail aged. The Redcliffe-Bribie-Caboolture Division of General Practice noted that:

... the Division was struck by the fact that the funding models did not allow for most preventative care. Put starkly, the current funding model maximises income for GPs when their patients are ill, not when their patients are well. It seems that this is like paying our swimmers to swim slowly but still

expect them to win medals. The country wants to achieve a well population, not an ill one!⁸⁷

3.91 Some of the differences between an illness model and wellness model relate to how funding arrangements affect the incentives for service delivery (table 3.2).

Table 3.2 Key differences between 'illness' and 'wellness' models for primary health care services

| Illness model | Wellness model |
|--|--|
| Service provided by general practitioners with support from practice nurses. | Service provided by a multidisciplinary team including GPs, wellness nurses, exercise physiologists, lifestyle coaches, fitness trainers, nutritionists, dieticians, counsellors |
| Emphasis on curing patients – addresses symptoms | Emphasis on keeping people well – addresses lifestyle issues before they become symptomatic |
| Mostly individual doctor-patient consultations at a practice | Significant role for nurses and allied health practitioners including group settings and domiciliary care. Consultations by phone and over the Internet |
| Funding of doctors through a fee for service model | A new funding model based on keeping patients well, and including budget holding for pharmaceuticals and diagnostics |
| Stand alone practices | A chain of Wellness Centres collaborating with other health, fitness, and welfare organisations in same locality |
| Occasional reference to lifestyle issues where it affects illness | Ongoing and regular concentration on lifestyle issues such as nutrition, exercise, and substance misuse |
| Fixed charges to patients | Patient co-payments based on lifestyles |
| Managed by doctors in their 'spare time' | Managed by managers under a new governance model |
| Patients phone in to book appointments | Patients can book appointments on the Internet |

Source Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 4.

3.92 The Commonwealth has introduced a range of measures that support moves towards a wellness model for primary health care delivery. These have included exercise physiology services under the Medicare allied health initiative, a 'well persons health check' available through Medicare for people around 45 years old with one or more health risks and subsidising the employment of practice nurses working in all urban areas of workforce shortage.⁸⁸

87 Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 2.

88 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Exercise physiologists eligible to provide services under Medicare*, 6 September 2005; media release, *Better health for all Australians*, 10 February 2006; media release, *More Government support for nurses working in general practice*, 11 April 2006.

- 3.93 Inquiry participants suggested a number of measures that would further strengthen the emphasis on building wellness into primary care including:
- greater use of ‘blended’ payments rather than strict fee-for-service payments that financially reward doctors for achieving or working towards different outcomes, such as increasing the use of information management and information technology, expanding provision of after hours care, student teaching and better prescribing of medicines;⁸⁹
 - wider access to the MBS by allied health professionals including physiotherapists, psychologists and nurses;⁹⁰
 - revised models of primary practice promoting a multidisciplinary team approach to treatment and prevention by providing for health services by providing access to a range of doctors and allied health professionals working in a coordinated manner.⁹¹ Fund holding of capitation-based payments by divisions of general practice was identified as one way of encouraging more formal team approaches;⁹² and
 - greater support for the development of information communication technology infrastructure to facilitate greater sharing of patient information and treatment options.⁹³
- 3.94 There appears to be broad support for a move to a wellness model in service delivery. The committee noted that there are concerns about involving allied health professionals outside of general practitioner-led care models and the effectiveness of fund pooling approaches to promoting different models of care.⁹⁴
- 3.95 While the committee generally supports the move towards a health system that is based around a wellness model, decisions about the

89 Western Australian Government, sub 124, p 24; Rural Doctors Association, sub 31, p 12.

90 Australian Physiotherapy Association, sub 118, p 3; Australian Psychological Society, sub 136, pp 4–5; Professor Stephen Leeder, sub 3, p 1; Western Australian Government, sub 124, p 9; Australian College of Health Service Executives, sub 141, p 11.

91 Australian Division of General Practice, sub 15, p 3; MBF Australia Limited, sub 29, p 5; Health Workforce Queensland, sub 113, p 2; Australian Physiotherapy Association, sub 118.

92 Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 2.

93 Rural Doctors Association of Australia, sub 31, p 13; Australian Association of Pathology Practices, sub 38, p 4; Pharmacy Guild of Australia, sub 41, p 5; Health Group Strategies, sub 116, p 25.

94 Australian Medical Association, sub 30, pp 27–28.

appropriateness of different types of health care are best made by medical practitioners and their patients.

Better use of patient information

- 3.96 Better use of information communication technology and patient level information is not only important in primary care, but has the potential to improve patient care in all settings. Costs and patient inconvenience can be reduced by, for example, avoiding duplication of tests and diagnostic procedures. Improving the range and timeliness of information available to clinicians should result in better diagnosis and treatment.
- 3.97 All governments have recognised the benefits of electronic storage and transmission of health records and have made significant investments in information technology systems. Hospitals and other organisations, such as divisions of general practice are also heavily involved in the development of information technology systems to allow better communication between providers.⁹⁵
- 3.98 The Commonwealth is leading the national approach to electronic health records through *HealthConnect* — an overarching national change management strategy to improve safety and quality in health care by establishing and maintaining a range of standardised electronic health information products and services for health care providers and consumers.⁹⁶
- 3.99 The committee notes that COAG recently agreed to accelerate work on a national electronic health records system to build the capacity for health providers, with their patient's consent, to communicate quickly and securely with other health providers across the hospital, community and primary medical settings. The Commonwealth will contribute \$65 million and the states \$65 million in the period to 30 June 2009.⁹⁷
- 3.100 The committee supports the objective of governments to implement effective electronic health records systems in a timely manner. The

95 Australian Divisions of General Practice, sub 66, pp 2–7; Sprogis A, transcript, 20 July 2006, p 61.

96 Department of Health and Ageing, *HealthConnect*: Introduction, viewed on 22 September 2006 at www.health.gov.au/internet/hconnect/publishing.nsf/Content/intro.

97 Council of Australian Governments, *Council of Australian Governments communique*, 14 July 2006 (2006), p 12.

Commonwealth needs to ensure that it continues to lead the development of information technology systems and provide appropriate levels of funding to ensure expanded use of technology in health care as soon as possible.

Commonwealth funding for medical services

- 3.101 The MBS is regularly updated to reflect government decisions about the services to be funded, to adjust schedule fee and benefit levels in accordance with government policy, and to respond to changes in clinical practice.
- 3.102 In relation to new medical technologies and procedures, the Minister for Health is advised by the Medical Services Advisory Committee (MSAC) which assesses their safety, effectiveness and cost-effectiveness. In relation to other issues, the Minister is advised by the Medicare Benefits Consultative Committee (MBCC).
- 3.103 In its recent report on Australia's health workforce, the Productivity Commission noted that the deliberations of MSAC and the MBCC are broadly confined to the inclusion of new technologies into the MBS and the review of items already covered by the schedule.⁹⁸ Other changes to the MBS flow from the development of new policies or programs within the government. The Commission saw merit in such changes being subject to a more transparent assessment process and recommended the establishment of a new advisory committee, subsuming the role of MSAC and the MBCC, which would publicly report its assessments.
- 3.104 The committee notes that the Commonwealth did not accept the Productivity Commission's recommendation to establish a new committee, but indicated that it would improve the efficiency and transparency of existing mechanisms and strengthen the links between MSAC and MBCC.⁹⁹
- 3.105 The committee supports the thrust of the Productivity Commission's conclusions and noted the Commonwealth's response.
- 3.106 The Productivity Commission also raised the issue of the appropriateness of MBS fee levels for procedural services relative to consultative services. The committee noted that, in response to the

98 Productivity Commission, *Australia's Health Workforce* (2005), p 171.

99 Council of Australian Governments, *Communique*, 14 July 2006, Attachment A.

Productivity Commission's recommendation, the Commonwealth indicated that it would review the MBS payment methodologies.

Recommendation 2

3.107 As a matter of priority, the Department of Health and Ageing undertake the actions specified in the July 2006 Council of Australian Governments' response to the Productivity Commission's health workforce inquiry to:

- **improve the efficiency and transparency of existing mechanisms to assess changes to the Medicare benefits schedule; and**
- **strengthen links between the Medical Services Advisory Committee and the Medicare Benefits Consultative Committee.**

Realigning responsibilities

3.108 One method of overcoming incentives for cost shifting and barriers to the continuity of care is a realignment of government responsibilities for different types of care. The model of care for veterans provided by the Department of Veterans' Affairs was sometimes cited as a successful model of one level of government managing the full health needs of a segment of the population.¹⁰⁰

3.109 There appear to be several areas where one level of government could take full responsibility for funding as a way of improving health outcomes and accountability including:

- defined population — older age groups may benefit from better coordination and management of their complex care needs.¹⁰¹ An incremental step towards the Commonwealth assuming greater responsibility for older Australians would be for the Commonwealth to meet the full costs of patients assessed as eligible for residential aged care but waiting in public hospitals for a vacant residential aged care place.¹⁰²

100 Australian Medical Association, sub 30, p 9; Enteral Industry Group, sub 119, p 2; Australian Health Care Association, sub 62, pp 10–11.

101 Australian Health Care Association, sub 62, pp 10–11; Catholic Health Australia, sub 35, pp 2–3.

102 Australian Medical Association, sub 30, p 9

- specific programs/treatments —mixed Commonwealth and state government funding for some programs and treatments has resulted in differences in access. Some areas suggested for a transfer of responsibility include pharmaceuticals, outpatient services, ambulance services and enteral nutrition.¹⁰³
 - geographic areas — selecting a designated region for fund pooling.¹⁰⁴ Several geographic pooled funding arrangements have been trialled or are in place including the Coordinated Care Trials and Multi Purpose Services Program.¹⁰⁵
- 3.110 Governments have discussed incremental changes to responsibilities in a number of areas as part of negotiations of the Australian Health Care Agreements.¹⁰⁶ These negotiations have largely been unsuccessful (see chapter 7).
- 3.111 While changing responsibilities appears to offer benefits for some parts of the population, gaining the agreement of governments has proven to be a significant barrier to reform.

Dental care

- 3.112 The provision of dental care in a timely manner can significantly affect a person's quality of life and future health costs. The Australian Dental Association noted that:

Like the health system generally, the organisation and delivery of dental care in Australia is characterised by the involvement of Commonwealth, State and territory, and Local Governments. Unlike the health system though, dental care in Australia is largely financed by individual out-of-pocket expenses, with direct payments and subsidies by various levels of government making up the balance of expenditure.¹⁰⁷

103 Australian Health Care Association, sub 62, pp 10–11; Council of Ambulance Authorities, sub 148, p 9; Enteral Industry Group, sub 119, p 2.

104 Australian Health Care Association, sub 62, pp 10–11.

105 Department of Health and Ageing, sub 142, pp 22–26.

106 Reid M, 'Reform of the Australian Health Care Agreements: progress or political ploy?', *Medical Journal of Australia* (2002), vol 177, no 6, pp 310–312; Duckett S, 'The 2003-2008 Australian Health Care Agreements: an opportunity for reform', *Australian Health Review* (2002), vol 25, no 6, pp 24-26.

107 Australia Dental Association, sub 28, p 1.

... all governments must recognise dentistry as an essential element of a nation's health service, and as such, oral health care should be available to every section of the community. Governments must also recognise that there are disadvantaged and special needs groups who will be unable to access reasonable levels of oral health care without assistance, and that they have a vital role in providing oral health services for individuals within these groups.¹⁰⁸

- 3.113 The Commonwealth and states have recently collaborated, through the National Advisory Committee on Oral Health established by the Australian Health Ministers' Conference (AHMC), to produce a report *Healthy mouths healthy lives: Australia's National Oral Health Plan 2004-2023*. The report, which was endorsed by AHMC on 29 July 2004, identifies a range of issues, particularly relating to funding arrangements and the dental workforce.
- 3.114 The committee welcomes the creation of this plan and urges the Commonwealth to take a leadership role in its implementation under the national health agenda. In this respect, dental health should be no different to other health care services. The need for Commonwealth leadership was also identified by the Australian Dental Association which said:
- The recognition of a relationship between oral and general health clearly identifies the need for the Commonwealth to undertake a leadership role in the delivery of dental services as an investment in dental care will not only alleviate dental disease but will have the flow-on effect of reducing later general health expenditure.¹⁰⁹
- 3.115 The committee is particularly concerned about the waiting times for public dental health services, and considers these to be under-funded. Many Australians who cannot afford private dental services are not receiving the services necessary to maintain oral health.
- 3.116 The Commonwealth should supplement states funding for appropriate public services so that reasonable access standards can be maintained, particularly for disadvantaged groups. Where appropriate, oral health services should also be covered in other Commonwealth programs such as aboriginal health programs. In this context, the committee noted the views of Professor Deeble and the

108 Australia Dental Association, sub 28, p 3.

109 Australia Dental Association, sub 28, p 13.

Australian Dental Association that funding through the MBS is probably not appropriate.¹¹⁰

- 3.117 Providing greater access to public funding for dental services will also need to be supported by a rise on the number of dentists over the short and medium term through increases in the number of university places (see chapter 4).
- 3.118 As discussed above, dental health should be an integral part of the national health agenda and, as such, access to public dental services is a joint responsibility of the Commonwealth and state governments. The committee considers that waiting times for access to public dental services are excessive and should be addressed as a matter of priority.

Recommendation 3

- 3.119 The Australian Government should supplement state and territory funding for public dental services so that reasonable access standards for appropriate services are maintained, particularly for disadvantaged groups. This should be linked to the achievement of specific service outcomes.**

Breaking down funding silos

- 3.120 The integrated nature of many health care services should require that governments give consideration to the broader effects of a proposed policy change to an existing program. Inquiry participants nominated a number of health programs where the broader health and social benefits of increased expenditure should be given greater recognition including:
- pharmaceuticals;¹¹¹
 - pathology and diagnostic imaging;¹¹²
 - emerging treatment technologies;¹¹³ and
 - social services such as housing and education.¹¹⁴

110 Australia Dental Association, sub 28, pp 20–21.

111 Medicines Australia, sub 42, p 22.

112 Australian Association of Pathology Practices, sub 38, p 1.

113 Medical Industry Association of Australia, sub 61, p 3; The Australian Proton Project Working Party, sub 115, p 2; St Jude Medical, sub 146, pp 1–2.

3.121 The Australian Diagnostic Imaging Association noted that:

There is not a government in the world, including this government, that will not accept that preventative medicine and early diagnosis is a far more effective health care delivery system than diagnosing middle and advanced stage disease. What CT, for example, has done is to provide some tools that have changed that paradigm. You can do earlier diagnosis quickly and more safely. More importantly, it is now being used not only as a diagnostic tool but as a triage tool. The only lever that we have used with, for and against us at the moment is a fiscal lever. I actually think that, because of what technology has done, we need some direction and some debate with the department of health to say there is possibly a new paradigm of health care.¹¹⁵

3.122 Clinical and cost effectiveness assessments for pharmaceuticals, medical services and vaccines are an important tool for ensuring evidenced-based access to high quality medical services.¹¹⁶

3.123 The committee supports evidence-based assessments for new technologies, including pharmaceuticals, vaccines, diagnostic tests and medical and procedures, prior to them being listed for reimbursement on the MBS and PBS.

3.124 Dr Neaverson and other inquiry participants highlighted a number of specific treatments or services that they believed to offer significant benefits to patients, but were not currently included for reimbursement under the MBS or PBS or where further research was required.¹¹⁷ Selected treatments or services that the committee considers warrant closer attention by expert bodies include:

- Providing incentives to doctors and patients at risk of developing cardiac events to undergo a six-week lifestyle and fitness program, including a requirement for such programs before prescribing lipid

114 Redcliffe-Bribie-Caboolture Division of General Practice, sub 110, p 1; Caboolture Shire Council (Qld), sub 103, p 8; Royal Australian College of General Practitioners, sub 19, p 3; Blissful Undisturbed Baby's Sleep, sub 134, p 2.

115 Shnier R, Australian Diagnostic Imaging Association, transcript 26 May 2006, pp 59–60.

116 Department of Health and Ageing, sub 142, p 29.

117 Dr M A Neaverson, sub 114; The Australian Proton Project Working Party, sub 115; Flinders Medical Centre, subs 86 and 122; John Barker and Associates, sub 126; Blissful Undisturbed Baby's Sleep, sub 134; Mr Bob Holderness-Roddam, sub 63, p 1.

lowering pharmacological agents. Estimated cost savings of adopting these proposals are over \$130 million;¹¹⁸

- Re-imburement by Medicare of cancer treatment using proton therapy. Advocates of the use of proton therapy in the treatment of cancer consider that proton therapy provides better clinical outcomes for most cancers where radiation therapy is the recommended treatment and produces highly favourable results for certain tumours not effectively controlled by conventional radiotherapy. This is especially important in the treatment of cancer in children. The cost of a course of treatment is estimated to be \$25,000 per patient;¹¹⁹ and
- Supporting the provision of home-based family nursing services by a qualified child and family health nurse. Some of the claimed benefits of such an approach include better health outcomes with early detection and intervention, reducing the burden on an overloaded public sector and reduced occurrence and severity of post-natal depression.¹²⁰

- 3.125 The committee has not considered the relative merits of providing public funding to any of the suggested treatments or services — an assessment that is best left to expert bodies such as the Therapeutic Goods Administration, the National Health and Medical Research Council, Pharmaceutical Benefits Advisory Committee and the Medical Services Advisory Committee.
- 3.126 The committee considers, however, that assessments of the merits of proposals for research, new services and technology that provide significant health benefits to patients should be done using the broadest possible framework, allowing for costs and benefits to be examined at a whole of community level.
- 3.127 Guidelines and practices for assessing or providing public funds for new research, services or products should allow maximum flexibility for public funding of beneficial research, services or products. This may provide for funding in advance of service delivery or on a time-limited basis to provide the opportunity for more evidence to be collected and for continued funding to be further evaluated.

118 Dr M A Neaverson, sub 114.

119 The Australian Proton Project Working Party, sub 115.

120 Blissful Undisturbed Baby's Sleep, sub 134.

Investing in public health

- 3.128 Many inquiry participants recognise the benefits in investing in public health as a means of preventing future health costs.¹²¹ The Victorian Health Promotion Foundation noted that:

We appear too consumed with the supply side of the health care equation and not enough concerned with the demand side. The best way to reduce costs and improve health at the same time is not to control the services provided but to reduce the need and demand for care. We need an approach based on health promotion alongside traditional approaches to diagnosis, treatment and prevention.¹²²

- 3.129 The Commonwealth and states have recently strengthened public health as part of the 2006–07 budget, committing \$500 million over five years towards the new national programme to promote good health and reduce the burden of chronic disease (*Australian Better Health Initiative*).¹²³
- 3.130 Where additional public health expenditure can be shown to cost effectively improve health status or reduce health risk factors, governments should be willing to invest immediately for the long term benefit of Australians and the health system.
- 3.131 The committee considers that the Commonwealth should take a leadership role, through the national health agenda, in promoting investment in public health. The Commonwealth should be prepared to jointly fund public health initiatives with states and support other action that complements any additional public health expenditure.

Conclusion

- 3.132 Many inquiry participants have presented evidence about problems with Australia's health care financing arrangements. Similar issues

121 Victorian Health Promotion Foundation, sub 8, p 2; Australian Healthcare Reform Alliance, sub 127, p 71; Government of South Australia, sub 117, p 2; Australian Lung Foundation, sub 112, p 3; Marion O'Shea, sub 89, p 2; Government of Victoria, sub 67, pp 1–2; ACT Government, sub 64, p 2; Macquarie Health Corporation, sub 55, p 7; Rural Doctors Association of Australia, sub 31, p 2; Royal Australian College of General Practitioners, sub 19, p 3.

122 Victorian Health Promotion Foundation - VicHealth, sub 8, p 2.

123 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Promoting health throughout life*, 9 May 2006.

have been raised in many previous reviews and inquiries and by health sector researchers and commentators.

- 3.133 The committee has not identified, and does not believe that there is, a single ‘magic bullet’ strategy that will resolve all of the system’s problems. Indeed, in many respects the system must strike a balance between competing pressures such as quality versus throughput and access versus affordability.
- 3.134 While this report recommends a range of actions to address particular issues, the committee considers the key recommendation of this chapter, the development of a national health agenda, to be its most important recommendation. The complexity of the health delivery and financing systems, the rate of development of new health technologies, the ever changing evidence base about best practice and rising community expectations mean that ongoing reform is needed. This needs to be guided through a process that the committee calls the national health agenda. Development and implementation of this national health agenda will require political will from all levels of government.

Funding a sustainable health workforce

If you are in metropolitan Sydney, or if you are in New South Wales, the further you are from the Harbour Bridge, the greater the impact of the shortage of trained doctors, nurses and allied health staff brought about by the restriction on places in universities and other colleges. The more it impacts on the workforce, this acts as a cap on the availability to provide services.¹

- 4.1 A skilled health workforce is critical to addressing the healthcare needs of the Australian community. Health funding arrangements need to give the right incentives for governments and health care providers to respond to the current demands for health services — as well as provide for a system that can train a health workforce that will meet the community's future health needs.
- 4.2 The committee's health funding inquiry overlapped with a significant review of Australia's health workforce conducted by Productivity Commission at the request of the Council of Australian Governments (COAG) during 2005.²
- 4.3 The COAG response to the Productivity Commission review included a number of significant structural changes such as medical professionals' registration and accreditation arrangements, workforce innovation and workforce planning.³ Where relevant, the COAG response is discussed further in this chapter.

1 Clout T, Hunter New England Health Services, transcript, 20 July 2006, p 5.

2 Productivity Commission, *Australia's Health Workforce* (2005).

3 Council of Australian Governments, *Communique*, 14 July 2006.

- 4.4 A recurring theme in submissions and oral evidence to the inquiry was that current health funding arrangements do not allow the health system to deliver a workforce that is able to meet current demands or have a training system that will be able to meet future health needs.
- 4.5 Some of the areas where workforce shortages were raised with the committee included general practice,⁴ nursing,⁵ allied health professionals such as psychologists and podiatrists,⁶ dentists⁷ and pathologists.⁸ Other health workforce professions where shortages have been identified include hospital and retail pharmacists, occupational therapists, physiotherapists, psychiatrists and sonographers.⁹
- 4.6 Part of the shortage of health workforce professionals is likely to be due to an underinvestment in the number of training places over the past 15–20 years. The committee considers, however, that health funding arrangements have also contributed to the current shortage in several ways including:
- a mal-distribution of health professionals across Australia, with shortages of GPs and most other health professionals in outer suburban areas, regional and rural areas;
 - high levels of ‘stress’ in public hospital training environment that leaves less time for quality training. In an environment where staff are trying to respond to high demands on service, there is little time or energy to take on professional roles with students, or with other staff; and
 - Visiting Medical Officers (VMOs) in public hospitals providing training for which some believe they are not adequately paid.
- 4.7 This chapter examines the current and future workforce needs of the Australian health system and how workforce training is structured and funded. Opportunities to address concerns about the number and quality of health professionals through changed funding and

4 Australian Divisions of General Practice, sub 15, p 3; Australian Medical Association, sub 31, p 16; Rural Doctors Association, sub 31, p 16; Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 5.

5 Australian Nursing Federation, sub 39, p 4.

6 Australian Healthcare Association, sub 62, p 5.

7 Australian Dental Association, sub 28, p 26.

8 Graves D, Royal Australian College of Pathologists, transcript, 5 July 2005, p 2.

9 Productivity Commission, *Australia's Health Workforce* (2005), p 337.

administration arrangements for health workforce training are also considered.

Australia's health workforce

- 4.8 The Australian health workforce consists of people employed in a wide range of occupations that provide health care, including doctors, nurses, dentists, pharmacists and allied health professions (such as physiotherapists, psychologists and podiatrists).
- 4.9 There were around 569,700 Australians employed in health occupations in 2005, accounting for around 5.7 per cent of the total workforce.¹⁰ While the health workforce increased in absolute terms by almost 118,000 (26 per cent) since 2001, there were some occupations where the number of health practitioners per 100,000 declined, such as generalist medical practitioners and pharmacists (table 4.1).
- 4.10 People employed in health occupations are often assisted in the delivery of health services by volunteers and people employed in other professions, such as social workers and administrative staff. While they make a valuable contribution the health system, the remainder of the discussion on health workforce concentrates on people employed in health occupations.

¹⁰ Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 316.

Table 4.1 Persons employed in health occupations, 2000 and 2005

| Occupation | 2000 | | 2005 | | % growth 2000– 2005 |
|--------------------------------------|----------------|---------------------------|----------------|---------------------------|---------------------------|
| | Number | Per 100'000 population | Number | Per 100'000 population | |
| Health services managers | 4,200 | 21.8 | 8,600 | 42.5 | 107.5 |
| Generalist medical practitioners | 36,700 | 191.5 | 36,300 | 178.6 | -1.0 |
| Specialist medical practitioners | 16,000 | 83.7 | 23,600 | 116.3 | 47.4 |
| Medical imaging professionals | 8,600 | 45 | 10,600 | 52.4 | 23.4 |
| Dental practitioners | 7,000 | 36.8 | 8,700 | 42.9 | 23.6 |
| Dental associate professionals | 4,300 | 22.5 | 5,700 | 28.1 | 32.5 |
| Dental assistants | 12,200 | 63.7 | 17,300 | 85.2 | 42.0 |
| Nursing workers: professionals | 181,100 | 945.6 | 204,700 | 1,006.9 | 13.0 |
| Enrolled nurses | 24,800 | 129.5 | 32,200 | 158.2 | 29.6 |
| Personal care and nursing assistants | 36,100 | 188.7 | 68,500 | 336.9 | 89.5 |
| Pharmacists | 15,300 | 80 | 14,900 | 73.3 | -2.8 |
| Physiotherapists | 12,100 | 63.4 | 14,300 | 70.6 | 18.1 |
| Psychologists | 9,300 | 48.4 | 13,900 | 68.6 | 50.5 |
| Occupational therapists | 5,400 | 28.4 | 7,800 | 38.4 | 43.3 |
| Podiatrists | 1,400 | 7.1 | 2,100 | 10.2 | 52.9 |
| Other allied health workers | 14,800 | 77.1 | 14,000 | 69.0 | -4.9 |
| Complementary therapists | 7,800 | 40.6 | 11,400 | 55.9 | 46.1 |
| Other health workers | 54,600 | 284.9 | 74,900 | 368.5 | 37.3 |
| All health workers | 451,800 | 2,358.80 | 569,700 | 2,802.40 | 26.1 |

Source Australian Institute of Health and Welfare, *Australia's health 2006 (2006)*, p 316.

4.11 Changes in the numbers of hours worked and the distribution of medical professionals also affects community access to health services. There has been a general reduction in the average hours worked in most health occupations due to a range of factors including:

- higher income levels allow some health workers to reduce workloads;
- a recognition that the long work hours traditionally worked in some medical professions may contribute to lower quality health care;

- an increase in the proportion of female health workers, who are more likely to work part-time or reduced hours over their careers; and
- an ageing workforce that reduces hours worked as they approach retirement.¹¹

4.12 International comparisons of the numbers of health professionals can be difficult because of differences in how each profession is defined and how workers are registered.¹² Compared to all OECD countries, Australia is in the top third of numbers of general practitioners per 100,000 population (see figure 2.5 in chapter 2).

4.13 In 2003, Australia had higher numbers of general practitioners and nurses per 100,000 population than several selected countries with economies and health systems similar to Australia (table 4.2).

Table 4.2 Health professionals employed in selected OECD countries, per 100,000 population, 1998 and 2003

| Occupation/year | Australia | New Zealand | Canada | USA | United Kingdom |
|-----------------------|-----------|-------------|--------|---------|----------------|
| General Practitioners | | | | | |
| 1998 | 1.3 | 0.8 | 1.0 | 0.8 | 0.6 |
| 2003 | 1.4 | 0.7 | 1.0 | 0.8 (a) | 0.6 |
| Medical specialists | | | | | |
| 1998 | 1.1 | 0.7 | 1.1 | 1.4 | 1.3 |
| 2003 | 1.2 | 0.7 | 1.1 | 1.5 (a) | 0.7 |
| Dentists | | | | | |
| 1998 | 0.5 | 0.4 | 0.5 | 0.5 | 0.4 |
| 2003 | 0.5 | 0.4 | 0.6 | 0.5 (a) | 0.5 |
| Nurses | | | | | |
| 1998 | 10.6 | 9.6 | 10.2 | 7.9 | 7.9 |
| 2003 | 10.4 | 9.1 | 9.8 | 7.9 (a) | 9.1 |

Note (a) relate to 2002.

Source Australian Institute of Health and Welfare, *Australia's health 2006 (2006)*, p 330.

11 Australian Institute of Health and Welfare, *Australia's health 2006 (2006)*, p 322; Foster P, *Queensland Health Systems Review: Final Report (2005)*, p 211; Wronski I, James Cook University, transcript, 16 March 2006, pp 21–22; O'Reilly B, Australian Dental Association, transcript, 5 July 2005, p 31.

12 Australian Institute of Health and Welfare, *Australia's health 2006 (2006)*, p 330.

Health workforce shortages

- 4.14 Many inquiry participants pointed out that a critical area of concern for the health system is workforce shortages.¹³ The National Rural Health Alliance noted that:

It is well known that there are currently national shortages in all parts of Australia's health workforce. Wherever there are shortages, the worst of them are in rural and remote areas.

The Alliance has, over the years, emphasised not only the shortage of doctors in rural and remote areas (which is well known) but also the shortages of nurses, allied health professionals, dentists, pharmacists and managers — which are less well known and recognised.¹⁴

- 4.15 Australia is not unique in experiencing health workforce shortages, competing overseas to attract and retain skilled health professionals that are in short supply internationally.¹⁵
- 4.16 Health workforce shortages in Australia have developed over a long period. In response to a perceived oversupply in the medical workforce in the early to mid 1990s, a cap on the number of medical school places was announced by the Commonwealth in May 1995.¹⁶ Under the cap, the number of new places in Australian medical schools was restricted to approximately 1,250 per year.¹⁷
- 4.17 The impact of workforce shortages, which initially were experienced in remote areas, has gradually spread to the suburbs of major cities. Professor Wronski noted that:

The tide has gone out in the health and medical workforce in the last 25 years. In the seventies and the eighties, I remember talking about the lack of workforce supply in Indigenous

13 See for example, Australian Medical Association (Queensland), sub 104, p 6; Australian Healthcare Association, sub 62, p 5; Australian Divisions of General Practice, sub 15, p 2; Australian Nursing Federation, sub 39, p 3; Kidney Health Australia, sub 58, p 5.

14 National Rural Health Alliance, sub 59, p 4.

15 Bach S, 'International migration of health workers: Labour and social issues', International Labour Organisation working paper no. 209 (2003); Simoens S., M. Villeneuve and J. Hurst, 'Tacking nurse shortages in OECD countries', OECD Health working papers no. 19; Department of Health and Ageing, submission to the Productivity Commission Health Workforce Study (2005), pp 28–29.

16 Birrell B, 'Medical manpower: the continuing crisis', *People and Place* (1996), vol 4, no 3.

17 Department of Health and Ageing 2003, Submission to the Senate Select Committee on Medicare Inquiry into the access to and affordability of general practice under Medicare, p 9.

communities. Then there was a lack of workforce supply in remote communities, a lack of workforce supply in rural and regional communities and now we have a lack of workforce supply in many of the metropolitan areas as well. It is just a feature of shortages spreading throughout the country.¹⁸

- 4.18 Not all inquiry participants agreed that there was necessarily a health workforce shortage. For some allied health professions or geographical areas, such as some areas of major capital cities, there appear to be sufficient numbers of health professionals.¹⁹ Others noted that it was possible to changing models of care, which expanded the role of allied health professionals and other health workers would lead to the workforce being used more efficiently.²⁰ Mr Menadue noted that:

We have a workforce structure which really has not been changed for the last 100 years. We have seen the very considerable public and social benefits of workforce restructuring in the blue-collar manufacturing area, but unfortunately the professions, particularly the health professions, have not really been touched by workforce restructuring. Demarcations and restrictive work practices abound. Professional people are trained in boxes and then they work in boxes. They are kept separate.²¹

- 4.19 Most Australian governments have recognised that there are workforce shortages in a number of medical professions and that there are also shortages in different regions. The National Health Workforce Framework, endorsed by Australian health ministers in 2004, includes a National Health Workforce Action Plan. The framework sets the vision that:

Australia will have a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. It will provide safe, quality, preventative, curative and

18 Wronski I, James Cook University, transcript, 16 March 2006, p 17.

19 Stevenson C, Hospital Reform Group, transcript, 26 May 2006, p 3.

20 Needham K, Hospital Reform Group, transcript, 26 May 2006, p 4; Wronski I, James Cook University, transcript, 16 March 2006, p 26; Chater B, Australian College of Rural and Remote Medicine, transcript, 16 March 2006, p 33.

21 Menadue J, transcript, 21 July 2006, p 29.

supportive care, that is population and health consumer focused and capable of meeting the health needs of the Australian community.²²

Training and recruitment pathways

4.20 The Department of Health and Ageing noted that the Commonwealth had a key responsibility for workforce planning outcomes:

The Australian Government undertakes to ensure that there is an adequate number of health professionals to meet population need now and into the future; that the health workforce is appropriately distributed to meet that need; and that suitable education and training arrangements are put in place for the health workforce. The health care workforce is a shared issue between the Australian Government and the states and territories.²³

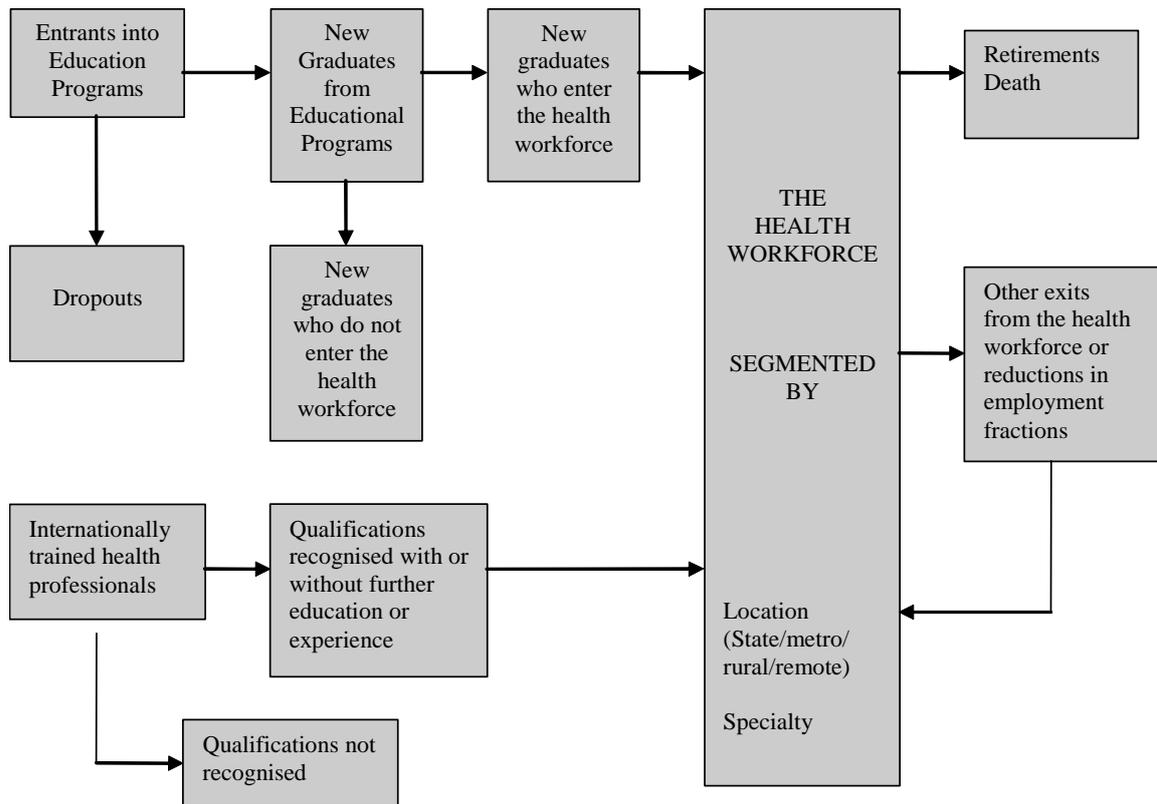
4.21 There are several points of entry and exit that affect the size and distribution of the health workforce (figure 4.1). Key inflows are from new Australian-trained graduates and internationally-trained health professionals who move to Australia on both a short and long term basis.

4.22 The number of domestic medical graduates has remained relatively unchanged over the period 1986 to 2004, averaging around 1,200 graduates per year (figure 4.2).

22 Australian Health Ministers Conference, *National Health Workforce Strategic Framework* (2004), p 13.

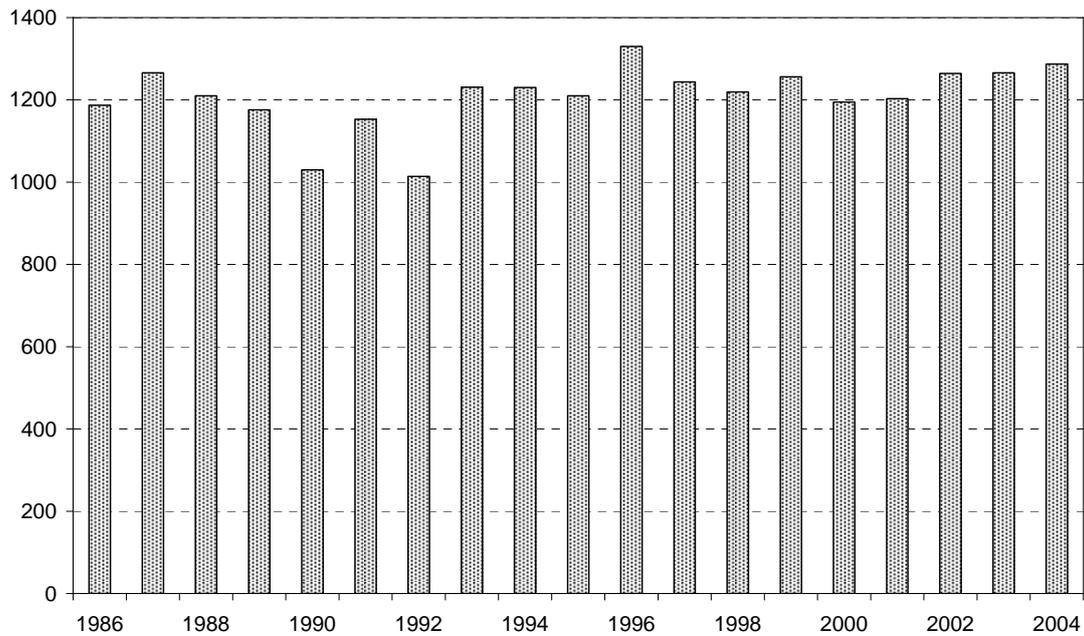
23 Department of Health and Ageing, sub 43, p 13.

