CHAPTER 2

THE ADEQUACY OF FUNDING FOR PUBLIC HOSPITALS

2.1 This chapter commences with a profile of the public hospital sector. The subsequent discussion provides some contextual background on the intergovernmental arrangements and mechanisms used to fund public hospitals including an overview of the practices adopted in each State and Territory to fund their public hospitals. Given this background, an assessment is then provided of the adequacy of funding for public hospitals now and in the future from several perspectives: the Commonwealth, the States and Territories, and consumers and other participants in the inquiry. Particular issues affecting rural and remote areas are also addressed.

Profile of the public hospital sector

2.2 Table 2 provides an overview of the size, activity and financial details of public hospitals in Australia, including the number of available beds, the number of separations, the proportion of separations which are same day separations, and details of the average length of stay, both in total and excluding same day separations. An indication of the workload of accident and emergency units is provided in the number of non-admitted occasions of service and details of expenditure are included. A breakdown of the activity of public hospitals in terms of public patients and private patients is also provided. The table contains data for both 1993-94 and 1997-98, permitting an analysis of changes over time.

2.3 Comparing 1993-94 and 1997-98, it is noteworthy that the number of available beds in public hospitals has declined by 5525. While the cost of hospital beds will vary quite dramatically within and between hospitals (eg intensive care beds will have a higher cost than other hospital beds), as an indication, the Australian Healthcare Association (AHA) calculated that the annual recurrent cost of a 50 bed medium sized rural hospital is $10 million.[1]

2.4 In terms of activity, while the annual number of separations has increased by 452 000, patient days have decreased by 755 000, reflecting, in the main, the decline in the numbers of private patient separations. Same day separations have increased from 34.2 per cent of total separations in 1993-94 to 43.3 per cent of separations in 1997-98. The notable changes over this period with regard to private patients in public hospitals are a decline in the number of private patient separations from 545 000 in 1993-94 to 355 000 in 1997-98 and, allied to this, a decline in patient revenue, from $1.08 billion in 1993-94 to $1.07 billion in 1997-98. This is partly, but not solely, related to the decline in the proportion of the population covered by private health insurance.

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1 Submission No.63, Additional Information, p.6 (AHA, Women's Hospitals Australia, Australian Association of Paediatric Teaching Centres).

Table 2: Profile of the public hospital sector, 1993-94 and 1997-98

Public acute and psychiatric hospitals	1993-94		1997-98	
Establishments				
No of hospitals	746		764	
Available beds	61 260		55 735	
Beds per 1000 population	3.4		3.0	
Activity				
Separations ('000)				
Public acute hospitals	3 296		3 748	
Public patients	2 557		3 222	
Private patients	545		355	
Public psychiatric hospitals	n.a.		23	
Same days separations as % of total				
Public acute hospitals	34.2		43.3	
Public patients	35.0		43.8	
Private patients	33.2		42.7	
Public psychiatric hospitals	n.a.		10.6	
Separations per 1000 population				
Public acute hospitals	185.6		201.2	
Public patients	144.0		173.0	
Private patients	30.7		19.1	
Public psychiatric hospitals	n.a.		1.2	
Patient days ('000)				
Public acute hospitals	15 907		15 152	
Public patients	12 029		12 460	
Private patients	2 529		1 419	
Public psychiatric hospitals	n.a.		1 409	
Average length of stay (days)	A	B	A	B
Public acute hospitals	4.8	6.8	4.0	6.4
Public patients	4.7	6.7	3.9	6.1
Private patients	4.6	6.4	4.0	6.2
Public psychiatric hospitals	n.a.	n.a.	62.4	69.7
Non-admitted occasions of service	n.a.		32 605 248	
Financial data				
Total salary expenditure ($'000)	6 897 956		8 242 305	
Total non-salary expenditure ($'000)	3 690 172		4 783 440	
Total recurrent expenditure ($'000)	10 588 128		13 025 745	
Total revenue ($'000)	1 083 619		1 068 763	

A = all separations B = excluding same day separations

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

Historical overview of the funding arrangements for public hospitals[2]

2.5 The Australian Constitution initially vested responsibility for hospital and health services with State governments. However, the 1946 Constitutional Amendment, which inserted section 51(xxiiiA), gave the Commonwealth power to legislate on:

> the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.[3]

2.6 This change in the Constitution, together with the revenue raising powers of the Commonwealth Government, has made it an important partner to the States and Territories, both in the funding of health services, and in determination of the key features of the Australian health care system. An important implication of this which has been noted in some of the submissions to the inquiry is that although the States and Territories have responsibility for the funding and delivery of health services, the Commonwealth has a major role in determining the level and nature of health services provision in Australia. A short overview of the extent of the Commonwealth's power in the health area is provided in the previous chapter.

2.7 The most important financial relationship between the Commonwealth and State and Territory governments in relation to public hospital services is through the Australian Health Care Agreements (previously Medicare Agreements). The current Health Care Grants (which have also replaced a number of smaller Specific Purpose Payments (SPPs) which have been rolled into the Agreements) were preceded by the Hospital Funding Grants, provided since the introduction of Medicare in 1984, and prior to that by cost-sharing agreements in relation to Medibank in the period since 1975. Before attempting to assess changes in the shares of Commonwealth and State and Territory funding of public hospital and other health services, it is useful to review briefly the arrangements under the different funding Agreements.

Arrangements prior to Medicare

2.8 The arrangements for Medibank, established in 1975, provided one of the first major inputs by the Commonwealth government in policy setting, funding and delivery of public hospital services. Under the funding Agreements (which were effectively ten year agreements, although in practice they were much more short-lived because of changes of government), the States agreed to provide free public hospital services and the Commonwealth agreed to 50-50 cost sharing of the costs of public hospital services. This was an open-ended commitment by the Commonwealth, which significantly increased its financial contribution to public hospital services.

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2 Material in this section is drawn from a research report prepared for the Committee by the Centre for Health Economics Research and Evaluation (CHERE) at the University of Sydney.

3 *The Constitution: as altered to 31 October 1986*, Canberra, AGPS, 1986, p.18.

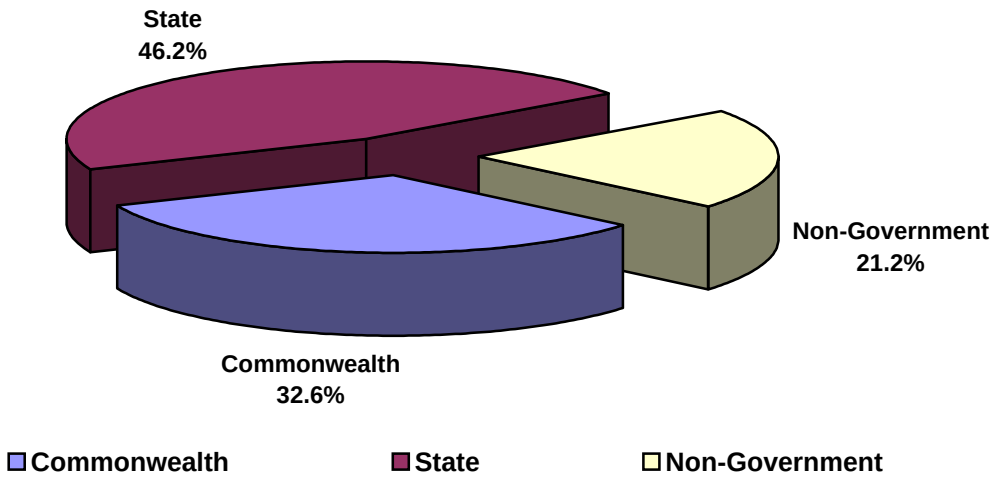
Commonwealth expenditure on public hospitals increased from $222.9 million in 1974-75 to $949.6 million in 1975-76. At the same time as the introduction of Medibank, the Commonwealth increased the use of Specific Purpose Payments (SPPs) to direct policy towards other programs and services, such as community health programs.

