

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

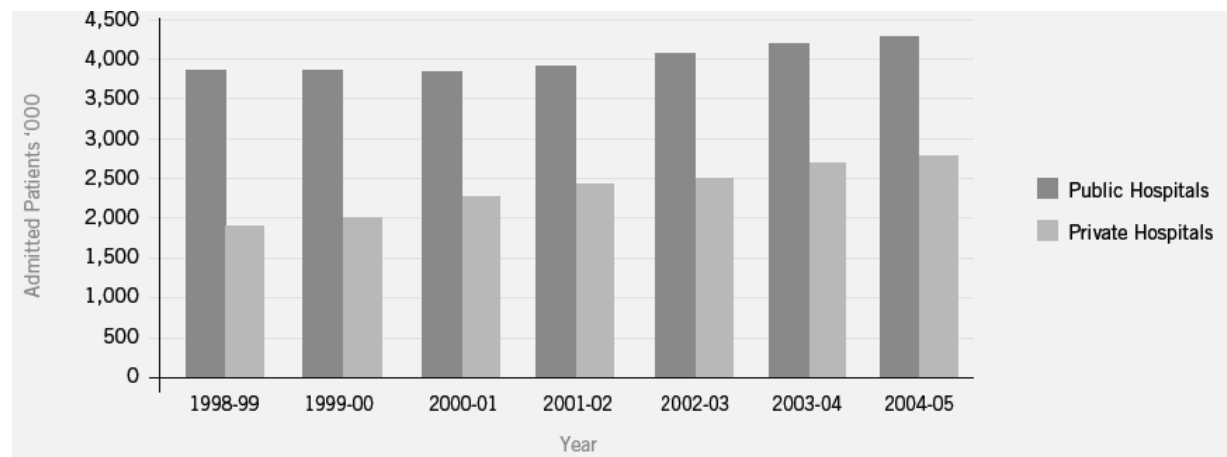
7.13 Total recurrent public hospital expenditure in 2004-05 was \$21.3 billion. This was an increase, after adjustment for inflation, of 5.3 per cent on the previous year. Average growth over the period 1994-95 to 2004-05, adjusted for inflation, was 4.4 per cent.¹⁰ These figures include the cost of 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 AHCA's.

- 7.20 Box 7.2 gives illustrative examples of the kinds of allegations that the department has investigated under the current AHCA's, 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 AHCA's.
- 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 AHCA's 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 AHCA's 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.