Figure 4.1 Factors affecting health workforce supply



Source Adapted from Duckett, S, *The Australian Health Care System (2004)*, p 75.

Figure 4.2 Medical course graduates, domestic students, 1986 to 2004 (number)



Source Council of Deans of Australian Medical Schools, *Student statistics, Table 5*, viewed on 26 September 2006 at www.cdams.org.au/pdf/2005%20Stats%20Tables%20for_%20website.pdf.

4.23 Data on graduates from allied health degrees at universities is less complete than for medical students. The available evidence indicates that there is an increase in the number of students completing courses in most allied health professions (table 4.3).

Table 4.3 Allied health university completions, 1993 to 2002

| Course | 1993 | 1996 | 1999 | 2002 |
|--------------------------|------|------|------|------|
| Nutrition and dietetics | 163 | 265 | 270 | 341 |
| Occupational therapy | 496 | 443 | 720 | 727 |
| Pharmacy | 479 | 621 | 301 | 846 |
| Physiotherapy | 744 | 724 | 893 | 869 |
| Podiatry | 102 | 114 | 129 | 114 |
| Radiography | 300 | 560 | 579 | 667 |
| Rehabilitation therapies | 244 | 308 | 334 | 367 |
| Speech pathology | 272 | 256 | 346 | 408 |

Source Australian Health Workforce Advisory Committee, *The Australian Allied Health Workforce: An Overview of Workforce Planning Issues (2006)*, pp 90–97.

4.24 In the case of nursing, there has been a significant increase in the number of students commencing tertiary nursing courses, with the number of commencing nursing students rising from 7,790 in 2001 to 9,675 in 2005.²⁴

4.25 Recent increases in the number of medical school graduates and new medical schools will lead to significant rise in graduates — rising from 1,300 in 2005 to more than 2,100 in 2010.²⁵ These projections do not take account more recent announcements by governments to expand the number of medical training places:

- 400 extra places announced in April 2006;²⁶
- 235 extra places for Queensland announced in May 2006;²⁷ and
- 200 extra places announced in July 2006.²⁸

24 Department of Education, Science and Training, Students 2005 [full year]: selected higher education statistics, viewed on 13 October 2006 at www.dest.gov.au/NR/rdonlyres/F1331710-F793-4E81-8867-B5FAF1AEC4DE/13781/2005_student_full_year_data.pdf.

25 Joyce C, J McNeil and J Stoelwinder, 'More doctors, but not enough: Australian medical workforce supply 2001–2012', *Medical Journal of Australia* (2006), vol 184, no 9, p 441.

26 Hon John Howard MP, Prime Minister, media release, *More doctors and nurses for the health system*, 8 April 2006.

27 Hon Stephen Robertson MP, Minister for Health, media release, *Queensland signs historic deal to produce more locally-trained doctors*, 10 May 2006.

- 4.26 The rising numbers of medical graduates and allied health graduates will place significant pressure on universities and public hospitals to provide sufficient clinical training opportunities. The situation in Western Australia was highlighted by the Doctors Reform Society (WA):

... we have gone from having, I think, in my year just over 100 graduates; in about three years time there are going to be 250. That means that now they are starting to have a bulge of about 250 entering clinical training in their third and fourth years of med school, and exactly how those people are going to be well trained when you have got a system that is understaffed and therefore busy and stressed, who are then going to need to find the time to teach two and a half times as many students, is going to be a very interesting period of time for our health system.²⁹

- 4.27 The Australian Medical Association (Queensland) also pointed out that there would be a similar situation in Queensland:

In 2004, the number of domestic graduates from Queensland Medical Schools was 225, or 5.79 per 100,000 population (compared with 6.34 per 100,000 population for all Australian Medical Schools). In 2005, 276, or 23 per cent more students graduated.

The intake to medical schools last year was 496, and this will increase to 554 by 2007 (based on current approvals).

Assuming the usual two per cent attrition rate, this means 543 graduates will be graduating by 2011 or 12.65 per 100,000 population, compared with 10.65 per 100,000 for all Australian Medical Schools. This means 318 extra graduates over 2004 levels, or a 141 per cent increase.³⁰

- 4.28 Funding and delivery of health workforce training is complex, with the Commonwealth and states contributing to various degrees to undergraduate (university) training and clinical training within public hospitals. This complexity was highlighted by the Hospital Reform Group:

28 Hon John Howard MP, Prime Minister, media release, *More doctors, nurses and allied health professionals for Australia's health system*, 13 July 2006.

29 Douglas S, Doctors Reform Society (WA), transcript, 24 August 2006, p 20.

30 Australian Medical Association (Queensland), sub 104, p 6.

As an undergraduate you belong to the universities, which are Commonwealth funded. You train in the hospitals, which are state funded places. You are taught by clinicians, who are paid for by the state or are privately funded, on their own time. You then become an intern, where you are part of a state system. But you are subject to credentialing by the Australian Medical Council, which is a federal system. You are registered by the state. You work in a state-paid position.

You then become a registrar in the college, which is a national or often international organisation. For example, my college, which is the College for Emergency Medicine, covers New Zealand and Singapore as well. You pay for all of the training courses that you have to undertake as part of that college training yourself. They are quite often delivered by unpaid people. Then you are expected to work numerous hours in the state system, which is part of your training, delivering essential services for which you have to undertake training courses that you pay for yourself.³¹

- 4.29 Meeting the clinical training needs of rising numbers of health trainees is likely to be a significant challenge for the health system in the short to medium term. The next section discusses how training is funded and delivered and how overseas doctors make a significant contribution to delivering health services, particularly in rural areas.

Undergraduate training arrangements

- 4.30 People wanting to join many health workforce occupations are generally required to undertake university undergraduate training, with the length of degree varying from 3 years for nursing up to 6 years for medicine. Entry for many health care professions is also possible through shorter post graduate courses for those students with an accredited undergraduate degree.
- 4.31 Funding for university places is negotiated annually through funding agreements, which set out the number of Commonwealth supported places in ten broad disciplines, including the two national priority areas of nursing and teacher education. Each discipline is funded at a different rate with agreements specifying the number of places for which the higher education provider will receive regional, enabling or medical loading.

31 Skinner C, Hospital Reform Group, transcript, 26 May 2006, p 12.

- 4.32 In 2006, medical places attracted a Commonwealth payment to universities of around \$16,000 per place, nursing received around \$10,000 per place and allied health professions such as physiotherapy received around \$7,000 per place.³²
- 4.33 Funding agreements are primarily based on discussions between the Department of Education, Science and Training and providers. However, for medicine new places are jointly determined by the Minister for Education, Science and Training and the Minister for Health and Ageing.
- 4.34 Governments are increasingly recognising the benefits of delivering health workforce training outside the major capital cities in sustaining health services in regional areas.³³ In recent years the Department of Health and Ageing has made direct contributions to the establishment of new medical clinical schools and departments of rural health at several universities, including 10 rural clinical schools.³⁴
- 4.35 Universities can also enrol full fee-paying domestic and international students within certain limits. The Commonwealth recently announced an increase in the cap on domestic full-fee paying students from 10 per cent to 25 per cent, adding around 300 extra medical places.³⁵ At the same time, assistance to full fee paying students through a loan program was increased from \$50,000 to \$80,000 and to \$100,000 for medicine.³⁶
- 4.36 The vocational education and training sector, funded by a mix of government funding and student fees, has a lesser overall role in health workforce education and training. Workforce groups that are typically educated in a vocational education and training setting include enrolled nurses, 'assistants' to more qualified professionals, some Aboriginal health workers and personal care workers.

32 See for example, Department of Education and Training, *Funding Agreement between the Commonwealth of Australia as represented by the Minister for Education, Science and Training through his delegate in the Department of Education, Science and Training and Griffith University regarding funding under the Commonwealth Grant Scheme in respect of the grant year 2006*, schedule 1.

33 Wronski I, James Cook University, transcript, 16 March 2006, p 19; Chater B, Australian College of Rural and Remote Medicine, p 31; Tobin P, Catholic Health Australia, transcript, 24 August 2005, p 13.

34 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Tamworth to become a medical training centre*, 14 February 2006.

35 Council of Australian Governments, *Communique*, 10 February 2006, p 12.

36 Hon Julie Bishop MP, Minister for Education, media release, *Growing our universities*, 9 May 2006.

Clinical training arrangements

- 4.37 While undergraduate medical training takes place in predominantly Commonwealth funded universities, clinical training is usually delivered in public hospitals — funded jointly by the Commonwealth and the states with the states wholly responsible for hospital service delivery (see chapter 7). Trainers are either salaried employees or VMOs.
- 4.38 There are three broad stages of clinical training for trainee doctors, each of which involves differing degrees of supervision:
- medical school (4 to 6 years) — At various stages of their course, the medical student will spend time in a clinical placement. This is normally in a public teaching hospital, although increasingly students are spending time in other settings such as general practice;
 - pre-vocational training — following graduation from medical school, junior doctors must complete a 12 month internship in a public hospital. An intern position is accredited by the relevant state postgraduate medical education council and will involve rotations into a number of disciplines, which generally include emergency medicine, surgery and medicine. Once they have completed this they will be granted general medical registration. Following this it is common for junior doctors to spend another 1 to 2 years in a variety of pre-vocational positions while they gain extra skills and determine which specialty they would like to pursue; and
 - vocational (specialist) training — junior doctors enter a specialist training program where they work as registrars in medical college accredited positions in public hospitals, and in the case of GP registrars - general practice. Once they have completed the College training program, they are granted Fellowship - which allows them to practice independently.
- 4.39 Public hospitals receive funding from state governments to provide clinical training. Additional funding is sometimes received from universities for the use of their facilities and for clinical training purposes as part of the explicit clinical training component in the Australian Government's contribution to medical and nursing course costs. However, for allied health courses, there is no separately identified clinical training component in government funding and

universities must meet the cost of any payments to public hospitals (or other training providers) from general funding sources.³⁷

- 4.40 Funding for specialist post graduate clinical training typically involves contributions from governments and trainees. In addition to supervision by specialist medical colleges:
- States meet infrastructure costs for the training conducted in their hospital facilities, as well as the labour component of training delivered by salaried hospital staff and, depending on contractual arrangements, some of the cost of supervision provided by College Fellows.
 - States also meet the salary and infrastructure costs of some unaccredited training positions in particular specialties.
 - Trainees make a contribution through payments to the relevant colleges, including meeting the administrative costs for the colleges of overseeing training programs and assessing trainees.
 - Private hospitals are providing and funding a small but growing amount of training to postgraduate medical students. A study of training in private hospitals noted an investment of \$35 million a year in the education and training of surgeons, doctors, nurses and other health care professionals.³⁸ In areas like dermatology, pathology and rheumatology, the private sector also provides training outside of the hospital setting (with some of these training places supported by subsidies from the Australian Government). The private hospital sector has also long played a role in postgraduate nurse training.³⁹
- 4.41 There are no health system wide estimates of the costs of clinical training. The Productivity Commission noted estimates of the cost of specialist training with the Royal Australasian College of Surgeons, which were in the order of \$100,000 to \$120,000 per trainee in 2003. The total trainee costs including additional infrastructure, equipment, nursing and allied health could amount to some \$1 million to \$2 million, depending on the sub specialty.⁴⁰

37 Productivity Commission, *Australia's Health Workforce* (2005), p 71.

38 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals: Report to the Australian Private Hospitals Association* (2005).

39 Productivity Commission, *Australia's Health Workforce* (2005), p 72.

40 Productivity Commission, *Australia's Health Workforce* (2005), p 73.

Migration

- 4.42 In recent years, Australia has generally relied heavily on recruiting doctors and nurses from overseas, with overseas trained doctors comprising around 25 per cent of the overall medical workforce.⁴¹ The distribution of overseas trained doctors is uneven, with the Rural Doctors Association of Australia noting that overseas trained doctors now make up over 30 per cent of the rural medical workforce generally and closer to 50 per cent in some states.⁴²
- 4.43 Overseas trained doctors have been an important source of recruitment to areas of shortage, with the number of doctors issued temporary visas between 2000-01 and 2002-03 rising from 2,062 to 2,739. Queensland was the major beneficiary, taking over 1,000 of these doctors.⁴³
- 4.44 Recognition of the skills and competencies of overseas health professionals and allowing them to practice in areas appropriate to their competencies supports good workforce deployment.
- 4.45 There have been a number of instances in recent years where the quality of services provided by some overseas trained doctors in public hospitals and general practice has been found to be unsatisfactory, or where overseas trained doctors have performed tasks for which they were not qualified or have not been appropriately supervised.⁴⁴
- 4.46 The committee considers that existing state-based and profession-based registration and accreditation arrangements would be strengthened by adopting a national framework. Of equal importance, however, is that the states ensure that overseas trained medical professionals are employed at levels for which they have been assessed, with appropriate supervision.
- 4.47 The committee supports COAG's positive response to the Productivity Commission's health workforce study that recommends establishing a national registration board and a national accreditation

41 Department of Health and Ageing, submission to the Productivity Commission Health Workforce Study, August 2005, p 4.

42 Rural Doctors Association of Australia, sub 31, p 4.

43 Birrell B and L Hawthorne, 'Medicare Plus and Overseas Trained Doctors', *People and Place* (2004), vol 12, no 2, p 89.

44 Mr Anthony Morris QC, sub 72; Australian Medical Association (Queensland), media release, *Change must occur at the coalface*, 10 August 2006; Dunlevy S, 'Doctor heal thyself: quacks in the system', *Sydney Morning Herald*, 2 September 2006, p 28; Oakley V, 'Bungles cost millions: Taxpayers set to foot the bill', *Sunday Telegraph*, 27 August 2006, p 9.

board. The committee also supports the agreement by COAG that the new national accreditation board recommended by the Productivity Commission should assume responsibility for the range of accreditation functions in relation to overseas trained health professionals carried out by existing profession-based entities.⁴⁵

Coordinating international recruitment efforts

- 4.48 The Commonwealth and states are active in recruiting health professionals from overseas. While the number of trainees within the Australian health system will significantly increase in the next five years, Australia is likely to remain reliant on attracting health professionals from overseas in the short to medium term.
- 4.49 The Commonwealth's recruitment has targeted doctors to work in areas of workforce shortage.⁴⁶ Most overseas doctors recruited by Commonwealth contracted recruitment agencies are general practitioners. However, 73 of the 233 overseas trained doctors placed in areas of workforce shortage as at May 2006 were working as specialists in areas such as surgery, radiology, psychiatry, pathology, orthopaedics, obstetrics and gynaecology and anaesthetics.⁴⁷
- 4.50 The Commonwealth and states do not directly compete for the same health professionals.⁴⁸ The Department of Health and Ageing noted that:

... the Commonwealth is not in competition with the States in regards to recruiting overseas trained doctors.

The recruitment activity being undertaken through the Australian Government recruitment program requires the medical practitioner to be providing services in approved districts of workforce shortage and have a minimum Medicare billing component. This recruitment activity assists states and territories to fill vacancies. The state and territory governments are still able to, and should be encouraged to, undertake recruitment to fill shortages within their state or territory.⁴⁹

45 Council of Australian Governments, *Communique, 14 July 2006*.

46 Department of Health and Ageing, sub 142, p 71.

47 Department of Health and Ageing, sub 142, p 71.

48 Tait S, Family Care Services, transcript, 17 March 2006, pp 28–29; Department of Health and Ageing, sub 142, p 71.

49 Department of Health and Ageing, sub 142, p 71.

- 4.51 Recruitment of overseas doctors by state governments is broadly focused on staffing public hospital positions, although all states also work with the Commonwealth to facilitate the recruitment of general practitioners within their jurisdictions. The committee noted that in 2006 several states were also actively recruiting in overseas markets for doctors and nurses to staff public hospitals and that individual hospitals and health services were also involved in recruitment efforts.⁵⁰
- 4.52 While the committee recognises that competition between the Commonwealth and states is limited, the move to adopt national registration and accreditation frameworks strengthens the need for the Commonwealth to better coordinate international recruitment efforts.

Recommendation 4

- 4.53 **The Department of Health and Ageing take a lead role to better coordinate the existing jurisdiction-based recruitment of overseas trained health professionals by the Commonwealth and state and territory governments.**

Reducing reliance on overseas-trained health professionals

- 4.54 Overseas trained health professionals are a valued part of the Australian health system. While overseas trained health professionals play, and will continue to play, a crucial role in addressing health workforce shortages, they must not be seen as a long-term solution.
- 4.55 Several inquiry participants expressed support for increasing the number of Australian-trained health workers to reduce our reliance on overseas health professionals.⁵¹ The Australian Health Care Association noted:

Looking at a very significant proportion of doctors imported from developing countries, one must stop and query the

50 Hon Stephen Robertson MP, Minister for Health (Qld), media release, *Queensland steps up recruitment drive for more doctors and nurses*, 13 July 2006; Hon John Hill, Minister for Health (SA), media release, *Bid for more medical places*, 29 May 2006; Mackender D, Hospital Reform Group, transcript, 26 May 2006, p 18.

51 Australian Medical Association, sub 30, p ; Armstrong F, Australian Healthcare Reform Alliance, transcript, 21 July 2006, p 49; Wronski I, James Cook University, 16 March 2006, p 29

ethics of trying to solve Australia's workforce problems with professionals who are even more urgently needed in their home countries.⁵²

- 4.56 The Commonwealth supports the principles in the Commonwealth Code of Practice for the International Recruitment of Health Workers that discourages the recruitment of doctors residing in developing countries. Medical recruitment agencies contracted by the Australian Government are prohibited from undertaking recruitment marketing activities or approaching doctors residing in developing countries.⁵³
- 4.57 The committee considers that Australia should aim to be self sufficient in producing adequate numbers of medical graduates to meet projected demand rather than rely on overseas trained doctors to supplement its existing limited, albeit expanding, supply. Given the length of time to train doctors and medical specialists, such a target could be realistically achieved over the next 10–15 years. The Commonwealth should also consider using the aid budget to expand training opportunities to assist developing countries improve their own skilled health workforce.
- 4.58 While this would require a significant up front investment by governments, it is likely to reduce the need to offer the significant incentives required to encourage health professionals to work in regional and rural areas.

Recommendation 5

- 4.59 **The Australian Government implement a strategy for Australia to:**
- **be self sufficient by 2021 in producing adequate numbers of health profession graduates to meet projected demand;**
 - **provide the necessary funding to expand the training system to accommodate the required number of students; and**
 - **consider using the AusAID budget to expand medical training to further assist developing countries.**

52 Australian Health Care Association, sub 127, p 6.

53 Department of Health and Ageing, Overseas-trained doctor initiatives: the benefits, viewed on 28 September 2006 at www.health.gov.au/internet/wcms/publishing.nsf/Content/factsheet-overseas_trained_doctors.

Sustainable health workforce training

- 4.60 This section examines different stages of health workforce training, focussing on the need to expand clinical training across the health system.
- 4.61 Health workforce planning and funding is integral to the national health agenda proposed by the committee in chapter 3. It is important that governments, as part of the national health agenda, provide mechanisms that are able to identify areas of health workforce shortage and rectify these in a timely manner.
- 4.62 Public hospitals perform a key role in training the future health workforce. There is evidence to suggest that in some states there is a declining emphasis on training:
- The three missions of public hospitals, teaching, service and research, remain essential elements of our health system today, yet with the increasing demands of a growing population and poor Queensland Health management, the primary role of public hospitals has moved. Teaching and research have been gradually subsumed by the escalating demands of service delivery.⁵⁴
- 4.63 Notwithstanding this declining emphasis, some health professionals remain committed to ensuring that training continues to be an important part of working in the public hospital system.⁵⁵ The Australian Medical Association noted that:
- Many of the cushions that used to make people think ‘I would still like to do my work here’ are being taken away. They are losing their ability to teach. Clinicians are just doing service delivery; they are not teaching. They are not having the time to do additional training. Ongoing innovative care and research, which is why we have got to where we are, is all but excluded from the sector now because of lack of funding and lack of time. We need to address those things.⁵⁶
- 4.64 The complexity and culture of training arrangements between the health and education sector was noted by Professor Wronski:

54 Dr Ross Cartmill, sub 107, p 4.

55 Skinner C, Hospital Reform Group, transcript, 26 May 2006, p 17.

56 Haikerwal M, Australian Medical Association, transcript, 28 November 2005, p 34.

... there is clearly still a cultural element in how the health system accommodates the education, training and research responsibilities. It is a very significant part of the quality and safety agenda in Australian hospitals. There is the big health system's relationship to university medical schools, nursing schools and those sorts of things. The fact that there are professors of surgery and professors of medicine wandering around the wards being paid quite often by a separate agency has a very important, implicit and explicit function in the quality and safety systems of our health system.⁵⁷

- 4.65 Health funding arrangements need to recognise the important role that hospitals and other service providers play in training and take advantage of other opportunities to improve the skills of the health workforce. This may include the need to be able to purchase training opportunities across the public and private sectors.

University-based health workforce training

- 4.66 It is important that the administrative arrangements that support health workforce training are sufficiently responsive to identify and fund the appropriate numbers of students for the health workforce.
- 4.67 The committee welcomes COAG's positive response to the Productivity Commission's recommendation that the Australian Government develop an agreement with the states for the allocation of places for university-based education and training of health professionals within each jurisdiction.⁵⁸
- 4.68 While the Department of Education and Training would remain the lead agency in negotiating with universities under the model agreed by COAG — albeit in consultation with the Department of Health and Ageing — the committee noted that there were several different approaches that could be adopted:
- giving the Department of Health and Ageing a direct involvement in setting priorities for the future health workforce and funding universities accordingly;⁵⁹

57 Wronski I, James Cook University, transcript, 16 March 2006, p 17.

58 Council of Australian Governments, *Communique*, 14 July 2006.

59 Duckett S, 'Interventions to facilitate health workforce restructure', *Australia and New Zealand Health Policy* (2005), vol 2, No 14; Productivity Commission, *Australia's Health Workforce: Position Paper* (2005), p LXXI.

- the Department of Health and Ageing providing funding directly to the medical schools for academic positions, outside the university funding process, to ensure parity with the hospital salaried positions of those with comparable qualifications and expertise;⁶⁰ or
- the Department of Health and Ageing providing top up funding to universities to ensure that they are able to 'purchase' clinical training time.⁶¹ Additional university funding to support clinical training for nursing students announced as part of the Department of Education, Science and Training 2006-07 budget.⁶²

4.69 The committee considers that the Department of Health and Ageing should play a greater role in working with the states and universities to identify and support the appropriate number of medical and nursing students and allied health trainees. This would be consistent with the department's increasing involvement in supporting infrastructure for the establishment of new medical schools.

4.70 Recognising that COAG's proposed arrangements are yet to be implemented, the committee considers that the Department of Education and Training should retain its place as the lead agency in relation to university funding for health workforce places. However, the Department of Health and Ageing needs to be well placed to provide advice, and possibly additional funding on a flexible basis, to ensure that quality research and teaching staff can be retained in universities and that students receive sufficient high quality clinical training opportunities.

60 Australian Medical Association (Queensland), sub 104, p 5.

61 Australian Physiotherapy Association, media release, *100 physios at risk of not graduating, APA warns*, 6 July 2006.

62 Department of Education, Science and Training, *Budget information: 2006 at a glance, May 2006*, p 4.

Recommendation 6

- 4.71 **The Minister for Science, Education and Training ensure that agreements about health workforce allocation and funding between the Department of Education, Science and Training and universities allow for supplementary funding by the Department of Health and Ageing to:**
- **provide support to universities to attract and retain key academic staff; and**
 - **ensure appropriate clinical training opportunities for medical and other health workforce students.**

Public sector clinical training

- 4.72 As previously noted, health workforce trainees are generally required to undertake significant amounts of clinical training as part of their education. Clinical training is generally conducted in public teaching hospitals, with trainees supervised by academic and medical staff.
- 4.73 A significant issue raised with the committee was the unavailability of sufficient clinical training opportunities for the large increase in medical students currently in, or about to enter, the training 'pipeline'.⁶³
- 4.74 Without access to high quality clinical training there is a risk that graduating students do not have the appropriate skills and experience to work safely and effectively. The lack of opportunities for postgraduate training was highlighted by Family Care Services:

We are training more doctors now in Australia, and that is ramping up over the next five years. But there is no point in training more doctors if you cannot give them their postgraduate experience in the hospitals. The Royal Australasian College of Surgeons for a long time has been telling people that there are not the registrar positions in the public hospitals to be able to train the people that they want to train. I know that the College of Surgeons gets blamed all the time for supposedly trying to manipulate its market to restrict entry to others doctors. Nothing could be further from the truth. We know that the College of Surgeons is desperate

63 Tait S, Family Care Services, transcript, 17 March 2006, p 29; Australian Medical Association (Queensland), sub 104, p 6; Iliffe J, Australian Nursing Federation, transcript, 7 April 2006, p 14; Australian Medical Association, sub 138, p 1.

to train another 150 surgeons, but there are no registrar positions left in the public hospitals.⁶⁴

- 4.75 The Australian Medical Association (Queensland) made a similar point after noting that there would be a significant increase in medical students in the next few years:

The issues would not appear to be a lack of medical students, but rather the ability to train them to become solo doctors. Without academics and staff specialists in place, there can be no future doctors. The change in medical student numbers therefore, must happen in a controlled manner. The issue with regard to academic staff is critical. When you quadruple the number of medical schools it is obvious that there will follow a significant increase in demand for academic staff. Couple this with the situation of lack of parity in salaries with the staff specialists and the crisis needs urgent attention.⁶⁵

- 4.76 Some of the areas that need to be urgently addressed to ensure that there are sufficient opportunities for quality clinical training within the public hospital system and within universities include:

- remuneration arrangements with medical trainers working in universities not keeping pace with public sector practitioners, reducing the incentives for people to remain as teachers and researchers within universities;⁶⁶
- remuneration arrangements for VMOs not always recognising that training is part of work arrangements or payment rates for VMOs are not sufficient to attract specialists to maintain or increase their work in public hospitals;⁶⁷
- exposure to patients and the acquisition of procedural skills being limited by the inadequate bed numbers and the cancellation of operating theatre schedules;⁶⁸
- high levels of stress and pressure in public hospitals that emphasise patient throughput, limiting the available time for quality teaching and learning;⁶⁹ and

64 Tait S, Family Care Services, transcript, 17 March 2006, p 29

65 Australian Medical Association (Queensland), sub 104, p 6.

66 Wronski I, James Cook University, transcript, 16 March 2006, p 18.

67 Dr Ross Cartmill, sub 107, p 4; Goulston K, Hospital Reform Group, transcript, 26 May 2006, p 14.

68 Australian Medical Association (Queensland), sub 104, p 6.

- the ageing profile of experienced medical practitioners leading to a significant reduction in the quality and number of available health professionals to train medical students in the next few years.⁷⁰

4.77 The committee considers that the urgent need to create more clinical training opportunities and the Commonwealth's significant financial contribution to health workforce training warrant the Commonwealth taking greater responsibility for training outcomes across the health system. The Australian Medical Association noted that:

While public hospitals are the responsibility of the States/Territories, it is time for the Commonwealth to take a much stronger position on the resources committed by State/Territory Governments to support the training of the future medical workforce. The Commonwealth must demand answers that include concrete strategies, backed by funding allocations. If necessary, the Commonwealth should consider explicitly outlining what funding is provided for medical training in future Australian Health Care Agreements and linking these monies to performance benchmarks.⁷¹

4.78 The committee would support a move to the explicit funding of clinical training in public hospitals by the Commonwealth. This could be part of, or separate to, future public hospital funding arrangements. Better identification of the costs of training and how existing funds are allocated to clinical training should lead to an improved understanding of how training funds can be more effectively used.

4.79 Funding clinical training outside the Australian Health Care Agreements may involve payments directly from the Commonwealth to public hospitals. The identification of the quantum of funds within current agreements for training and appropriate adjustments to other aspects of public hospital funding will also need to be considered as part of any new arrangements.

4.80 Such an approach has some risks, including diluting the strong culture of training that exists in public hospitals and within health workforce professions generally. However, better support for trainers

69 Mackender D, Hospital Reform Group, transcript 29 March 2006, p 9; Haikerwal M, Australian Medical Association, transcript, 28 November, p 34.

70 Goulston K, Hospital Reform Group, transcript, 29 March 2006, p 1; Cartmill R, transcript, 16 March 2006, p 59.

71 Australian Medical Association, sub 138, p 2.

and training infrastructure may lead to the strengthening of training over the long term.

- 4.81 The committee considers that a purchasing agreement for training needs to recognise the importance of training in regional areas, which may sometimes be delivered at a higher cost than in a capital city location.

Recommendation 7

- 4.82 **The Australian Government develop explicit purchasing agreements for clinical training with public health care providers. The purchasing agreement would cover:**

- **funding levels — adequate to support existing and planned levels of training in both metropolitan and regional locations;**
- **specified outcomes — including the quantity and quality of training conducted; and**
- **performance measures — allowing timely assessment of progress in meeting obligations.**

Private sector training

- 4.83 While the public sector is the most significant provider of clinical opportunities for training future health professionals, the private sector also makes an important contribution to training the health workforce.
- 4.84 As previously noted, a study of training undertaken for the Australian Private Hospitals Association found that Australia's private hospitals invest \$35 million a year in the education and training of surgeons, doctors, nurses and other health care professionals.⁷² Private hospitals receive no funding from governments or private health funds to support this investment in the nation's future medical workforce.⁷³

72 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals: Report to the Australian Private Hospitals Association (2005)*.

73 Roff P, Australian Health Insurance Association, transcript, 23 August 2005, p 16.

- 4.85 Some training in private hospitals is supported by formal links to a university. Areas where the private sector is already involved in training include:
- a range of graduate and postgraduate nursing courses in areas such as critical care nursing, peri-operative nursing, oncology, rehabilitation and midwifery;
 - specialist medical programs such as ear, nose and throat surgery, ophthalmology and cardiology; and
 - allied health professional training for physiotherapy and nutrition and dietetics — including both postgraduate courses and continuing medical education.⁷⁴
- 4.86 The need for greater opportunities for training in the private sector is also supported by the fact that there some medical procedures are now more likely to be performed in a private hospital setting rather than in public hospitals.⁷⁵ Experiencing the differences between public and private sectors during training was also seen as a benefit. The Hospital Reform Group told the committee that:
- The private sector and the public sector offer very different training opportunities as well. The public sector offers good, general bedside medicine. The private sector offers people with one problem, people with surgical procedures and people in outpatient settings.
- I think there are different training opportunities. Current trainees miss out on some of those opportunities available in the private sector, and we need to get more of them as well.⁷⁶
- 4.87 There appears to be widespread acceptance by health professionals for greater involvement of the private sector in participating in training.⁷⁷ The Hospital Reform Group told the committee that:

74 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals: Report to the Australian Private Hospitals Association* (2005), pp 12–19.

75 Australian Private Hospitals Association, sub 24, p 2.

76 Skinner C, transcript, 26 May 2006, p 21.

77 Australian Private Hospitals Association, sub 24, p 2; Australian Medical Association, sub 30, p 30; Catholic Health Australia, sub 35, p 20; Iliffe J, Australian Nursing Federation, transcript, 7 April 2006, p 14; Tait S, Family Care Medical Services, transcript, 17 March 2006, p 29; Parkes H, Department of Health (SA), transcript, 7 April 2006, p 30; Australian Medical Association (Queensland), sub 104, p 11; Guerin M, Australian Diagnostic Imaging Association, transcript, 7 April 2006, p 27.

We have now a large number of private hospital beds but private hospitals do very little teaching, whether it is of doctors, medical students, radiographers or physiotherapists. The teaching is primarily done in the public sector. I think the Commonwealth could use some stick nationwide to encourage the inevitable, which is that teaching has to occur in the private hospital sector. It will happen. We will deal with the culture change amongst our colleagues; it would help if you did something on a national scale to encourage hospitals in the private sector to teach. Ramsay have done this successfully at Greenslopes in Brisbane. But not much is happening elsewhere.⁷⁸

4.88 The committee supports an expansion of training opportunities in the private sector. However, significant effort will need to be given to overcome some of the impediments to expand training within the private sector. In a study commissioned the Australian Private Hospitals Association, some of the barriers identified by private hospitals providing education and training included:

- cost;
- lack of capacity or facilities; and
- insufficient flexibility in rostering.⁷⁹

4.89 A further barrier to more widespread acceptance of training in the private sector is likely to be acceptance by patients that some medical and nursing staff involved in their treatment will be at varying stages of training. The Australian Medical Association (Queensland) noted that:

There are issues with regard to patient understanding of privately funded care and their consent to being used for teaching purposes within the private system. Public education is needed if training were to proceed in this context.⁸⁰

4.90 The committee considers that the Commonwealth needs to take a lead role in promoting to the community the need for, and benefits of,

78 Goulston K, transcript, 26 May 2006, p 20.

79 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals: Report to the Australian Private Hospitals Association (2005)*, p 26.

80 Australian Medical Association (Queensland), sub 104, p 11.

appropriate clinical training for health workforce trainees to be undertaken in the private sector.

- 4.91 The Commonwealth has direct experience in negotiating and funding training outcomes with the private sector. The most recent memorandum of understanding with the pathology profession has directly provided funding for 10 pathology training positions for five years.⁸¹ The arrangement provides for funding to the private pathology sector to provide the training for private employees, with the Royal College of Pathologists of Australasia setting the criteria for the training. Registrars must spend at least two years of training in the public sector with the remaining training in the private sector. The positions are divided up by state – two in Queensland, four in New South Wales, three in Victoria and one in Western Australia.⁸²
- 4.92 The committee considers that Commonwealth is best placed to build on the existing training culture in the private sector and address the barriers to expanding training. The adoption of a more explicit purchasing framework for funding training in the public sector (see above) should assist in identifying and funding training opportunities in the private sector.
- 4.93 The committee also considers that rather than wait for the development of purchasing agreements, in the short-term the Commonwealth should also look at opportunities to directly fund private and not-for-profit health care providers.

Recommendation 8

- 4.94 **The Australian Government take advantage of expanding opportunities for private sector health providers to conduct clinical training and, where appropriate, enter into purchasing arrangements to fund this training.**

81 Department of Health and Ageing, *Pathology Quality and Outlays Memorandum of Understanding between the Australian Government and the Australian Association of Pathology Practices and the Royal College of Pathologists and the National Coalition of Public Pathology, 1 July 2004 to 30 June 2009* (2004), clause 11.

82 Nogrady, B, 'Countdown to Crunch Time', *Pathway*, viewed on 4 October 2006 at www.rcpa.edu.au/pathway/article.asp?article=31.

Health workforce flexibility

- 4.95 Health workforce flexibility has several different aspects, including changing the tasks that health workers perform and how they are able to move across different jurisdictions, employers and different types of health and aged care service providers.
- 4.96 Several governments have recently announced arrangements that involve a degree of task substitution including support for nurses working in general practice and the introduction of 'hospitalists' (a clinician with specialist training in acute care) at NSW public hospitals.⁸³
- 4.97 An efficient health system needs flexible workforce arrangements to adapt to changes in priorities, technology, models of care and market conditions for attracting and retaining an internationally mobile health workforce.
- 4.98 In some areas of health care, funding arrangements can directly affect the tasks health professionals perform. For example, in recent years, the role of some allied health professionals, including physiotherapists and Aboriginal health workers, has been expanded through changes to the Medicare Benefits Schedule (MBS).⁸⁴ In other areas of health service delivery, such as within public hospitals, health funding arrangements have less influence on who performs different tasks and how models of care are structured.

Facilitating task substitution

- 4.99 As discussed in chapter 3, the Commonwealth-funded Medicare Benefits Schedule (MBS) is influential in shaping new models of care. While new models of care include elements of task substitution, there are areas of health care where there are opportunities for task substitution without changing models of care.
- 4.100 Health funding arrangements can directly and indirectly affect the tasks performed by health workers. The Productivity Commission noted that payment arrangements can affect:

83 Hon Tony Abbott, Minister for Health, media release, *More Government support for nurses working in general practice*, 11 April 2006; Hon Paul McLeay, Parliamentary Secretary for Health, media release, *New career for doctors in NSW public hospitals*, 24 August 2006.

84 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Exercise physiologists eligible to provide services under Medicare*, 6 September 2005; media release, *New Medicare items for Indigenous health, refugees and palliative care*, 1 May 2006.

- decisions by consumers about what sort of health care services to consume and from whom they acquire them;
- the career choices of health care workers — both as to fields of study and to the extent of specialisation within chosen fields;
- the location decisions of those workers and whether they practise in the public or private sectors;
- the boundaries between health professions; and
- methods of practice, including referral patterns and the willingness to assess different models of service delivery, or to countenance changes in scopes of work.⁸⁵

4.101 For the most part, the MBS only covers non-medical services provided after referral by doctors. This reduces the participation of nurses and many allied health professions in providing primary health care services.

4.102 Expanded access to the MBS was suggested as a potential solution for general practitioner shortages, with allied health professionals often in a position to provide appropriate care for patients.⁸⁶ The Australian Physiotherapy Association noted that:

... on some occasions, the physiotherapist diagnoses a condition that requires care by a medical specialist. The physiotherapist then advises the patient that they must see a specialist, but in order to attract a Medicare rebate for the specialist's services, a GP referral is required. Naturally the patient attends the GP, although there is no clinical reason to do so. Thus, the patient's and GP's time is wasted and an MBS consultation is billed unnecessarily.

There is no clinical reason why the patient should not receive a rebate on the physiotherapist's referral. In fact, the current system can lead to a delay in patients receiving the required intervention and thus exacerbate the consequences of their injury or condition. There is precedence for this change to MBS referral for physiotherapy arrangements, as patients currently receive a full rebate on an optometrist referral to an ophthalmologist.⁸⁷

85 Productivity Commission, *Australia's Health Workforce* (2005), p 154.

86 Australian Physiotherapy Association, sub 118, p 4; Australian Healthcare Reform Alliance, sub 127, p 75; Australian Psychological Society, sub 136, p 8.