2.9 A number of factors, including the need to control expenditure, led to the cost-sharing arrangement being amended from May 1976. The Commonwealth contribution was then limited to 50 per cent of approved hospital operating costs. This gave the Commonwealth the capacity to implement changes in the level of funding it provided. In addition, the new Coalition Government amended the scheme, allowing for individuals to opt for private health insurance or to make voluntary contributions to the public system. Charges for public hospital services were also re-introduced, although they were heavily subsidised for pensioners and those on low incomes.

2.10 Cost-sharing agreements between the Commonwealth and the States persisted in some States until 1980, and in South Australia and Tasmania until 1983. However, these additional outlays were offset by their inclusion in the Commonwealth Grants Commission (CGC) equalisation process. From 1981, based on recommendations of the Jamison inquiry, cost-sharing arrangements were replaced by Identified Health Grants.

2.11 Figure 4 indicates the proportion of public hospital funding contributed by the Commonwealth government, the State and Territory governments and the non-government sector (mainly individuals and private health insurance funds) in 1982-83, the year prior to the introduction of Medicare.

Figure 4: Commonwealth and State/Territory Governments and Non-Government Contributions towards Public Hospital Funding – 1982-83



Source: Calculated from data supplied by CHERE sourced to AIHW data.

Medicare Agreements 1984-1988

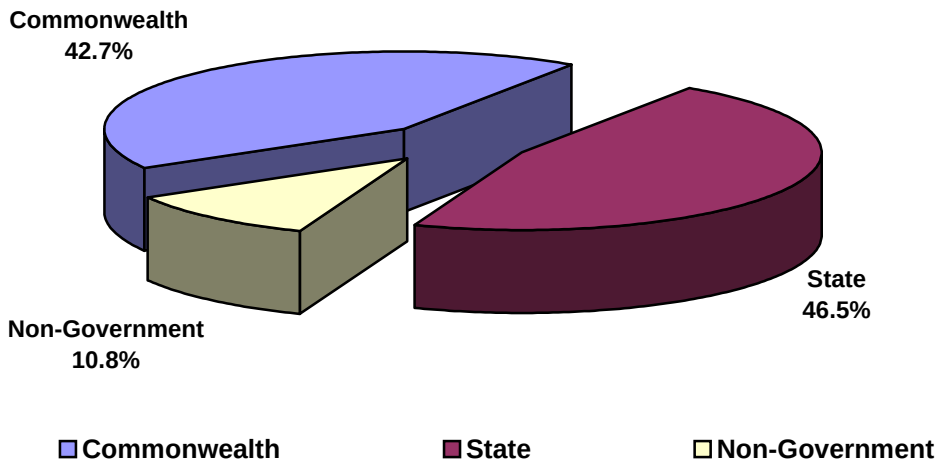
2.12 Medicare was introduced in February 1984, reinstating Agreements between the Commonwealth and the States which aimed to ensure universal access to free public hospital services. Commonwealth payments to the States consisted of Identified Health Grants and a Medicare Compensation Grant. The aim of the Medicare Compensation Grant was to compensate States for the loss of private patient revenue, resulting from a shift of patients from private to public status following the reintroduction of free public hospital services. The Commonwealth paid the States a per diem amount for each bed-day which shifted from private status to public status, and a contribution of $50 per bed-day for increased utilisation as a result of public hospital services being free.[4] In addition, the grant provided for compensation in relation to the elimination of charges for outpatient services, the additional cost of providing medical services to public patients, and new arrangements for nursing home type patients.

2.13 The Agreement between the Commonwealth and the States and Territories also provided for funding for new community health services. During the period of the 1984-1988 Agreements, there were a number of other changes to Commonwealth health policy which impacted upon public hospital services, including removal of the bed-day subsidy to private hospitals, and removal of the after-hours medical fee loading for GPs.

4 It is worth noting, however, that the impact of the utilisation factor was not as anticipated because of issues such as declining length of stay and industrial action by doctors. In later Agreements and negotiations separations rather than bed-days have been used as a measure of utilisation.

2.14 Figure 5 indicates the proportion of funding for public hospitals contributed by the Commonwealth government, the State and Territory governments and the non-government sector during the term of the first Medicare Agreement, 1984-1988.

Figure 5: Commonwealth, State/Territory Governments and Non-Government Contributions towards Public Hospital Funding – 1983-84 to 1987-88



Source: Calculated from data supplied by CHERE sourced to AIHW data.

Medicare Agreements 1988-1993

2.15 The second round of Medicare Agreements between the States, Territories and the Commonwealth replaced the Medicare Compensation Grants and the Identified Health Grants with the base funding grants included in the new Hospital Funding Grants. However, it has been argued that for a number of reasons, the growth in the previous Grants had been low, leading to a lower initial funding base for the second round Grants. This point was made by Dr Deeble, who argued in his submission to the inquiry that 'unrealistically low rates of growth [had been] built into the Commonwealth's hospital contribution. The deficiency was greatest in the first 8 years of its life'.[5]

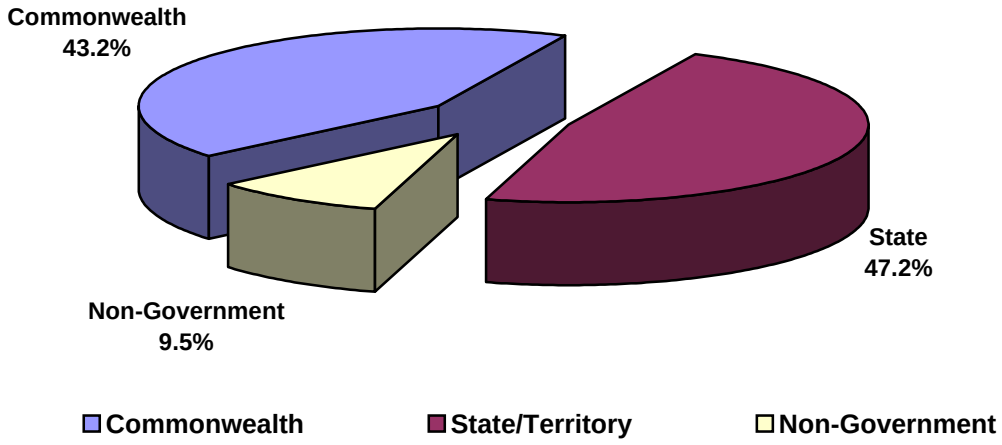
2.16 The base grant during the period of the Agreements was adjusted for inflation (based on 75 per cent of the Award Rates of Pay Index and 25 per cent of the Consumer Price Index (CPI)) and for growth in the population (based on age and sex weighted hospital utilisation). The base grant was to be adjusted if a State's or Territory's proportion of private bed-days exceeded the national average, or if the State per capita level of in-hospital Medicare benefit payments exceeded the national average by more than 5 per cent.

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

2.17 In addition to the base grant, the Commonwealth also provided funding for the treatment of HIV/AIDS patients (adjusted for population growth and increases in the number of AIDS patients) and grants for the development of incentives programs. These amounts were quarantined for adjustment under the Commonwealth Grants Commission (CGC) processes (unlike the base grant). The funding for incentives programs reflected an increased involvement by the Commonwealth in hospital policy development, because it provided the opportunity for the Commonwealth to encourage service innovation. Incentive funding was provided for palliative care, day surgery and early discharge programs, and for development and implementation of casemix information systems and management in public hospitals.

2.18 Figure 6 indicates the proportion of funding for public hospitals contributed by the Commonwealth government, the State and Territory governments and the non-government sector during the term of the second Medicare Agreements 1988-1993.

Figure 6: Commonwealth, State/Territory Governments and Non-Government Contributions towards Public Hospital Funding – 1988-89 to 1992-93



Source: Calculated from data supplied by CHERE sourced to AIHW data.

Medicare Agreements 1993-1998

2.19 The third round of Medicare Agreements between the Commonwealth and the States and Territories commenced from 1 July 1993, and, as with the previous Agreements, there was little change to the basic arrangements whereby the States and Territories provided free public hospital services to eligible persons, and the Commonwealth provided funding. From 1992, the Medicare Principles and Commitments as well as the new funding arrangements were established under Commonwealth legislation (the *Medicare Agreements Act 1992*). As noted earlier, these principles related to choice to be treated as a public patient, universality of access and equity in service provision.

2.20 However, there were some changes to the funding arrangements between the Commonwealth and the States and Territories. The base grant continued to be calculated in the same way (although $400 million was removed from the base grant and included in bonus pools, and quarantined from the CGC processes), that is, adjusted for inflation (based on 75 per cent of the Award Rates of Pay Index and 25 per cent of the Consumer Price Index) and for weighted population growth. As well as the base grant, two bonus payment pools were introduced to encourage improved public access.

2.21 Bonus Pool A was to be distributed to States and Territories for additional public bed-days above a benchmark proportion of 51.5 per cent of total bed-days, and included penalties for a State or Territory if the share of public bed-days was below 51.5 per cent. That is, if a State or Territory treated more public patients, resulting in a greater proportion of its bed-days being public bed-days, then it would receive funds from Bonus Pool A. However, if the proportion of public bed-days fell below the minimum of 51.5 per cent in a State or Territory then financial penalties would apply.

2.22 Bonus Pool B was to be distributed to States and Territories that increased their share of public bed-days over the public share in 1990-91. That is, if a State's or Territory's share of public bed-days was, say, 53.5 per cent in 1990-91 and the jurisdiction treated a greater proportion of public patients in 1993-94, resulting in the share of public bed-days increasing to 54.0 per cent, then it would receive funds from Bonus Pool B.

2.23 In addition, there were penalty clauses in relation to the base grant if a State's or Territory's level of per capita expenditure on the Medicare Benefits Schedule (MBS) exceeded the national average by more than 1.11 per cent. The Agreement also included funding (in the form of incentives packages) for other reforms relating to improvements in quality and management of services. This again reflected increasing Commonwealth involvement in policy development in relation to hospital services.

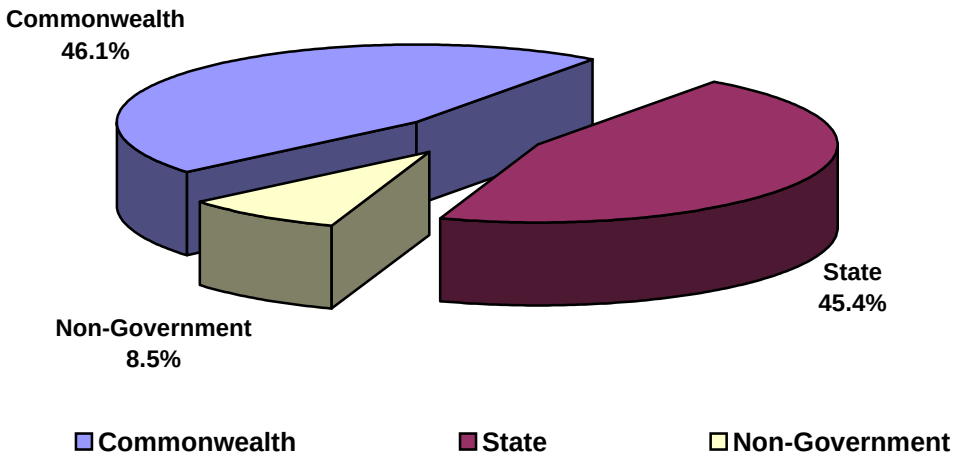
2.24 Finally, an important addition to the 1993-1998 Agreements was the provision that the amount of funding provided by the Commonwealth would be reviewed if the proportion of the population covered by supplementary hospital insurance (as opposed to basic table insurance) fell by at least 2 percentage points from the June 1993 level (the so-called '2 per cent reviews'). This reinstated as an explicit part of the Agreements recognition of the relationship between the level of private health insurance coverage and the demand for public hospital services. However, it is notable that when the reviews did take place as a result of continued decline in private health insurance coverage, the Commonwealth and the States and Territories could not reach agreement about the financial impact or the level of compensation which was appropriate.

2.25 This reflects an important factor that has not been adequately quantified in negotiations over financing public hospital services between the Commonwealth and the States and Territories, and is reflected in some of the submissions to the inquiry. This issue is discussed in a later section of this chapter, which will canvass issues

related to the inquiry's term of reference dealing with the adequacy of current funding levels to meet future demand for public hospital services.

2.26 Figure 7 indicates the proportion of funding for public hospitals contributed by the Commonwealth government, the State and Territory governments and the non-government sector during the term of the third, and final Medicare Agreements, 1993-1998. Unlike the periods covered by the previous agreements, under the third Medicare Agreements, from 1993-94 to 1997-98, the proportion of public hospital funding contributed by the Commonwealth exceeded that contributed by the States and Territories.

Figure 7: Commonwealth, State/Territory Governments and Non-Government Contributions towards Public Hospital Funding – 1993-94 to 1997-98



Source: Calculated from data supplied by CHERE sourced to AIHW data.

Australian Health Care Agreements 1998-2003

2.27 The 1998-2003 Australian Health Care Agreements (AHCAs) represent, in some ways, a significant departure from its two predecessors, the Medicare Agreements. The 1998-2003 AHCAs encompass greater scope for altering funding levels and also enable flexibility in service provision. This section will focus on those changes and highlight some points of contention between the States and Territories and the Commonwealth.