87 Australian Physiotherapy Association, sub 118, p 4.

- 4.103 Another example of increasing task substitution was in the area of child birth. Mr Menadue told the committee that:

In Australia about 10 per cent of normal births are delivered by midwives. In the United Kingdom that figure is 50 per cent and in Sweden it is 70 per cent. That situation exists in Australia due to restrictive practices, usually in the name of quality and safety. They abound across the health system.

There are big productivity dividends to be obtained by addressing this question of the health workforce. One way of doing that is, frankly, by political, administrative or executive leadership by governments in Australia, and the second is by using the MBS system to encourage and promote greater up-skilling, sharing and teamwork within the health system.⁸⁸

- 4.104 Not all inquiry participants supported moves towards task substitution, noting that the quality and safety of care could be compromised.⁸⁹ The Australian Medical Association (Queensland) noted that:

AMA Queensland supports a medical led team approach to patient care. The supervised collaborative approach is the best approach for quality care. I am a GP. We work in a team approach. We have practice nurses; we work with our allied health colleagues. We are really committed to this sort of a process and we believe that our patients are best cared for in this situation. But we do have some concern as to the person who is to take the ultimate responsibility. Interestingly enough, usually it is the doctor who has to take ultimate responsibility, even when something goes wrong. But in fact they are not there leading the decision making. So we see that as a huge issue.⁹⁰

- 4.105 The committee broadly supports moves towards expanding the role of allied health professionals and changing referral pathways in areas where the efficiency of the health system can be improved without compromising the quality of care. However, decisions about task substitution should be made by an expert group that examines the potential effects on the quality of patient care.

88 Menadue J, transcript, 21 July 2006, p 29.

89 Australian Medical Association, media release, *COAG Reform Agenda for Health – A Blurred Vision*, 14 July 2006; Australian Medical Association (Queensland), sub 104, pp 8-10;

90 Hodge Z, Australian Medical Association (Queensland), transcript, 16 March 2006, p 70.

- 4.106 As previously noted, the committee supports COAG's positive response to the Productivity Commission's recommendation that a single accreditation board be established for health professional education and training.⁹¹ The committee considers that the establishment of this body should lead to greater discussion about task substitution within the health workforce. It will be important that this body focus on the quality of care from the view of the patient, rather than the competing interests of different medical and allied health professions.
- 4.107 A single national accreditation framework is an important step in highlighting areas where task substitution can be explored. However, the committee also considers that payment systems through the MBS or other methods of funding (such as grants to Divisions of General Practice) need to be closely integrated with decisions about task substitution so different models of care can be implemented in a timely fashion.

Recommendation 9

- 4.108 **The Australian Government ensure that the new national health professions' accreditation body's decisions about changes in models of care arising from task substitution are also reflected in funding arrangements.**

Fringe benefits tax exemptions

- 4.109 Health services are provided by a range of government and non-government providers. Many non-government providers operate on a not-for-profit basis. The relative importance of not-for-profit providers varies across different health care settings, with not-for-profit providers delivering a high proportion of services in the private hospitals, public teaching hospitals and aged care services.⁹²
- 4.110 Under the *Fringe Benefits Tax Assessment Act 1986*, 'public benevolent institutions' and certain public hospitals have some advantages in attracting and retaining staff through providing fringe benefits tax (FBT) exemptions.⁹³

91 Council of Australian Governments, *Communique*, 14 July 2006.

92 Catholic Health Australia, sub 35, pp 5–6.

93 *Fringe benefits Tax Assessment Act 1986*, s 57A.

- 4.111 Assessments of public benevolent institution status and whether public hospital employees qualify for FBT exemptions are made by the Australian Tax Office, which has developed guidelines to assist providers in establishing whether their employees qualify for the FBT exemptions.
- 4.112 Public benevolent institution status is not automatically given to a not-for-profit service provider, which is generally required to satisfy a range of criteria including organisational form, activities and operations, and the policies and procedures that guide operations.⁹⁴ Likewise, there are a number of elements that define eligibility for public hospital status, including how public ownership is structured, the provider's predominant objectives and specific services provided.⁹⁵
- 4.113 For providers with public benevolent institution status, the FBT exemption is limited to certain excluded fringe benefits and \$30,000 of each employee's individual grossed-up non-exempt amount of fringe benefits. For public hospitals, or where the employer is a government body and the employee works exclusively for a public hospital or a non-profit hospital, or a public ambulance service, a limit of \$17,000 of non-exempt fringe benefits applies.⁹⁶
- 4.114 The Treasury estimates that the capped exemption for certain public hospitals and non-profit hospitals cost \$240 million in foregone tax revenue in 2005-06.⁹⁷ The exemption for public benevolent institutions, some of whom may not provide health care or aged care services, is estimated to cost a further \$250 million in foregone tax revenue in 2005-06.⁹⁸
- 4.115 The high degree of interaction and movement of the health workforce between the public and private sectors and across different types of health services suggest that it is important that skilled workers are attracted to and retained in areas where health care is most effective.
- 4.116 The Productivity Commission's recent health workforce research report noted a range of ways FBT arrangements could be modified to

94 Australian Taxation Office, Taxation Ruling 2003/5, Definition of a Public Benevolent Institution for Taxation Purposes.

95 Australian Taxation Office, ATO Practice Statement 2001/19, Definition of Hospital for FBT Purposes.

96 *Fringe benefits Tax Assessment Act 1986*, s 57A.s

97 The Treasury, *2005 Tax expenditures statement* (2005), p 118.

98 The Treasury, *2005 Tax expenditures statement* (2005), p 120.

favour those working in rural and remote areas, so as to facilitate recruitment and retention.⁹⁹

- 4.117 While remuneration is only one aspect of an employee's working conditions, access to FBT exemptions appear to give some health service providers an advantage in attracting and retaining staff. The Institute of Medical and Veterinary Science (IMVS), a South Australian government authority that provides a comprehensive range of diagnostic and consultative services in pathology and a key trainer of pathology students, told the committee that:

As a State Government Statutory Authority the IMVS recruits the majority of its staff from within the Health Sector, at either a state, national or international level. With the loss of [public benevolent institution] status the IMVS is significantly disadvantaged in recruiting staff in comparison with other health units, at both intra and interstate levels, as these organisations have the hospital [public benevolent institution] status.

This results in a situation whereby staff working at the IMVS are paid less than commensurate staff doing identical duties at other institutions.¹⁰⁰

- 4.118 Not having access to FBT exemptions for staff was considered by IMVS to adversely affect their ability to attract and retain staff:

To enable the IMVS to continue to provide quality pathology services it must be able to continue to recruit the best staff. This has not always been achievable and has resulted in some staff declining positions in preference to other organisations when the IMVS offers what are in effect inferior salary rates.

Not only is our ability to attract staff compromised by the current inequity, but we have also had difficulty in retaining our existing staff. Staff have sought employment elsewhere, were they have access to salary sacrifice benefits.

This is not only an issue with respect to medical staff and scientists but has become an issue in those areas where there is clearly a defined skill shortage such as human resources, information technology, cytology screening, nursing and finance, all of which are areas that have lost staff to

⁹⁹ Productivity Commission, *Australia's Health Workforce* (2005), p 219.

¹⁰⁰ Institute of Medical and Veterinary Science, sub 128, p 4.

alternative institutions that enjoy the Hospital Public Benevolent Institution status.¹⁰¹

- 4.119 These problems in attracting skilled staff were also shared by the City of West Torrens, an owner and operator of a 115 bed residential aged care service (St Martins):

... one of the most significant problems facing Council in the recruitment and retention of registered and enrolled nurses to its aged care facility, was the [Australian Taxation Office's] refusal to grant St Martins the very same taxation status afforded other not for profit and charitable providers of approved residential aged care services.¹⁰²

- 4.120 The City of West Torrens summarised a relative order of advantage for health care service providers in attracting and retaining skilled nursing staff as:

It is clear therefore that the agencies best placed to recruit and retain [registered nurses] and [enrolled nurses] in South Australia are, in order,

- public hospitals, with 10-15% better pay rates and [public benevolent institution] status;
- private hospitals, better pay rates but no [public benevolent institution] status;
- aged care providers with [public benevolent institution] status;
- private aged care providers, with pay rates higher than the industry average but funded by (private) client fees; and
- aged care providers without private clients and no [public benevolent institution] status.

The City of West Torrens falls into the last category, a very small group!¹⁰³

- 4.121 Removing impediments to health workforce mobility is not only based on balancing mobility between for-profit and not-for-profit health providers. A broader argument for removing barriers to workforce mobility is based on allowing the workforce to move to areas of need to facilitate the introduction of new models of care, such

101 Institute of Medical and Veterinary Science, sub 128, p 4.

102 City of West Torrens (SA), sub 133, p 1.

103 City of West Torrens (SA), sub 133, p 2.

as out-of-hospital care and a focus on prevention, detection and early intervention.¹⁰⁴

- 4.122 It is difficult to predict what the new models of care will be or how they may change demand for different health professionals. However, it is important that employment arrangements do not unnecessarily restrict workforce mobility, allowing for a smoother adjustment to newer and more appropriate models of care.

Recommendation 10

- 4.123 **The Australian Government amend the *Fringe Benefits Tax Assessment Act 1986* so that:**

- **local governments operating aged care facilities are able to qualify for fringe benefits tax exemptions granted to public benevolent institutions for employees involved in the aged care facility; and**
- **fringe benefits exemptions applying to public employers delivering health services in hospital-based settings also apply to public employers providing health services in other settings.**

104 Institute of Medical and Veterinary Science, sub 128, p 3; Australian College of Health Service Executives, sub 141, p 11; Australian Association of Gerontology, sub 52, p 2; Health Workforce Queensland, sub 113, p 2.

Rural and regional health services

Equity and efficiency are touted as fundamental attributes of our health system. In practice, however, major inequities and inefficiencies in the distribution of resources, services and funding, particularly between urban and rural areas, make a mockery of these principles.¹

- 5.1 People living in regional, rural and remote parts of Australia are generally at a disadvantage in accessing health care services compared to their city counterparts.
- 5.2 This chapter examines some of the factors that contribute to reduced access for communities outside of the major urban areas and considers some funding options for governments to address the major inequities.
- 5.3 As noted in chapter 4, health workforce shortages are more pronounced the greater the distance from urban areas. High quality health care services cannot be delivered without an appropriate number and mix of skilled health professionals. Health workforce training and funding arrangements need to support an equitable distribution of health carers so some communities do not miss out on the health care they need.

1 Rural Doctors Association of Australia, sub 31, p 5.

Regional, rural and remote disadvantage

5.4 Approximately 34 per cent of Australians live outside major urban areas.² There are clear, measurable differences in health outcomes and health risk factors between Australia's urban and rural populations (figure 5.1). The National Rural Health Alliance noted that:

in aggregate, health status is poorer outside the capital cities, health risk factors are more common, and the range of services narrower and more costly to access. There is evidence of worse health outcomes in remote and very remote areas, not all associated with the higher proportion of Indigenous population in remote areas.³

Figure 5.1 Selected health indicators, by remoteness area

| | Major City | Inner Regional | Outer Regional | Remote | Very Remote |
|---|---------------------------|----------------|----------------|----------------------|----------------------|
| | Standardised ratio | | | | |
| Males <65 years with profound/severe activity restriction (1998) ^(a) | 1.00 | 1.57 | 1.46 | n.a. | n.a. |
| Females <65 years with profound/severe activity restriction (1998) ^(a) | 1.00 | 1.27 | 1.03 | n.a. | n.a. |
| Pertussis notifications (2001) | 1.00 | *1.31 | *1.88 | *1.90 ^(b) | *1.90 ^(b) |
| Ross River virus notifications (2001) | 1.00 | *3.15 | *4.85 | *8.71 ^(b) | *8.71 ^(b) |
| Perinatal deaths (1999–2001) | 1.00 | *1.13 | *1.28 | *1.43 | *2.42 |
| Deaths (all ages, 1997–1999) | 1.00 | *1.06 | *1.10 | *1.13 | *1.50 |
| Deaths, non-Indigenous (all ages, 1997–1999) | 1.00 | *1.05 | *1.08 | *1.03 | 0.95 |
| Death >74 years, non-Indigenous (1997–1999) | 1.00 | *1.03 | *1.04 | *0.93 | 0.71 |
| Death <65 years, non-Indigenous (1997–1999) | 1.00 | *1.11 | *1.15 | *1.13 | *1.21 |
| | Number | | | | |
| Average DMFT teeth in 6 year olds (1998) ^{(a)(c)} | 1.45 | 1.93 | 1.87 | 1.71 | 1.88 |
| Average DMFT teeth in 12 year olds (1998) ^{(a)(c)} | 0.84 | 0.98 | 0.85 | 1.02 | 1.09 |

(a) Statistical significance is not available for these results.

(b) These ratios are not specific to Remote or Very Remote areas, but are averages for remote areas generally.

(c) Decayed, missing and filled permanent teeth. See Chapter 2.

Notes

1. Reported standardised ratios are indirectly age-standardised using Major Cities age-specific rates. The ratios are a way of comparing the levels of health in various areas with that in a reference area, in this case Major Cities. A ratio of 1.5 for mortality, for example, indicates that there were 1.5 times as many deaths as expected had the age-specific rates for Major Cities been applied to the population in that area.
2. Ratios that are statistically different to 1.00 are marked with an asterisk (except for activity restriction and DMFT teeth, for which information on statistical significance was not available).

Source Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 243.

2 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 241.

3 National Rural Health Alliance, sub 59, p 3.

- 5.5 The Rural Doctors Association noted that standardised mortality data show death rates in Australia increase with rurality:

Australians living in regional, rural and remote areas are 10% more likely to die of all causes than those in major cities, and 50% more likely to do so if they live in very remote areas. Life expectancy also declines as rurality increases: from 77.9 to 72.2 for males and 83.9 to 78.5 for females. The main specific causes of higher death rates outside Major Cities include ischaemic heart disease and 'other circulatory diseases', chronic obstructive pulmonary disease, motor vehicle accidents, diabetes, suicide, other injuries and prostate, colorectal and lung cancer, many of which are largely preventable.⁴

- 5.6 Access largely depends on the presence of appropriate numbers of skilled health professionals, the availability of infrastructure such as a hospital or community medical centre and the affordability of services.

- 5.7 In general terms, there are fewer health professionals per capita and people often live great distances away from town centres. The more chronic or urgent the problem, then the more difficulty in accessing the specialist treatments required. The Productivity Commission noted that:

For patients, access to primary and emergency care services can be many hours away, potentially impacting on health outcomes. And access to more specialised services, only available in major population centres, involves even longer travel times, and greater financial costs and disruption to family life and work.⁵

- 5.8 While access to medical specialists may be limited in more sparsely settled areas, the geographic spread of nursing professionals is relatively even (table 5.1).

4 Rural Doctors Association of Australia, sub 31, p 6.

5 Productivity Commission, *Australia's Health Workforce* (2005), p 203.

Table 5.1 Health workforce — Persons employed in selected health occupations per 100,000 population, by remoteness areas, 2003

| Occupation | Major cities | Inner regional | Outer regional | Remote | Very remote | Total |
|------------------------------|--------------|----------------|----------------|-----------------|--------------|--------------|
| Medical practitioners | 326 | 179 | 155 | 154 | 130 | 283 |
| NSW | 327 | 179 | 107 | 76 | 66 | 327 |
| Victoria | 338 | 173 | 132 | 211 | .. | 338 |
| Queensland | 296 | 157 | 154 | 71 | 78 | 296 |
| South Australia | 387 | 135 | 133 | 130 | 87 | 387 |
| Western Australia | 279 | 114 | 128 | 145 | 168 | 279 |
| Tasmania | .. | 354 | 138 | 111 | 121 | .. |
| Northern Territory | .. | .. | 537 | 460 | 170 | .. |
| ACT | n.p. | n.p. | .. | .. | .. | n.p. |
| Nurses (a) | 1,120 | 1,166 | 1,115 | 1,193 | 1,082 | 1,120 |
| NSW | 1,010 | 1,180 | 1,044 | 1,044 | 1,305 | 1,115 |
| Victoria | 1,246 | 1,387 | 1,497 | 1,350 | .. | 1,355 |
| Queensland | 1,013 | 981 | 967 | 891 | 1,164 | 1,038 |
| South Australia | 1,434 | 784 | 1,251 | 1,281 | 1,238 | 1,434 |
| Western Australia | 1,068 | 755 | 1,144 | 1,083 | 1,195 | 1,076 |
| Tasmania | .. | 1,520 | 875 | 706 | 1,726 | 1,331 |
| Northern Territory | .. | .. | 1,541 | 2,236 | 813 | 1,575 |
| ACT | n.p. | n.p. | .. | .. | .. | 1,182 |
| Dentists | 57.6 | 34.5 | 27.7 | 18.1 (b) | | 48.7 |

Note (a) Includes registered and enrolled nurses.

(b) Combined average for remote and very remote areas.

n.p. not published. .. not applicable. Regional rates for medical practitioners exclude 1,870 practitioners who did not report the region in which they worked, whereas the total includes these practitioners.

Some practitioners make regular visits outside their place of residence and therefore lower numbers of medical practitioners per 100,000 populations may understate the number of people providing health services to people living in remote areas.

Source Australian Institute of Health and Welfare (AIHW), *Australia's health 2006 (2006)*, pp 325–329; AIHW, *Medical labour force 2003 (2005)*, Table 2.8; AIHW, *Nursing and midwifery labour force 2003 (2005)*, Table 12; Australian Institute of Health and Welfare, *Australia's health 2004 (2004)*, p 262.

Sustainable regional and rural health workforce

5.9 As discussed in chapter 4, there are a number of broad issues that need to be addressed to provide for an increased number of well trained health professionals. Inquiry participants also noted a range of health workforce issues that specifically related to attracting and

retaining health professionals outside of the major capital cities including:

- the availability of appropriate infrastructure to support the required broad range of health services and provide a supportive and stimulating environment for health professionals to work and train;⁶
- providing appropriate financial and other incentives to ensure that sufficient numbers of health professionals are attracted and retained in regional and rural areas;⁷ and
- the need to support different models of care and provide specific training and assistance for regional and rural health professionals.⁸

5.10 The committee notes that as part of the COAG's health workforce response in July 2006, the Australian Health Ministers' Conference will ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular requirements of rural and remote areas.⁹

5.11 The committee also noted that COAG has asked that health ministers to undertake work and provide proposals, involving both Commonwealth and state government programs, to COAG by mid-2007 on ways to improve rural and remote health service delivery.¹⁰

5.12 The committee supports these developments, and considers that the health ministers should address some of the particular concerns outlined by inquiry participants below.

6 Dr Ross Cartmill, sub 107, p 4; National Rural Health Alliance, sub 59, p 3; Australian Institute of Medical Scientists, sub 12, p 2; Clout T, Hunter New England Health, transcript, 20 July 2006, p 22.

7 Kidd M, Royal Australian College of General Practitioners, transcript, 5 July 2005, p 58; Clout T, Hunter New England Health, transcript, 20 July 2006, p 11; Marion O'Shea, sub 89, p 3; Dr Vladimir Vizec, sub 73, p 2; Local Government Association of NSW and Shires Association of NSW, sub 18, p 9.

8 Chater B, Australian College of Rural and Remote Medicine, transcript, 16 March 2006, p 30; O' Reilly B, Australian Dental Association, transcript, 5 July 2005, p 6; Western Australian Local Government Association, sub 34, p 8.

9 Council of Australian Governments, *Communique*, 14 July 2006.

10 Council of Australian Governments, *Communique*, 14 July 2006.

Infrastructure and training opportunity support

- 5.13 Several inquiry participants pointed to clear evidence that training of the health workforce in regional and rural areas was more likely to lead to trainees working in these areas sometime in the future.¹¹

Professor Wronski noted the example of recent graduates from James Cook University in Townsville:

We have had one graduation of medical students. Thirty-seven of the incoming cohort of medical students came from North Queensland and seven were from interstate. In terms of internship positions, 51 of 58 have stayed in Queensland, 31 are working in North Queensland and seven have gone interstate. There is no doubt that rural origin as well as where you train are the most significant predictors of where you are likely to work.¹²

- 5.14 Health workforce trainees can also benefit from spending parts of their training in regional and rural areas. The Australian College of Rural and Remote Medicine told the committee that:

There is often a concept that you need to do extra things in rural practice; in fact, those extra things are rural practice, and we need to acknowledge that. It is not just city based practice with a bit added on. You really need to understand what it means to treat somebody with a snakebite or with a heart attack in your town. You cannot learn that at the Royal Brisbane Hospital; you have to learn it in practice.¹³

- 5.15 The Commonwealth and the states have significantly increased their support for training to be conducted in regional and rural areas, with the establishment of over 10 rural clinical schools and new medical schools in regional areas in recent years.¹⁴ Opportunities for more health workforce trainees to spend time in regional areas should increase significantly as rising numbers of trainees enter the training pipeline in the next few years (see chapter 4).

- 5.16 The committee considers that it is important that funding arrangements for training recognise the value of training in regional

11 National Rural Health Alliance, sub 59, p 5; Wronski I, transcript, 16 March 2006, p 19; Aboriginal Medical Services Alliance NT, sub 149, attachment A, p 4.

12 Wronski I, transcript, 16 March 2006, p 19.

13 Chater B, transcript, 16 March 2006, p 30.

14 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Tamworth to become a medical training centre*, 14 February 2006.

and rural areas and provide the appropriate funding to conduct high quality training outside of the major urban areas.

- 5.17 While on the one hand there are opportunities being created to train the future health workforce in regional and rural areas, the committee also noted that there were significant concerns about the impact of the closure of smaller country hospitals on access to health services, the quality of care and training opportunities.¹⁵ The Rural Doctors Association of Australia noted that:

...the problem ... is that the Commonwealth gives the money to the states, (which) ... then use their own judgment and discretion subject to their own political pressures, to distribute it. This means that many small rural hospitals are starved of funds, they are downgraded and they close.¹⁶

- 5.18 The provision of health services in regional, rural and remote areas needs to take account of how treatment can be best delivered to the patient. In some cases, this may mean that patients in regional, rural and remote areas need to be transported to other areas. The Australian Health Insurance Association noted that:

We have a community psyche that seems to think a hospital is a place where you go for whatever treatment you need in one facility. All the evidence and all the science which I have read indicates to me that is no longer relevant. It is much safer to go to a hospital which specialises in the sorts of treatments that you need. It is a particular problem in regional Australia where again there is a view that every town must have its own hospital to provide services to the community. That, in fact, is no longer necessarily in the best interests of the patient.¹⁷

- 5.19 The Australian Medical Association (AMA) has proposed that a broader 'public interest test' should be applied when governments are looking at closing country hospitals which would consider:

- the impact on the maintenance of skills of the local medical workforce;
- the impact on the health needs of the local community;

15 Rural Doctors Association of Australia, sub 30, p 15; Leishman J, Caboolture Shire Council (Qld), transcript, 17 March 2006, pp 13-14; Western Australian Local Government Association, sub 34, p 8.

16 Stratigos S, Rural Doctors Association of Australia, transcript, 28 June 2005, p 17.

17 Schneider R, Australian Health Insurance Association, transcript, 23 August 2005, p 26.

- the social and employment impacts on the local community; and
 - the availability and proximity of alternative resources.¹⁸
- 5.20 The committee broadly supports the AMA's proposal, which should lead to governments making more informed decisions about the impact of closing public hospitals or reducing the services they provide.
- 5.21 The committee considers that the Commonwealth should further examine this proposal as part of its negotiations with the states over the next five-year public hospital funding agreements (see chapter 7). The national health agenda, proposed by the committee in chapter 3, also provides an opportunity for governments to provide communities with a clearer expectation about the standards of service that they will receive.

Incentives

- 5.22 There are a range of incentives offered by governments for health workforce professionals to work in regional, rural and remote areas. While many health professionals willingly work in these areas without financial and other incentives, there appears to be broad agreement that incentives need to be in place to ensure that access to health professionals is reasonably equitable — particularly in times of workforce shortage.
- 5.23 Hunter New England Health emphasised that the non-financial elements were also important to attract and retain skilled health professionals:

... salaries are only one component of things that allow you to attract and retain. For senior clinicians—be they doctors, nurses or allied health staff—sustainability of their capacity to teach, having a range of services that they can provide so that their professional skills are retained and having confidence in the quality of the services that will be provided, being able to be involved in research and having a range of services in which they can ply their trade are also significant parts of the package.

Another package in rural and remote areas is: what is available for the partner? What is their profession? What is

18 Australian Medical Association, media release, *Country Hospitals Must be Kept Viable – AMA*, 25 July 2006.

available for them in employment? Another issue is: what is available for education of children? How can I do that? What is the package available in relation to that? What are the issues around accommodation? Is it possible to find someone to act in a locum capacity when I want to go on leave? There is absolutely no point in just looking at salaries and wages; you have to look at the whole package. For some people, the driver is salary until you get to a certain level, and then those other things kick in.¹⁹

5.24 Incentives offered by the Australian Government to attract and retain health workforce in regional areas in recent years include:

- higher payments for selected Medicare Benefits Schedule items to general practitioners providing services in regional and rural areas. For example, doctors in country Australia and Tasmania can claim an extra payment every time they bulk bill a child under 16 or a person with a concession card;²⁰
- supporting the continuation of selected specialist services. For example, from November 2006, GPs providing obstetric services in rural and remote areas who deliver 20 or more babies a year will be eligible for a procedural payment of \$17,000 per year.²¹
- supporting locum and training for rural health professionals. For example, a recent \$500,000 pilot locum relief service for rural specialist obstetricians provided subsidised locum support to 20 rural obstetricians.²²

5.25 There are also incentives for health workforce trainees and overseas trained doctors migrating to Australia to work in regional and rural areas. For many overseas trained doctors, agreeing to work in an area of workforce shortage is a requirement of their visa and their entitlement to receive Medicare benefits on behalf of their patients.

5.26 Some health workforce trainees are also given incentives to work in regional and rural areas through conditions attached to their training arrangements. For example, the medical bonded rural scholarships

19 Clout T, Hunter New England Health, transcript, 20 July 2006, pp 6–7.

20 Hon John Howard MP, Prime Minister of Australia, media release, *Medicare plus: Protecting and strengthening Medicare*, 18 November 2003.

21 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Increased support for GP obstetricians in rural Australia*, 8 September 2006.

22 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Pilot project to provide locum relief for rural obstetricians*, 4 July 2006.

program provides an annual scholarship of around \$22,300 in return for a requirement that students agree to practice in rural areas of Australia for six years upon completion of their basic medical and postgraduate training.²³

- 5.27 Getting the right mix and level of incentives is important. Governments need timely information about the quantity and quality of services delivered in targeted areas and services to ensure that incentives are having the desired effect.

Models of care and support

- 5.28 Many inquiry participants noted that the delivery of health services in regional and rural areas was generally structured in a more flexible way, allowing for greater degree of task substitution, multidisciplinary approaches to health care and a broader range of roles for general practitioners.²⁴ While funding arrangements may underpin some of this flexibility, the use of different models of care is also related to health workforce issues.²⁵

- 5.29 Flexible service delivery arrangements are more likely to meet the needs of local communities and be more accepted. The Australian College of Rural and Remote Medicine noted that:

...immunisations, dressings, smear tests and midwifery.
They have been accepted wholeheartedly by the rural groups.

...In my practice I have nurses, visiting psychologists, a social worker and a diabetic educator. All of those people within my practice. They do that very well. They are well accepted by the community and they take a lot of load off.²⁶

- 5.30 As noted in chapter 3, the committee does not generally consider that introducing greater substitutability and flexibility in care models in regional and rural areas is necessarily the best response to providing health services in instances of workforce shortage. The preferred

23 Department of Health and Ageing, Medical Rural Bonded (MRB) Scholarships, viewed on 19 October 2006 at www.health.gov.au/mrbscholarships.

24 Carnel K, Australian Divisions of General Practice, transcript, 30 May 2005, p 30; Lambert J, Hospital Reform Group, transcript, 29 March 2006, p 9; Australian Physiotherapy Association, sub 118, p 10; Royal Australian College of General Practitioners, sub 66, p 10.

25 Kidd M, Royal Australian College of General Practitioners, transcript, 5 July 2005, p 58.

26 Chater B, Australian College of Rural and Remote Medicine, transcript, 16 March 2006, p 33.

response would be increasing the number of health professionals to the required level to match the community's needs.

- 5.31 The remaining part of this chapter considers a range of different funding models for the provision of health services to regional and rural areas.

Alternative funding models

- 5.32 The availability of health workforce in rural and regional areas acts as a cap on what would otherwise be broad access under Medicare to subsidised pharmaceuticals and medical services. Hunter New England Health told the committee that:

It is also true that if we do not have the workforce in our area health service for the services we provide, people cannot access them. I think that is a problem. I think it is rural and remote communities that are missing out. It is not the sole challenge, but one of the significant challenges for us as a society and for governments in general is how to overcome and change the system of funding we have got at the moment, which causes that perversion, because it is based, at the Commonwealth funding end, on an uncapped model that is dependent upon the workforce.²⁷

- 5.33 The marked variation for selected population centres was highlighted to the committee by the Hunter Urban Division of General Practice, who noted differences between funding levels per person for GP services under the Medicare from \$66 per person in northern Queensland to \$243 per person in inner Sydney.²⁸

- 5.34 While the Rural Doctors Association supported fee for service arrangements as the basic mechanism for remunerating medical care in regional and rural areas, they also considered that other funding options needed to be examined:

... introducing further contestability into health care funding arrangements will not deal with the inequitable distribution of health care resources between urban and rural areas. The lack of services and providers means there is little

27 Clout T, Hunter New England Health, transcript, 20 July 2006, p 9.

28 Sprogis A, Hunter Urban Division of General Practice, transcript, 20 July 2006, p 52.

competition in rural areas, so that traditional market constructs, which are in any case always difficult to apply to health care, are not applicable. Furthermore, a competitive purchaser-provider system would place heavy and perhaps unachievable demands on the skills and capacity of regional purchasing authorities to compete for both human and financial resources.²⁹

- 5.35 The Commonwealth and the states are involved in a range of fund pooling programs, such as the Coordinated Care Trials and the Multi-Purpose Services (MPS) Program.³⁰ The MPS Program brings the health services in a rural community come together under one management structure, receiving Commonwealth funding for flexible aged care places and state funding for a range of health services. There are currently 94 operational MPSs nationally, with most in New South Wales (34), Western Australia (29) and Queensland (16).³¹
- 5.36 The committee accepts that workforce shortages do affect access to health services outside of major urban areas under current funding arrangements. While there will be a significant rise in the number of health professionals in the next 5–10 years, it is likely that there will continue to be a need to support funding arrangements that target the particular health care needs of people living in regional, rural and remote areas.
- 5.37 Inquiry participants nominated a range of proposals to modify funding arrangements to address health care issues for regional, rural and remote areas:
- fund pooling between governments to provide for a more flexible allocation of existing health resources across the target population. There are existing examples, such as the MPS program where governments have pooled funds to provide health services to specific communities.³² As part of a 2005-06 budget initiative, the Commonwealth and states agreed to consolidate their respective funding for nominated health programs in certain agreed rural and remote communities with populations of less than 7,000;³³

29 Rural Doctors Association of Australia, sub 31, p 10.

30 Department of Health and Ageing, sub 142, p 30.

31 Department of Health and Ageing, sub 142, p 24.

32 Department of Health and Ageing, sub 142, pp 24–25.

33 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Developing the health workforce to meet community needs*, 9 May 2006.

- the provision of 'top up' funding to regional areas that is notionally underfunded under Medicare, the pharmaceutical benefits scheme and the private health insurance rebate. These funds could be allocated by fund-holding bodies such as local governments or Divisions of General Practice to purchase appropriate services on behalf of their local community;³⁴
- building on the existing fee-for-service arrangements with higher reimbursement for rural patients, combined with an appropriate indexation mechanism;³⁵
- the employment of more salaried doctors in areas of doctor shortage;³⁶
- capitation (ie: population-based) payments adjusted for relative disadvantage to fund-holding bodies that purchase the full range of health services for their target population, building in incentives for patient care and appropriate targeted incentive schemes;³⁷ and
- allocating regionally-based provider numbers that give doctors access to Medicare rebates in specific areas.³⁸

5.38 Some of the funding models developed in chapter 3 also have relevance for regional and rural areas. The proposal that the Commonwealth be the single funder of around 30 regionally-based purchasers of health services appears to offer a greater focus on regional health needs than other models, such as fund pooling by governments at a high level.³⁹

5.39 As previously stated, the committee supports the work of health ministers in developing options for COAG by mid-2007 on proposals to improve rural and remote health service delivery.

5.40 As part of the national health agenda recommended by the committee in chapter 3, there should be clear standards developed about the delivery of health services in regional, rural and remote areas. Clearer service standards should then guide the use of the mix of funding models to meet these standards.

34 Sprogis A, Hunter Urban Division of General Practice, transcript, 20 July 2006, p 53

35 Rural Doctors Association of Australia, sub 31, p 20.

36 Western Australian Local Government Association, sub 34, p 7.

37 Redcliffe-Bribie-Division of General Practice, sub 81, p 22; Piterman, L, 'No place for fee-for-service in future health system', *Australian Doctor*, 25 August 2006, p 22.

38 Dr Vladimir Vizec, sub 73, p 1; Local Government Association of NSW and Shires Association of NSW, sub 18, p 9;

39 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27.

Recommendation 11

- 5.41 **The Minister for Health and Ageing, in consultation with state and territory health ministers and as part of the national health agenda (see recommendation no. 1), develop standards for the delivery of health services in regional, rural and remote areas.**
- 5.42 The committee also considers that the delivery of health services by public hospitals in regional, rural and remote areas should be considered as part of the renegotiation of the next Australian Health Care Agreements (described in chapter 7).

Local government

...while local government has an involvement in health issues right across the spectrum... It is a community role that we play and, depending on the situation, whether it is in rural and regional Australia or in the metro areas, it is a very diverse role that we play in health issues. ... (There is a) crisis situation. ... It is a funding role that we are reluctant to play. We see it as a responsibility of other tiers of government to be involved in for the benefit of our communities.¹

- 6.1 The range and scope of local government functions has changed over recent decades. Traditionally, local governments looked after roads and waste management. Increasingly, local governments are involved in funding and delivering a broad range of community services, including some health services.

... some of the things that we have done, most of them over the last eight to 10 years... a health centre, which is about seven years old now, that accommodates the doctor, a dentist... infant health nurse... housing for our doctor, certainly with free rent; we have attracted a physiotherapist to the down, built a house, and he services other areas from Bruce Rock... The construction and maintenance costs for all houses ... running costs for vehicles ... guaranteed salaries for doctors... We also carry the locum costs.

¹ Miller B, Local Government Association of NSW and Shires Association of NSW, transcript, 21 July 2006, pp 1-2.

...

Uncertainty is the issue for us. We want to be more involved as a community, as a council. We would like direct funding from the Commonwealth.²

Recognition of local government

- 6.2 Local government is not recognised in the Australian Constitution. The states are responsible for the local government legal framework.
- 6.3 The lack of constitutional recognition for local governments can be problematic. In its 2003 inquiry into cost shifting onto local government, the House of Representatives Standing Committee on Economics, Finance and Public Administration (the Hawker committee) recommended the development of a Federal-State intergovernmental agreement which identifies the roles and responsibilities of local governments in delivering federal and state programs.³
- 6.4 The intergovernmental agreement was signed by the three levels of government on 11 April 2006. The Australian Local Government Association noted that the agreement would 'help ease the cost shifting burden carried by Australia's 700 councils'.⁴
- 6.5 On 6 September 2006, the Commonwealth government implemented a major recommendation made by the Hawker committee, giving public acknowledgement to the considerable contribution that local government makes for Australians. The President of the Australian Local Government Association, Cr Paul Bell:

... welcomed the tabling in Federal Parliament of a resolution recognising the role of local government as historic and symbolic step on the road to formal constitutional recognition.

This is a milestone for local government and for Australia as a whole ... For the first time, both houses of Federal Parliament have the opportunity to recognise the role and importance of

2 Strange S, Shire of Bruce Rock (WA), transcript, 24 August 2006, pp 6–8.

3 House of Representatives Standing Committee on Economics, Finance and Public Administration, *Rates and taxes: A fair share for responsible local government* (2003), p 22.

4 Australian Local Government Association, media release, *IGA on cost shifting: Historic agreement to ease cost shifting burden on councils*, 12 April 2006.

local government as part of Australia's system of democratic government.

Local government works tirelessly to deliver services and infrastructure to local communities and to provide a voice for those communities on important local issues.⁵

6.6 In moving the motion of recognition in the House of Representatives, the Minister for Local Government, Territories and Roads indicated that, in response to the Hawker committee, the Commonwealth Government agreed to:

- develop an intergovernmental agreement with state and federal governments on relations with local government;
- develop a new national principle under the *Local Government (Financial Assistance) Act 1995* specifying that financial assistance grants (FAGs) for amalgamated councils would be maintained for four years after amalgamation; and
- review the interstate distribution of the roads component FAGs through the Commonwealth Grants Commission.⁶

Roles and responsibilities

6.7 Local governments are diverse in the range and scale of services they provide. State government legislation generally imposes few limitations of what services local governments provide.⁷ There is flexibility in that each state has its own legislation, and thus functions of local government vary between states and local governments.

6.8 The Australian Local Government Association noted that the range and scope of local government services has expanded over recent decades to include a growing range of human services including:

- population-based health services;
 - ⇒ environmental health activities such as environmental protection, water and air quality monitoring and pollution abatement activities;

5 Australian Local Government Association, media release, *ALGA welcomes historic Parliamentary Resolution*, 7 September 2006.

6 House of Representatives Debates, 6 September 2006, p 94.

7 House of Representatives Standing Committee on Economics, Finance and Public Administration, *Rates and taxes: A fair share for responsible local government* (2003), p 1.