2.28 In the previous Medicare Agreement 1993-98, funding levels were based on the base grant with some scope for variation based on population, age, sex, award rates of pay and CPI. It further included penalties for States with higher than average MBS growth rates and bonus payments for improved public access. In the 1998-2003 AHCAs, variations to the base health care grant can be made on the basis of a weighted population index (based on population growth and ageing), changes in hospital output costs, known as the Hospital Output Cost Index (HOCI), changes in the veteran population and private health insurance coverage.

The Hospital Output Cost Index

2.29 As noted above, under the AHCAs, funding to the States and Territories is partially indexed to a hospital output cost measure (HOCI). State funding increases should the HOCI rise, and decreases if the HOCI goes down. Whilst the Commonwealth and States agreed to this in principle, the formulation of the HOCI has been a point of contention. The AHCAs state that the parties will commit to the development of a suitable index for adjusting the Health Care Grants to reflect changes in hospital output costs. The AHCAs also state that in the case of a dispute, an independent arbiter may be proposed and that the parties will use their best endeavour to reach a settlement. The fall-back position, in case there was disagreement on the HOCI, was that the Commonwealth would use a default 0.5 per cent measure.

2.30 A brief outline of the process leading to the appointment of an independent arbiter was provided by the New South Wales Government in its submission:

> States and Territories commissioned the Australian Bureau of Statistics to develop an index (to be used in conjunction with a productivity dividend) to reflect the change in hospital input costs. This index was estimated to be 4.2% in 1998-99. In another display of disregard for the public hospital system, the Commonwealth refused to consider this index and decided to retain the default indexation arrangements. States and Territories invoked the arbitration provision and an independent arbiter was appointed to resolve the dispute.[6]

2.31 The independent arbiter, Mr Ian Castles, who was appointed by the Commonwealth, recommended that the HOCI should comprise the CPI plus 0.5 per cent and that a review should be held to assess any effect of the GST. In response to a question on notice during the Senate Community Affairs Legislation Committee's scrutiny of the 1999-2000 Additional Estimates, the Commonwealth Department of Health and Aged Care (DHAC) outlined the reasons why the Commonwealth had decided to reject the recommendation of the independent arbiter on the HOCI:

> …the Commonwealth decided not to adopt the arbiter's recommendation because there was no evidence that output costs were increasing at the rate of increase of the Consumer Price Index, far less at that rate plus 0.5%.
>
> Evidence from State budget papers indicated that States collectively expected output costs per separation to increase by 1.2 per cent in 1999-2000, or about the same rate of increase as Wage Cost No.1. This is in line with long term trends in hospital output costs.[7]

6 Submission No.79, p.19 (NSW Government).

7 Senate Community Affairs Legislation Committee, *Examination of Additional Estimates 1999-2000: additional information received*, v. 2, May 2000, p.145.

2.32 The Commonwealth Government's position on the HOCI was contained in a letter dated 23 December 1999 from the Minister for Health and Aged Care, Dr Wooldridge, to his State and Territory counterparts. In this letter, the Minister advised that the Commonwealth Government had decided to index the health care agreements by wage cost index 1 (WCI 1), which is a mix of 75 per cent of the wage index and 25 per cent of the CPI. However, in evidence, the Western Australian Health Department argued that the independent arbiter:

> looked at wage cost index 1 and considered that as a possible indexation and he commented in his report–something with which we all agree–that it does not bear any relationship to the cost of producing outputs in the health sector. He actively rejected that as a possible index, as we do.[8]

2.33 Concerns have been raised by several State governments about the Commonwealth's position on the HOCI and these concerns are discussed later in this chapter. DHAC has advised that the Minister for Health and Aged Care has approved the AHCA funding arrangements for 1999-00 and 2000-01, using WCI 1 as the HOCI.

Casemix-based funding

2.34 Casemix refers to the range and types of patients treated by a hospital.[9] Casemix-based funding has become the dominant form of funding of public hospitals in most jurisdictions. The objective of casemix-based funding is to fund hospitals on the basis of their output, what they actually do, rather than on the basis of the level of funding provided in the previous year. However, casemix-based funding does not fund hospitals on the basis of how much it costs them to care for and treat a particular mix of patients but rather on the basis of how much each jurisdiction is prepared to pay for the care and treatment of the casemix.

2.35 While casemix-based funding has provided a useful means of requiring hospitals to focus on their costs, it is not entirely clear whether knowledge has actually improved on the reasons why costs for the same procedure vary between different hospitals or precisely how much it should cost to treat a particular patient with a particular condition. The Committee of Presidents of Medical Colleges pointed to these shortcomings when it told the Committee that 'most hospitals do not have real understanding of what it costs to treat an individual patient. Without that, it cannot have a good classification system'.[10]

2.36 The Australian College of Health Service Executives (ACHSE) explained to the Committee the difference between what casemix aims to do and the resource allocation process of government which determines the level of funding that will be provided to public hospitals. ACHSE argued that:

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8 *Committee Hansard*, 25.2.00, p.278 (Health Department of Western Australia).

9 Australian Institute of Health and Welfare, *Australia's Health 2000*, Canberra, AIHW, 2000, p.439.

10 *Committee Hansard*, 23.3.00, p.493 (Committee of Presidents of Medical Colleges).

> it is important to have costing systems that tell us what it costs for units of activity, and casemix does that. Where the difference is, is then allocating on a proportional basis of the total funds available where there is a gap between the price paid for a unit of activity and the cost of delivering that activity. I think that is why a lot of people are saying that therefore casemix does not work.[11]

2.37 Recognition by State and Territory governments that casemix does not provide adequately for a wide range of the functions and responsibilities of different hospitals, such as teaching and staff development, has led to increases in the fixed grants which they provide to hospitals together with variable casemix-based payments. However, other shortcomings have been summarised by Professor George Palmer as: 'some patients do not properly belong in any of the casemix groups' and, 'for the same DRG[12], certain costs, notably for intensive care, may be incurred in treating some patients but not others'. Palmer argues that these costs are high and may together 'represent more than 20% of the aggregate costs of acute-care hospitals'.[13] Other concerns with casemix-based funding include perverse incentives to discharge patients quickly. The Royal Australasian College of Physicians (RACP), the Australian Consumers Association (ACA) and the Health Issues Centre concluded in their joint submission that:

> generally, it is agreed that casemix funding forces hospitals to examine and use their resources more efficiently, and encourages clinicians to consider the economic impact of their clinical decisions. It also clearly encourages throughput.[14]

2.38 Finally, the South Australian Salaried Medical Officers Association (SASMOA) argued that while casemix 'is acknowledged as having changed the focus of health care':

> we believe that the casemix system is now past its use-by date. Outcome and evidence-based measures of performance should now be developed and adopted to underpin the funding model.[15]

However, this is not a universal view, with a representative of ACHSE informing the Committee that: 'I do not think casemix is by its use-by date'.[16]

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11 *Committee Hansard*, 23.3.00, p.549 (ACHSE).

12 DRGs, or diagnosis related groups are used in casemix classification systems. Australian acute hospitals use AN-DRGs to classify patients admitted to hospital into groups with similar conditions and similar use of hospital resources. This then enables comparisons to be made of the activity and performance of hospitals. (Australian Institute of Health and Welfare, *Australia's Health 2000*, p.440).

13 Palmer, G 'Evidence-based health policy-making, hospital funding and health insurance', *Medical Journal of Australia*, vol. 172, 7.2.00, p.131.

14 Submission No.45, p.11 (RACP, ACA, Health Issues Centre).

15 *Committee Hansard*, 23.2.00, p.187 (SASMOA).

16 *Committee Hansard*, 23.3.00, p.549 (ACHSE).

Overview of State and Territory funding arrangements for public hospitals[17]

2.39 It is important to note that in all States and Territories, hospitals and health services receive a capped budget each year, although this budget will generally be based on the anticipated mix of patients and conditions which the hospital is expected to treat and the price which the State or Territory is prepared to pay for each separation. The extent to which casemix information is used to fund ambulatory services and community health services varies considerably across the States and Territories. Similarly, within this broadly dominant model, there continues to be funding on the basis of block grants, often historically determined.

2.40 The fact that hospitals and health services in all jurisdictions are funded via capped budgets is an important feature of the Australian health system. It is only at the margins that public hospitals are able to increase total funding or budget share by undertaking more activity. In addition, once the budget is set, the incentives are for hospitals and health services to manage as efficiently as possible the demand for services, within the given budget and the operating environment.

2.41 A notable difference between the States and Territories is the extent to which the Department of Health in each jurisdiction is seen as a direct purchaser of services from hospitals and health services or as a funder of regional based services for a defined population. This latter model is most fully articulated in NSW which continues to be committed to needs adjusted population based funding to Area Health Services, which are then responsible for managing services. In other jurisdictions the principle of population based management is less explicit. However, to some extent this relates to the size and geographical distribution of the population. The following is an overview of the funding arrangements in each State and Territory.

New South Wales

2.42 In NSW, health services provision is funded, organised and delivered on an Area Health Service basis. Area Health Services are responsible for the management of the health of a geographically defined population. A needs-adjusted population-based funding formula is used as a basis for allocating resources to Area Health Services, although the formula also includes components relating to cross-boundary flows for tertiary services. Area Health Services are then responsible for funding and managing the constituent health services. Hospitals and other health services within an Area Health Service are funded on the basis of a global capped budget. In many Area Health Services, casemix information is used as a basis for determining the budget shares of individual hospitals within the Area Health Service, although some hospitals and health services continue to be funded on a historical basis.

2.43 However, some important changes to these arrangements were announced recently by the New South Wales Minister for Health in his response to the reports of

17 Material in this section of the report has been primarily based on the research report prepared for the Committee by the Centre for Health Economics Research and Evaluation (CHERE).

two recent inquiries in New South Wales, chaired by the Right Hon Ian Sinclair (Ministerial Advisory Committee on Smaller Towns) and Mr John Menadue (NSW Health Council). Key initiatives to be implemented include episode funding[18] for all planned and acute hospital admissions and a three-year recurrent health budget.[19]

Victoria

2.44 Victoria implemented casemix-based funding for hospital services from 1 July 1993. Since the initial introduction of casemix funding, there have been a number of changes to how services are funded and organised. Hospitals now receive a fixed annual grant related to overheads and some other services, and a variable case payment. Variable payments account for approximately 40 per cent of total hospital budgets.

2.45 In practice, the funding model involves determining an individual hospital's share of the State's global capped budget on the basis of casemix weighted volume, that is, the number and mix of patients and conditions which are expected to be treated during the year. Thus, each hospital has a capped budget, which is related to a specified volume of activity. However, a component of the State's global budget is also allocated on the basis of a tender pool, whereby rural hospitals and metropolitan health care networks can bid for additional activity in terms of volume and price. Activity-based funding arrangements (that is, funding on the basis of what is done) have also been extended to encompass ambulatory services.

2.46 Metropolitan health services in Victoria have been organised in terms of metropolitan health care networks, which are responsible for providing health services to a defined geographical region. In the recent Government Response to the Ministerial Review of Health Care Networks, a new approach was outlined to managing Victorian public hospitals, with a key change seeing the replacement of the existing seven networks with twelve Metropolitan Health Services.[20]

South Australia

2.47 South Australia implemented casemix-based funding for hospital services from 1 July 1994. Hospitals received an annual grant relating to fixed costs and an activity based payment, which covers both admitted and non-admitted patients, although since 1995 intensive care units have been separately funded. Hospital service agreements are used to specify minimum levels of service, and the scope and level of

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18 Episode funding, as described in the Menadue report, is a similar approach to that of casemix-based funding. Episode funding 'involves negotiating a price for a certain treatment based on recommended clinical practice. The cost will be influenced by the volume, length of stay, the severity of the illness and use of services such as operating theatres, nursing, pathology and accommodation'. (NSW Health Council, *A Better Health System: the report of the NSW Health Council*, p.57).

19 Minister for Health, Hon C Knowles, *Working as a Team–the Way Forward: Ministerial Statement*, 8.3.00, pp.3, 5.

20 Victoria, Ministerial Review of Health Care Networks, *Government Response to the Ministerial Review*, May 2000, p.3.

services to be provided by each hospital. Further developments are extending the use of casemix-based funding to a range of other services, including mental health services. In practice, as in Victoria, the casemix funding system involves the use of casemix adjusted volume and a unit price to determine a hospital's share of the total capped budget for hospital services.

Queensland

2.48 Since 1996-97, Queensland has separated the functions of funding, purchasing and provision of health services. State health services are organised into Health Service Districts which are responsible for the provision of services. Queensland Health purchases services from the Health Service Districts on the basis of service agreements which specify price, casemix and volume. The Queensland Hospital Funding Model consists of several variable components and three fixed components. The variable components, which include an acute inpatient payment, a sub and non-acute patient payment, a designated psychiatric unit payment and an ambulatory payment, are dependent on projections of hospital throughput in the service areas and associated average prices. By comparison, the fixed components, teaching grant, research grant and special grants are determined at the commencement of the funding period.[21]

Western Australia

2.49 Health services in Western Australia are broadly organised and funded on a purchaser-provider model. The Health Department of Western Australia acts as a purchaser of services from Health Service Boards. There are 23 Health Service Boards across the state, with the largest being the Metropolitan Health Services Board. Services are purchased on the basis of a service agreement which specifies casemix adjusted volume, price and other factors such as quality. In 1997-98, Western Australia implemented a casemix-based model for purchasing episodes of care from the Health Service Boards. This model groups admitted patient episodes into core and exceptional episodes. This latter category is used where a patient episode becomes unusually costly due to a long stay in hospital or very expensive inputs (eg high cost drugs). The Health Department of Western Australia's *Annual Report 1998-99* states that it is evaluating the nature of episodes of care through administrative audit and clinical audit processes.[22]

Tasmania

2.50 Tasmania introduced casemix-based funding for its public hospitals from 1 July 1997. The funding model comprises five components: variable payments, including admitted patients (except in designated units such as mental health, palliative and rehabilitation patients) and nursing home type patients; fixed payments,

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21 Queensland Health, *Hospital Funding Model: technical paper*, Brisbane, Queensland Health, July 1999, p.1.