- ⇒ development, implementation and enforcement of public health policies and regulations in areas such as water, air or food standards;
- ⇒ health promotion and preventative health programs and services such as health inspections to uphold food quality standards, maternal and child health, immunisation clinics and palliative care;
- ⇒ recreation and leisure facilities and services, including parks and sporting centres; and
- ⇒ promoting resident access to health services by providing information in specific languages;
- aged care services including high and low care residential services and the provision of services under the joint Commonwealth-state funded Home and Community Care program; and
- medical services including offering 'lifestyle packages' (covering accommodation, fully equipping consulting rooms, travel and assistance with locum relief) and the ownership and operation of hospitals or medical practices.⁸

6.9 Submissions to the inquiry from individual local governments, state local government associations and other local government organisations highlighted the extent of the diversity of services across local governments.⁹ Selected examples of services where local government met all, or the great majority of the cost of services are provided in box 6.1.

8 Australian Local Government Association, sub 36, pp 4–8.

9 Dubbo City Council (NSW), sub 4, p 1; Bankstown City Council (NSW), sub 13, p 2; Pine Rivers Shire Council (Qld), sub 22, pp 2–4; City of Darebin (Vic), sub 32, p 1; City of Mandurah (WA), sub 46, p 1; City of West Torrens (SA), sub 123, p 2; Shire of Laverton (WA), sub 147, pp 1–2; Shire of Bruce Rock (WA), sub 152, pp 1–3; Caboolture Shire Council (Qld), sub 103, p 3; Local Government Association of NSW and Shires Association of NSW, sub 8, pp 5–8; Municipal Association of Victoria, sub 33, pp 4–6; Western Australian Local Government Association, sub 34, pp 4–8; Council of Capital City Lord Mayors, sub 144, pp 3–4.

Box 6.1 Health services funded and provided by selected local governments

Immunisation

Pine Rivers Shire Council (Qld) receives \$3 for every child (under 8 years) immunised. The Council notes that this is significantly less than payments to GPs (\$15). In 2004-05, Pine Rivers Shire Council expected to spend \$150,000 on the immunisation program and a further \$14,000 on a new data base. Expected revenue was \$11,000. Thus council is therefore providing \$153,000 from its own resources to fund the immunisation program.¹⁰

The City of West Torrens (SA) subsidises around 50 per cent of the cost of each immunisation, for a total annual cost to the City of around \$550,000.¹¹

Primary care incentives — attracting and retaining health professionals

Members of the Local Government Association of NSW and Shires Association of NSW noted significant contributions by their members to attract primary care practitioners including:

- 30 councils provided 45 centres for 59 doctors at an annual cost of \$465,065;
- 26 councils provided 48 houses for 53 doctors at an annual cost of \$541,528;
- 12 councils provided 13 centres for 13 dentists at an annual cost of \$228,800; and
- 10 councils provided equipment for 18 doctors at an annual cost of \$63,500.¹²

The Shire of Laverton (WA) provides a significant cash incentive of \$110,000 plus a fully serviced vehicle for private and business use to attract and retain a doctor in the local community. Other incentives are also provided to nurses, with a total annual cost to the Shire of around \$171,000.¹³

The Shire of Bruce Rock (WA) provided capital costs of \$288,900 for a medical centre and fit out costs of \$23,728 for a dental surgery. Construction costs for housing for a doctor, physiotherapist and dentist totalled over \$850,000.¹⁴

Funding and expenditure

6.10 At an aggregate level, there are three major sources of revenue for local government:

- municipal rates;

10 Pine Rivers Shire Council (Qld), sub 22, p 4.

11 City of West Torrens (SA), sub 123, pp 2–3.

12 Local Government Association of NSW and Shires Association of NSW, sub 18, p 6.

13 Laverton Shire Council (WA), sub 147, p 1.

14 Shire of Bruce Rock (WA), sub 152, p 1.

- user charges; and
- grants and subsidies from other spheres of government.¹⁵

6.11 Since 1998-99, local government has become increasingly reliant on other sources of revenue (such as dividends, fines and interest income), with a decline in the proportion of funding from grants and subsidies from other levels of government (table 6.1).

Table 6.1 Local government revenue sources, share of total revenue (per cent), 1998-99 to 2004-05

| Revenue source | Share of total revenue (per cent) | | |
|----------------------|-----------------------------------|---------|---------|
| | 1998-99 | 2001-02 | 2004-05 |
| Rates | 38.5 | 37.4 | 38.0 |
| Grants and subsidies | 13.1 | 13.6 | 10.4 |
| User charges | 32.6 | 30.9 | 30.8 |
| Interest | 2.3 | 2.1 | 2.8 |
| Other | 13.5 | 16.1 | 18.1 |
| Total | 100.0 | 100.0 | 100.0 |

Source Australian Bureau of Statistics, *Government Finance Statistics, Australia, 2004-05, Cat No 5512.0, Table 399.*

- 6.12 Trends at a national level can mask variations between individual local governments. The National Rural Health Alliance noted that there are significant differences in revenue raising capacity and the sources of revenue between local governments, especially in rural areas.¹⁶
- 6.13 The major source for grants to local government comes from the Australian Government in the form of FAGs. The Australian Government pays FAGs to state governments for distribution to local government via State Grants Commissions. In 2004-05, local government received \$1.6 billion in FAGs.¹⁷
- 6.14 Local governments contribute significantly to the provision of public health services. The most recent estimates by the Australian Institute of Health and Welfare note expenditure on public health-type services of around \$222.5 million in 1999-00.¹⁸

15 Australian Local Government Association, sub 36, p 10.

16 National Rural Health Alliance, sub 59, p 8.

17 Australian Local Government Association, Financing local government, viewed on 11 October 2006 at www.alga.asn.au/policy/finance/finfax/3.revenue.php.

18 Australian Institute of Health and Welfare, *National public health expenditure report, 1999-00 (2002)*, p 98; Australian Local Government Association, sub 36, p 5.

6.15 As previously noted, local government services were traditionally centred on roads and waste management. However, in some jurisdictions local governments also make a significant contribution to funding a range of human services that contribute to better health, including welfare services, housing and recreation facilities. Table 6.2 shows the differences between jurisdictions in local government spending on human services as a proportion of total expenditure.

Table 6.2 Local government community services expenditure as a proportion of total expenditure, by state, 1998-99 to 2004-05

| Service | NSW | Vic | Qld | SA | WA | Tas | NT | Total |
|---------------------------------|------|------|------|------|------|------|------|-------|
| Health | | | | | | | | |
| 1998-99 | 1.0 | 2.9 | 1.5 | 2.3 | 2.1 | 3.3 | 1.4 | 1.8 |
| 2001-02 | 1.0 | 2.8 | 1.0 | 1.8 | 2.0 | 2.7 | 2.2 | 1.6 |
| 2004-05 | 1.2 | 1.4 | 1.0 | 2.3 | 1.9 | 2.1 | 2.5 | 1.4 |
| Social security and welfare | | | | | | | | |
| 1998-99 | 3.4 | 13.6 | 1.1 | 3.2 | 4.8 | 2.6 | 1.4 | 5.2 |
| 2001-02 | 4.2 | 13.9 | 0.9 | 3.2 | 4.9 | 3.3 | 2.2 | 5.4 |
| 2004-05 | 4.9 | 16.0 | 1.1 | 4.8 | 5.1 | 3.4 | 2.5 | 6.3 |
| Housing and community amenities | | | | | | | | |
| 1998-99 | 23.3 | 18.0 | 31.3 | 17.1 | 15.4 | 36.4 | 31.4 | 23.2 |
| 2001-02 | 25.0 | 17.8 | 28.0 | 13.9 | 15.1 | 34.4 | 18.3 | 22.7 |
| 2004-05 | 23.4 | 19.2 | 29.1 | 16.9 | 15.2 | 36.1 | 21.6 | 23.1 |
| Recreation and culture | | | | | | | | |
| 1998-99 | 10.4 | 17.5 | 8.9 | 16.9 | 23.0 | 12.2 | 14.3 | 13.3 |
| 2001-02 | 10.9 | 16.8 | 9.5 | 15.3 | 21.8 | 12.7 | 10.4 | 13.1 |
| 2004-05 | 15.1 | 17.4 | 9.9 | 17.2 | 22.0 | 11.0 | 8.9 | 14.8 |

Source Australian Bureau of Statistics, *Government Finance Statistics, Australia, 2004-05, Cat No 5512.0, Tables 331-339.*

Cost shifting to local government

6.16 The issue of cost shifting was raised in many local government submissions to the inquiry.¹⁹ The Australian Local Government Association estimated that cost shifting has a negative impact on

¹⁹ Dubbo City Council (NSW), sub 4, p 1; Bankstown City Council (NSW), sub 13, pp 2-3; Local Government Association of NSW and Shires Association of NSW, sub 18, p 11; Western Australian Local Government Association, sub 34, p 8; City of Mandurah (WA), sub 46, p 3.

councils of between \$500 million and \$1.1 billion each and every year.²⁰

6.17 As discussed in chapters 2 and 3, cost shifting is a complex issue. In the context of cost shifting to local governments, the Hawker committee noted that there were two main types of behaviour that constituted cost shifting:

The first is where local government agrees to provide a service on behalf of another sphere of government but funding is subsequently reduced or stopped, and local government is unable to withdraw because of community demand for the service. The second is where, for whatever reason, another sphere of government ceases to provide a service and local government steps in.²¹

6.18 Devolution to local governments and 'raising the bar' by increasing required standards of service were also considered by the Hawker committee to constitute cost shifting to local governments where adequate funding was not provided.²²

6.19 Two areas not considered to be cost shifting by the Hawker committee related to local governments stepping in to provide services where the community demands improvement and where individual local governments choose to expand their service provision as a matter of policy choice.

6.20 Dubbo City Council (NSW) noted several examples of alleged cost shifting to local government in the area of health care services:

- building and provision to medical practitioners of rent free housing, medical offices and surgeries;
- investing direct funding and staff time in advertising, the production of promotional material and other incentive activities to attract medical practitioners to their areas; and

20 Australian Local Government Association, media release, *IGA on cost shifting: Historic agreement to ease cost shifting burden on councils*, 12 April 2006.

21 House of Representatives Standing Committee on Economics, Finance and Public Administration, *Rates and taxes: A fair share for responsible local government* (2003), pp 42–43.

22 House of Representatives Standing Committee on Economics, Finance and Public Administration, *Rates and taxes: A fair share for responsible local government* (2003), pp 42–43.

- in some cases, local governments contributing to the salaries of medical practitioners.²³
- 6.21 Other examples of local governments meeting all or part of the cost of health care services that could be considered as cost shifting raised by local governments include:
- inadequate indexation and under-funding by the Commonwealth and the states for jointly funded programs such as the Home and Community Care program, resulting in local governments needing to meet both demand growth and the increase in costs above that provided by indexation arrangements;²⁴
 - funding for immunisation services that do not cover the full cost of service provision;²⁵ and
 - local governments stepping in to fund programs from which other levels of government have withdrawn.²⁶
- 6.22 Examples of local governments providing significant capital and recurrent funding to attract health service providers are more difficult to classify as cost shifting, as they may reflect a clear choice by these governments to contribute to the provision of health services in their communities.
- 6.23 The committee acknowledges that without local governments assuming responsibility for funding the health services in their community, it is likely that their communities will be further disadvantaged. It is important that the Commonwealth and the states develop health funding models that do not leave local communities without access to the health services they need.

Population shifts and ageing

- 6.24 Several local governments noted that there were significant population shifts to certain areas that were putting pressure on community infrastructure. Caboolture, in Queensland, is regarded as one of the fastest growing local government areas in Australia, with

23 Dubbo City Council (NSW), sub 4, p 1.

24 Municipal Association of Victoria, sub 33, p 6.

25 City of West Torrens (SA), sub 123, p 2; Pine Rivers Shire Council (Qld), sub 22, pp 3–4.

26 MacKenzie M, Western Australian Local Government Association, transcript, 24 August 2006, p 11.

the population of 130,000 people expected to expand to 200,000 by 2025.²⁷

- 6.25 Coupled with these large population shifts is population ageing, which can also be concentrated in areas with rapid population growth. The City of Mandurah (WA) noted that:
- As one of the fastest growing local government areas in Western Australia, and indeed Australia - Mandurah's average annual growth rate over the 10-year period to 2004 was 5.3% (and in 2004 was 7.8%), compared with the Western Australian and Australian averages of 1.5% and 1.2% respectively - Mandurah is increasingly becoming a favourite destination for retirees.²⁸
- 6.26 The committee notes that some local governments experiencing significant population growth established a national 'sea change taskforce' in 2004 to consider options for addressing the challenge of rapid growth in coastal areas.²⁹ The sea change taskforce noted that current methods of planning, funding and managing rapid population and tourism growth in coastal areas are inconsistent and inadequate.³⁰
- 6.27 Demographic ageing of the population is likely to bring additional pressures for local governments to address gaps in services provided by other levels of government.

Supporting local governments - health services

- 6.28 The committee recognises that local governments make a significant and often under recognised contribution to improving the health of their local communities. Without appropriate funding support, local governments are not likely to be able to sustain the level and quality of services they currently provide.

27 Caboolture Shire Council (Qld), sub 103, p 3.

28 City of Mandurah (WA), sub 46, p 2.

29 National Sea Change Taskforce, The challenge of coastal growth, viewed on 8 November 2006 at www.seachangetaskforce.org.au/Publications/The%20Challenge.pdf.

30 National Sea Change Taskforce, The role of the taskforce, viewed on 8 November 2006 at www.seachangetaskforce.org.au/About/about.html.

- 6.29 Adequate support for the provision of health services by local governments also requires a broader consideration of local government financing issues.
- 6.30 The committee considers that adopting one of the funding models discussed in chapter 3, including the Commonwealth as a single funder or the pooling of funds between different levels of government, could further clarify the role of local governments in funding and/or delivering health services.
- 6.31 An important step in addressing local government funding issues is the motion moved in the House of Representatives acknowledging the continuing and valuable contribution that local governments across Australia are making to this nation's health care. It stresses the importance of governments at all levels working together for the wellbeing of Australia and all Australians.
- 6.32 The Minister for Local Government, Territories and Roads indicated that the intergovernmental agreement, signed in April 2006, would provide for:
- ... greater financial transparency between three spheres of government in relation to local government services and functions ... to improve the relationship by increasing consultation between governments on local government matters ... (and) when a responsibility is devolved to local government, local government is consulted and the financial and other impacts on local government are taken into account.³¹
- 6.33 The intergovernmental agreement is an important step to acknowledge and support the role that some local governments play in funding and delivering services, including health care. The committee considers that all governments need to give priority to developing processes within their jurisdictions to give effect to the intergovernmental agreement's principles so that future funding agreements for health-related services can be appropriately structured.

31 House of Representatives Debates, 6 September 2006, p 94.

Recommendation 12

- 6.34 **The Minister for Local Government, Territories and Roads give priority to the development of processes and guidelines to assist Australian Government agencies implement the principles of the Inter-Governmental Agreement on Local Government, as announced by the Australian Government on 6 September 2006.**
- 6.35 The Australian Government recently announced an increase in the funding cap for rural communities wishing to build medical clinics from \$200,000 to \$400,000 per project through the Rural Medical Infrastructure Fund (RMIF).³² Medical facilities for allied health professional services will also be eligible for funding under the program. The committee welcomes this change, which allows eligible local governments to better support the establishment of health services in their communities.
- 6.36 The committee noted with concern, however, the considerable capital investments already made by some local governments and councils in the establishment of health care facilities within their communities. While ratepayers have been funding substantial building works for some time, there is no provision through the RMIF for facilities that have recently commenced or been completed. It is unfortunate a one-off grant provision, as a 'part contribution', has not been provided for in order to acknowledge the important contributions already made by some local governments.

32 Hon Warren Truss MP, Minister for Transport and Regional Services, media release, *RMIF changes mean more benefits to local communities*, 22 August 2006.

Public hospital services

The Australian Health Care Agreements form an important partnership between the Commonwealth Government and each of the State and Territory Governments to deliver public hospital services to the Australian population. The ability of the governments to work together to provide public hospital services is a core element of the Australian health care sector.¹

- 7.1 Hospital services are a critical part of the health system and, as such were the subject of much of the evidence presented to the committee. This section of the report describes the current public funding arrangements and service provision, discusses issues relating to the accountability of governments and recommends some changes to funding arrangements.

Australian Health Care Agreements (AHCAs)

- 7.2 State governments provide hospital services through a variety of arrangements including the ownership or funding of public hospitals and contract arrangements with private hospitals. Any hospital, irrespective of ownership, can treat public and private patients.
- 7.3 The Australian Health Care Agreements (AHCAs) underpin the Commonwealth's contribution to funding for hospital services provided to public patients.

1 Hon Tony Abbott MP, Minister for Health and Ageing, sub 102, p 1.

- 7.4 Under the AHCAs, the Commonwealth agrees to contribute to the cost of state public hospital services and the states agree that services will comply with the principles and conditions set out in the agreements.
- 7.5 The principles are drawn from the *Health Care (Appropriation) Act 1998* and are incorporated in the agreements in the following terms:
- The primary objective of this Agreement is to secure access for the community to public hospital services based on the following principles:
- (a) Eligible persons are to be given the choice to receive, free of charge as public patients, [the range of] health and emergency services [that were available on 1 July 1998];
 - (b) Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and
 - (c) Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.²
- 7.6 An important condition introduced in the current AHCAs is that growth in states' own source funding must match the cumulative growth in Commonwealth funding over the life of the agreements.³ This, in effect, sets a 'floor' level of funding that each state must contribute, based on its actual level of funding in 2002-03.
- 7.7 The agreements have evolved since 1984, when funding agreements were introduced to compensate the states for cost increases and revenue losses associated with the establishment of Medicare. Since 1988, there have been a series of five-year agreements,⁴ which have introduced various incentives for system reform, rewards or penalties for higher or lower public levels of public service provision and increased accountability arrangements.⁵
- 7.8 The AHCAs are not legally enforceable contracts between governments. The Department of Health and Ageing noted that they

2 Australian Health Care Agreements 2003-2008, clause 6 and clause 7 (a) taken together.

3 Australian Health Care Agreements, clause 11.

4 Two sets of Medicare Agreements covering the period 1988 to 1998 and two sets of Australian Health Care Agreements covering the period 1998 to 2008.

5 Duckett S, *The Australian Health Care System* (2004), p 45.

should be considered as ‘funding’ agreements rather than ‘purchasing’ agreements:

The central characteristic of the agreements is that they are not purchasing arrangements; they are effectively funding arrangements. The Commonwealth makes available an amount of money which is about half of the cost to the states of running public hospitals, and the states get that amount without regard to the volume of services they actually carry out.⁶

- 7.9 Under the agreements, the states are responsible for service delivery and retain flexibility in determining how, and where, public hospital services are delivered. Indeed, there is no requirement that the services specified in the agreements need to be carried out in public hospitals:

You could posit an extreme view, where a state says, ‘We’re not going to run any hospitals, and we will basically outsource all of our public hospital services to the private sector.’ It would be hard to imagine that ever happening, but I do not believe that, as long as there is no cost to the people who opted to go for that service, it would not be at odds with the health care agreement. The health care agreements are about the patients’ experience; the ownership management of the hospital facility is an issue for the state or territory government on which the agreements are agnostic.⁷

- 7.10 Sections 6 and 13 of the *A New Tax System (Commonwealth–State Financial Arrangements) Act 1999* require the bulk of AHCA funds to be absorbed into the pool of GST revenue. This combined pool is then distributed between the states using per capita relativities derived by the Commonwealth Grants Commission.⁸ This has the effect of redistributing AHCA funds between the states based on their relative need for general revenue assistance as assessed by the Commission. While the cost of providing public hospital services is a part of this assessment, it is only one of a multitude of factors considered.

- 7.11 Similar arrangements existed during the period from 1988 until the introduction of the GST, with AHCA or Medicare Agreement funds

6 Maskell-Knight C, Department of Health and Ageing, transcript, 28 November 2005, p 6.

7 Davies P, Department of Health and Ageing, transcript, 28 November 2005, p 23.

8 See The Treasury, *Federal Financial Relations 2006-07*, Budget Paper No 3 (2006), table 8, p 10.

being 'absorbed' into the pool of Financial Assistance Grants to the states (see Box 7.1).

Box 7.1 History of public hospital funding arrangements

During the 1970's, the Commonwealth withdrew from public hospital cost sharing arrangements with the states and established a form of general revenue assistance known as Identified Health Grants.

When universal access to free public hospital services was introduced under Medicare in 1984, specific hospital grants to the states were reintroduced to compensate them for the loss of patient revenues.

In 1988, these Identified Health Grants and Medicare Compensation Grants were rolled together into the 1988–93 Medicare Agreements. The current arrangement of 'absorbing' hospital funding grants into the pool of general revenue assistance was commenced under these agreements.

Three subsequent five year funding agreements have been made between the Commonwealth and the states – the 1993–98 Medicare Agreements, the 1998–2003 AHCAs and the 2003–08 AHCAs.

Source: Senate Community Affairs References Committee, First report - Public hospital funding and options for reform (2000), pp 31–37.

Funding and services

7.12 As noted in chapter 2, over the five years of the current agreements (2003–08), state governments will receive an estimated \$42 billion from the Commonwealth, with \$7.95 billion provided in 2004-05.⁹

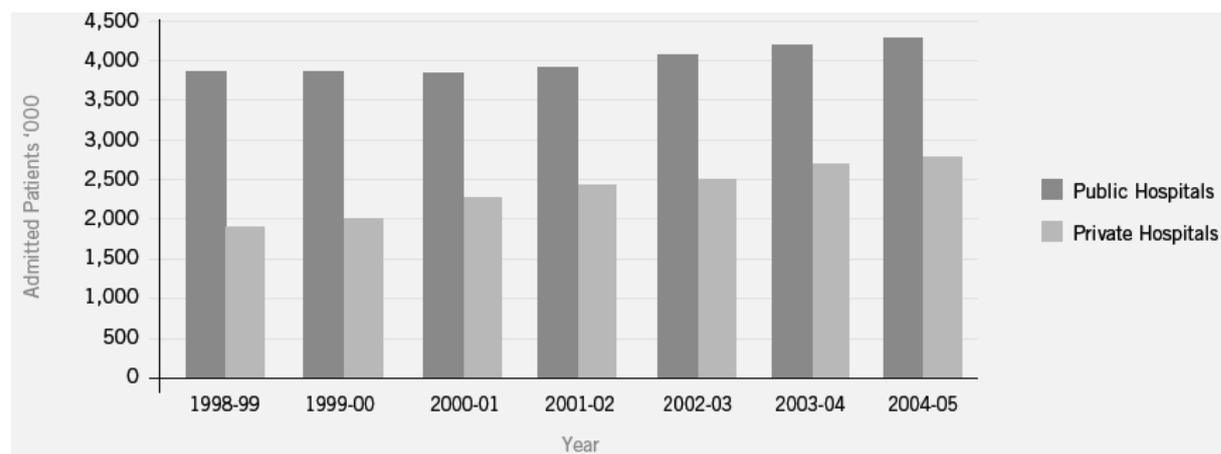
7.13 Total recurrent public hospital expenditure in 2004-05 was \$21.3 billion. This was an increase, after adjustment for inflation, of 5.3 per cent on the previous year. Average growth over the period 1994-95 to 2004-05, adjusted for inflation, was 4.4 per cent.¹⁰ These figures include the cost of treatment of private patients in public hospitals.

⁹ Department of Health and Ageing, *The state of our public hospitals, June 2006 report* (2006), p 12.

¹⁰ Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), p 56.

7.14 This funding supported 4.3 million patient admissions to public hospitals, 37 million outpatient occasions of service and 4.3 million emergency department patients. As shown in figure 7.1, public hospital admissions have increased by 10.6 per cent since 1998-99 while private hospital admissions have increased by 47 per cent over the same period¹¹.

Figure 7.1 All hospital admissions – number of patients admitted, 1998-99 to 2004-05



Source Department of Health and Ageing, *The state of our public hospitals, June 2006 report (2006)*, p 19.

7.15 In 2004-05, some 41.9 per cent of the funding for all hospital services (public and private) was sourced from the Commonwealth, while 38.0 per cent was from state and local governments and 20.1 per cent from non-government sources.¹²

7.16 Data published by the Department of Health and Ageing shows that, nationally, waiting times for access to elective surgery in public hospitals is deteriorating. In 1998-99, 90 per cent of elective surgery admissions were within the recommended time but only 82 per cent of admissions in 2004-05 were within the recommended time.¹³ While the percentage of emergency department patients seen within the recommended time has been stable at around 69 per cent since 2003-04, the fact that over 30 per cent of patients wait too long is a

11 Department of Health and Ageing, *The state of our public hospitals, June 2006 report (2006)*, pp 19, 38 and 42.

12 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05 (2006)*, p 57.

13 Department of Health and Ageing, *The state of our public hospitals, June 2006 report (2006)*, p 27.

concern.¹⁴ This deterioration has been more marked in some states than others, as shown in figure 7.2.

Figure 7.2 Elective surgery — percentage of all admissions seen within recommended time, states and territories, 2004-05 (1998-99)

| Rank | | 2004-05 | 1998-99 | |
|------|------------------------------|---------|---------|---|
| 1 | Queensland | 91 | 92 | 2 |
| 2 | Victoria | 86 | 91 | 4 |
| 3 | South Australia | 83 | 93 | 1 |
| 3 | Western Australia | 83 | 85 | 6 |
| 5 | New South Wales | 77 | 90 | 5 |
| 5 | Northern Territory | 77 | 92 | 2 |
| 7 | Australian Capital Territory | 68 | 75 | 7 |
| 8 | Tasmania | 66 | 75 | 7 |
| | Australia | 82 | 90 | |

Source Department of Health and Ageing, *The state of our public hospitals, June 2006 report (2006)*, p 27.

- 7.17 The AHCA's impose a range of accountability requirements on the states, including compliance with the principles (see paragraph 7.5), matching the growth in Commonwealth funding, reporting against specified performance indicators, participating in the development of new performance indicators and maintaining a public patients' hospital charter and an independent complaints body.¹⁵ About 4 per cent of AHCA funds are conditional on the states complying with the core accountability requirements.¹⁶
- 7.18 As a part of its assessment of states' AHCA compliance, the Department of Health and Ageing has established a formal process for handling allegations of the agreements. This involves investigation at department level between the Commonwealth and the relevant state.
- 7.19 The Department reports annually to the Minister for Health and Ageing on whether the states have met their obligations under the agreements. This includes a summary of the type of complaints investigated and the results of these investigations. The committee understands that, if an allegation of systematic breaches is ever substantiated, the Department will notify the Minister who can

14 Department of Health and Ageing, *The state of our public hospitals, June 2004 report (2004)* p 41; *The state of our public hospitals, June 2005 report (2005)*, p 40; *The state of our public hospitals, June 2006 report (2006)*, p 38.

15 Australian Health Care Agreements, clauses 10 to 13.

16 Australian Health Care Agreements, clause 25.

penalise the state by forfeiture of its compliance payment. The committee also understands that no such penalties have been imposed under the current AHCAs.

- 7.20 Box 7.2 gives illustrative examples of the kinds of allegations that the department has investigated under the current AHCAs, and the results of the investigation.

Box 7.2 Selected examples of alleged breaches of 2003–08 Australian Health Care Agreements

Hospital A

Allegation— Newspaper articles reported that the hospital wrote to local general practitioners (GPs) demanding that they provide their patients with private referrals to outpatient services.

Investigation outcome — The state health authority denied that the letter demanded private referrals, but provided information about the correct process if they wished to refer patients for private services. The health authority sent a replacement letter that more clearly explained the options available and provided a referral form that more clearly indicates it is for private referrals only.

Hospital B

Allegation — Claims that outpatient clinics were billing for outpatient services.

Investigation outcome — The state health authority advised that, as a result of the concerns being raised, the hospital reviewed its referral processes and is ensuring that staff are aware of the compliance requirements. Patients will only be treated privately where they hold a valid referral and choose to be treated privately.

Hospital C

Allegation — A new laboratory service was introduced with all outpatient services billed to the Medicare Benefits Schedule (MBS).

Investigation outcome — The state health authority advised that public services were available and provided data showing that a high proportion of services were being provided free of charge as public services.

Hospital D

Allegation — The hospital returns 'general referrals' to outpatient clinics to local GPs with a request that they provide private referrals.

Investigation outcome — The state health authority agreed that the hospital had been incorrectly requesting private referrals for several months, and instructed the hospital to cease the practice.

Hospital E

Allegation — Hospital billing all endoscopies to the MBS.

Investigation outcome —Hospital staff misunderstood advice from Medicare Australia about appropriate referrals and assumed that all services could be bulk-billed. Once the mistake was known, the inappropriate billing was stopped. Medicare Australia was advised so that it could determine if it would be appropriate to seek reimbursement of benefits paid.

Source Compiled by the committee based on confidential evidence from the Department of Health and Ageing.

- 7.21 The committee noted that the ‘floor’ funding level that state governments must maintain allows historical disparities between states funding to be maintained.
- 7.22 The committee also noted assessments made by the Commonwealth Grants Commission of the states’ actual expenditure on hospital related services and the expenditure required to provide the average level of services.¹⁷ The relationship between these actual and ‘required’ expenditure levels are shown in tables 7.1 and 7.2.

Table 7.1 Inpatient services, assessment results, 2004-05 (\$ per capita)

| | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Avg |
|-----------------------------|--------|--------|--------|--------|---------|--------|--------|---------|--------|
| Actual \$ per capita | 858.45 | 912.56 | 645.24 | 797.04 | 1031.34 | 639.34 | 735.71 | 1233.86 | 834.04 |
| Assessed \$ per capita | 839.93 | 797.09 | 838.58 | 815.06 | 906.93 | 863.09 | 653.88 | 1320.87 | 834.04 |
| Ratio of actual to assessed | 1.02 | 1.14 | 0.77 | 0.98 | 1.14 | 0.74 | 1.13 | 0.93 | 1.00 |

Source Department of Health and Ageing, sub 155, p 2.

17 Department of Health and Ageing, sub 155, p 1.

Table 7.2 Non-inpatient and community health services, assessment results, 2004-05 (\$ per capita)

| | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Avg |
|-----------------------------|--------|--------|--------|--------|--------|--------|--------|---------|--------|
| Actual \$ per capita | 415.09 | 342.59 | 384.02 | 515.96 | 510.31 | 794.20 | 528.75 | 810.02 | 423.19 |
| Assessed \$ per capita | 415.09 | 393.80 | 434.56 | 450.52 | 409.44 | 456.23 | 394.41 | 1004.94 | 423.19 |
| Ratio of actual to assessed | 1.00 | 0.87 | 0.88 | 1.14 | 1.25 | 1.74 | 1.34 | 0.81 | 1.00 |

Note Non-Inpatient and Community Health Services may be provided in hospitals or may substitute for hospital based services.

Source Department of Health and Ageing, sub 155, p 2.

7.23 The committee noted in particular the low level of expenditure in Queensland relative to the Commission's assessment of expenditure needed to provide services equivalent to other states.

The 'blame game'

7.24 Several inquiry participants noted that public hospital funding arrangements can lead to a 'blame game' as each level of government seeks to deflect blame for service delivery problems to the other.

7.25 The Australian Healthcare Association noted that:

The existing dual public hospital funding arrangements lead to lack of accountability (the 'blame game') and creates problems in terms of day-to-day service delivery.¹⁸

7.26 In relation to AHCAs in particular, the Combined Pensioners and Superannuants Association of NSW quoted Professor Deeble's view that:

The parties' obligations are [thus] quite different. On the Commonwealth side it is to pay money, on the State and territory side to deliver services to acceptable standards, whatever the cost. It is an arrangement guaranteed to create discord and blame-shifting.¹⁹

18 Australian Healthcare Association, sub 62, p 11.

19 Combined Pensioners and Superannuants Association of NSW Inc, sub 9, p 2.

- 7.27 The roles and responsibilities of the Commonwealth and the states are articulated in the *Health Care (Appropriation) Act 1998* and in the AHCAs.
- 7.28 The Act empowers the health minister to make grants to the states (section 4), but only if satisfied that the state is adhering to the principles (section 6) (see paragraph 7.5). The principles include access based on clinical need and within a clinically appropriate period. While there must be room for policy interpretation of the practical meaning of the principles, they should preclude imposing limits on the availability of services based on policy or funding criteria alone.
- 7.29 The AHCAs limit the Commonwealth's funding responsibility to making a contribution to the cost of public hospital services.²⁰ The formulas used to calculate this contribution recognise demand growth pressure linked to population growth and ageing and include an additional 1.7 per cent 'utilisation growth factor' applied to about 72 per cent of funds.²¹
- 7.30 This formula approach gives the Commonwealth a high level of certainty about its expenditure by passing to the states the financial risk for growth above the formula provision. This is exacerbated by the gap between the price index allowed by the Commonwealth (averaging around 2 per cent) and the actual rise in health care costs in the range of 4 – 7 per cent that the states claim to be experiencing.²² While some efficiency improvement by the states should be expected, a gap of five percentage points, if accurate, effectively discounts the proportion of demand growth risk that the Commonwealth is accepting.
- 7.31 The inconsistency between the clinical need basis of the Act, and AHCAs that transfer financial risk to the states, is at the heart of the 'blame game'. It gives both levels of government a basis for blaming the other when patients believe that Medicare's promise of access based on clinical need is not delivered.
- 7.32 The committee considers that this is an unsatisfactory arrangement as neither level of government is appropriately accountable to its electorate. This could be resolved if the Commonwealth either:

20 Australian Health Care Agreements, Clause 9.

21 Australian Health Care Agreements, Schedule E.

22 ACT Government, sub 64, p 4; Western Australian Government, sub 124, pp 13–15; Towler S, Department of Health (WA), transcript, 24 August 2006, p 34.

- varies its funding arrangements so that the ‘utilisation growth factor’ can rise or fall in response to the actual level of services provided on the basis of clinical need; or
- defines the number of services that it is willing to fund in a way that is consistent with its funding and indexation formulae.

Recommendation 13

7.33 In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government either:

- **vary its funding arrangements so that the ‘utilisation growth factor’ can rise or fall in response to the actual level of services provided on the basis of clinical need; or**
- **define the number of services that it will fund, in a way that is consistent with its funding and indexation formulae.**

Recommendation 14

7.34 In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government ensure that indexation arrangements reflect actual cost increases discounted by an appropriate efficiency dividend.

7.35 The logical approach to addressing this accountability problem would be to remove one level of government from the field. If, however, the states assumed full responsibility they could still deflect blame to the Commonwealth while they remain dependent on transfer payments from the Commonwealth.

7.36 Commonwealth accountability does not, however, inevitably lead to becoming the owner or manager of the public hospital system. The Commonwealth can be a purchaser of services as it already is for veterans, or remain a funder providing that it accepts financial risk for changes in the demand for services. In either scenario, the Commonwealth should set service delivery and quality standards while the states could continue to provide services as an agent of the Commonwealth.

7.37 Accepting funding responsibility for in-hospital services would also make the Commonwealth the beneficiary of any investments it makes

in models of care that reduce hospitalisation. This incentive for allocative efficiency is notably absent at present.

- 7.38 The committee notes the views of some respondents that incremental and cooperative reform is preferable to ‘big bang’ reforms,²³ and is also conscious that changes in governments’ roles and responsibilities have broader implications for Commonwealth-state financial relations.
- 7.39 An incremental approach is consistent with the committee’s preferred approach to developing a national reform agenda as discussed in chapter 3.
- 7.40 Another feature of the ‘blame game,’ which is referred to in chapter 5, is the accountability of governments for the closure of rural and regional hospitals, or reductions of services at such hospitals.
- 7.41 The AHCAs impose a requirement on states to ensure equitable access to public hospital services to all eligible people regardless of their geographic location. While the committee accept that this cannot mean that every town has a hospital providing a full range of services, it is concerned that the AHCAs provide no guidance about the standard of access that is needed to satisfy the principle of equitable access. States are, in effect, allowed to determine what the principle means. The committee believes this process should be more transparent.
- 7.42 The definition of appropriate service delivery standards should, however, have regard to a range of matters that are outside the scope of the current AHCAs. Issues such as the availability of private specialist services and the level of support provided through patient travel and accommodation schemes are also relevant. Development of a national health agenda as discussed in chapter 3 would provide a forum for a more integrated approach to definition of access standards.

23 Wainwright D, Australian Medical Association, transcript, 23 August 2005, p 7; Podger A, transcript, 31 May 2006, p 1; Government of South Australia, sub 117, p 1; Australian Healthcare Association, sub 62, p 9; Australian Nursing Federation, sub 39, p 18.

Recommendation 15

- 7.43 **In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government should define the standards that states must meet to satisfy the principle of equitable access to public hospital services, particularly in relation to people living in rural and regional areas.**

AHCAs as a vehicle for health reform?

- 7.44 Many inquiry participants see AHCAs as a vehicle for significant health system reform,²⁴ while others are critical of their reform credentials.²⁵
- 7.45 Previous attempts to use AHCA negotiations to initiate health reforms have had limited success. While commitments to reform have been included in AHCAs, the progress in designing and implementing reform has generally not lived up to expectations.²⁶
- 7.46 Limited progress on reform can be at least partly attributed to the amount of money involved and its impact on overall Commonwealth-State financial relations. AHCAs account for about 6 per cent of total state revenues and the funds are redistributed by being absorbed into the GST pool. This makes AHCAs, in effect, another form of general revenue assistance.
- 7.47 When governments consider their objectives for new AHCAs, health policy considerations must compete with broader fiscal relations issues. Further, any reform proposals that involve 'transfer' of funds between governments, particularly on a bilateral basis, face extra complications because of the redistribution of funds through the GST pool.
- 7.48 The committee is concerned these factors are not conducive to achieving the best health policy arrangements and reduce the scope for incremental change.

24 Australian Healthcare Association, sub 62, p 10; Australian Nursing Federation, sub 39, p 10.

25 Local Government Association of NSW and Shires Association of NSW, sub 18, p 4.

26 Duckett S, 'The Australian Health Care Agreements 2003-08', *Australia and New Zealand Health Policy* (2004), vol 1, no 5; Podger A, 'Directions for health reform in Australia', *Productive Reform in a Federal System* (2005), Productivity Commission, p 50.