22 Health Department of Western Australia, *Annual report 1998/99*, Perth, the Department, 1999, p.39.

including teaching and staff development, research, clinical development, admitted patients in designated units, ambulatory care and accreditation; site specific payments, including lease payments, magnetic resonance imaging, and transfers; a Special Purpose Payment Pool, including highly specialised drugs, risk management of high cost patients and medico-legal settlements; and a Transition Payment Pool.[23]

Northern Territory

2.51 Northern Territory hospital services are funded using a casemix based funding model. The Territory Health Services purchases services from the network of public hospitals on a purchaser-provider basis. In doing so, Territory Health Services uses a Hospital Budgeting Model which incorporates activity-based funding. Territory Health Services have established internal performance agreements with the public hospitals, based on the Hospital Funding Model. The model determines the financial requirement for Territory public hospitals based on the anticipated volume of services and activities and applies a Northern Territory Specific Price to the expected activity. The price is based on the national benchmark with adjustments to account for specific cost drivers unique to the Northern Territory.[24]

Australian Capital Territory

2.52 Since 1996-97 health services in the Australian Capital Territory have been organised broadly in terms of a purchaser-provider model, with the ACT Department of Health and Community Care purchasing services from providers on the basis of contracts. The contracts use casemix to specify the volume and price of acute inpatient services, an ambulatory classification system is used to specify the volume and price of ambulatory care services, and non-acute inpatient services are funded on a per diem basis. The ACT is also implementing output-based funding for community health services.

Adequacy of funding level for public hospitals

2.53 The majority of submissions to the inquiry regard the level of funding for public hospitals to be inadequate. Ten per cent of submissions argued that the question of adequacy was impossible to answer, while a small number stated that current levels of funding were potentially adequate, but were unable to meet current levels of demand due to inefficiencies.

2.54 This section examines the issue of adequacy of funding by reflecting the differing perspectives of participants in the inquiry about where the problems lie. It then attempts to assess the adequacy of funding for public hospitals now and in the future. When considering the data in this section it is important to note that the

23 Commonwealth Department of Health and Aged Care, Acute and Coordinate Care Branch, *State and Territory Casemix Developments*, at http://www.health.gov.au/casemix/statedev.htm, last updated 16.4.99.

24 Submission No.69, Additional information, p.1 (Northern Territory Government).

differing claims, particularly those of the two levels of government, may all be correct and accurate–to an extent. What needs to be borne in mind is that any change in underlying assumptions such as the base year used for comparative purposes will alter the outcome of any comparison. Not surprisingly, the Commonwealth selects a different base year than the States and Territories in making its comparison on relative spending efforts, with each level of government seeking to portray its own efforts as superior to the other. While all choices of a base year are defensible to an extent, the end result of the different claims tends to obscure the details of what has occurred and how this may impact on the adequacy of funding for public hospitals now and in the future.

The Commonwealth's position

2.55 The Commonwealth Department of Health and Aged Care (DHAC) selected 1991-92 as the base year from which to make comparisons about the relative funding efforts of itself and the States and Territories for public hospitals. The Commonwealth does not fund hospitals directly, nor does it purchase hospital services. Rather, it provides funding to the States and Territories for the provision of public hospital services. DHAC argues that over the period 1991-92 to 1996-97:

> there was a significant increase in productivity over the period with the rate of separations increasing at just over twice the rate of real levels of funding;
>
> Commonwealth funding kept pace with the rate of increase in activity over the period but State funding did not; and
>
> consequent savings arising from the increase in productivity accrued to the States.[25]

2.56 DHAC drew attention in its submission to variations between the States and Territories in the level of 'States-own'[26] funding of public hospitals in each jurisdiction over this period. Increases in real terms were calculated for New South Wales, Queensland and the ACT, while funding decreased in real terms in the other jurisdictions, except Western Australia, where funding was almost the same in real terms in 1996-97 as in 1991-92.[27]

2.57 With regard to the Commonwealth's own funding under the current AHCAs, DHAC argues that funding provided in 1998-99 represents a real increase of 11 per cent when compared to 1997-98, the last year of the previous Medicare Agreement. It

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25 Submission No.38, p.9 (DHAC).

26 The term 'States-own' funding refers to the funding provided by each State and Territory for public hospital services but excludes the funding provided by the Commonwealth to each jurisdiction under the Australian Health Care Agreements. It therefore does not represent the total funding by each State and Territory for public hospital services but rather, that component of funding which the State or Territory has provided from its own revenue (including from general financial assistance grants (FAGS) from the Commonwealth)

27 Submission No.38, p.8 (DHAC).

estimates that total health care grants to the States and Territories under the AHCAs will increase in real terms by a further 4.1 per cent in 1999-2000, 2.3 per cent in 2000-01, 2.5 per cent in 2001-02 and 2.4 per cent in 2002-03.[28]

2.58 Indexation arrangements under the AHCAs are quite different to those under previous agreements. Earlier in this chapter, an overview was provided of the dispute between the Commonwealth and the States and Territories over the level at which the hospital output costs index (HOCI) should be set. The Commonwealth's view is that the HOCI is part of the overall increase in funding and should be judged in that context. This aspect of the Commonwealth's position was presented by Mr Andrew Podger, Secretary of DHAC, in evidence to a recent Senate Estimates hearing, although the comment also reflects the so-called 'blame shifting' which is endemic in this area of Commonwealth-State relations:

> so while there is a dispute over the indexation factor, it is in fact quite a generous arrangement in total adjustments each year. One of the issues, of course, is that a number of the states have not been increasing their amount of money by as much as we are, notwithstanding their disputation that we should put in more.[29]

2.59 Data in Figure 8 indicates the percentage change 1998-99 to 1999-00 in funding by the Commonwealth to each State and Territory under the AHCAs and the States'-own funding in each jurisdiction for its public hospitals. The data, provided by DHAC, supports the Commonwealth's claims that it is increasing funding to the States under the AHCAs and that some of the States and Territories are not increasing funding for their public hospitals at the same rate as the Commonwealth.