Recommendation 16

- 7.49 **In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government consider dividing funds into separate streams through which it can:**
- **provide general revenue assistance to the states as a supplement to the Goods and Services Tax (GST) pool; and**
 - **make specific purpose payments to the states to support its policy objectives in relation to public hospital services and health system reform. These payments:**
 - ⇒ **should be linked to outcomes and performance standards; and**
 - ⇒ **should not be absorbed into the GST pool.**
- 7.50 The health reform objectives supported by the specific purpose payments should be consistent with the national reform agenda discussed in chapter 3.
- 7.51 While redistribution of AHCA funds through the GST pool achieves the broader objective of horizontal fiscal equalisation, this objective is also achieved in relation to other specific purpose payments (SPPs) through a different method. That is, the Commonwealth Grants Commission ‘includes’ these SPPs in its calculations to derive the per capita relativities that are used to distribute the GST pool. If the AHCAs were treated as ‘included’ SPPs rather than being ‘absorbed’ into the GST pool it would remove a possible barrier to reform of funding arrangements at the boundaries between hospital and non-hospital care.
- 7.52 The committee acknowledges that this change in equalisation methodology could have some effect on the distribution of funds between states, but considers that the option should be examined. It may also be possible to develop transitional arrangements to manage any such effects.

Recommendation 17

- 7.53 **The Australian Government should make specific purpose payments to the states and territories for the provision of public hospital services subject to horizontal fiscal equalisation using the Commonwealth Grants Commission's 'inclusion' method rather than by being absorbed into the Goods and Services Tax (GST) pool. This would require amendments to the *A New Tax System (Commonwealth -State Financial Arrangements) Act 1999*.**

Facilitating change in service delivery

- 7.54 One of the themes in the evidence presented to the committee is the constant change in clinical practice. This can mean that services drift from one setting to another, or one kind of service is substituted for another, and can result in costs moving from one funder to another.
- 7.55 Funding arrangements need to be flexible enough to respond to any such changes that improve patient care or reduce overall costs. This requires an acceptance that services can move from settings or programs funded by the states into settings or programs funded by the Commonwealth, and vice versa.
- 7.56 The AHCAs, on the other hand, commit the states to providing the range of public hospital services that were historically provided. While this is ill-defined, it can nevertheless be a barrier to the provision of appropriate services through Commonwealth funded programs.
- 7.57 For example, the integration of renal dialysis services into a Commonwealth funded aboriginal medical service would be inconsistent with the AHCAs. The agreements do provide for negotiation of arrangements in such circumstances,²⁷ but the requirement for cost-neutrality must inhibit the use of this provision.
- 7.58 While the committee accepts the need for funding adjustments between the Commonwealth and the states, this should not prevent the implementation of appropriate changes to care arrangements. If necessary, funding adjustments could be made post hoc. Where reforms affect all states, funding adjustments could be made to

27 Australian Health Care Agreements, clause 17.

general revenues assistance while bilateral reforms may need to be handled through SPPs.

Recommendation 18

7.59 The Australian Government should ensure that the terms and conditions associated with future public hospital arrangements do not lock-in historical Commonwealth-state service provision models. Future arrangements should:

- **support the movement of services between Commonwealth and state funded programs where this leads to better quality or more cost effective care; and**
- **allow post hoc adjustments to Commonwealth-state funding arrangements if necessary.**

7.60 While funding arrangements should support the movement of services away from hospital settings when this is appropriate, patients' existing right to access services free of charge should be protected wherever possible.

7.61 Many outpatient and emergency department services provided in public hospitals are equally accessible in community settings as private patient services. These are subsidised by the Commonwealth through the Medicare Benefits Schedule. This creates an incentive for states to encourage movement of services into community settings.

7.62 The Australian College for Emergency Medicine commented on this issue in the following terms:

There is some overlap in the Emergency department and General Practice patient population when the setting of care delivery is often governed by availability. This has driven such measures as attempts to divert patients from one setting to the other (especially outside of business hours), often at extra expense and without a common accountability.

We believe that the separate state and federal funding streams for these areas has not contributed positively to attempts to address this undesirable situation.²⁸

28 Australasian College for Emergency Medicine, sub 17, p 1.

- 7.63 There may, however, be advantages in services remaining in the hospital setting, particularly where integration of complex care needs or provision of training opportunities are relevant.
- 7.64 If the Commonwealth funded all of these services, the care setting is more likely to be determined by service quality and cost effectiveness issues. The committee noted that the Commonwealth already funds such services at specific locations using section 19(2) of the *Health Insurance Act 1973*.²⁹ This mechanism could be applied generally or alternative grant funding arrangements could be developed.

Recommendation 19

- 7.65 **The Australian Government consider extension of Medicare Benefits Schedule funding, or substitute grant funding, to public outpatient and emergency department services.**

Funding public hospital services after 2008

- 7.66 The current Australian Health Care Agreements (AHCAs) expire on 30 June 2008. While new agreements between the Commonwealth and the states are essential, the committee supports some divergence from the current AHCA model, as expressed in the recommendations in this chapter and some of the recommendations in chapter 9 (Improving accountability).
- 7.67 The committee has two principle objective in this area:
- to make both levels of government more accountable to the Australian people for achieving the stated objectives of the current AHCAs; and
 - to remove barriers to future reforms that have the potential to improve the quality or cost effectiveness of health services.
- 7.68 The Commonwealth's accountability for achievement of the principles set out in the *Health Care (Appropriation) Act 1998* is enhanced if its funding is more closely linked to the states' service delivery obligations (recommendations 13, 14 and 15). Accountability to the

29 Towler S, Department of Health (WA), transcript, 24 August 2006, p 33 and p 38; Council of Australian Governments, *Communique*, 10 February 2006, attachment D, p 2.

public for the performance of public hospitals is enhanced through compulsory accreditation and higher performance reporting requirements (recommendations 25 to 29 (in chapter 9)).

- 7.69 Recommendation 16 disentangles the AHCA's current function of providing general revenue assistance to the states from their other functions of setting public hospital service standards, performance indicators and accountability requirements. The adoption of this recommendation would allow health ministers to develop the national health agenda based on health policy and health outcome considerations alone. Governments will still have to regularly review the aggregate level of Commonwealth transfer payments to the states, but this is a whole-of-government issue that is best separated from Commonwealth-state negotiations about health specific funding arrangements.
- 7.70 Incremental reform, particularly on a bilateral basis, would be complicated by the current method for achieving horizontal fiscal equalisation. Similarly, adherence to a historical definition of 'public hospital services' that cannot be funded through Commonwealth programs imposes an inappropriate constraint on reform. The adoption of recommendations 17 and 18 remove these barriers to health reform.
- 7.71 In recommendation 19 the committee proposes an immediate change in Commonwealth-state funding responsibilities in relation to outpatient and emergency department services. These services are mostly substitutable for services funded through the Medicare Benefits Schedule and other Commonwealth programs. There are, therefore, incentives to move these services away from hospital settings even if this does not improve patient care or access.

Private health

... one of the things that is often overlooked is just how significant the private health insurance sector is in terms of total funding. If you look at how much health funds pay collectively around the nation, they actually pay as much for hospital services as any state government. Last year health funds paid more as an industry than the government of New South Wales, which was the biggest payer of hospital services.¹

Private health sector

- 8.1 The private health sector makes an important contribution to the Australian health system, complementing services provided in the public sector and providing choice for patients. It is closely integrated with the public sector in many ways, and changes in policy in the public or private sector can have significant flow-on effects to other parts of the health system.
- 8.2 Private sector participation in the Australian health system encompasses a wide range of services delivered by health professionals (for example, doctors, dentists and physiotherapists) under fee for service arrangements. In this chapter, the committee has concentrated on that part of the private sector covering private health

¹ Australian Health Insurance Association, private briefing 15 June 2005.

insurance and those providers mainly delivering services in a private hospital setting.

- 8.3 This chapter specifically addresses the terms of reference that require the committee to give particular consideration to how to best ensure that a strong private sector can be sustained into the future and identify innovative ways to make private health insurance a still more attractive option.
- 8.4 During the course of the inquiry, the Commonwealth has announced a number of significant reforms affecting private health insurance and the role of private hospitals. These changes are broadly supported by the committee and will play a role in strengthening the private sector.

Private hospitals

- 8.5 Private hospitals in Australia treat almost four in every ten hospital patients (39 per cent of all separations), with around 2.7 million separations in 2003-04.² The number of patients treated in private hospitals has increased by over 30 per cent in the past 10 years, with most of the increase from same-day patients in acute and psychiatric hospitals (table 8.1).

Table 8.1 Private hospital separations, 1994-95 to 2004-05 ('000)

| | 1994-95 | 1999-00 | 2000-01 | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
|--|----------------|--------------|----------------|----------------|----------------|----------------|----------------|
| Free standing day hospital facilities | 189.9 | 349.0 | 393.8 | 433.3 | 471.7 | 505.6 | 537.5 |
| Private acute and psychiatric - same day | 465.0 | 857.0 | 956.0 | 1,092.0 | 1,104.0 | 1,126.0 | 1,209.0 |
| Private acute and psychiatric - overnight stay | 4,957.0 | 5,375.0 | 5,569.0 | 5,703.0 | 5,644.0 | 5,697.0 | 5,590.0 |
| Total | 5,611.9 | 6,581 | 6,918.8 | 7,228.3 | 7,219.7 | 7,328.6 | 7,336.5 |

Source Australian Bureau of Statistics, *Private Hospitals, Australia (2006)*, Cat No 4390.0, July.

- 8.6 In 2004-05, there were 532 private hospitals operating in Australia, including 259 acute hospitals, 26 psychiatric hospitals and 247 free standing day hospitals.³ Almost two-thirds of private acute and

2 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2004-05 (2006)*, p 17.

3 Australian Bureau of Statistics, *Private Hospitals, Australia (2006)*, pp 21, 35.

psychiatric hospitals and 74 per cent of available beds were in capital cities.⁴

- 8.7 Not all private acute and psychiatric hospitals are operated on a for-profit basis — 30 per cent are operated by religious or charitable organisations and 14 per cent comprise bush nursing, community and memorial hospitals.⁵
- 8.8 Ownership structure can significantly affect the operation of private hospitals. Not-for-profit operators generally have a lower obligation to provide information about their operations and are exempt from income tax. Not-for-profit operators may also be exempt from some local government rates and be able to access fringe tax benefit exemptions for salary packaging purposes.⁶
- 8.9 The Australian Private Hospitals Association provided the committee with a broad outline of the hospital services provided by private hospitals compared to the public sector:
- 56 per cent of all surgery
 - 77 per cent of knee procedures
 - 71 per cent of Major wrist/hand/thumb procedures
 - 68 per cent of same day mental health treatment
 - 55 per cent of hip replacements
 - 52 per cent of chemotherapy
 - 46 per cent of all cardiac valve procedures
 - 42 per cent of all coronary bypass operations.⁷
- 8.10 In 2004-05, private hospitals received income of \$6.6 billion, 95 per cent of which was derived from patients (or their health funds).⁸ The profitability of private acute and psychiatric hospitals sector has generally been low in recent years, with operating margins averaging around 6 per cent. This does not represent a significant return on the capital invested in these facilities considering that relatively risk free assets such as 10-year government bonds have returned an average of 5.6 per cent since June 2001.⁹ Higher operating

4 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), p 21.

5 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), p 22.

6 Australian Health Service Alliance, sub 5, p 2; Australian Health Insurance Association, sub 16, pp 32–33; Moore D, City of West Torrens (SA), transcript, 2 May 2006, pp 40–41.

7 Australian Private Hospitals Association, sub 24, p 2.

8 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), p 9.

9 Reserve Bank of Australia, Bulletin statistical tables: Financial Markets(F Tables), Capital Market Yields – Government Bonds - Monthly - F2, viewed on 8 November 2006 at www.rba.gov.au/Statistics/Bulletin/F02hist.xls.

margins have been achieved in free standing day hospital facilities, which have averaged around 17 per cent since 1999-00.¹⁰

- 8.11 The trend in capital expenditure by private hospitals has not directly reflected the increase in activity in recent years, with annual investment averaging around \$350 million for acute and psychiatric hospitals and \$23 million for free standing day hospital facilities.¹¹
- 8.12 In 2004-05, private hospitals employed over 48,500 full time equivalent staff, with almost 95 per cent employed in acute and psychiatric hospitals and the remainder in free standing day hospitals.¹²
- 8.13 A report commissioned by the Australian Private Hospitals Association on education and training activities by private hospitals found that the sector as a whole would spend at least \$36 million each year on providing education and training, with only \$1 million of this funding effort recovered by way of fees.¹³ The majority of programs offered (65 per cent) were for nursing students and staff. Medical programs and allied health programs accounted for 18 per cent and 17 per cent of programs respectively.¹⁴

Private health insurance

- 8.14 Private health insurance was introduced in 1953 for hospital and medical benefits. The nature of private health insurance has altered several times, mainly reflecting the introduction of universal health insurance coverage via Medibank in 1975 and subsequent adjustments to private health insurance policies.¹⁵
- 8.15 As at June 2006, more than 8.8 million Australians were covered by private health insurance for hospital treatment.¹⁶ Private health

10 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), p 7.

11 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), pp 20, 34.

12 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), pp 20, 34.

13 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals and day surgeries* (2005), Report to the Australian Private Hospitals Association.

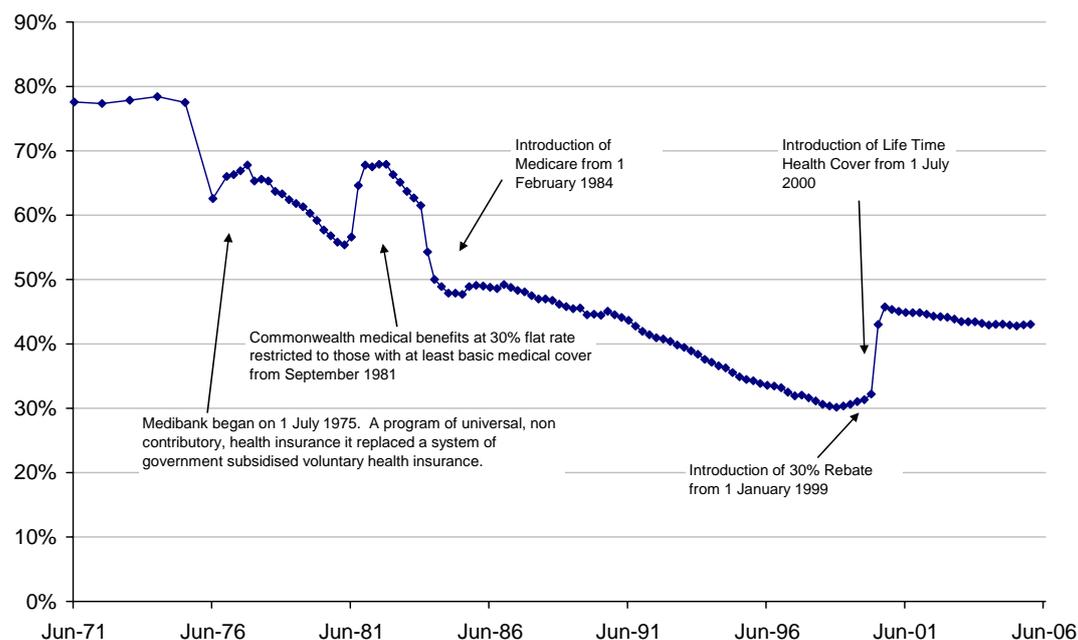
14 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals and day surgeries* (2005), Report to the Australian Private Hospitals Association.

15 Department of the Parliamentary Library, *Australian Health Insurance Arrangements 1969 to 5 March 1983*, Basic Paper No. 14; Duckett S, *The Australian Health Care System* (2004), pp 295-296.

16 Private Health Insurance Administration Council, Industry Statistics, Statistical Trends Membership and Benefits Statistics, viewed on 3 October 2006 at www.phiac.gov.au/statistics/trends/index.htm.

insurance coverage has increased significantly in recent years in response to a range of initiatives to boost membership, including the introduction of Life Time Health Cover on 1 July 2000 — which encourages people to take out private health insurance earlier in life to avoid paying an extra 2 per cent for each year they remain uninsured after their 31st birthday (figure 8.1).

Figure 8.1 Proportion of population covered by private hospital insurance, 1971–2006



Source *Private Health Insurance Administration Council, Industry Statistics, Statistical Trends Membership and Benefits Statistics, viewed on 3 October 2006 at www.phiac.gov.au/statistics/trends/index.htm.*

- 8.16 The Commonwealth government has made a significant contribution to private health insurance since January 1999 through a 30 per cent rebate on the cost of premiums (increased in 2005 to 35 per cent for people aged 65 to 69 and 40 per cent for people aged 70 and over). In 2004-05, the cost of the rebate was around \$2.5 billion, or around \$1,000 a year to a privately insured average family.¹⁷
- 8.17 Another Commonwealth government policy to encourage people to take out private health insurance is the Medicare surcharge, which was introduced in July 1997. The surcharge applies to singles earning more than \$50,000 per annum and couples and most families earning more than \$100,000 per annum who do not choose to have private

17 Australian Institute of Health and Welfare, *Australia's Health 2006* (2006), p 310; Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Private health cover increases again*, 15 August 2006.

hospital insurance. The surcharge is an additional 1 per cent of taxable income above the normal 1.5 per cent Medicare levy.

- 8.18 The proportion of different segments of the population covered by private health insurance is uneven, with differences according to age, place of residence and income levels.¹⁸ In regional areas, there are fewer incentives to take out private health insurance due to the lack of private providers, including private hospitals and other allied health professionals.¹⁹ MBF Australia noted that private health insurance was purchased by people on a wide range of income levels:

The latest [Australian Bureau of Statistics] survey confirmed that more than 1 million people on household incomes less than \$18,200 per annum have private health insurance, 2.3 million on household incomes less than \$33,000 are privately insured. Almost half of the insured population have gross household incomes less than \$51,000. So nearly 4 million people with hospital cover earn less than average weekly earnings.²⁰

- 8.19 Community rating has long been a central feature of private health insurance in Australia. Unlike other insurance products, health insurance is not related to individual risk. The principle of community rating is that persons should not be discriminated against in obtaining or retaining hospital coverage. In setting premiums or paying benefits, funds cannot discriminate in relation to a member on the basis of health status, age, race, sex, sexual orientation, and use of hospital, medical or ancillary services or general claiming history.²¹
- 8.20 Private health insurance may cover all hospital accommodation and care expenses or the patient may have to pay a gap (or an out-of-pocket cost). The amount the patient will have to pay will depend upon the type of cover they have purchased and whether the doctor and/or hospital and health fund have a gap agreement or gap cover scheme in place.
- 8.21 Hospital cover can only cover the costs of services provided when patients are admitted to hospital. Where medical services are

18 Australian Bureau of Statistics, *National Health Survey: Summary of results (2006)*, Cat No 4364.0, p 67.

19 Catholic Health Australia, sub 25, p 33; McCafie G, Australian Council of Social Services, transcript, 21 September 2005, p 66; Combined Pensioners and Superannuants Association of NSW, sub 9, p 10; MBF Australia Limited, sub 29, p 11.

20 MBF Australia Limited, sub 29, p 11.

21 Department of Health and Ageing, sub 43, p 25.

provided on a non-admitted basis such as outpatient services, patients are responsible for paying the gap between whatever the doctor charges and the Medicare benefits schedule rate.

- 8.22 There are around forty registered health insurance funds operating in Australia, of which 14 have restricted membership — only allowing membership to people who belong to a particular organisation or community. Only four funds operate on a for-profit basis, with the remaining funds using any surpluses generated for the benefit of contributors (box 8.1).²²

Box 8.1 Private health insurance funds

Open funds – not-for-profit

Australian Health Management Group
 Cessnock District Health Benefits Fund
 Credicare Health Fund Limited
 GMHBA
 HBF Health Funds
 Health Insurance Fund of W.A.
 Central West Health
 Health-Partners Inc
 Hospitals Contribution Fund of Australia
 Latrobe Health Services
 Manchester Unity Australia
 MBF Australia Limited
 Medibank Private
 Mildura District Hospital Fund
 N.I.B. Health Funds
 Queensland Country Health
 St Luke's Medical & Hospital Benefits Association
 United Ancient Order of Druids Friendly Society
 Westfund
 CY Health
 GMF Health

Restricted funds – not-for-profit

ACA Health Benefits Fund
 CBHS Friendly Society
 Defence Health
 Health Care Insurance
 Lysaght Peoplecare
 Navy Health
 Phoenix Health Fund
 Qld Teachers' Union Health Fund
 Railway & Transport Health Fund
 Reserve Bank Health Society
 SA Police Employees' Health Fund
 Teachers Federation Health
 The Doctors' Health Fund
 Transport Health

Open funds - For-profit

Australian Unity Health
 BUPA Australia Health
 Grand United Corporate Health
 MBF Alliances

Source: Private Health Insurance Administration Council, Registered Health Benefits Organisations Operating in Australia, viewed on 15 November 2006 at www.phiac.gov.au/healthfunds/list.htm.

22 Department of Health and Ageing, sub 43, p 22.

- 8.23 Consumer choice of health funds is limited due to the high concentration of membership (six funds holding approximately 76 per cent of the market), the number of closed membership funds and the strong regional focus of some funds. The Department of Health and Ageing noted that only one fund operates on a national basis.²³
- 8.24 The Department of Health and Ageing manages a number of regulatory issues including the assessment of the annual premium increases requested by health funds. The premium round process requires health funds to justify their premium increases to the government. This is now done at around the same time each year and announced in March. Each health fund makes a submission to the Minister for Health regarding their proposed premium increases.²⁴
- 8.25 The Private Health Insurance Administration Council closely scrutinises these submissions and the Department of Health and Ageing provides advice to the Minister on the submissions. The *National Health Act 1953* (the Act) only allows the Minister for Health to disallow an increase for the following reasons:
- might result in a breach of the Act or conditions of registration;
 - imposes an unreasonable or inequitable condition affecting the rights of contributors;
 - adversely affects the financial stability of the fund; or
 - is contrary to the public interest.²⁵
- 8.26 The committee noted that an application for a rise in premiums has been disallowed on only one occasion.²⁶
- 8.27 Health funds purchase health services from a range of providers. The majority of benefits are directed to private hospitals, which have experienced a declining share of total fund benefits over time (figure 8.2).

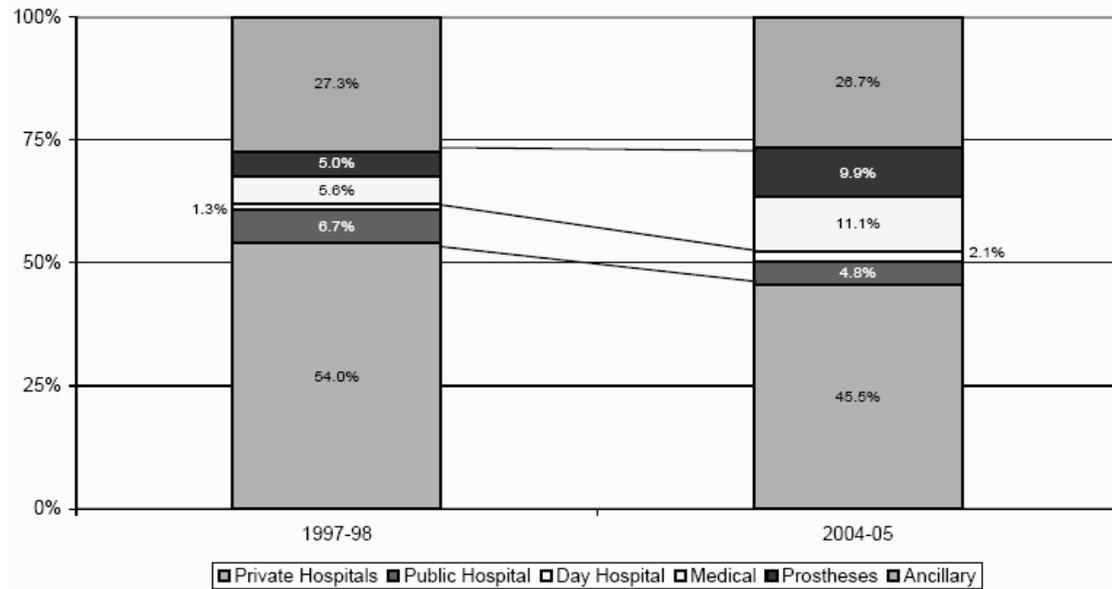
23 Department of Health and Ageing, sub 43, p 23.

24 Department of Health and Ageing, sub 43, p 26.

25 Department of Health and Ageing, sub 43, p 26.

26 Hon Michael Wooldridge, Minister for Health, media release, *Minister moves to guard consumers against health insurance premium rises*, 28 March 2001.

Figure 8.2 Private health fund payments, 1997-98 to 2004-05



Source *Private Health Insurance - policy issues, Presentation to PHIAC Directors Education Program Linda Addison, Assistant Secretary Private Health Insurance 21 February 2006, viewed on 12 October 2006 at www.phiac.gov.au/publications/presentations/melbfeb06/addison.pdf.*

8.28 Despite the significant increase in private health insurance membership since July 2000 the overall profitability of the industry has remained relatively unchanged, with the value of benefits paid to members increasing largely in line with total income (table 8.2).

Table 8.2 Private health insurance fund finances, 1999-00 to 2004-05

| | 1999-00 | 2000-01 | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
|--|---------|---------|---------|---------|---------|---------|
| Contribution income (\$m) | 5,462 | 7,132 | 7,265 | 7,885 | 8,637 | 9,384 |
| Investment and other income (\$m) | 214 | 226 | 66 | 194 | 296 | 373 |
| Total income (\$m) | 5,676 | 7,358 | 7,331 | 8,079 | 8,933 | 9,757 |
| Benefits (\$m) | 4,578 | 5,663 | 6,558 | 7,055 | 7,630 | 8,238 |
| Management expenses/other (\$m) | 717 | 843 | 805 | 829 | 852 | 893 |
| Expenditure (\$m) | 5,295 | 6,506 | 7,363 | 7,884 | 8,482 | 8,928 |
| Surplus/deficit (\$m) | 381 | 852 | -32 | 196 | 447 | 626 |
| Surplus/deficit as % of contribution income | 7.0% | 11.9% | -0.4% | 2.5% | 5.2% | 6.8% |
| Contribution income growth (%) | 10.9% | 30.6% | 1.9% | 8.5% | 9.5% | 8.7% |
| Benefits growth (%) | 6.2% | 23.7% | 15.8% | 7.6% | 8.2% | 8.0% |
| Proportion of contribution income returned as benefits (%) | 84% | 79% | 90% | 89% | 89% | 88% |

Source Department of Health and Ageing, submission 43, p 23; updated for 2004-05 from Private Health Insurance Administration Council, Operations Of The Registered Health Benefits Organisations Annual Report 2004-05 (2005).

Making private health insurance more attractive

8.29 A range of policies have successfully increased the number of people covered by private hospital insurance by 3.2 million since December 1998, with the proportion of the population covered rising from 30.2 per cent to 43 per cent.²⁷

8.30 Since the inquiry commenced the Commonwealth has implemented a number of policy changes and announced several budget initiatives to make private health insurance more attractive. Since March 2005, the number of people covered by private hospital insurance increased by 140 000 people, with the proportion of the population covered by private hospital insurance rising from 42.9 per cent to 43 per cent.²⁸

8.31 Notwithstanding the success these policies to make private health insurance attractive to the community— it is clear that there are several challenges to attracting new people to take out private health

27 Private Health Insurance Administration Council, Industry Statistics, Statistical Trends Membership and Benefits Statistics, viewed on 12 October at www.phiac.gov.au/statistics/trends/index.htm.

28 Private Health Insurance Administration Council, Industry Statistics, Statistical Trends Membership and Benefits Statistics, viewed on 12 October at www.phiac.gov.au/statistics/trends/index.htm.

cover and retain existing health insurance fund members. These include concerns by health fund members about out-of-pocket costs and rising premiums.

- 8.32 While there is not universal support for the continuation of the private health insurance rebate in its current form,²⁹ many inquiry participants noted its effectiveness in making private health insurance more affordable and its contribution to maintaining the coverage of private health insurance among the population.³⁰ A health fund member's response to the Australian Health Insurance Association noted that:

My wife and I are self-funded retirees who have relied heavily on private health insurance (name of fund) for oncology services during [my wife's] treatment for non-Hodgkin's lymphoma during the past five years. We have received the 30 per cent rebate from its introduction, enabling us to continue to remain with the private health system since joining (fund) on 14 August 1959. That we received a rebate of \$995 on the premium of \$3318 paid last financial year guaranteed that we could continue with private health insurance.³¹

- 8.33 The committee considers that the private health insurance rebate remains essential in making private health insurance more affordable and supports its retention to make private health insurance more affordable.

Recent policy changes

- 8.34 There have been a number of major policy changes and initiatives relating to private health insurance since the inquiry commenced (box 8.2).

29 Combined Pensioners and Superannuants Association of NSW, sub 9, p 7; Australian Council of Social Service, sub 25, p 5; City of Darebin (Vic), sub 34, p 4; Marion O'Shea, sub 89, p 2.

30 Catholic Health Australia, sub 35, p 3; Australian Private Hospitals Association, sub 24; pp 3-4; Australian Health Insurance Association, sub 16, pp 40-42.

31 Australian Health Insurance Association, sub 16, p 41.

Box 8.2 Private health insurance related reforms and initiatives, 2005–2006

Rebate increase— From April 2005, the private health insurance rebate increased to 40 per cent for people aged 70 years or older and to 35 per cent for people aged from 65 to 69 years.³²

Strengthening the powers of the Private Health Insurance Industry Ombudsman— From July 2006, the powers of the Ombudsman were extended to cover the investigation and resolution of consumer complaints about the services they receive from their private health insurance.³³

Strengthening the portability of health insurance — From December 2005, people transferring between health insurance funds were no longer required to re-serve their waiting periods.³⁴

Supporting better consumer information about private health insurance —Health funds will be required to publish standard information that will include premiums, waiting periods, exclusions, hospital and medical gaps, and excesses. A website will be developed and managed by the Ombudsman to allow consumers to make product comparisons.³⁵

Improvements to products: Broadening coverage to out of hospital services — From April 2007, health funds will be able to offer products that cover a broader range of health care services that do not require admission to hospital but which are part of an episode of hospital care or substitute for or prevent hospitalisation.³⁶

Rewarding loyalty for long term private health insurance members — From July 2010, people who have a Lifetime Health Cover loading and who have held private health insurance with a loading for ten years continuously, will have their loading removed.³⁷

Consolidation of regulatory framework — The current legislative framework will be consolidated as far as possible into a single Private Health Insurance Act. The focus will be on regulating private health insurance products, rather than the activities of health funds as is now the case. It is expected that the new Act will commence in November 2007.³⁸

Improved risk equalisation arrangements — From 1 April 2007, new risk equalisation arrangements will operate to improve the level of risk sharing between funds; to protect small funds from catastrophic claims; and to remove an existing financial penalty on single parents.

32 Hon Tony Abbott MP, Minister for Health, media release, *Private Health Insurance Rebate increases today for older Australians*, 1 April 2005.

33 Hon Tony Abbott MP, Minister for Health, media release, *New powers for the Private Health Insurance Ombudsman*, 9 November 2005.

34 Hon Tony Abbott MP, Minister for Health, media release, *Private health insurance: more portable*, 1 December 2005.

35 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Greater choice in private health*, 9 May 2006.

36 Department of Health and Ageing, sub 143, p 5.

37 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Greater choice in private health*, 9 May 2006.

38 Department of Health and Ageing, sub 143, p 6.

The new arrangements will be sufficiently flexible to incorporate the introduction of cover for broader health care services.³⁹

Assessing applications for premium increases — Under the proposed consolidated private health insurance legislation, applications for premium increases must be approved unless the Minister is satisfied that the proposed change would be contrary to the public interest. The Government will issue guidance on the factors to be taken into account by the Minister in exercising this power.⁴⁰

Uniform quality standards for privately insured services — From July 2008, uniform safety and quality standards will apply to privately insured services to ensure services are provided by suitably qualified providers and in accredited facilities. The standards will be developed with the private health industry and the Australian Commission on Safety and Quality in Health Care.⁴¹

- 8.35 Inquiry participants nominated several of these areas as requiring reform, including broadening the coverage of private health insurance to out of hospital services, strengthening portability and providing better information to consumers about health insurance products.⁴²
- 8.36 The committee supports these changes, which should have the effect of making private health insurance more attractive. While the Department of Health and Ageing has undertaken some modelling to determine the likely effects of a number of these changes on the proportion of the population, the purpose of the proposed changes is to provide value to consumers, improve competition in the industry, and ensure the sustainability of the sector.

Addressing private health insurance cost drivers

- 8.37 Despite strong government support for private health insurance, the attractiveness of private health insurance products is likely to be significantly affected by the quantum of future price increases. In recent years, private health insurance premiums have risen at a faster

39 Department of Health and Ageing, sub 143, p 6.

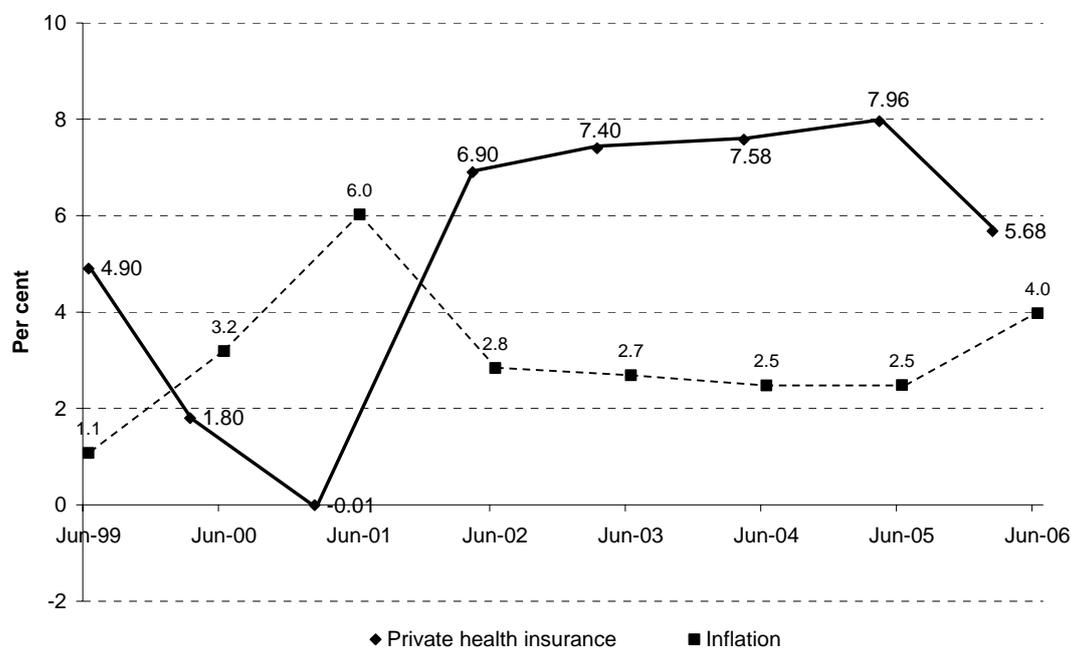
40 Department of Health and Ageing, *Private Health Insurance Bill 2006: Guide to the exposure draft* (2006), p 6.

41 Department of Health and Ageing, sub 143, p 7.

42 Australian Health Insurance Association, sub 16, pp 2–3; Health Insurance Restricted Membership Association of Australia, sub 6, p 3; Fitzgibbon M, NIB Health Funds, transcript, 20 July 2006, p 70; Health Group Strategies, sub 116, p 49; Australian Private Hospitals Association, sub 24, p 12; Strategic Planning Group for Private Psychiatric Services, sub 20, p 28; Hopkins H, Consumers' Health Forum of Australia, transcript, 21 September 2005, p 18.

rate than inflation, which has averaged 3.1 per cent per year since June 1999 (figure 8.3).⁴³

Figure 8.3 Average private health insurance premium increases, June 1999 to June 2006



Source Minister for Health media releases, 1 June 1999, 16 February 2000, 8 March 2001, 26 February 2002, 14 March 2003, 27 February 2004, 2 March 2005 and 24 February 2006.

8.38 Premium increases, however, are not entirely related to the rising cost of services. They also reflect changes in the average number and mix of services per member.

8.39 The Australian Health Insurance Association told the committee that:

... all of the studies that have been done indicate that, when premiums are somewhere between three per cent and 3.5 per cent of average weekly earnings, people seem to be prepared to pay that. In fact, our membership numbers are growing. They have grown consistently in the last nine or so months. But if one looks at surveys, there is clearly a red alert from members about the costs of private health insurance.⁴⁴

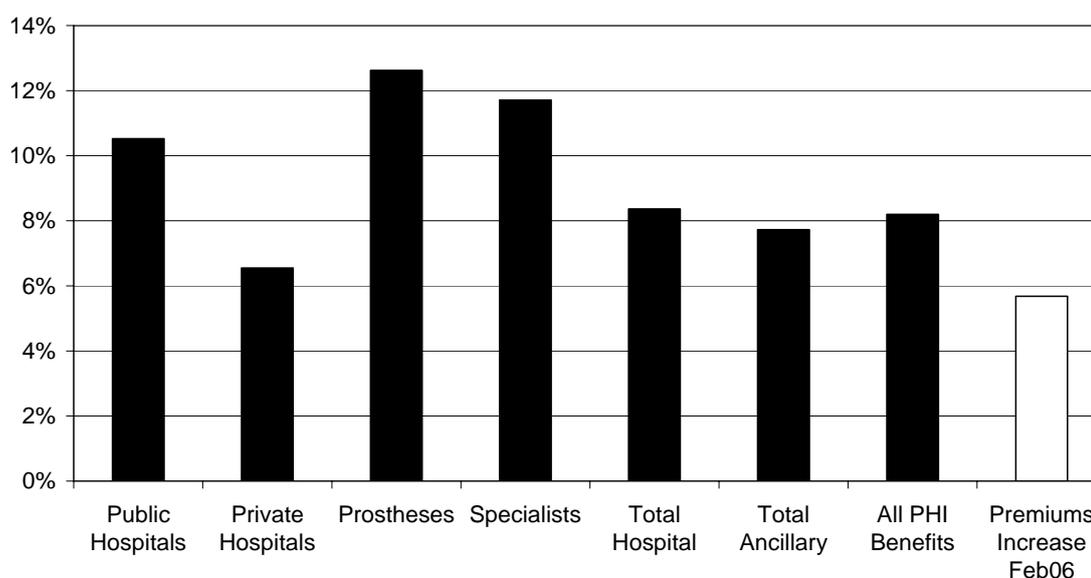
8.40 Effective strategies to address the drivers of rising private health insurance premiums are necessary to ensure that the private sector remains strong.