2.60 While this contention is supported by the data in respect of New South Wales and Victoria and to a lesser extent the ACT, there has been no increase in percentage terms by the Commonwealth in its funding to Western Australia and the increase in funding to Queensland and Tasmania is below the effort of the respective jurisdictions. Funding by the Commonwealth to the Northern Territory from 1998-99 to 1999-00 under the AHCA has fallen quite dramatically. DHAC has advised that the variation in funding for the Northern Territory is 'largely attributable to the removal of the one-off Transition Adjustment of $19 million included in the Health Care Grant in 1998-99 only'.[30]

2.61 Agreement was reached between the Commonwealth and the States and Territories that the percentage growth in the combined grants to each jurisdiction (comprising the health care grants and general revenue grants) in the later years of the AHCAs 'would be based on the application of the equalisation relativities determined

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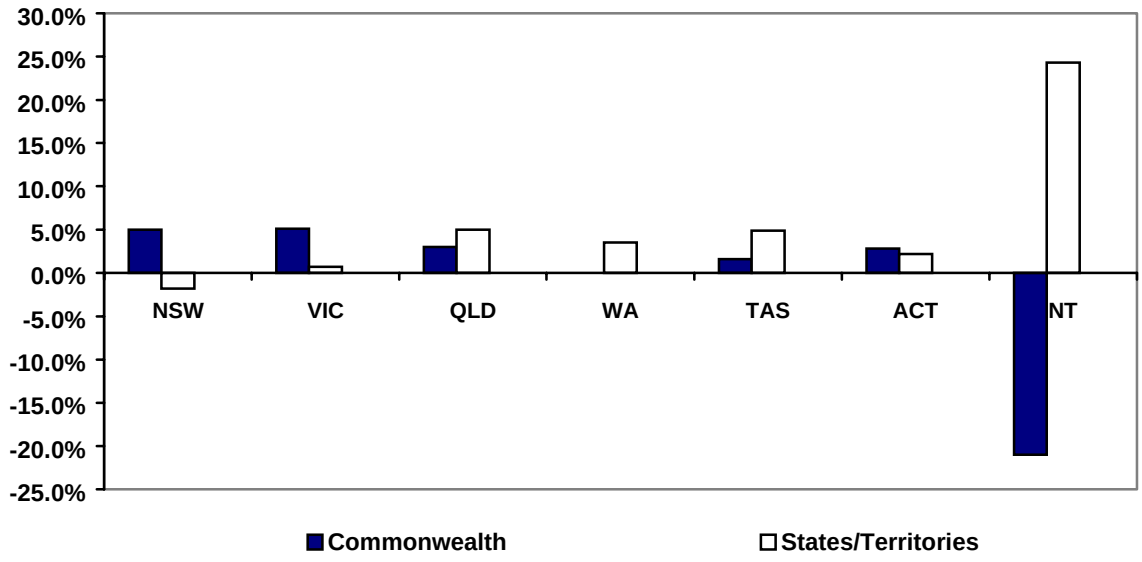
28 Submission No.38, p.11 (DHAC).

29 Senate Community Affairs Legislation Committee, Supplementary Additional Estimates Hearing, *Committee Hansard*, 2.5.00, p.68.

30 Submission No.38, Additional information, 19.6.00, p.1 (DHAC).

by the Commonwealth Grants Commission'.[31] Under these arrangements the Northern Territory is expected to receive the greatest per capita allocation of any jurisdiction in later years. The data in Figure 8 is a further example of the necessity for greater transparency in the funds available from each jurisdiction for public hospital services. A different picture would likely emerge from a chart indicating the percentage change in the following period, 1999-00 to 2000-01, in jurisdictions' funding for public hospitals.

Figure 8: Public Hospital Funding – Commonwealth funding under AHCAs and States' own funding: percentage change 1998-99 to 1999-00



Source: Compiled from: *Submission No.38, Additional Information,* 17.1.00, pp.3-10.

Note: The Commonwealth Department of Health and Aged Care argues that presentation of data in South Australia's Budget Papers for 1999-00 did not enable a similar calculation to the other jurisdictions. However, after adjusting for program changes, DHAC estimates that funding by South Australia for its public hospitals fell by 5.2 per cent over this period.[32]

The position of the States and Territories

2.62 Each of the States and Territories have taken the opportunity to either provide a submission to the inquiry or have appeared before the Committee and offered evidence on the issues relevant to the inquiry's terms of reference. It is not proposed to detail the position of each jurisdiction on all of the issues around the adequacy of funding because, while the particularities may vary, the States and Territories are united in their general claim that the current level of funding by the Commonwealth is inadequate. The States and Territories presented several reasons to support this claim. New South Wales, for example, draws upon the claim made by Dr Deeble in both his submission and evidence that current levels of funding by the Commonwealth will be

31 Submission No.38, Additional information, 19.6.00, p.1 (DHAC).

32 Submission No.38, Additional Information 17.1.00, p.7 (DHAC).

inadequate because unrealistically low levels of increase were built into hospital funding grants to the States in the early years of Medicare:

> the second Medicare agreement (1988 to 1993) continued the very low 'real' growth rates on the Commonwealth side. In fact, the increase in federal contributions barely covered population growth.[33]

2.63 The New South Wales Government draws also on a report prepared by consultants Access Economics for the six States and the Northern Territory during negotiations on the AHCAs in 1998. The report analysed the relative funding efforts of the two tiers of government and found that an informed analysis requires more than comparisons based on a reference year. Access Economics proposed that 'the correct approach is to assess trends over a longer period of time, comparing efforts throughout each of the five-year agreements', and concluded that:

> the assessment of the wider picture invites the conclusion that the States and Territories have pulled their weight in terms of funding the public hospital and public health systems. Relative funding efforts cannot be sensibly assessed without regard to the wider picture. In particular, it is essential to have regard to the impact of Commonwealth policies including the restrictions embodied in Medicare and the progressive reduction, since the mid-1970s, in overall Commonwealth payments to the States.[34]

2.64 This latter point is of importance to the States and Territories because the funding available for their public hospitals is a composite of the specific purpose hospital funding grants (under the AHCAs) and the general purpose financial assistance grants (FAGs) both of which are paid to them by the Commonwealth. With effect from 1 July 2000, the FAGs have been replaced with revenue from the GST which, over time, may provide the States and Territories with greater flexibility in the funding available for their public hospitals.

2.65 An indication of the gradual decline in general purpose grants as a proportion of GDP is provided in Figure 9.

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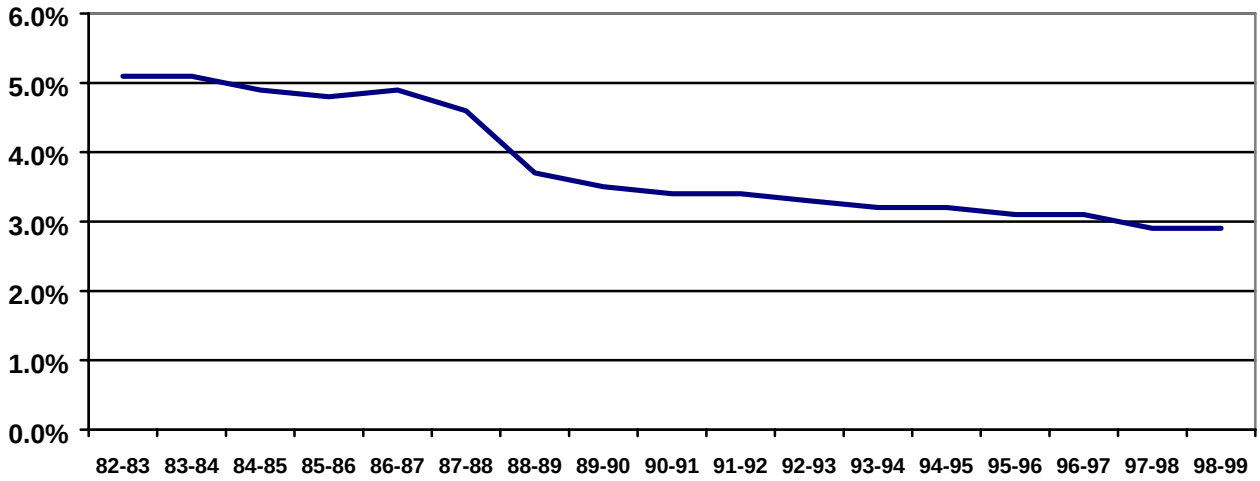
33 Submission No.50, p.14 (Dr Deeble).