43 Australian Bureau of Statistics, *Consumer Price Index, Australia* (2006), Cat No 6401.0, July, p 9.

44 Armitage M, Australian Health Insurance Association, transcript, 4 September 2006, p 27.

8.41 The Australian Health Insurance Association noted that there were several categories that contributed most to premium increases in 2005, with the most significant being prostheses, specialists and payments to public hospitals (figure 8.4).

Figure 8.4 Annual change on private health insurance (PHI) fund benefits paid, Year ending March 2006 (per cent)



Source Australian Health Insurance Association, sub 156, p 2.

8.42 Strategies to address the major areas of expenditure growth suggested by health funds include:

- deregulation of health insurance products to expand opportunities to provide services that substitute for, or prevent, in-hospital treatment (see previous discussion on private health insurance industry reforms);⁴⁵
- supporting appropriate billing systems to allow true simplified billing;⁴⁶
- improving the quality and safety of care to provided to reduce avoidable infections and readmissions;⁴⁷

45 Health Insurance Restricted Membership Association of Australia, sub 6, p 3; Australian Health Insurance Association, sub 16, p 26; Fitzgibbon M, NIB Health Funds, transcript, 20 July 2006, p 70; MBF Australia Limited, sub 29, pp 24–25; Australian Divisions of General Practice, sub 15, p 6.

46 MBF Australia Limited, sub 29, p 26.

47 Australian Health Insurance Association, sub 16, p 26.

- more rigorous clinical and economic prostheses list, as well as indications and restrictions on use;⁴⁸
- strengthening informed financial consent and providing greater information to patients about doctors' gap fees;⁴⁹ and
- encouraging greater competitive tension between health funds and private hospitals by supporting broader provision of information on the part of private hospitals and changing the floor for contract negotiations by abolishing or changing the requirements for qualifying for 2nd tier status.⁵⁰

- 8.43 As previously discussed, the committee supports the Commonwealth's reforms to broaden the coverage of private health insurance to offer products that cover a broader range of health care services.
- 8.44 While arrangements for broader coverage are still under consideration, the committee is concerned about the potential for quality of care to be compromised if care is provided outside of a hospital setting. It is important that the final arrangements are based on providing appropriate services that include equivalent safety and quality standards that are required for similar services in hospitals.
- 8.45 To address the rising costs of prostheses, the Australian Health Insurance Association suggested that there should be a more rigorous assessment process prior to widespread use,⁵¹ noting that:
- If 25 per cent of these joint replacements are going wrong, we would like to see that changed quite specifically—particularly when that is not impossible from other examples that we see when we look around the world. The frequently quoted example is Sweden. They have had a joint replacement registry for over 25 years and their similar joint replacement requirement is seven per cent, not 25 per cent. Every time the percentage of revisions comes down by one per cent, the system saves \$15 million plus. If we had the same joint revision rate as Sweden, I have seen it quoted that we would

48 MBF Australia Limited, sub 29, p 26; Armitage M, Australian Health Insurance Association, transcript, 4 September 2006, p 24.

49 MBF Australia Limited, sub 29, p 26.

50 Australian Health Insurance Association, sub 16, p 3; MBF Australia Limited, sub 70, p 25.

51 Australian Health Insurance Association, sub 16, p 3.

save in the vicinity of \$75 million to \$150 million. That is clearly a significant saving.⁵²

8.46 The National Joint Replacement registry recently noted that a one percentage point reduction in the rate of revisions for joint replacements (equivalent to around 1,200 per year) would save in the order of \$16–\$32 million per year.⁵³ Some of the proposals to improve the outcomes of joint replacement surgery included:

- the development of clinical guidelines by the orthopaedic profession for joint replacement surgery; and
- a re-evaluation of the regulatory activities governing hip and knee replacement prostheses in Australia to be based on proven clinical advantage of new prostheses.⁵⁴

8.47 The committee supports efforts to increase the understanding of the outcomes of using different types of prostheses through registers such as the Australian Orthopaedic Association National Joint Replacement Registry. While the Therapeutic Goods Administration assesses new prostheses for their safety, an assessment of the cost effectiveness of new medical devices is not undertaken.

8.48 The committee sees significant merit in extending to prostheses an outcomes-based assessment framework that leads to the timely use of cost-effective prostheses.

Recommendation 20

8.49 **The Australian Government introduce an outcomes-based assessment process that:**

- **examines the clinical benefits of new prostheses prior to their widespread use in Australia; and**
- **reviews the effectiveness of prostheses currently in use.**

52 Armitage M, Australian Health Insurance Association, transcript, 4 September 2006, p 24.

53 Graves S and V Wells, 'A review of joint replacement surgery and its outcomes: appropriateness of prostheses and patient selection', prepared for the for The Australian Centre For Health Research Ltd, October 2006, p 7.

54 Graves S and V Wells, 'A review of joint replacement surgery and its outcomes: appropriateness of prostheses and patient selection', prepared for the for The Australian Centre For Health Research Ltd, October 2006, p 9.

Unexpected out of pocket expenses

- 8.50 People are concerned about their out-of-pocket costs for medical services, particularly when these are unexpected.⁵⁵ Unexpected costs can reduce the attractiveness of private health insurance.
- 8.51 There are three ways in which privately insured people can incur out-of-pocket (or 'gap') expenses when they go to hospital and it is possible for a patient to have out-of-pocket expenses arising in any or all of these ways:
- on doctors' fees for medical services;
 - because they have a health insurance product which involves some risk-sharing; and/or
 - on hospital accommodation charges, if their health fund does not have a contract with the private hospital to which they are admitted.⁵⁶
- 8.52 In 2004-05 the average payment by patients where a gap was paid was \$103.98.⁵⁷ In the March quarter 2006, around 82.6 per cent of in-hospital medical services were provided to patients with no out-of-pocket costs, with a further 5.3 per cent of services were provided with a known gap.⁵⁸ Both the size of the average gap paid and the proportion of services where gaps are not paid have increased in recent years (figure 8.5).

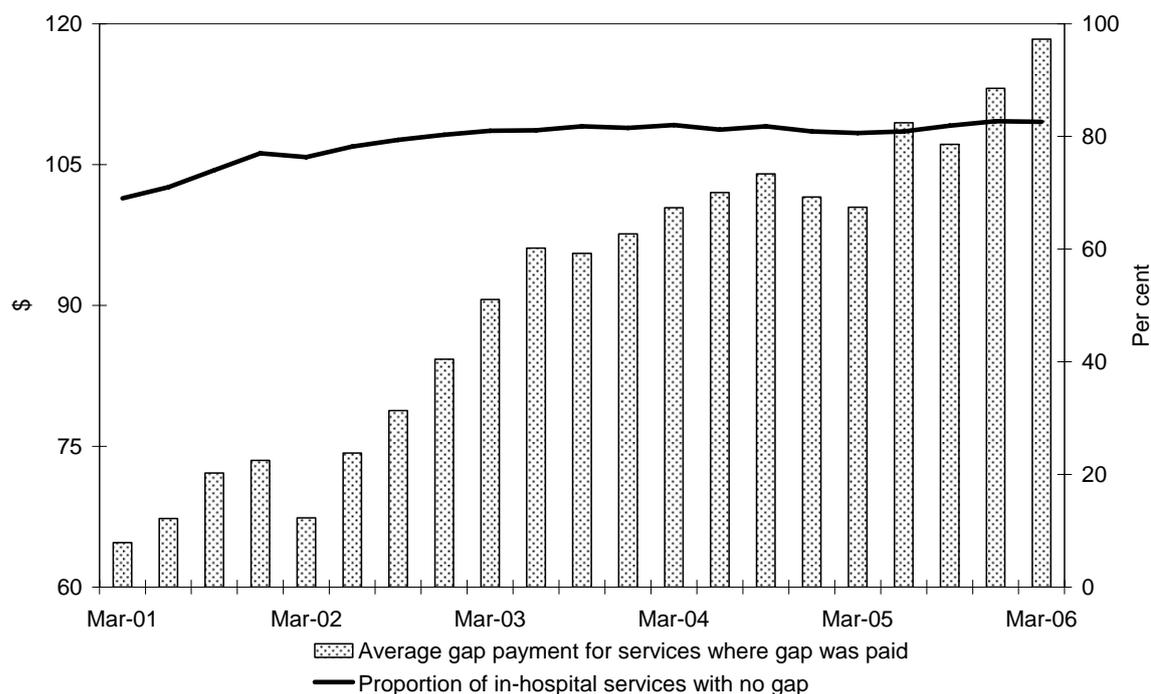
55 Brown D, sub 125, pp 2-4; Australian Health Insurance Association, sub 16, p 30; Health Insurance Restricted Membership Association of Australia, sub 6, p 4; Private Health Insurance Ombudsman, sub 75, pp 6-7; MBF Australia Limited, sub 70, p 4;

56 Department of Health and Ageing, sub 43, p 33.

57 Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2004-05* (2005), p 50.

58 Private Health Insurance Administration Council, *Industry Statistics, Medical gap for insured in-hospital services – March quarter 2006*, viewed on 25 July 2006 at www.phiac.gov.au/statistics/medicalgapinfo/gapmar06/index.htm.

Figure 8.5 Medical gap for insured in-hospital services, March 2001 to March 2005



Source *Private Health Insurance Administration Council, Industry Statistics, Information on Gap Services and Payments, viewed on 26 July 2006 at www.phiac.gov.au/statistics/medicalgapinfo/index.htm.*

8.53 Some gap cover arrangements permit doctors to charge patients an out-of-pocket cost over and above what the health fund will cover. However, the level of cost to be borne by the patient will be controlled by the terms of the gap cover arrangements in place between the doctor and the health fund. Where doctors are not participating in gap cover arrangements at all, there is no control over what they can charge and therefore no limit on what the patient might have to pay out of their own pocket.

8.54 In some cases consumers can misinterpret as a 'gap' payment the out-of-pocket expenses they are required to bear through taking out an insurance policy that offers reduced benefits in return for a lower premium. For example, some products require a one-off 'excess' payment or a daily co-payment towards the cost of hospital treatment, or may exclude or restrict the level of benefits payable by the health fund for certain services.⁵⁹

59 Department of Health and Ageing, sub 43, p 33.

8.55 The Consumers' Health Forum of Australia told the committee that:

A person who has decided to hold onto their private health insurance often does not really test out how well it is going to work for them until they have to use it. It has been a big concern that, having held on, they then often get surprise gap payments that were rather more than they expected. These can result from not having the right health cover. Maybe they took it out a long time ago or maybe the health cover has changed and they do not know all of the exclusions that now exist.⁶⁰

8.56 It is important that holders of private health insurance regularly review the level of benefits for which they are covered. As part of a 2006-07 budget initiative, health funds would be required to provide consumers with standard product information for each product they sell and the Private Health Insurance Ombudsman will be funded to create a new website to provide consumers with information that makes it easier to compare health funds and the products they sell.⁶¹

8.57 The 2006-07 Budget also included additional funding for information campaigns to raise public awareness of the benefits private health insurance, including an ongoing direct marketing campaign targeting consumers who, from 1 April 2007, face deadlines under Lifetime Health Cover.⁶²

8.58 The committee considers that it is important that these campaigns include a component that adequately informs consumers about the need to evaluate the type of health cover that they have purchased on a regular basis.

8.59 The benefits to be paid by health funds towards hospital accommodation charges are agreed under contract between individual health funds and individual hospitals. Generally, a patient's hospital accommodation charges will be fully covered if they are treated in a hospital that has a contract with their health fund. However, if a patient is treated in a hospital that does not have a contract with their health fund, the patient may encounter a significant out-of-pocket cost.

60 Hopkins H, Consumers' Health Forum of Australia, transcript, 21 September 2005, p 18.

61 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Greater choice in private health*, 9 May 2006.

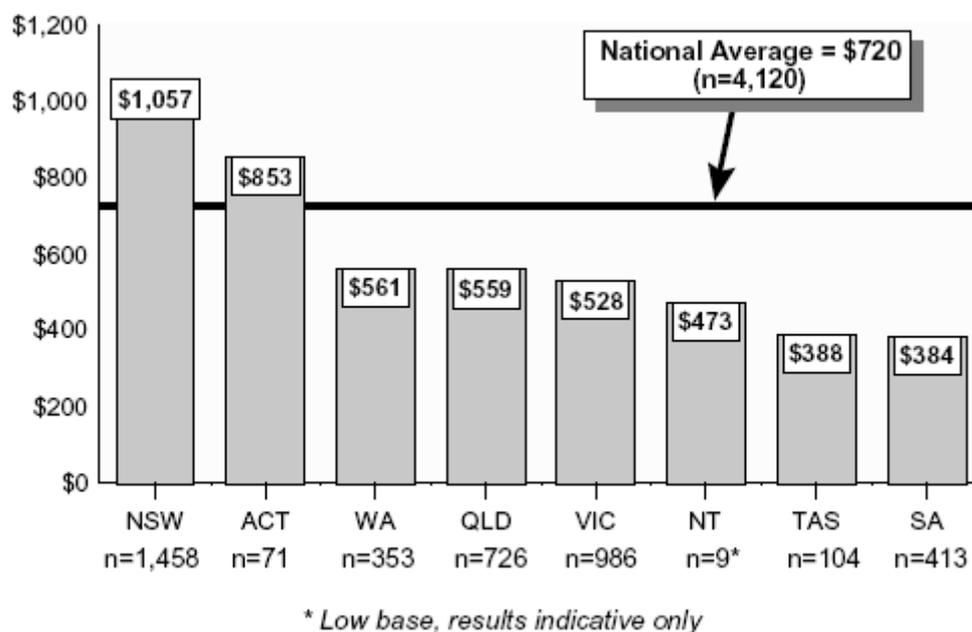
62 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Greater choice in private health*, 9 May 2006.

Informed financial consent

- 8.60 Informed financial consent is the consent to treatment obtained by a doctor from a patient, prior to treatment whenever possible, after the doctor has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about treatment.
- 8.61 Health fund members considering hospital treatment need to discuss fees and benefits in detail with their doctors and health funds to determine whether there will be any out-of-pocket cost. Doctors using health fund gap cover arrangements are required to advise patients in advance of the likely cost of medical treatment and the patient is then able to agree whether to go ahead with treatment. However, there is no requirement for doctors who are not participating in gap cover to inform their patients of likely costs.
- 8.62 A recent survey of informed financial consent commissioned by the Department of Health and Ageing found that:
- 44% of in-hospital episodes involved a gap.
 - 21% of in-hospital episodes involved a gap and a lack of [informed financial consent] IFC.
 - In 2004 an estimated 800,000 service occasions involved a gap and a lack IFC (based on projections of all in-hospital patients).
 - Lack of medical IFC (and presence of gap) is more evident amongst pre-planned admissions (21%) than emergency admissions (14%).
 - Satisfaction with cost information available prior to admission is significantly higher among same-day patients (65%) versus overnight patients (58%).
 - Lack of IFC is more associated with higher gaps.
 - Among patients with a gap exceeding \$1,000 (9% of all patients sampled), 55% reported lack of IFC from one or more medical professionals.
 - When a gap occurs the average gap per episode is \$720.⁶³
- 8.63 The survey also noted that the average size of gap per episode varied significantly between states and territories (figure 8.6).

63 Department of Health and Ageing, *Summary of key findings – Informed financial consent/patient election consumer survey* (2004), TQA Research, exhibit 2, p 1.

Figure 8.6 Average dollar gap for those having a gap, by jurisdiction



Source Department of Health and Ageing, *Informed financial consent/patient election consumer survey (2004)*, TQA Research, exhibit 2, p 22.

8.64 The committee is aware that the Australian Medical Association (AMA) is campaigning to assist doctors to provide information to patients about doctors' fees.⁶⁴

8.65 One solution to ensure informed financial consent was proposed by the Australian Health Insurance Association:

... have the principal specialist responsible for the organisation of the team and responsible for either arranging the gaps or advising the patient of what the gaps would be. One could take it even further, indeed. I am sure this would be unacceptable to the medical profession, but it could be done in the way that my builder uses. There is no reason why the specialist could not charge a bulk amount for all of the team and be responsible for paying them.

I do not pay the carpenter, the bricklayer, the plumber or the electrician; I pay my builder and he sorts it out with all the other guys. I trust my builder to pick good tradesmen to do all the work and I go and talk to them myself. I have got a private-patient relationship with the carpenters at the moment, but I do not pay them. For some reason, we have not

64 Australian Medical Association, *Informed Financial Consent: Let's Talk About Fees*, viewed on 29 September 2006 at www.ama.com.au/web.nsf/doc/WOOD-6S9822.

been able to put that into health care, and it seems to me rather illogical.⁶⁵

- 8.66 The committee notes that the Australian Government has made it clear that if there is no significant improvement by May 2007, it will move to legislate to require doctors to obtain informed financial consent. To measure how effective voluntary action has been in improving the incidence of informed financial consent the Department of Health and Ageing will repeat the consumer survey in late 2006 and early 2007.⁶⁶
- 8.67 Patients are dissatisfied when they experience out-of-pocket costs where doctors do not tell them about the potential costs that they face. Patients are entitled to know in advance the likely full cost of their treatment, including those assisting surgeons such as anaesthetists. The committee recognises that there may be instances where it is difficult to obtain informed consent, such as in emergency situations.

Recommendation 21

- 8.68 **The Australian Government amend private health insurance legislation to require that a single coordinating doctor be required to obtain informed financial consent from a patient in relation to all treating health professionals in all but the most exceptional circumstances (such as emergencies). The patient should consent in advance to the cost of the full range of services provided by all health professionals involved in the patient's care.**

Portability

- 8.69 The portability of health insurance benefits between health funds is an important element of consumer choice. Fund and provider self interest must never be allowed to influence a person's decision about his or her health cover choices.
- 8.70 Several inquiry participants noted that portability can be used to the disadvantage of individual health funds and for the benefit of practitioners in situations where medical practitioners provide advice to patients about which particular health fund to join.⁶⁷

65 Schneider R, transcript, 21 September 2005, p 61.

66 Department of Health and Ageing, sub 143, p 8.

67 Powlay J, Private Health Insurance Ombudsman, transcript, 21 September 2005, p 12;

- 8.71 While transfer to a recommended health fund may have a favourable outcome for the patient in terms of out-of-pocket costs for that doctor's fees for a particular episode of treatment, the committee notes that doctors wouldn't (and shouldn't need to) have a detailed understanding of other implications of changing to the fund (eg. for other doctor fees, hospital bills or allied health services).⁶⁸
- 8.72 The Private Health Insurance Ombudsman told the committee that:
- I am strongly of the view that doctors should not be able to do this. The AMA ethics statement counsels doctors against advising their patients to purchase any type of product. There are many other implications for people of changing their health insurance, other than just what happens to that particular doctor's bill. Although doctors will argue that they are doing this for the benefit of their patients, when you unpick it all it is all about how much money they can charge. That is my view.⁶⁹
- 8.73 The practice of medical practitioners recommending to patients to move between funds to access particular benefits does not appear to be widespread.⁷⁰ The Committee welcomes the Ombudsman's comment, nevertheless expresses its concern at the potential destabilising effect on the industry and the possible mixing of financial considerations with clinical decision making by medical practitioners (see below).
- 8.74 The committee noted the Private Health Insurance Ombudsman had prepared and gained agreement to protocols setting out what hospitals and funds should and shouldn't say to patients in contract dispute situations:
- Hospitals may also choose to communicate with current, former or potential patients. These communications may include:
- Advice on which funds have [Hospital Purchaser Provider Agreements] (HPPAs) with the hospital

Ginnane G, Private Health Insurance Administration Council, transcript, 21 September 2005, p 30; Australian Health Insurance Association, sub 16, p 23; Health Insurance Restricted Membership Association of Australia, sub 6, p 4.

68 Private Health Insurance Ombudsman, sub 83, p 3.

69 Powlay J, transcript, 21 September 2005, p 12.

70 Private Health Insurance Ombudsman, sub 83, p 4.

- Advice on which funds no longer have HPPAs with the hospital
- Advice on the potential for out of pocket expenses for treatment of members of a non-contracted fund
- Advice on how to avoid out of pocket expenses

The communications must not:

- Advocate that the member transfer to a particular health fund or class of funds (eg. those with which the hospital has a current contract/HPPA).⁷¹

8.75 The committee welcomes the development and implementation of such a protocol between hospitals and health insurance funds. However, in the case of advice from doctors, there appear to be two competing views on how a resolution can be achieved:

- legislating to discourage practitioners from giving such advice;⁷² and
- gaining agreements with doctors through education and voluntary compliance.⁷³

8.76 The Private Health Insurance Administration Council (PHIAC) told the committee that:

I am aware that the National Health Act has quite a substantial fine—I think it is \$50,000—where health funds encourage high-risk members to move to other health funds. That was actually put into the legislation some years ago to prevent risk shedding, if you like. That applies only to health funds. Certainly PHIAC believes it ought to apply to everybody that behaves in that manner—other providers, hospitals and doctors.⁷⁴

8.77 The committee noted the Australian Medical Association's view that:

... provided the doctor does not exercise any compulsion over the patient and provided the patient is the main beneficiary of the advice, there is nothing wrong with doctors providing advice and in fact the provision of such advice is demanded

71 Private Health Insurance Ombudsman, sub 83, p 4.

72 Ginnane G, Private Health Insurance Administration Council, transcript, 21 September 2005, p 30; Private Health Insurance Industry Administration Council, sub 85, p 2.

73 Private Health Insurance Ombudsman, sub 83, p 4.

74 Ginnane G, transcript, 21 September 2005, p 30.

by patients and is necessary for the efficient operation of the private market.⁷⁵

- 8.78 The committee considers that it is important to establish more robust guidelines to discourage medical practitioners and private hospitals providing specific advice to patients about changing health funds. The development of such guidelines needs to be accompanied by appropriate resources for education and guidance material to assist doctors in handling requests from patients for their advice.

Recommendation 22

- 8.79 **The Australian Government, in conjunction with the Australian Medical Association, establish guidelines for private hospitals and health funds that discourage medical professionals and private hospitals providing specific advice to their patients about transfer private health insurance funds and/or products.**
- 8.80 The committee appreciates that medical practitioners are under increasing pressure to provide informed financial consent on the one hand and an ethical requirement to avoid advising their patients to purchase any type of product on the other. These pressures are not likely to diminish, with the marketing of new health credit products by financial institutions through medical practices.⁷⁶

Improving the value of private health insurance

- 8.81 Individuals purchase private health insurance for a number of reasons. A key influence for many people is aversion to risk and the benefits of risk pooling.⁷⁷ This is supported by a recent Australian Bureau of Statistics survey, which noted that ‘security, protection and peace of mind’ was the most common group of reasons for having private health insurance (43 per cent of those insured).⁷⁸
- 8.82 The Health Insurance Restricted Membership Association of Australia noted that:

75 Australian Medical Association, sub 84, p 1.

76 Consumer Law Centre of the ACT & Care Inc Financial Counselling Service, sub 154, pp 2–6.

77 Industry Commission, *Private Health Insurance* (1997), p 169.

78 Australian Bureau of Statistics, *National Health Survey: Summary of results* (2006), Cat No 4364.0, p 13.

It is unfortunate that private health insurance is viewed by many consumers differently to other insurance they purchase. Consumers have expectations that they will recoup their contributions to private health insurance in the short term as compared to their house insurance, or even motor vehicle insurance where they hope never to recoup their contribution.

This factor alone makes the product unattractive to many in the community, particularly the young and healthy who are needed to keep the system viable.⁷⁹

- 8.83 Some other factors that are important in decisions about whether to take out private health insurance are likely to include:
- allows for a choice of doctor and choice of hospital;
 - quicker access to treatment; and
 - financial considerations.⁸⁰
- 8.84 The reasons that lead to an individual purchasing health insurance are likely to change over an individual's lifetime. A range of factors, such as a person's age, income, family responsibilities and changing government policies will affect decisions about which type of health insurance product to buy or whether to remain insured.
- 8.85 Perceptions about the value of private health insurance are at the forefront of decisions to take out private health insurance.⁸¹ Assessing value needs to consider the range of incentives ('carrots') and disincentives ('sticks') put in place for people to take out private health insurance.
- 8.86 Inquiry participants suggested a range of measures that would increase the attractiveness of private health insurance using additional carrots, sticks, a combination of approaches or the provision of additional information including:
- discounting for low claiming members — awarding a 'loyalty bonus' via a discount in premiums if a member claims less than a

79 Health Insurance Restricted Membership Association of Australia, sub 6, p 4.

80 Australian Bureau of Statistics, *National Health Survey: Summary of results (2006)*, Cat No 4364.0, p 68;

81 MBF Australia Limited, sub 29, p 32.

certain dollar value per annum or where claims have been reduced by say 10 per cent compared to the previous year;⁸²

- Australian Tax Office to advise paymasters of the surcharge and provide them with details of appropriate pay-as-you-earn (PAYE) deduction amounts. The system should also require paymasters to alert employees of their potential exposure to the levy prior to deducting the necessary PAYE amount. This would allow prospective surcharge payers to determine whether they wished to take out insurance or pay the surcharge in a prospective manner;⁸³
- remove the current disincentive arising from fringe benefits tax on employer subsidised health insurance;⁸⁴
- increasing the private health insurance surcharge to 2 per cent (currently 1 per cent);⁸⁵
- increasing the Lifetime Health Cover loading to 3 per cent (currently 2 per cent);⁸⁶ and
- enhancing the viability of rural and regional private hospitals through funding service planning and capital equipment purchases.⁸⁷

8.87 While these suggestions may lead to small changes in the number of people with private health insurance, the committee considers that the broader changes recently announced are likely to be of greater benefit in attracting and retaining people to hold private health insurance.

8.88 Some of these suggestions should, however, be revisited if the broader changes do not have the expected impact in supporting the proportion of the population covered by private health insurance.

Medical savings accounts

8.89 Medical savings accounts (MSAs) (also referred to as Health Savings Accounts) are often raised in Australian and overseas health reform debates as an alternative private insurance and health savings

82 MBF Australia Limited, sub 29, p 32.

83 Australian Health Insurance Association, sub 16, p 38.

84 Australian Health Insurance Association, sub 16, p 4; MBF Australia Limited, sub 29, p 7; Health Insurance Restricted Membership Association of Australia; sub 6, p 6.

85 Catholic Health Australia, sub 35, p 34.

86 Catholic Health Australia, sub 35, p 34.

87 Catholic Health Australia, sub 35, p 33.

model.⁸⁸ They were first introduced in Singapore in 1984 as part of a major restructuring of that country's health system. While there are a variety of types of MSA, they can be generally defined as 'the voluntary or compulsory contribution of payments by individuals, households or firms into a personalised savings account that serves to spread the financial risk of poor health over time'.⁸⁹

8.90 There are two main components to MSAs:

- a single or family savings account from which routine medical expenses are paid. Contributions are made by some combination of the individual, employers or government. Individual contributions are usually tax exempt. There may be restrictions on the type of medical services that can be purchased through these accounts. As with other types of insurance there may be deductibles or co-payments; and
- accompanying this savings account is a high-deductible insurance plan to cover catastrophic medical expenses. The premiums for this insurance may come from the savings account. There can be considerable variation in the application of catastrophic insurance. However, in most models coverage does not begin until a threshold of expenditures has been reached.

8.91 The precise balance between each of these components varies enormously from country to country. Other variations between MSA models include the mix between public or private funding, the question of whether there is a 'safety net' mechanism for disadvantaged persons (and how this is funded), the question of whether contributions to MSAs are voluntary or compulsory, and

88 For Australian examples, see Delaat W, *PBS reform for a healthy Australia*, speech to the National Press Club, Canberra, 3 August 2005; Gross P, 'Radical reform of Medicare and private health insurance inevitable, says Gross', *Healthcover*, December 2002—January 2003; Gross P, 'Support for Medical Savings Accounts to augment private health insurance', *Healthcover*, June-July 2002; Schwartz S, *Saving Australia's health care system: nostrums or cures*, speech, Bert Kelly Lecture Series—No. 3, 25 November 1998. For international examples, see Gratzner D, 'It's time to consider Medical Savings Accounts', *Canadian Medical Association Journal* (2002), vol 167, no 2; Gollatz J et al., 'Combining mandatory health insurance and Medical Savings Accounts', *Health Insurance and Managed Care Interface* (2002); Ramsay C, 'Medical Savings Accounts: Universal, Accessible, Portable and Comprehensive Health Care for Canadians', *Fraser Institute—Critical Issues Bulletin* (1998); Massaro T. and Y. Wong, 'Positive experience with Medical Savings Accounts in Singapore', *Health Affairs* (1995).

89 Dixon A, 'Are Medical Savings Accounts a Viable Option for Health Care?', *Croatian Medical Journal* (2002), vol 43, no 4.

whether MSAs cover all or only a particular segment of the population.

- 8.92 There appear to be three main benefits for introducing MSAs:
- to encourage savings for the expected high costs of future medical care;
 - to encourage consumers to avoid over-consumption of healthcare (known as the problem of ‘moral hazard’) by exposing them to the cost of health services; and
 - to mobilise additional health system funding.⁹⁰
- 8.93 Several inquiry participants advocated that greater consideration should be given to the use of MSAs in an Australian context.⁹¹ While most referred to broadly exploring the use of MSAs, Health Group Strategies put forward a more detailed proposal on how MSAs could be incorporated or trialled in Australia (box 8.3).
- 8.94 Medical savings accounts are a feature of health funding arrangements in Singapore, the United States, China and South Africa. The committee noted that a New Zealand health insurer had recently introduced a MSA product as an alternative to private health insurance.⁹² Some of the features of the MSA product introduced in New Zealand include:
- health management account (like a bank account), exclusively for health- and wellbeing-related transactions, with a member’s card that works like an EFTPOS card and an optional overdraft facility;
 - access to a growing network of health merchants that welcome *activa* members and accept *activa* cards as payment;
 - special offers for members on health-related products and services;
 - a ‘Serious Health Event Benefit’ that pays members a lump sum (dependant on age) if they experience a major health problem; and

90 Hanvoravongchai P, *Medical Savings Accounts: lessons learned from international experience*, Discussion Paper No. 52 (2002), World Health Organisation, p. 1.

91 Health Group Strategies, sub 116, p 35–38; Australian Doctors’ Fund, sub 45, p 5; Medicines Australia, sub 42, p 22; MBF Australia Limited, sub 29, pp 30–31; Australian Medical Association, sub 30, pp 21–22; Leeder S, transcript, 5 July 2005, p 66; Fitzgibbon M, NIB Health Funds, transcript, 20 July 2006, p 69.

92 Gross P, ‘Time to try the Kiwi way on health cover’, *Australian Financial Review*, 29 September 2005, p 63.

- an optional cost effective health insurance plan, to provide members with a safety net for unexpected events.⁹³

Box 8.3 Detailed proposals for Medical Savings Accounts in Australia

An approved Medical Savings Account (MSA) that can pay for:

- a mandatory high deductible, minimum coverage health insurance plan that allows new incentives (including no-claim bonuses) to reduce risk factors and trivial claims;
- at the insuree's informed choice, an optional catastrophic plan that covers high-cost care at a lower premium than today's insurance;
- the insuree's choice to meet co-payments imposed at the point of service from the MSA.
- the individual or household with a personal MSA would receive each year a risk-rated income—based subsidy from the government, applicable only to health insurance coverage;
- using much the same calculation proposed by advocates of the Health Reform Commission the subsidy would be the cashed-out value of all government subsidies for Medicare, PBS and private health insurance, indexed for inflation;
- low income groups would have the same subsidy, but there would be a need to consider safety nets;
- any MSA balance at the end of the year would be rolled over and would be tax-exempt. Any MSA balance at death would pass to the estate of the deceased;
- as in some US MSA's, healthy behaviour would entitle the insuree to a higher interest rate on the MSA balance if they maintained weight loss or stopped smoking for 2 years in a row, or they would receive lower private health insurance premiums in year 3;
- individuals could opt for care at public or private hospitals, and all hospitals would be paid by today's casemix method but weighted higher for hospitals submitting data on their safety, efficiency and clinical quality;
- the market for transparent quality and safety, supported by health insurers and state governments advertising agreed performance data, would allow consumers to see what they are buying; and
- the MSA would pay 100 per cent for all preventive care, offer discounted weight reduction products and pay bonus interest rates on the MSA balances, all embedded in US and South African MSA models. This is an economic incentive that will appeal to the young, as the take-up rates of the new New Zealand accounts suggest.

Source: Health Group Strategies, sub 116, pp 35–36.

93 Activa, viewed on 29 September 2006 at www.activa.co.nz/.

- 8.95 The Parliamentary Library identified a number of important limitations for MSAs that would need to be considered prior to adoption in Australia:
- MSAs by themselves are not effective instruments for financing the health expenses of the chronically ill and poor (both of whom tend to deplete their accounts more quickly than they can add to them and therefore require some form of safety net). Given that, under the current Australian system, it is the cost of treating patients in these categories that consumes much of government expenditure, it could be argued that MSAs would not significantly reduce government expenditure on health;
 - demand for health care is a function not only of consumer purchasing power but also of consumer expectations and health needs;
 - the assumption that, under MSAs, ‘consumer power’ might also be decisive in reducing the cost of health services tends to underplay the important role of government involvement in keeping health costs under control; and
 - some argue that MSAs may lead to ‘perverse’ decisions by consumers in relation to their healthcare—for example, healthy people with high balances may be encouraged to seek relatively trivial services, while the very sick, afraid of exhausting their MSAs, may be more likely to economise their use of services. On the other hand, there is some evidence from the US provider of MSAs, CIGNA Healthcare, indicating that consumers can reduce healthcare expenditure while also making greater use of preventative health measures. While the evidence from CIGNA [Healthcare] was mainly about the use of medication in control of chronic illnesses such as diabetes, Paul Gross has argued that with proper information and support, MSAs can also be used to provide incentives for consumers to adopt more healthy lifestyles.⁹⁴
- 8.96 The recent deregulation of health insurance products offers significant scope for health insurers to develop a health insurance product that incorporate features of MSAs or a separate MSA outside the standard health insurance product framework.
- 8.97 The committee considers that there is merit in undertaking more research into how MSAs could be introduced into the Australian health financing system.

⁹⁴ Parliamentary Library, *Medical Savings Accounts—a possible health reform option for Australia?*, Research note no 26 2005-06, 23 March 2006.

Recommendation 23

- 8.98 **The Department of Health and Ageing undertake further research to examine how medical savings accounts could be introduced within the Australian health financing system as a health savings and insurance vehicle.**

Sustaining a strong private health sector

- 8.99 A strong private sector relies on positive relationships between insurers and service providers. Important too are relationships with the public sector — a high degree of integration can make the best use of available resources and fair competition between private and public providers can drive improvements in technical efficiency.

Better integration of private and public sectors

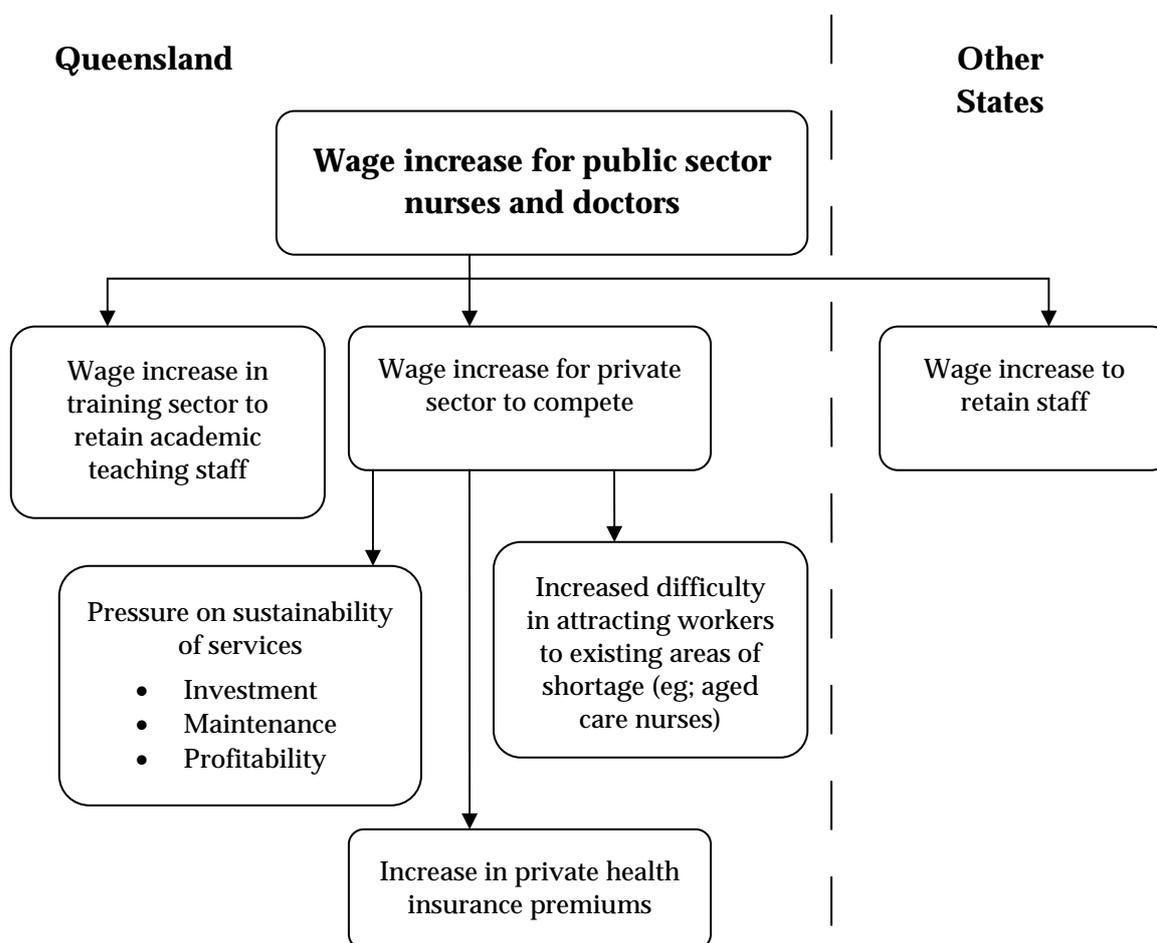
- 8.100 Many participants noted the importance of better integrating the private and public sectors as a way of maximising the effectiveness of available resources and providing for better continuity of care for patients.⁹⁵
- 8.101 The need for a close relationship between the public and private sectors is due to several factors including:
- the use of shared resources (staff and facilities) — including in some areas the co-location of public and private hospitals, with patients, staff and medical services moving freely between the public and private facilities;
 - continuity of care for patients treated across sectors;
 - the treatment of public patients in private facilities;
 - planning the development of future facilities and workforce requirements;

⁹⁵ Australian Healthcare Association, sub 62, p 12; Australian Association of Gerontology, sub 53, p 5; Strategic Planning Group for Private Psychiatric Services, sub 20, p 5; Local Government Association of NSW and Shires Association of NSW, sub 18, p 14; Health Care Reform Alliance, sub 127, p 75; Macquarie Health Corporation, sub 55, p 7; National Network of Private Psychiatric Sector Consumers and their Carers, sub 14, p 12; Bankstown City Council (NSW), sub 13, p 4.

- part public funding (through the Medicare Benefits Schedule) of privately provided services; and
- patient choice about provision of service in a public or private sector setting.

8.102 The impact of changes in the public sector on the private sector was recently highlighted in Queensland, following a decision of the Queensland Government to significantly increase pay rates for public sector nurses by 25.3 per cent over three years to March 2009.⁹⁶ The flow-on effects of this decision were experienced by universities, private health funds, private hospitals, aged care providers, holders of private health insurance and by other states (figure 8.7).

Figure 8.7 Integration of public and private sectors — impact of increases in pay rates to public sector nurses



Source Australian Private Hospitals Association, transcript, 7 April 2006; Australian Medical Association (Queensland), transcript, 16 March 2006; Wronski I, James Cook University, transcript, 16 March 2006, Department of Health (SA), transcript, 2 May 2006.

⁹⁶ Hon Steven Robertson, Minister for Health (Queensland), media release, *Queensland Health Nurses offered almost \$1B pay deal*, 2 March 2006.

- 8.103 The need for a process to recognise and support this integration was supported by several participants.⁹⁷ Catholic Health Australia noted that the Commonwealth, as a key stakeholder in the private health industry, can play a role in fostering greater industry dialogue:

... the Commonwealth is best placed to convene such meetings, which could be known as the Australian Private Health Council. This Council could meet say twice per year and its deliberations could be used to inform industry participants, as well as Ministers and their Departments, on developments within the industry and any policy issues or proposals arising from those developments which may need to be addressed.⁹⁸

- 8.104 The need for improved dialogue at a state level was also recognised by the Australian Private Hospitals Association:

The lack of acknowledgment by state governments of the existence of the private sector creates major problems in developing any real relationships and synergies between the two. They have no interest in the private sector at all. Every now and then there is an inquiry which stimulates some interest, and because they have been told they have to do this they exhibit interest for a while.

The most recent example was only a couple of years ago in New South Wales. That dies after a few months and you hear nothing more about it.⁹⁹

- 8.105 The committee considers that the Commonwealth should support mechanisms to promote better communication between the public and private sectors as part of the national agenda (discussed in chapter 3). These arrangements should also provide for the participation of the states, who are also involved in a broad range of planning and regulatory issues.

Contracting arrangements

- 8.106 The relationship between health funds and private hospitals can involve a degree of commercial tension. There is always potential for

97 Catholic Health Australia, sub 30, p 20; Health Group Strategies, sub 116, p 47.

98 Catholic Health Australia, sub 30, p 20

99 Clark L, Australian Private Hospitals Association, transcript, 24 August 2005, p 12.

negotiations to break down as in any commercial relation, and sometimes they do.

- 8.107 Contracting between health funds and private hospitals determines, among other things, the amount a fund will pay for hospital accommodation and nursing care when a fund member is treated. Health funds are free to choose with which facilities they will seek a contract, having regard to the needs of their members. These decisions may take into account, for example, the types of services offered at a particular facility, the number of similar facilities within a locality and the residential profile of their membership.
- 8.108 Private hospitals and private day hospital facilities receive hospital benefits from health funds through either a hospital purchaser provider agreement that they have negotiated with the fund or, where a contract does not exist, the Australian Government determined default benefit. Health funds are required to cover all eligible members that receive hospital treatment even where the fund has no contract with the hospital, with payments at a 'default rate'.
- 8.109 There are two levels of default benefits:
- the basic default benefits — primarily paid for private patients in public hospitals. In setting the basic default benefits the Australian Government increases the benefits each financial year by March on March consumer price index (2 per cent for 2003-04). The average benefit for overnight shared ward accommodation for 2004-05 was \$255; and
 - the second tier default benefit — introduced because of concerns about health funds commencing selective tendering processes. The benefit is no less than 85 per cent of the average of rates referred to in the relevant fund's contracts, for comparable hospitals in each state for an equivalent episode of hospital care. To qualify for second tier benefits, a hospital must meet agreed quality criteria.
- 8.110 A key issue for health funds and private hospitals was the nature of contracting. MBF Australia noted that:
- Fund members have benefited from HPPAs through:
- certainty of fee coverage for services at hospitals with an HPPA ("known" gap);
 - higher benefits for services at hospitals with an HPPA, including "no-gap" policies for hospital accommodation; and

- lower premiums than would otherwise have been the case, due to the ability of health funds to manage the cost of hospital services through negotiating the HPAs and efficiencies introduced into the private hospital system as a consequence.¹⁰⁰

8.111 The Australian Private Hospitals Association took a different view towards contracting arrangements, noting that:

The strategy of negotiation seems to one of attrition and tender, and I would use the word ‘tender’ in inverted commas. The tender ends up being an opportunity to renegotiate. They start at minus 1.5 per cent and slowly go up, and it takes months. Who benefits? The health funds benefit because they keep the cash that they would have paid out in normal increases. They are not taking into account the financial movements, the costs and the actual money they are keeping. So essentially it is a take it or leave it, or scare them, approach with significant downsides to hospitals if they go off contract and go into co-payments.¹⁰¹

8.112 While contacting between funds and hospitals does create tension within the industry, there are a range of ongoing cooperative arrangements that have been established to improve health outcomes for patients in private hospitals (box 8.4).

8.113 Suggestions by participants to improve contracting arrangements inevitably are based around changing the bargaining power of each negotiating party. Some of the changes to contracting and negotiating arrangements proposed by health funds include:

- abolition of default benefit rates — mandatory default benefits are used as a negotiating lever to force funds to pay higher prices and reduce their ability to negotiate pay for performance criteria. They may also reduce the quality of care provided by facilities that are unable to secure a contract;¹⁰² and
- increasing information requirements for private hospitals — imposing requirements on hospitals to publish a range of financial and clinical data would give health funds an improved basis to

100 MBF Australia Limited, sub 29, p 25.

101 Toemoe G, Australian Private Hospitals Association, transcript, 24 August 2005, p 4.

102 Australian Health Insurance Association, sub 16, p 33; MBF Australia Limited, sub 29, p 26; sub 47, p 2.

negotiate contracts and to provide essential information to consumers about the hospitals in which they are being admitted.¹⁰³

Box 8.4 Strategic Planning Group for Private Psychiatric Services — a case study of private sector collaboration

The Strategic Planning Group for Private Psychiatric Services (SPGPPS) brings together a coalition of providers, funders and recipients of mental health services with the commitment to facilitate progress in the provision of mental health services in the private sector.

Members of the SPGPPS include the Australian Medical Association, The Royal Australian and New Zealand College of Psychiatrists, The Royal Australian College of General Practitioners, Commonwealth Department of Health and Ageing, Department of Veterans' Affairs, Mental Health Consumers and Carers, Australian Private Hospitals Association and the Australian Health Insurance Association.

Several members of the SPGPPS contribute to the development and collection of a minimum data set, from which de-identified data forms the basis for quarterly reports are prepared and distributed to participating hospitals and private health insurance funds.

The National Network of Private Psychiatric Sector Consumers and their Carers (National Network) is funded by several members of the SPGPPS to represent Australians who contribute to Health Funds and who receive treatment and care, within the Australian private sector, for their mental illness or disorder. The National Network provide a point of reference and a mechanism for consumer and carer participation and advice to key organisations, committees and working groups requiring private sector input.

While there are many differences between constituent groups, the SPGPPS model has enabled participants to find consensus and a way forward on many difficult and contentious issues. The SPGPPS, originally established in 1993, has recently negotiated funding arrangements with its members for the period 2007–2009. From 1 January 2007, the SPGPPS will be restructured into the 'Private Mental Health Alliance'.

Source: SPGPPS, sub 20; SPGPPS, transcript, 21 September 2005; transcript, 24 May 2006.

8.114 Comments on contracting arrangements relating to private hospitals included:

- retaining default benefits — Provides protection to hospitals and patients and supports the private sector in taking some pressure off public hospitals;¹⁰⁴

¹⁰³ MBF Australia Limited, sub 29, p 26; Australian Health Insurance Association, sub 16, pp 32–33; Australian Health Service Alliance, sub 5, pp 2–3.

¹⁰⁴ Wainwright D, Australian Medical Association, transcript, 23 August 2005, p 16; Roff P, Australian Private Hospitals Association, transcript, 23 August 2005, pp 15–16.

- increasing the transparency of health insurer’s negotiations with private hospitals — To provide information to hospitals about the weighting of the criteria that will be used to assess whether a hospital is offered a contract (financial, market and services, quality and safety, compliance, and efficiency) and how hospitals are compared with each other;¹⁰⁵
 - better sharing of risks between health funds and hospitals — A range of risks that have been transferred to hospitals by health funds, potentially adding to the costs of private hospitals including the bundling of pharmacy into the overall payment system, capping inpatient days and critical care days through the use of aggressive step and the collection by hospitals, rather than by the health fund, of patient contributions;¹⁰⁶ and
 - delaying contract negotiations — delayed renegotiations well beyond the date of expiry (in some cases by 12 months or more) with no ability for retrospective payments results in hospitals not receiving indexation for significant cost increases beyond their control (e.g. nursing wage increases, medical supplies and technology costs and professional indemnity premiums).¹⁰⁷
- 8.115 While the committee appreciates that there can be tension between health funds and private hospitals, competition is an important element in promoting choice and improving efficiency. Nevertheless, it is important that health funds support the long-term profitability of efficient private hospitals to provide adequate funds for continued investment in high quality health care and timely expansion of capacity.
- 8.116 The committee considers that, in light of the significant regulatory changes to the private health insurance industry that are currently underway, it may be too early to contemplate changes to the contracting environment between health funds and service providers.

Promoting ‘fair’ competition

- 8.117 Several inquiry participants noted that funding arrangements do not always provide for ‘fair’ competition between private and public

105 Australian Private Hospitals Association, sub 24, p 9.

106 Australian Private Hospitals Association, sub 24, p 14.

107 Australian Private Hospitals Association, sub 24, p 14.

sector providers — in some cases the private sector appears to be favoured whilst in others the public sector may have advantages.¹⁰⁸

- 8.118 Competition between the public and private sectors can be important to promote efficiency in service delivery. Competition also plays a role in encouraging the appropriate investment in new technologies or the development of new facilities.
- 8.119 The Australian Diagnostic Imaging Association noted that some public hospitals were encouraging their clinicians to undertake private sector work, even when there were large numbers of tests that had not been examined by radiologists:

We are aware and concerned that there are 8,000 unread films in the state of Queensland right now in the public system; there are hundreds of films at Westmead Hospital not being read.

... it concerns us that we are competing against public hospitals who have already had their equipment paid for and who have already had their staff paid for through other grants, yet they are working on Medicare work in the private sector.¹⁰⁹

- 8.120 The Commonwealth and industry groups are addressing some of the uneven playing fields between public and private sector providers. For example, in pathology services, only private sector providers are eligible to receive a patient episode initiation (PEI) fee, which is intended to cover some of the fixed costs involved in testing, including collecting and managing a sample. From May 2007, public providers will also be entitled to a PEI fees. While the payment amount (\$2.40) is substantially below the PEI paid for a range of tests, public and private providers have agreed to a process that may lead to removing the distinction between public and private providers.¹¹⁰

108 Australian Diagnostic Imaging Association, sub 21, p 1; Graves D, Royal College of Pathologists of Australasia, transcript, 5 July 2005, p 9; Kindon D, Australian Association of Pathology Practices Inc., transcript, 7 April 2006, p 26; Clark L, Australian Private Hospitals Association, transcript, 24 August 2005, p 6; Schneider R, Australian Health Insurance Association, transcript, 23 August 2005, p 75.

109 Barnier G, transcript, 26 May 2006, p 57.

110 Department of Health and Ageing, *Pathology Quality and Outlays Memorandum of Understanding between the Australian Government and the Australian Association of Pathology Practices and the Royal College of Pathologists and the National Coalition of Public Pathology, 1 July 2004 to 30 June 2009* (2004), clause 8.2–8.3.

- 8.121 Providing a level paying field between public and private sector providers is important to introduce some market forces in the health sector. Where possible, the Commonwealth and the states should look at developing costing rules or other ways of providing for fair competition with private sector providers.

Improving accountability

Whilst it is recognised that health systems must strive at all times for efficiency, it is also true that the basic societal investment in health needs to be at a sustainable level. ...it would be of value for this current process to test societal expectations of the health service, and the community's willingness to invest a greater proportion of national wealth in this area.¹

- 9.1 Accountability is often linked to a range of concepts including responsibility, responsiveness, regulation and control.² In this chapter, the committee examines how the community's high expectations to access high quality affordable health care can be at odds with the ability of governments to properly resource health care services. The committee also discusses a range of processes that involve the community in decision making about the allocation of health resources and how health service providers can be more accountable to their patients.

Community expectations

- 9.2 As noted in chapters 3 and 7, the current division of responsibility between the Commonwealth and the states weakens political

1 Australian College for Emergency Medicine, sub 17, p 2.

2 Mulgan R, *Accountability Issues in the New Model of Governance* (2002), Discussion Paper No.91

accountability to the community for government actions to address health care issues.

9.3 It is also difficult for governments to be accountable for the delivery of high quality affordable health care if there is a clear mismatch between the expectations of the community and the priorities set by governments for the resources allocated to the health system.

9.4 Many inquiry participants noted that the community has high expectations about what the health care system can deliver.³ These high expectations can relate to different aspects of health care including:

- access — free or affordable health care in a convenient setting;
- quality — effective health care delivered by skilled health professionals in a safe environment;
- timeliness — health care provided according to clinical need, taking into consideration the impact that delaying treatment can have on the ability of community members to participate in community activities; and
- high technology — health care which incorporates the latest technology and advances in medicine.

9.5 High or rising expectations in all of these areas generate significant pressures on the health system. As noted in chapter 7, in most states people face significant waiting times for elective surgery in public hospitals, and in many jurisdictions too much of the elective surgery is not carried out within the clinically appropriate time.

9.6 The difficulties of meeting the community's expectations for public hospital services within a fixed budget were illustrated to the committee by the head of a NSW public health provider:

I say to people all the time, and my managers in particular, 'We have the budget we have.' If there is a part we cannot control and we must service—such as emergency departments and critical care areas—then we have to do less of the things that are not as clinically urgent or important for health outcomes. There is no simple equation for that; there is

3 Wainwright D, Australian Medical Association, 23 August 2005, p 8; National Health and Medical Research Council; sub 49, p 2; Health Insurance Restricted Membership Association of Australia, sub 6, p 5; Mackender D, Hospital Reform Group, transcript, 29 March 2006, p 6; Australian Doctors' Fund, sub 78, p 25; Mr Anthony Morris QC, sub 72, p 31.

no magic bullet. That has to be the outcome, and that is a concern.⁴

- 9.7 The need for rationing, or queuing, is an inevitable outcome in health systems where price is not generally used to limit demand and where there are rising community expectations.⁵ The Australian Healthcare Association noted that:

In social policy, of which health care is an aspect, as we invest and reach a certain benchmark performance, there is a natural inclination for us as human beings to expect the bar to rise, because we can further improve the condition or the conditions under which we live. Therefore, assuming that there is a particular quantum of investment at any point in time, there is always going to be a rationing, according to the way in which that investment is disbursed.⁶

- 9.8 Several inquiry participants noted the need for governments to better communicate to the community the anticipated effects of current resourcing on access to health care. Catholic Health Australia noted that:

The political climate for too long has deluded the community into believing that quality health services can be delivered for relatively little outlay. Clearly, community discontent signals that this strategy has run its course.⁷

- 9.9 The Australian Society of Anaesthetists noted that:

The general public cannot even enter the debate if they do not understand the problems. Frequently, in every state, you hear talk of the routine eight-week closedown over Christmas and six weeks over Easter. This is because they do not have the budget to fund services through that time. They are not routine at all. They may be now. They have become routine, but they should not be. Until we actually say to the public, 'We do not have enough money to do all the hip replacements, therefore, the waiting list will be three years,' the public cannot even have the debate because they do not understand the problem. Once they understand, they can

4 Clout T, Hunter New England Health, transcript, 20 July 2006.

5 Ham C and A Coulter, 'Introduction: International experience of rationing (or priority setting)', *The global challenge of health care rationing* (2000).

6 O'Conner D, Australian Healthcare Association, transcript, 26 May 2006, p 47.

7 Sullivan M, Catholic Health Australia, transcript, 23 August 2005, p 6.

then have the debate and decide whether more resources need to be devoted through increased taxation or taking it from some other area.⁸

- 9.10 The Australian Council of Social Service pointed to the need for resources to be allocated carefully:

It is uncontroversial that health services should be provided according to need but it is also the case that not all needs can be met. The real resources required to run a health system and in particular the health work force are in limited supply. Running an efficient, effective and equitable health system is therefore about setting priorities.⁹

- 9.11 The committee supports the need to better communicate with the community about the level and standard of health care that can be provided. The clearer specification of 'acceptable' service standards advocated by the committee as part of the national health agenda (see chapter 3) should contribute to improving community expectations about how resources are linked to outcomes. Possible mechanisms for improving community consultation and responsiveness to community views are discussed later in this chapter.

Public hospital elective surgery waiting times

- 9.12 While clinical need is used to determine the urgency with which a public patient is treated in public hospitals, patients with less urgent conditions can still experience significant pain and discomfort. Dr Cartmill told the committee that:

We are told in the public sector to treat category 1 patients or long-wait category 2. Category 3 patients do not get treated.

In urology, category 3 patients have lifestyle problems, such as prostatic disease and bladder outlet obstruction. Those patients have real symptoms, their quality of life is significantly impaired and they are just not getting treated.¹⁰

- 9.13 Several inquiry participants noted that there was a need to make access to health care fairer and more transparent, given the lengthy

8 Mulcahy A, Australian Society of Anaesthetists, transcript, 23 August 2005, p 10.

9 McCafie G, Australian Council of Social Service, transcript, 21 September 2005, p 65.

10 Cartmill R, transcript 16 March 2006, p 57.

waiting times for some kinds of elective surgery.¹¹ One example provided to the committee was the need for a quantitative measurement tool to prioritise patients seeking breast reduction surgery and abdominoplasty (box 9.1). The Doctors' Reform Society (WA) noted that:

... the state governments ration using waiting lists. It is hotchpotch, it is inequitable and it produces strange results. I think rationing is not only inevitable, it is a good thing, and I think the PBS—and I am not saying it is a perfect system by a long way—is great. 'This is what we fund and this is how we can limit what can be spent on pharmaceuticals.' But it must transparent and it must be coordinated on a big scale.¹²

Box 9.1 Services for breast reduction and abdominoplasty surgery

Evidence shows that breast reduction and to a lesser extent abdominoplasty (more commonly known as a 'tummy tuck') improves patients' general health significantly. This surgery may also play a wider role in illness prevention because it enables people to exercise and have a healthier lifestyle. However, it is often seen as 'low priority' as compared to excision of cancers, but in a longer term view, if it helps to prevent heart disease it is a good investment of health spending.

Because public hospitals have limited resources to treat any non-urgent cases (even though they may result in great health benefit), only a few of these cases are performed each year. Typically, a patient in South Australia will wait between 2 and 10 years from the time they are put on a waiting list.

The introduction of a quantitative measurement tool for patients seeking this surgery would allow fairer prioritisation of patients. It may also be decided by the government that the patients who were given a low priority score by this method would be advised to seek treatment in the private sector. This would free up resources in the public hospitals for those who had significant health problems from their large breasts or overhanging abdomens and mean that those who really needed the surgery could actually receive it. This system would reduce public hospital waiting lists and be fairer.

Source: Flinders Medical Centre, sub 86 and 122; Dean, N and Griffin, P, transcript 2 April 2006, pp 1–13.

11 Flinders Medical Centre, sub 86, p 1; Mackender D, Hospital Reform Group, 29 March 2006, transcript, p 3; Australian Healthcare Reform Alliance, sub 127, p 10.

12 Ralls J, Doctors Reform Society (WA), transcript, 24 August 2006, p 27.

- 9.14 The committee considers that further effort should be devoted by governments to making waiting lists fairer. The Australian Government — through the National Health and Medical Research Council — should give priority to supporting research that examines how waiting list management systems can be improved.

Recommendation 24

- 9.15 The Australian Government, in conjunction with the states and territories, give priority to undertaking research to develop mechanisms to make waiting lists for public hospital elective surgery fairer.**

'Hidden' waiting lists

- 9.16 Most states report, or are moving to report, information about waiting lists and waiting times for public hospital services, in some cases on a quarterly basis.¹³ Such reporting can better inform the community about the capacity of the health system and also provide information to clinicians about how to best care for their patients.
- 9.17 Nevertheless, there can be 'hidden' waiting lists comprising patients who experience delays in seeing specialists in outpatient clinics prior to being added to elective surgery waiting lists.¹⁴
- 9.18 While it is difficult to measure the number of patients who must wait to be assessed by specialists prior to treatment, it is important that the waiting list information produced by the states reflects delays in accessing health care throughout the whole episode of treatment.
- 9.19 The committee considers that accountability and transparency can be improved through the development of additional sources of

13 See for example, Victorian Department of Human Services, *Your hospitals: A six-monthly report on Victoria's public hospital, January to June 2006*, viewed on 9 November 2006 at www.health.vic.gov.au/yourhospitals/yourhospitals0606.pdf; ACT Health, *ACT Health Public Services Performance Report Quarter 4 2005-06*, viewed on 9 November 2006 at www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1157669065&sid=.

14 Wainwright D, Australian Medical Association, transcript, 23 August 2005, p 10; Flinders Medical Centre, sub 86, p 2; Australian Medical Association Victoria, media release, *Elective surgery waiting list not a true reflection of wait*, 28 September 2006; Victorian Auditor-General, *Access to specialist medical outpatient care (2006)*, p 89; Australian Medical Association Tasmania, media release, *Tasmanian elective surgery waiting lists statistics exposed*, 6 April 2005.

information about the delays that can be encountered in accessing specialists in outpatient clinics.

Recommendation 25

- 9.20 In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government provide incentives for the states and territories to report in a consistent manner on patient waiting times for access to specialists in outpatient clinics.**

Responsiveness

- 9.21 The responsiveness of service providers to local community needs can be an important part of being accountable for the effective and efficient delivery of health services.
- 9.22 Several inquiry participants noted that there are a range of mechanisms that allow health care services to be responsive to the needs of local communities including:
- governance structures for health providers that provide for community representation on governing boards or consultative committees; and ¹⁵
 - local government as an advocate or service provider.¹⁶
- 9.23 Another form of community consultation — ‘citizens juries’ — were suggested by inquiry participants as an alternative for involving the community in decisions about allocating health resources (box 9.2).¹⁷ Mr Menadue noted that:

My observation is that when community groups are well informed about priorities and the options involved, they invariably put, for example, mental health and aboriginal health at the top of the list well ahead of hospitals and hospital beds. Informed community members usually give

15 Victorian Government, sub 67, p 7

16 Shire of Bruce Rock (WA), sub 152, p 1; Shire of Laverton (WA), sub 147, p 1; Western Australian Local Government Association, sub 34, p 7.

17 John Menadue, sub 140, p 1; Australian Healthcare Reform Alliance, sub 127, p 10; Australian Physiotherapy Association, sub 118, p 13; Australian Health Association, sub 62, pp 13–14; Goulston K, Hospital Reform Group, transcript, 29 March 2006, p 10.

much lower priority to life-extending interventions in the last stage of terminal illness, some fertility treatments and hospital super-specialties. Making choices is hard, but my experience is that when the community is well informed it comes to realistic and what I think are sensible decisions on the priorities of health spending. We must obtain informed advice from the community.¹⁸

Box 9.2 Informing decision making using citizen's juries

Citizen's juries are a technique designed to enhance the engagement of the community in the making of public policy.¹⁹ They are commonly used in the development of broad policy goals or resolution of particularly challenging issues (for example, issues involving complex ethical or technical questions). They have been used in North America, Europe and Australia across a range of policy areas, including healthcare, roads and the environment.²⁰

How do they work?

There are various approaches to running a citizen's juries but the main components usually include:

- the formation of a group to participate in the process (sometimes the group is randomly selected, other times it is drawn from recognised stakeholders);
- the presentation of 'evidence' to the group by various relevant experts;
- an opportunity for the group to discuss the evidence; and
- a vote by the group on the issue/s under discussion.

One of the main objectives of citizens' juries (like other 'deliberative' techniques such as focus groups) is to gain a more advanced understanding of community attitudes than can be expected from more common techniques such as surveys. However, unlike most other deliberative approaches, a key feature of citizens' juries is the presentation of important technical and other information to participants by experts. This means that the information obtained from citizens' juries is potentially more considered and more reflective than that available from other approaches.

(continued over)

18 John Menadue, sub 140, p 1.

19 Curtain C, 'What role for citizens in developing and implementing public policy?', National Institute for Governance Conference: Facing the Future: Engaging Stakeholders and Citizens in Developing Public Policy (2003).

20 Dolan P., R. Cookson and B. Ferguson, 'Effect of discussion and deliberation on the public's views of priority setting in health care: Focus group study', *British Medical Journal* (1999), Vol 318, Issue 7188, pp. 916-919; Mooney G. and S. Blackwell, 'Whose health service is it anyway? Community values in healthcare', *Medical Journal of Australia*, (2004), vol 180, no 2, pp 76-78; Carson L. and B. Martin, 'Random selection of citizens for technological decision making', *Science and Public Policy* (2002), vol 29, no 2, pp 105-113.

Citizens' juries in healthcare policy

Citizens' juries are often proposed for the healthcare policy area because they offer the possibility of clarifying issues that are beyond clinical and other forms of technical evaluation. According to Mooney and Blackwell:

Above the level of individual clinical decisions, there are questions of resource allocation and policy that are very much social choices. They still have to be informed by technical information. In between, doctors are faced with many decisions where it is less clear which values should apply. Partly this is because it is difficult to decide where the dividing line should come between professional and social value judgments; partly because some decisions are so technical and complex that citizens cannot make truly informed choices. However, citizens may accept their limitations in some areas of decision making, while insisting on their right to decide in others.²¹

For example, it is commonly suggested that citizens' juries could make an important contribution to addressing the problem of scarcity of resources in healthcare. The idea is that this approach could both enhance public understanding of the problem and lead to more open and productive debates about how to use finite resources to the best effect.²²

The evidence—pros and cons

There are a number of studies reporting success in obtaining informed and considered contributions from participants in citizens' juries. For example, participants in Western Australian citizen's juries decided upon more community-focused (as opposed to consumer-focused) approaches to health system priority-setting after being presented with expert evidence and given time to discuss and deliberate.²³ Further, convenors of a British citizen's jury concluded that the public was much more willing to engage in the complexity of issues associated with setting priorities in health care when they have been given an opportunity to discuss the issues.²⁴

Nevertheless, citizens' juries are much more resource intensive than most traditional forms of community consultation (particularly in terms of the investment of time and financial resources). There are also crucial issues associated with the design of citizens' juries. For example, a number of studies have shown how such issues as the choice of participants and the framing of the themes under discussion can have significant impacts on the results of a citizens' jury.²⁵

21 Mooney G and Blackwell, 'Whose health service is it anyway? Community values in healthcare', *Medical Journal of Australia* (2004), vol 180, no 2, p. 77.

22 Baume P, 'A Different 'Health' Debate is needed now', *New Matilda* (2005), 7 December.

23 Mooney G and Blackwell, 'Whose health service is it anyway? Community values in healthcare', *Medical Journal of Australia* (2004), vol 180, no 2, p 76.

24 Dolan P, R Cookson and B Ferguson, 'Effect of discussion and deliberation on the public's views of priority setting in health care: Focus group study', *British Medical Journal* (1999), vol 318, Issue 7188, p. 916.

25 Hendriks C, 'Participatory storylines and their influence on deliberative forums', *Policy Sciences* (2005), vol 38, pp 1–20; Carson L and B Martin, 'Random selection of citizens for technological decision making', *Science and Public Policy* (2002), vol 29, no 2, pp 105–113;

- 9.24 Some of the funding models proposed in chapter 3 support the need for greater community input by providing resources to communities for management on a regional basis. While local governments appear to be well placed to provide a forum for local input in some cases, alternative mechanisms such as citizen's juries also appear to provide a realistic means for community engagement.
- 9.25 Governments need to better engage with the community about their expectations and priorities in health care. While supporting the intent of citizen's juries and other forms of community engagement, the committee considers that they are no substitute for the political accountability of elected governments. Accordingly, the committee sees a role for consumers in setting the national health agenda (see recommendation 1 in chapter 3).

Safety and quality

- 9.26 Quality is difficult to define because it is a broad term which of itself has little agreed meaning.²⁶ The NSW Department of Health has articulated a framework for managing six dimensions of quality: safety, effectiveness, appropriateness, consumer participation, efficiency, and access.²⁷
- 9.27 In terms of accountability for safety and quality, this section is concerned mainly with the reporting to the public and patients of the positive and adverse outcomes of these six criteria.
- 9.28 The Commonwealth and the states are involved in improving health care safety and quality at a broader level, with the formation of the Australian Commission on Safety and Quality in Health Care in January 2006.²⁸ The Commission, which succeeded the Australian Council for Safety and Quality in Health Care (ACSQHC), will lead and coordinate improvements in safety and quality in health care in

Dutwin D, 'The character of deliberation: equality, argument, and the formation of public opinion', *International Journal Of Public Opinion Research* (2003), vol 15, no 3; Zwart I, 'Local deliberation and the favouring of nature', Institute for Social Research (2005).

26 Department of Health and Aged Care, *The Quality of Australian Health Care: Current issues and future directions*, Health financing series occasional paper (2000), vol 6, p 5.

27 Department of Health (NSW), *A Framework Managing the Quality of Health Services New South Wales*, viewed on 12 October 2006 at www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_585.pdf.

28 Department of Health and Ageing, sub 43, p 16.

Australia by identifying issues and policy directions, and recommending priorities for action.²⁹

9.29 The Medicare Agreements and Australian Health Care Agreements (AHCAs) (see chapter 7) have played an important part in improving public accountability for safety and quality issues:

- requirements for the states to establish public hospital charters and the establishment of complaints handling bodies to resolve complaints relating to public hospital services were included as part of the 1993–98 Medicare Agreements;³⁰ and
- requirements to develop indicators relating to adverse events were included as part of the 2003–08 AHCAs, building on the efforts of the ACSQHC.³¹

9.30 Traditionally, the quality of health care has been seen as a natural consequence of a sound medical education and good intentions on the part of medical practitioners.³²

9.31 The provision of safe and high quality health care in Australia is supported by a range of arrangements including high standards of education and training for students, accreditation and registration arrangements for practitioners, assessments by independent bodies such as the Therapeutic Goods Administration and accreditation of health facilities.

Hospital accreditation

9.32 A key mechanism for improving quality has been the process of hospital accreditation. Although other forms of accreditation exist, the principal accreditation agency in Australia is the Australian Council on Health Care Standards (ACHS), who accredit 74 per cent of all hospitals and 87 per cent of all hospital beds across Australia.³³

29 Australian Health Ministers, Joint communiqué, *Australian Health Ministers move forward on new commission on safety and quality*, 18 November 2005.

30 See for example, *Agreement between the Commonwealth of Australia and the State of New South Wales in relation to the provision of Public Hospital Services and Other health services: From 1 July 1993 to 30 June 1998*, clause 4.1–4.6.

31 See for example, *Australian Health Care Agreement between the Commonwealth of Australia and the State of Queensland 2003–2008*, schedule C, clause 12.

32 Department of Health and Aged Care, *The Quality of Australian Health Care: Current issues and future directions*, Health financing series occasional paper (2000), vol 6, p 3.

33 Duckett S, *The Australian Health Care System* (2004), p 157; Australian Council on Health Care Standards, sub 65, p 3.

9.33 Only in Victoria are all public hospitals required to be accredited, with participation by public hospitals in other states voluntary.³⁴ In 2004-05, the proportion of public hospital beds accredited by ACHS or another agency ranged from 72 per cent in Tasmania to 100 per cent in Victoria, NT and the ACT (see figure 9.1).

Figure 9.1 Public hospitals and beds – number and proportion accredited, states and territories, 2004-05

| Rank | | hospitals accredited | | beds accredited | |
|------|------------------------------|----------------------|------------|-----------------|------------|
| | | Number | Percentage | Number | Percentage |
| 1 | Australian Capital Territory | 2 | 100 | 669 | 100 |
| 1 | Northern Territory | 5 | 100 | 570 | 100 |
| 1 | Victoria | 144 | 100 | 11875 | 100 |
| 4 | South Australia | 74 | 94 | 4889 | 98 |
| 5 | Queensland | 153 | 86 | 9585 | 98 |
| 6 | New South Wales | 181 | 78 | 19615 | 95 |
| 7 | Western Australia | 66 | 71 | 4766 | 97 |
| 8 | Tasmania | 3 | 11 | 915 | 72 |
| | Australia | 628 | 83 | 52884 | 97 |

Source Department of Health and Ageing, *The state of our public hospitals, June 2006 report (2006)*, p 11.

The ACHS's most recent report, citing results from 2003 and 2004, noted that there were hospitals where performance needed to improve in a number of areas including:

- The emergency management systems required attention in 173 organisations (26 per cent) to ensure that they were adequately protecting patients and staff;
- Patient care was considered compromised (as indicated by the allocation of High Priority Recommendations) in eight organisations because of the lack of formal clinical processes relating to medical staff availability, credentials and competencies of staff, appropriate resources to perform the clinical service, clinician involvement and responsibilities in care delivery, for example in the consent process; and
- Patients, visitors and staff were at risk ... in 10 organisations because of inadequate attention to fire safety.³⁵

34 Duckett S, *The Australian Health Care System* (2004), p 157.

35 Australian Council on Healthcare Standards, *National Report on Health Services Accreditation Performance 2003 and 2004* (2005), pp 2-3.

- 9.34 Public reporting of accreditation reports is not mandatory, although some accredited hospitals — usually those that receive positive reports — do make these available to the public via the Internet.³⁶
- 9.35 The ACHS noted that:
- At present, there is no requirement for health services to disclose the content of their accreditation report or their Quality Action Plan. It is ACHS policy to encourage health services to publish their accreditation report or a modified statement of accreditation performance either on their web site or on the ACHS web site. Few organisations do so; understandably organisations that have received a very positive report are generally happy and willing to do so.³⁷
- 9.36 The committee considers that mandatory public reporting of accreditation reports would give strong incentives to hospital management to quickly address issues identified during the accreditation process. While accreditation is not a panacea to improving quality, nor a requirement of funding arrangements in the current Australian Health Care Agreements, the committee notes that the Commonwealth intends that all privately insured health services will be required to meet accreditation standards set by the Minister for Health.³⁸
- 9.37 The committee considers that all public and private hospitals should be required to be accredited with the Australian Council on Healthcare Standards, or an equivalent accreditation agency, and publish their accreditation reports in a timely manner.

36 Robinson M, Australian Council on Healthcare Standards, transcript, 5 July 2005, p 71.

37 Australian Council on Healthcare Standards, sub 51, p 3.

38 Department of Health and Ageing, *Private Health Insurance Bill 2006 :Guide to the exposure draft* (2006), p 9.

Recommendation 26

9.38 In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government require all public hospitals to:

- **be accredited by the Australian Council on Healthcare Standards (or an equivalent accreditation agency); and**
- **publish their accreditation reports within three months of being completed.**

Recommendation 27

9.39 The Australian Government prohibit the payment of private health insurance benefits for hospital services unless the relevant hospital:

- **is accredited by the Australian Council on Healthcare Standards (or an equivalent accreditation agency); and**
- **publishes their accreditation reports within three months of being completed.**

Reporting adverse events

9.40 Several inquiry participants noted a number of cases of adverse incidents in public hospitals, dissatisfaction with the quality of care provided by medical practitioners and claims of a less transparent culture within some hospital administrations.³⁹

9.41 Mr Anthony Morris QC noted that in Queensland:

The institutional reaction to adverse events and crises is consistently the same: first, you deny the facts; secondly, you bury the evidence; and thirdly, you shoot the messenger.

People who are ‘trouble-makers’ — that is, those (especially clinicians) who raise concerns and identify problems — are subjected to ‘trumped up’ disciplinary complaints and threats of civil and criminal action; have their honesty, their motives, and their clinical competence challenged; are victimised with

³⁹ John Menadue, sub 140, p 2; Health Group Strategies, sub 116, p 12; Mr Anthony Morris QC, sub 72, p 18; Ms Susan Dale, sub 100; Whistleblowers Australia, sub 93, p 24;

inconvenient rosters and other workplace impediments; and are otherwise bullied until they are eventually eased (or squeezed) out of the system altogether.⁴⁰

9.42 Informing patients about the quality of care they have received, or may receive, is important in making health practitioners, or the institutions and service providers for which they work, accountable to the community and their patients. The availability of appropriate information about the quality and safety of health care can also drive changes to improve future health care and inform patients about where they should seek health care.

9.43 The states provide a range of information to the community and patients about the safety and quality of public hospital health care. The Victorian Government noted that:

... public hospitals in Victoria are already highly accountable.

- Through their community consultative structures they are accountable to their local communities.
- Through their boards, and through their annual reporting requirements they are accountable to the Victorian Parliament.
- Through the six monthly Your Hospitals report, they are accountable to the whole community.
- Through the regular provision of information to the Australian Institute of Health and Welfare under the National Health Information Management Agreement they provide a wealth of information available to those who seek a detailed understanding of health care provision.
- Through their requirement to maintain accreditation, they are accountable for the maintenance of high quality services.
- Through their internal clinical governance arrangements they are accountable for the reporting and minimization of adverse events and through the Sentinel Event Program Annual Report there is accountability to the wider community, and
- Through the Victorian budget process and Auditor-General requirements accountability in relation to system financial performance is maintained.⁴¹

40 Anthony Morris QC, sub 72, p 18.

41 Victorian Government, sub 67, p 7.

- 9.44 A sentinel event is an adverse event that occurs because a hospital system and process deficiencies and which results in death, or serious harm to, a patient. Examples of sentinel events include:
- procedures involving the wrong patient or body part;
 - retained instruments or other material after surgery requiring re-operation or further surgical procedure;
 - medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs;
 - maternal death or serious morbidity associated with labour or delivery; and
 - unexpected death or serious disability reasonably believed to be preventable.⁴²
- 9.45 The committee notes that health ministers had agreed to publicly report sentinel event data by the end of 2005 in a National Sentinel Events Report.⁴³ As yet, however, only New South Wales, Victoria, South Australia and Western Australia have publicly reported on sentinel events.⁴⁴ The committee notes that Queensland, Tasmania, the Northern Territory and the Australian Capital Territory have not yet regularly reported on the incidence of adverse events, despite Queensland experiencing numerous reports of adverse events in the past few years.
- 9.46 The committee considers that the transparent reporting of sentinel events by states is important. This would enable development of preventative strategies to ensure improved patient safety. Regular reporting by the states needs to be encouraged, as it should assist in the creation of a more open culture that supports learning and improvement.

42 Western Australian Department of Health, Office of Safety and Quality in Health Care: Sentinel Events, viewed on 8 November 2006 at www.health.wa.gov.au/safetyandquality/sentinel/index.cfm#definition.

43 Department of Health and Ageing, Sentinel events, viewed on 11 October 2006 at [www.health.gov.au/internet/safety/publishing.nsf/Content/6A2AB719D72945A4CA2571C5001E5610/\\$File/sentnlevnt31305.pdf#search=%22sentinel%20events%20report%20vic%20toria%22](http://www.health.gov.au/internet/safety/publishing.nsf/Content/6A2AB719D72945A4CA2571C5001E5610/$File/sentnlevnt31305.pdf#search=%22sentinel%20events%20report%20vic%20toria%22).

44 Department of Human Services (Vic), *Sentinel event program Annual report 2004–05* (2005), December; NSW Health, *Patient Safety and Clinical Quality Program: Second report on incident management in the NSW public health system 2004–2005* (2005); Department of Health (WA), *Delivering Safer Health Care in Western Australia The Second WA Sentinel Event Report 2005–2006* (2006); Department of Health (SA), *Improving the System: South Australian Patient Safety Report 2003–2004* (2006).

Recommendation 28

- 9.47 **The Australian Government require all state and territory governments to regularly publish reports on sentinel events occurring in their public hospitals.**

Better information about clinician performance

- 9.48 Good information about individual clinician performance can support greater choice by patients and provide an important source of feedback to clinicians about the performance of their peers.

- 9.49 Several inquiry participants noted that the absence of information about clinician performance did not allow patients to clearly differentiate between the quality of services provided.⁴⁵ Catholic Health Australia noted that:

One of the features that distinguishes health care from other goods and services is that consumers suffer a considerable disadvantage in terms of knowledge and access to information about their treatment options and the relative performance of providers (doctors and hospitals) in delivering that treatment. [Catholic Health Australia] strongly supports the rights of consumers to be able to make informed choices about their treatment and choice of provider.⁴⁶

- 9.50 Information about the individual performance of cardiac surgeons has been publicly available in some jurisdictions in the United States for several years and more recently in the United Kingdom.⁴⁷ Public reporting of this information in the United Kingdom has largely stemmed from concerns about the insular and 'club culture' of the National Health Service and the creation of a 'patient centred' system.⁴⁸ In the United States, the availability of public reporting

45 Fitzgibbon M, NIB Health Funds, transcript, 20 July 2006, p 67; Health Group Strategies, sub 116, p 36; Catholic Health Australia, sub 35, p 3.

46 Catholic Health Australia, sub 35, p 3.

47 Neil D, S Clarke and J Oakley, 'Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues', *Medical Journal of Australia* (2004), vol 181, no 5.

48 Neil D, S Clarke and J Oakley, 'Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues', *Medical Journal of Australia* (2004), vol 181, no 5, p 266.

systems was expected to allow better informed consumers to demand quality and that poor performers would be disciplined by the market.⁴⁹

- 9.51 There appear to be concerns from some parts of the medical profession that public reporting of individual clinicians' performance will lead to defensive medicine and an avoidance of high-risk patients.⁵⁰ On the other hand, there appear to be benefits to providing more information to patients about a clinician's performance, with the Australian Council on Healthcare Standards noting that:

With respect to some of the public reporting, there was the New York cardiac reporting where they put up reports on different surgeons in different hospitals and their outcomes. The consumers could not have cared less. They saw it but they did not change their attendance patterns, they did not change their choices. But it made those doctors who were not performing improve their performance. In fact, it did work for the health professionals, but the consumers did not change.⁵¹

- 9.52 In Australia, outcome data for individual surgeons are collected by many hospitals and surgeons themselves, but they are not centrally coordinated into a comprehensive database, and no surgeon-specific data are available to the public.⁵²
- 9.53 The committee considers that, on balance, safety and accountability can be strengthened through wider public reporting of clinician performance. However, it is important that reporting is not simply based on crude measures such as death rates, but consider broader issues such as patient mix, complexity and performance standards.

49 Neil D, S Clarke and J Oakley, 'Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues', *Medical Journal of Australia* (2004), vol 181, no 5, p 267

50 Hughes C and P Mackay, 'Sea change: public reporting and the safety and quality of the Australian health care system', *Medical Journal of Australia* (2006), vol 184, no 10.

51 McDonald H, Australian Council on Healthcare Standards, transcript, 5 July 2005, p 75.

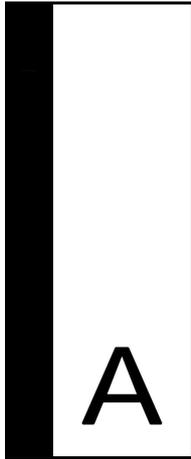
52 Neil D, S Clarke and J Oakley, 'Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues', *Medical Journal of Australia* (2004), vol 181, no 5.

Recommendation 29

- 9.54 **The Australian Government support the development of hospital and clinician-based performance information systems to better inform patients about the competence of health care providers and strengthen accountability of health professionals and health service providers. Reporting systems should allow, where appropriate, for performance information to be qualified to reflect differences in the type of patients being treated.**

Hon Alex Somlyay MP

Chair



Appendix A – List of Submissions

- 1 Orphan Australia Pty Ltd
(Also see sub 52.)
- 2 Ms Maureen Mileham
- 3 Australian Health Policy Institute, University of Sydney -
Prof Stephen Leeder
- 4 Dubbo City Council (NSW)
- 5 Australian Health Service Alliance Ltd
- 6 Health Insurance Restricted Membership Association of
Australia
- 7 Royal College of Pathologists of Australasia
- 8 Victorian Health Promotion Foundation - VicHealth
- 9 Combined Pensioners & Superannuants Association of NSW Inc
- 10 Australian Institute of Health and Welfare
- 11 GlaxoSmithKline Australia Pty Ltd
- 12 Australian Institute of Medical Scientists
- 13 Bankstown City Council (NSW)
- 14 National Network of Private Psychiatric Sector Consumers and
their Carers
- 15 Australian Divisions of General Practice Ltd

- 16 Australian Health Insurance Association Ltd
(Also see sub 156.)
- 17 Australasian College for Emergency Medicine
- 18 Local Government Association of NSW and Shires Association
of NSW
- 19 Royal Australian College of General Practitioners
(Also see subs 66, 69.)
- 20 Strategic Planning Group for Private Psychiatric Services
- 21 Australian Diagnostic Imaging Association
- 22 Pine Rivers Shire Council (Qld)
- 23 Sunshine Coast Division of General Practice - Mrs Ann Barker
- 24 Australian Private Hospitals Association
(Also see subs 57, 97, 98.)
- 25 Australian Council of Social Service
- 26 Ms Narelle Ladd
- 27 Royal College of Nursing, Australia
- 28 Australian Dental Association Inc
(Also see sub 77.)
- 29 MBF Australia Limited
- 30 Australian Medical Association Limited
(Also see subs 54, 84, 101, 138.)
- 31 Rural Doctors Association of Australia
- 32 Darebin City Council (Vic)
- 33 Municipal Association of Victoria
- 34 Western Australian Local Government Association
- 35 Catholic Health Australia
- 36 Australian Local Government Association
- 37 Doctors Reform Society (WA)
- 38 Australian Association of Pathology Practices Inc
- 39 Australian Nursing Federation
- 40 Australian Society of Anaesthetists

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- 41 Pharmacy Guild of Australia
- 42 Medicines Australia Inc
- 43 Australian Government - Department of Health and Ageing
(Also see subs 102, 142, 143, 155.)
- 44 Mr Ed Gorkic
- 45 Australian Doctors' Fund Limited
(Also see sub 78.)
- 46 City of Mandurah (WA)
- 47 Name suppressed
- 48 Caloundra Home and Community Care Association (Qld) -
Mr Malcolm Graham
- 49 National Health and Medical Research Council
- 50 RWM Consultancy
- 51 Australian Council on Healthcare Standards
(Also see sub 65.)
- 52 Orphan Australia Pty Ltd
(Supplementary to sub 1.)
- 53 Australian Association of Gerontology Inc
- 54 Australian Medical Association
(Supplementary to sub 30. Also see subs 84, 101, 138.)
- 55 Macquarie Health Corporation (NSW)
- 56 Mr E D Webber
- 57 Australian Private Hospitals Association
(Supplementary to sub 24. Also see subs 97, 98.)
- 58 Kidney Health Australia
- 59 National Rural Health Alliance Inc
- 60 Northern Territory Government – Minister for Health
(Also see subs 129, 151.)
- 61 Medical Industry Association of Australia
- 62 Australian Healthcare Association
- 63 Mr Bob Holderness-Roddam

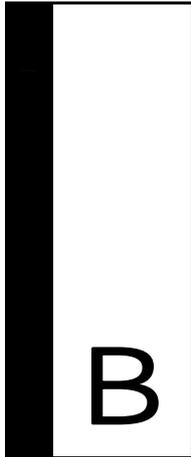
- 64 ACT Government – Minister for Health
- 65 Australian Council on Healthcare Standards
(Supplementary to sub 51.)
- 66 Royal Australian College of General Practitioners
(Supplementary to sub 19. Also see sub 69.)
- 67 Victorian Government – Minister for Health
- 68 Mr Barry Morgan
- 69 Royal Australian College of General Practitioners
(Supplementary to subs 19, 66.)
- 70 MBF Australia Limited
(Supplementary to sub 29.)
- 71 Hinchinbrook Therapy Centre (Qld)
- 72 Mr Anthony Morris QC
- 73 Dr Vladimir J Vizec
- 74 Australian Government - Department of Veterans' Affairs
(Also see sub 158.)
- 75 Private Health Insurance Ombudsman
(Also see sub 83.)
- 76 Charles Darwin University - Prof Lesley Barclay and
Dr Suzanne Belton
- 77 Australian Dental Association Inc
(Supplementary to sub 28.)
- 78 Australian Doctors' Fund Limited
(Supplementary to sub 45.)
- 79 Sussex Inlet Foundation for Community Development Inc
- 80 Mr David Hetherington
- 81 Redcliffe-Bribie-Caboolture Division of General Practice (Qld)
(Also see sub 110.)
- 82 Maternity Coalition Inc
- 83 Private Health Insurance Ombudsman
(Supplementary to sub 75.)
- 84 Australian Medical Association Limited
(Supplementary to subs 30, 54. Also see subs 101, 138.)

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- 85 Private Health Insurance Administration Council
- 86 Flinders Medical Centre and University of Adelaide
(Also see sub 122.)
- 87 Dr G J Morris
- 88 Ms Jody Mogensen
- 89 Ms Marion O'Shea
- 90 Dr David Hartman
- 91 Mr T M Hickey
- 92 James Cook University, Vascular Biology Unit -Associate
Professor Jonathon Golledge
- 93 Whistleblowers Australia
- 94 Drs B & E Goldman
- 95 Ms Christine Corner
- 96 Dr Peter Fon
- 97 Australian Private Hospitals Association
(Supplementary to subs 24, 57. Also see sub 98.)
- 98 Australian Private Hospitals Association
(Supplementary to subs 24, 57, 97.)
- 99 Confidential
- 100 Ms Susan Dale
- 101 Australian Medical Association Limited
(Supplementary to subs 30, 54, 84. Also see sub 138.)
- 102 Hon Tony Abbott MP, Minister for Health and Ageing
(Supplementary to sub 43. Also see subs 142, 143, 155.)
- 103 Caboolture Shire Council (Qld)
- 104 Australian Medical Association - Queensland
- 105 Confidential
- 106 Confidential
- 107 Dr Ross Cartmill
(Also see sub 120.)
- 108 Collins Group Pty Ltd

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- 109 Mr E D Webber
- 110 Redcliffe-Bribie-Caboolture Division of General Practice (Qld)
(Supplementary to sub 81.)
- 111 Confidential
- 112 Australian Lung Foundation
- 113 Health Workforce Queensland
- 114 Dr M A Neaverson
- 115 Australian Proton Project Working Party
- 116 Health Group Strategies Pty Limited
- 117 Government of South Australia – Minister for Health
(Also see sub 131.)
- 118 Australian Physiotherapy Association
- 119 Enteral Industry Group
- 120 Urological Society of Australasia - Dr Ross Cartmill
- 121 Mr Vic Bayliss
- 122 Flinders Medical Centre and University of Adelaide
(Supplementary to sub 86.)
- 123 City of West Torrens (SA)
(Also see sub 133.)
- 124 Western Australian Government
- 125 Mr Duncan Brown
(Also see sub 137.)
- 126 John Barker and Associates
- 127 Australian Health Care Reform Alliance
- 128 Institute of Medical and Veterinary Science
- 129 Northern Territory Government – Minister for Health
(Supplementary to sub 60. Also see sub 151.)
- 130 Multiple Sclerosis Australia
- 131 Government of South Australia
(Supplementary to sub 117.)
- 132 Confidential

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- 133 City of West Torrens (SA)
(Supplementary to sub 123.)
- 134 Blissful Undisturbed Baby's Sleep Pty Ltd
- 135 Confidential
- 136 Australian Psychological Society Ltd
- 137 Mr Duncan Brown
(Supplementary to sub 125.)
- 138 Australian Medical Association Limited
(Supplementary to subs 30, 54, 84, 101.)
- 139 Union of Australian Women (NSW)
- 140 Mr John Menadue AO
- 141 Australian College of Health Service Executives
- 142 Australian Government - Department of Health and Ageing
(Supplementary to subs 43, 102. Also see subs 143, 155.)
- 143 Australian Government - Department of Health and Ageing
(Supplementary to subs 43, 102, 142. Also see subs 155.)
- 144 Council of Capital City Lord Mayors
- 145 Hunter New England Area Health Service (NSW)
- 146 St Jude Medical Australia Pty Ltd (NSW)
- 147 Shire of Laverton (WA)
- 148 Council of Ambulance Authorities Inc (SA)
- 149 Aboriginal Medical Services Alliance Northern Territory
- 150 Sentiens Pty Ltd
- 151 Northern Territory Government - Minister for Health
(Supplementary to subs 60, 129.)
- 152 Shire of Bruce Rock (WA)
- 153 Australian Breastfeeding Association
- 154 Care Inc - Financial Counselling Services and the Consumer
Law Centre of the ACT
- 155 Australian Government - Department of Health and Ageing
(Supplementary to subs 43, 102, 142, 143.)

- 156 Australian Health Insurance Association Ltd
(Supplementary to sub 16.)
- 157 Confidential
- 158 Australian Government – Department of Veterans’ Affairs
(Supplementary to sub 74.)
- 159 Australian Breastfeeding Association
(Supplementary to sub 153.)



Appendix B – List of Exhibits

- 1 Australian Society for Medical Research – letter to Hon Tony Abbott MP, titled *Accelerating Discovery and Capturing the Returns: A 5-Year Plan for Investment in Health and Medical Research in Australia (2006-2011)*; 26 August 2005.
- 2 TQA Research Pty Ltd, *Consumer Survey – Informed Financial Consent* – conducted for Australian Government Department of Health and Ageing, report issued 10 March 2005.
- 3 Strategic Planning Group for Private Psychiatric Services, Innovative Models Working Group *Discussion Paper: The Assessment of Models of Funding Service Delivery for Private Psychiatric Services*, August 2005.
[Related to submission no. 20]
- 4 Australian Government – Department of Health and Ageing, *The state of our public hospitals, report*, June 2005.
[Related to submission no. 43]
- 5 Australian Health Insurance Association Ltd, *Private Hospital Share of Private Health Insurance Benefit Payments: Financial years 1999-2005*, Data Source: PHIAC Quarterly Statistics. (Received from AHIA, 21 September 2005)
[Related to submission no. 16]

- 6 Australian Society for Medical Research – letter to Hon John Howard, titled *Accelerating Discovery and Capturing the Returns: A 5-Year Plan for Investment in Health and Medical Research in Australia (2006-2011)*; 26 August 2005.
- 7 Australian Society for Medical Research, *Accelerating Discovery and Capturing the Returns: A 5-year plan for investment in health and medical research in Australia 2006-2011 – Response to the Investment Review of Health and Medical Research: Sustaining the Virtuous Cycle for a Healthy, Competitive Australia*, December 2004 – Prepared and jointly submitted by: Association of Australian Medical Research Institutes (AAMRI), Australian Society for Medical Research (ASMR), Research Australia Ltd, August 2005.
- 8 Confidential
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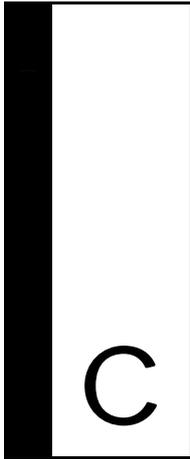
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- 28 Kaiser Permanente, PowerPoint Presentation, *Population Management for Chronic Conditions*, 26 September 2005.
(Provided by Mr Paul Gross, Health Group Strategies Pty Limited, 26 May 2006)
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- 30 Australian Institute of Health and Welfare, *Funding of Public Hospitals, 1997-98 to 2003-04*, related to Health Care Agreements.
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- 32 Australian Health Care Reform Alliance, *Demographics name and address list*, printed 9 June 2006.
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- 33 Menadue, John, *How the politically urgent pushes the important aside*, Address at University of South Australia to graduating students in the Division of Health Sciences, 28 March 2006.
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- 34 Menadue, John, *Leadership and Change Management - What Role do Values and Ethics Play?* - Address to Australian College of Health Service Executives, Yarra Valley, 9 March 2006.
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- 35 Menadue, John, *Principles and Priorities for Health Care Policy Development* - Address to L21 Health and Aged Care Forum, Sydney, 22-23 November 2005.
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- 36 Menadue, John, *Subsidising Private Health Insurance - Throwing more good money after bad*, New Matilda Pty Ltd, February 2006
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- 37 Menadue, John, *Spin doctors and the micro-management of health*, New Matilda Pty Ltd, December 2005.
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- 38 Menadue, John, *Curing Sick Hospitals*, New Matilda Pty Ltd, September 2005.
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- 39 Menadue, John, *Health Sector Reform Part 1: Workforce Reform*, New Matilda Pty Ltd, July 2005.
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- 40 Menadue, John, *Health Sector Reform Part 2: Primary Care and Wellbeing*, New Matilda Pty Ltd, July 2005.
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- 41 Menadue, John, *The Hospital tail wags the Health Dog*, New Matilda Pty Ltd, March 2005.
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- 42 Menadue, John, *A coalition of the willing*, New Matilda Pty Ltd, January 2005.
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- 44 Australian Government, Department of Health and Ageing, *A New Strategy for Community Care: The Way Forward*, report, Commonwealth of Australia, 2004.
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- 51 Tracy, Sally & others, *An integrated service network in maternity - the implementation of a midwifery-led unit*, downloaded from www.bmj.com.
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- 53 Michael, Robin, *Dr Len Notaras: 36 Redefining Hours*
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- 54 Royal Darwin Hospital, *Royal Darwin Hospital Bali responses - People, Practice and Planning*, pamphlet.
(Received from Dr Robin Michael, August 2006)
- 55 West Australian Local Government Association (WALGA), *Finding the best medicine: Information for Local Government on GP recruitment and retention*, WALGA and the Western Australian Centre for Remote and Rural Medicine, 2005.

- 56 Osteoporosis Australia, *Osteoporosis in Australia*, PowerPoint presentation, September 2006.
- 57 Australian Proton Project Working Party, PowerPoint presentation on Australian National Proton Facility; *Masters Program in Medical Radiation Physics*, Centre for Medical Radiation Physics, University of Wollongong; ACCEL Proton Therapy; IBA Particle Therapy, *Integrating the Ultimate Particle Therapy Facility for You*, IBA 2006. (Provided by Sue Bleasel, Australian Proton Project Working Party, September 2006) [Related to submission no. 115]
- 58 Australian Medical Association (AMA), *Training and support for the future medical workforce: a looming crisis if left unattended*, AMA briefing paper, August 2006 [Related to submission nos. 30, 54, 84, 101, 138]
- 59 Australian Health Policy Institute, The University of Sydney, copy of letter from Professor Stephen Leeder AO to Mr Ed Webber re participation in the Institute's health workforce study, September 2006. [Related to submission no. 3]



Appendix C – List of Public Hearings and Site Inspections

Public Hearings

Monday, 30 May 2005, Canberra, ACT

Australian Divisions of General Practice Ltd

Ms Kate Carnell, Chief Executive Officer

Ms Leanne Wells, Manager, Policy and Development

Ms Liesel Wett, Deputy Chief Executive Officer

Department of Health and Ageing

Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch

Ms Rachel Balmanno, Assistant Secretary (Acting), Strategic Planning Branch

Mr Philip Davies, Deputy Secretary

Ms Rosemary Huxtable, First Assistant Secretary (Acting), Acute Care Division

Mr Charles Maskell-Knight, Adviser, Medical Indemnity Branch

Mr Nick Mersiades, First Assistant Secretary, Ageing and Aged Care Division

Ms Samantha Robertson, Assistant Secretary (Acting), Medicare Benefits Branch

Tuesday, 28 June 2005, Melbourne, VIC

Australasian College for Emergency Medicine

Dr Andrew Singer, President

Knox City Council

Mr Gerard Jose, Director, Community Services

Municipal Association of Victoria

Ms Clare Hargreaves, Senior Advisor, Social Policy

Mr Gerard Jose, Community Services, Knox City Council

Orphan Australia Pty Ltd

Mr Alastair Young, Managing Director

Rural Doctors Association of Australia

Dr Ken Mackey, Immediate Past President

Ms Susan Stratigos, Policy Adviser

Victorian Health Promotion Foundation (VicHealth)

Prof Alan Moodie, Chief Executive Officer

Ms Caroline Sheehan, Acting Director, Health Promotion Innovation

Tuesday, 5 July 2005, Sydney, NSW

Australian Council on Healthcare Standards

Ms Heather McDonald, Executive Manager Customer Services

Ms Maureen Robinson, Executive Manager Development

Australian Dental Association Inc.

Dr William O'Reilly, President

Combined Pensioners & Superannuants Association of NSW Inc

Mr Robert Jay, State Secretary

Mr Mario Mifsud, State President

Mr David Skidmore, Policy and Information Officer

Royal Australian College of General Practitioners

Prof Michael Kidd, President

Dr Vasantha Preetham, Vice President, Royal Australian College of General Practitioners Western Australia

Mr Ian Watts, National Manager, General Practitioner Advocacy and Support

Royal College of Pathologists of Australasia

Dr Debra Graves, Chief Executive Officer

University of Sydney

Prof Stephen Leeder, Director Australian Health Policy Institute

Tuesday, 23 August 2005, Sydney, NSW**Roundtable**

Mr Michael Roff, Australian Private Hospitals Association

Mr Ian Burningham, MBF Australia Limited

Mr Angus Norris, MBF Australia Limited

Mr Bruce Harrison, Australian Health Service Alliance

Mr Russell Schneider, Australian Health Insurance Association

Dr Andrew Mulcahy, Australian Society of Anaesthetists

Mr John O’Dea, Australian Society of Anaesthetists

Mr Bruce Levy, Medibank Private Limited

Mr Francis Sullivan, Catholic Health Australia

Mr Patrick Tobin, Catholic Health Australia

Dr Dana Wainwright, Australian Medical Association

Wednesday, 24 August 2005, Sydney, NSW**Roundtable**

Mr Greg Brown, North Shore Private Hospital

Mr Michael Roff, Australian Private Hospitals Association

Mr George Toemoe, St Luke's Hospital Complex

Dr Leanon Clark, Australian Private Hospitals Association

Dr Michael Coglin, Australian Private Hospitals Association

Mr Lewis Saliba, Cabrini Health

Mr Roger Greenman, Cabrini Health

Ms Mary Foley, St Vincents and Mater Health

Mr Patrick Tobin, Catholic Health Australia

Wednesday, 21 September 2005, Canberra, ACT**Australian Council of Social Service**

A/Prof Donald Harvey, Health Policy Advisor

Mr Gregor Macfie, Policy Officer

Australian Government - Private Health Insurance Administration Council

Ms Gayle Ginnane, Chief Executive Officer

Australian Health Insurance Association Ltd

Mr Russell Schneider, Chief Executive Officer

Consumers' Health Forum of Australia

Ms Helen Hopkins, Executive Director

Private Health Insurance Ombudsman

Mr John Powlay

Strategic Planning Group for Private Psychiatric Services (SPGPPS) and National Network of Private Psychiatric Sector Consumers and their Carers

Dr Bill Pring, Chair, SPGPPS Information Strategy Working Group

Ms Christine Gee, Chair, Australian Private Hospitals Association (APHA) Psychiatric Committee

Mr Paul Mackey, Director, Policy and Research, APHA

Mr Brian Osborne, Chair, Australian Health Insurance Association (AHIA) Mental Health Committee

Ms Janne McMahon, Chair, National Network of Private Psychiatric Sector Consumers and their Carers

Mr Phillip Taylor, Executive Officer, SPGPPS

Monday, 28 November 2005, Canberra, ACT**Australian Medical Association**

Dr Mukesh Haikerwal, President

Ms Julia Nesbitt, Director, General Practice and E-Health

Dr Choong-Siew Yong, Vice-President

Department of Health and Ageing

Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch

Ms Judith Blazow, Medical and Pharmaceutical Services Division

Ms Yvette Costmeyer, Acting Assistant Director, Policy Analysis Section, Policy and International Branch

Ms Judith Daniel, Assistant Secretary, Primary Care Programs Branch

Mr Philip Davies, Deputy Secretary

Mr Charles Maskell-Knight, Acting First Assistant Secretary, Acute Care Division

Ms Samantha Robinson, Assistant Secretary (Acting), Medicare Benefits Branch

Mr Rodney Schreiber, Director, Policy Analysis Section, Policy and International Branch

Mr Nathan Smyth, Assistant Secretary, Health Priorities and Suicide Prevention Branch

Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch, Acute Care Division

Thursday, 16 March 2006, Brisbane, QLD

Individuals

Mr Anthony Morris QC, former Commissioner of Inquiry into Bundaberg Hospital

Australian College of Rural and Remote Medicine

A/Prof Bruce Chater, Immediate Past President

Ms Marita Cowie, CEO and Company Secretary

Australian Medical Association of Queensland

Dr Zelle Hodge, President Elect

Ms Colleen Smyth, Senior Policy Officer

James Cook University, The Townsville Hospital & The Mater

Prof Ian Wronski, Pro-Vice Chancellor; Dean, Faculty of Medicine, Health and Molecular Sciences

Mount Olivet Hospital

Mr Philip Sheedy, General Manager

Redcliffe-Bribie-Caboolture Division of General Practice

Dr Ralph Smallhorn, President and Medical Director

Mr John Stafford, Project Officer

Visiting Medical Officers of AMA Queensland

Dr Ross Cartmill, President

Whistleblowers Australia

Mr Kevin Lindeberg

Dr Brian Senewiratne, Member

Friday, 17 March 2006, Caboolture, QLD**Aspen Medical Pty Ltd**

Mr Glenn Keys, Managing Director

Caboolture Shire Council

Cr Joy Leishman, Mayor

Ms Julie Bruynius, Manager, Community Development Unit

Cr Lynette Devereaux, Councillor

Ms Jane Frawley, Community Planning Coordinator

Ms Virginia Day, Centacare Bribie Community Options

Mrs Christine Minetti, Special Projects, Bribie Community

Family Care Medical Services

Mr Stuart Tait, Executive Chairman

Pine Rivers Shire Council

Mrs Pamela Jenkins, Director, Lifestyle and Environment

Friday, 7 April 2006, Canberra, ACT**Australian Association of Pathology Practices Inc**

Dr Michael Guerin, President

Mr David Kindon, Chief Executive Officer

Australian Nursing Federation

Ms Victoria Gilmore, Federal Liaison Officer

Ms Jill Iliffe, Federal Secretary

Australian Private Hospitals Association

Ms Lucy Fisher, Executive Director, Queensland Branch

Mr Paul Mackey, Director of Policy and Research

Mr Michael Roff, Executive Director

Medical Industry Association of Australia

Mr David Ross, Director, Healthcare Access

Mr Brian Vale, Chief Executive Officer

Pharmacy Guild of Australia

Mr John Dowling, President, Tasmanian branch of th Pharmacy Guild

Dr Michael Tatchell, Director, Health Economics

Tuesday, 2 May 2006, Adelaide, SA**City of West Torrens**

Mr Declan Moore, Group Manager, City Services

Hon John Trainer, Mayor

Flinders Medical Centre and University of Adelaide - Clinicians (various)

Dr Nicola Dean, Department of Plastic and Reconstructive Surgery,
Flinders Medical Centre

Mr Philip Griffin, Head of Unit, Department of Plastic and
Reconstructive Surgery, Flinders Medical Centre

Government of South Australia, Department of Health

Ms Heather Parkes, Acting Director, Office of Health Reform

Dr Richenda Webb, Director, Clinical Systems, Public Health and
Clinical Coordination

Kidney Health Australia

Dr Timothy Matthew, Medical Director

Ms Anne Wilson, Chief Executive Officer

Friday, 26 May 2006, Sydney, NSW**Australian Diagnostic Imaging Association**

Mr Gary Barnier, Executive Member

Dr Ronald Meikle, President

Mr Edward (Jim) Pryce, Treasurer

Dr Ronald Shnier, Vice-President

Australian Healthcare Association

Prof John Deeble, Health Economist Consultant

A/Prof Deborah Green, Immediate Past President

Mr Daniel O'Connor, General Manager

Ms Prue Power, Executive Director and Company Secretary

Health Group Strategies Pty Limited

Mr Paul Gross, Director

Hospital Reform Group

Professor Kerry Goulston

Dr Darryl Mackender, Senior Staff Specialist Gastroenterologist,
Gosford Hospital

Professor Malcolm Fisher, Intensive Care Specialist, NSW Health

Ms Kerry Stevenson, Allied Health Professional

Mrs Kate Needham, Intensive Care Nurse

Dr Clare Skinner, Emergency Physician Trainee, Royal North Shore
Hospital

Mrs Deborah Latta, Health Care Manager

Wednesday, 31 May 2006, Canberra, ACT**Individuals**

Mr Andrew Podger, Private Capacity

Thursday, 20 July 2006, Newcastle, NSW**Individuals**

Mr Duncan Brown, Private Capacity

Australian Psychological Society, Newcastle Branch

Mr Cecil Russell, Member of Branch Committee

Hunter New England Area Health Service

Mr Terry Clout, Chief Executive

A/Prof David Crompton, Area Director, Mental Health Service

Ms Carolyn Hastie, Midwifery Manager, Belmont Birthing Service

Ms Judith Kennedy, Deputy Director, Mental Health Service

Hunter Urban Division of General Practice

Dr Arn Sprogis, Chief Executive Officer

NIB Health Funds Limited

Mr Mark Fitzgibbon, Chief Executive Officer

Union of Australian Women

Ms Betty Mawdsley, Secretary, Newcastle Branch

Friday, 21 July 2006, Sydney, NSW**Individuals**

Mr John Menadue, Private Capacity

Dr Richard Scotton, Private Capacity

Australian Health Care Reform Alliance

Ms Fiona Armstrong, Executive member

Dr Michael Kidd, Executive member

Ms Viola Korczak, Executive member

Local Government Association of NSW and Shires Association of NSW

Mr Noel Baum, Strategy Manager - Community Team, Policy and Research

Cr Bruce Miller, Vice President, Shires Association of NSW Executive Council

Ms Vanessa Whittington, Public Health Policy Officer

The Australian Lung Foundation

Mr Bryan Clift, Consumer Consultant

Dr William Darbishire, Chief Executive Officer

Prof Peter Frith, Chair, Chronic Obstructive Pulmonary Disease National Program Committee

Prof Christine Jenkins, Member, Chronic Obstructive Pulmonary Disease Coordinating Committee

Dr Rima Staugas, President, Thoracic Society of Australia and New Zealand

Wednesday, 23 August 2006, Darwin, NT**Aboriginal Medical Services Alliance Northern Territory**

Mr Robert Curry, Program Manager and Physiotherapist

Mr John Paterson, Executive Officer

Charles Darwin University, NT

Prof Lesley Barclay, Graduate School for Health Practice, Institute of Advanced Studies

Northern Territory Department of Health and Community Services

Dr Rosy Warden, Director, Strategic Health Policy

Dr Tarun Weeramanthri, Assistant Secretary, Quality and Strategy

RWM Consultancy

Mr Rollo Manning, Principal

Thursday, 24 August 2006, Perth, WA**Government of Western Australia, Department of Health**

Mr Kim Darby, Director, Business Enhancement, WA Country Health Service

Mr Peter King, Acting Chief Financial Officer

Mr Mark Miller, Manager, Federal Affairs Branch

Dr Peter Wynn Owen, Executive Director, Mental Health

Mr Michael Pervan, Director

Dr Simon Towler, Executive Director, Health Policy and Clinical Reform

Mr Colin Xanthis, Acting Executive Director, Health System Support

Doctors Reform Society of Western Australia

Dr Scott Douglas, Treasurer

Dr Jane Ralls, President

Western Australian Local Government Association (WALGA)

Mrs Jennifer Bow, Deputy Chief Executive Officer, Shire of Bruce Rock

Mr Jed Handmer, Policy Officer, WALGA

Ms Michelle Mackenzie, Community Policy Manager, WALGA

Mr Stephen Strange, Shire President, Shire of Bruce Rock

Mr Barrye Thompson, Chief Executive Officer, Shire of Laverton, Western Australia

Monday, 4 September 2006, Canberra, ACT**Australian Health Insurance Association**

Hon Michael Armitage, Chief Executive Officer

Australian Physiotherapy Association

Ms Kerren Clark, Manager, Policy and External Relations

Ms Catherine Nall, National President

Department of Veterans' Affairs

Mr Richard Bartlett, National Manager, Primary Care Policy Group

Ms Roslyn Beard, Project Officer, Medical and Allied Health Policy Section, Primary Care Policy Group

Site Inspections**Thursday 29 June 2005, Ballarat, VIC****Ballarat IVF Clinic, Wendouree**

Dr Russell Dalton, Clinical Director, Ballarat IVF

Ballarat Day Procedure Centre and IVF laboratory, Wendouree

Dr Mark Yates, Clinical Director, Subacute Medicine, Ballarat Health Services

Board members of Ballarat Health Services

Wednesday 6 July 2005, Sydney, NSW**St George Private Hospital, Kogarah**

Prof Michael Chapman, Chairman, IVF Directors Group

Ms Susan Channon, Chief Executive Officer, IVF Australia

Dr Richard Porter, Director (Clinical), IVF Australia

Dr Adrienne Pope, President, Fertility Society of Australia

Wednesday 24 August 2005, Sydney, NSW**North Shore Private Hospital, St Leonards**

Mr Greg Brown, Chief Executive Officer

Monday 20 February 2006, Latrobe, TAS**Glaxosmithkline Factory, via Latrobe**

Mr Geoff Zippel, Director, Chemicals Division

Mr Mike Doyle, Research & Field Manager

Mr Scott Ryan, Government Affairs Manager

Mr Keith Rice, Chief Executive, Tasmanian Poppy Growers' Association

Friday 24 March 2006, Sydney, NSW**Australian Nuclear Science and Technology Organisation, Lucas Heights**

Dr Ian Smith, Executive Director

Dr Nabil Morcos, Acting Head of Radiopharmaceutical Research

Mr Ian Turner, General Manager, Australian Radiopharmaceuticals and
Industrials

Dr John Bartlett, Acting Head, Institute of Materials and Engineering
Science

Tuesday 2 May 2006, Adelaide, SA**Queen Elizabeth Hospital Dialysis Facilities, Woodville and Wayville
Campuses, Woodville South**

Dr Graeme Russ, Director Nephrology, Queen Elizabeth Hospital

Dr Tim Mathew, Medical Director, Kidney Health Australia

Ms Dee Parkhurst, Registered Nurse, Queen Elizabeth Hospital
Wayville

Wednesday 3 May 2006, Adelaide, SA**Institute of Medical and Veterinary Science (IMVS) Pathology Laboratories, Adelaide**

Mr Kevin Kelly, Chair, IMVS Council

Prof Brendon Kearney, Director

Mr Mark Cawthorne, Deputy Director

Dr Geoffrey Higgins, Deputy Head, Infectious Diseases Laboratories
Virology

Dr Ivan Bastian, Deputy Head, Infectious Diseases Laboratories
Microbiology

Dr Tom Dodd, Head, Anatomical Pathology

Dr Barney Rudzki, Head, Molecular Pathology

Mr John Glasson, Chief Operating Officer, Division of Clinical Pathology

Thursday 20 July 2006, Newcastle, NSW**Belmont Birthing Unit, GP Access After Hours, Belmont Hospital, Belmont**

Ms Yvonne Patricks, Service Manager Belmont Hospital

Ms Elise Campbell, Midwife

Ms Lauren Chiplin, Communication officer

Ms Amanda Francis, GP Access After Hours

Wednesday 23 August 2006, Darwin, NT**National Critical Care and Trauma Response Centre
Royal Darwin Hospital**

Mr Robin Michael, General Manager, Royal Darwin Hospital

Dr Len Notaras, Medical Superintendent, Royal Darwin Hospital

Mr Peter Campos, Assistant Secretary, Acute Care Services, NT Health
Department