34 Access Economics, *Comparative Effort in Health Financing by the Commonwealth and State Governments: report prepared for the Health Departments of the States and the Northern Territory*, Canberra, Access Economics, June 1998, p.19.

Figure 9: Commonwealth Payments to the States and Territories (a)(b)
General Revenue Assistance as a Proportion of GDP 1982-83 to 1998-99



(a) Six States and NT to 1987-88, Six States and both Territories thereafter.

(b) The chart shows gross levels of assistance. No deductions have been made for State fiscal contributions which applied for the period 1996-97 to 1998-99.

Sources: Federal Financial Relations, *Budget Paper No.3, 1999-2000* and various earlier editions. *National Income, Expenditure and Product, ABS (cat no 5206.0).*

2.66 Queensland Health and the New South Wales Government each acknowledged that the current AHCA was an improvement in several respects over the previous Medicare Agreement.[35] However, a specific area of concern for Queensland is what it regards as an underfunding of the State under the (Commonwealth-funded) Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) due to the decentralised nature of the State and the consequent relative undersupply of medical practitioners and community pharmacies in many areas. Queensland estimates that it is out-of-pocket by some $31 million.[36] The Tasmanian Government mounted a similar argument with regard to MBS benefits in Tasmania, in its submission to the inquiry.[37] If this argument were progressed to its logical conclusion, there would be a redistribution of MBS payments from New South Wales and, to a lesser extent, Victoria, to the other jurisdictions.

2.67 However, this calculation by Queensland takes no account of other Commonwealth-funded programs such as those for Indigenous health services nor does it take account of the New South Wales Government's argument that due to the horizontal fiscal equalisation arrangements, it (NSW) is 'subsidising the health

35 See, for example, *Committee Hansard*, 11.11.99, p.70 (Queensland Health) and Submission No.79, p.16 (NSW Government).

36 Submission No.41, p.18 (Queensland Government).

37 Submission No.67, p.5 (Tasmanian Government).

services of some other states and territories'.[38] New South Wales calculates that while its entitlement under the AHCAs is to about 34.2 per cent of the pool of funds, it receives only around 30.4 per cent of the pool 'after the Grants Commission redistributes a proportion of the NSW entitlement to other states and territories'.[39]

2.68 Clearly, this type of circular argument does not advance an assessment of the adequacy of funding for public hospitals. Horizontal fiscal equalisation is a reality of Commonwealth-State financial relations and can be supported on a range of social grounds. In addition, the claim for MBS funding to be equalised on a notional per capita basis on the grounds of fairness is not quite as straightforward as it might appear. There are a variety of factors which explain differences between jurisdictions and within jurisdictions with regard to the availability of, and benefits for, out-of-hospital services. While the availability of GPs in particular areas is one factor which contributes to the differences in per capita MBS benefits, it is not the only reason. For example, the ACT received a lower per capita payment of MBS benefits ($288) than any other jurisdiction, excluding the Northern Territory, in 1997-98 and was well below the Australia-wide per capita benefit of $354. Queensland received $341 in Medicare benefits per capita in 1997-98.[40]

2.69 There are two key areas where the States and Territories have concerns about the adequacy of funding for public hospitals, both now and in the future. These concerns relate to the hospital output costs index (HOCI) and to taxation issues, principally the GST (both in terms of revenue and also in its impact on public hospitals) and fringe benefits tax (FBT).

Specific concerns: the Hospital Output Costs Index

2.70 The general issues around the hospital output costs index (HOCI) were discussed earlier in this chapter but specific State and Territory government concerns are outlined below. The recommendation of the independent arbiter, Mr Ian Castles, was that the HOCI should comprise the CPI plus 0.5 per cent.

2.71 The Queensland Government argued that the adoption of the recommendation of the independent arbiter would mean that:

> effectively, this formula would mean a $21 million increase in funding for Queensland this year and $237 million over four years.[41]

2.72 The Health Department of Western Australia commented on the inappropriateness of the Commonwealth Government's offer of wage cost index 1 for the HOCI:

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38 Submission No.79, p.18 (NSW Government).

39 Submission No.79, p.18 (NSW Government).

40 Commonwealth Department of Health and Aged Care, *Electorate Profiles*, May 1999.

41 *Committee Hansard*, 22.3.00, p.469 (Queensland Minister for Health).

> wage cost index 1 is not a health related index, it is a general index, and so it does not relate in particular to either wages or other costs in the health sector. The purpose of the hospital costs output index and the agreement that we came to in negotiating Australian health care agreements was to reflect the costs in the health sector, not some more arbitrary figure like wage cost 1.[42]

2.73 The Northern Territory Government estimated that 'under the current offer from Dr Wooldridge, we are to get an extra $600 000. We believe that figure should be $1.4 million'.[43]

2.74 In the view of the Health Department of New South Wales:

> the estimated difference between the Commonwealth's offer and the arbiter's recommendation, which is CPI plus 0.5 per cent, in New South Wales is enough to run one rural hospital–$23 million.[44]

2.75 The Victorian Government claimed that the issue of the HOCI indexation was the 'most urgent problem facing the Australian health system' and that the difference between the Commonwealth's offer and the arbiter's recommendation represented a 'reduction in the real value of the Health Care Grants to Victoria' of the order of $220 million over four years.[45]

2.76 The South Australian Government provided the Committee with a table which included the estimated variation between the Commonwealth Government's offer of wage cost 1 as an index and the arbiter's recommendation. According to the South Australian Government's calculations, it would receive $54.2 million less over four years under the Commonwealth's offer than under the arbiter's recommendation, while the States and Territories combined would receive some $628.6 million less over the four years to 2002-03.[46]

2.77 The Tasmanian Government argued that the Commonwealth's default position 'is considered inadequate'[47], while the ACT Government stated that 'if the result of that arbitration had been accepted, we would have approximately $7 million coming to the ACT'.[48]

2.78 It is possible to argue that the States and Territories held high expectations of the process specified in the AHCAs with regard to the HOCI and that these

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42 *Committee Hansard*, 25.2.00, p.278 (Health Department of Western Australia).

43 *Committee Hansard*, 24.2.00, p.239 (NT Minister for Health).

44 *Committee Hansard*, 21.3.00, p.343 (Health Department of NSW).

45 Victorian Government, Additional Information, 23.3.00, p. 4-5

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

47 Submission No.67, p.3 (Tasmanian Government).

48 *Committee Hansard*, 11.4.00, p.643 (ACT Minister for Health).

expectations have not been met. The process for establishing an agreed HOCI has held no more guarantees for the States and Territories than did the so-called '2 per cent review' process under the previous Medicare Agreement (described earlier) which the States and Territories had expected would deliver them compensation for the decline in the proportion of the population covered by private health insurance. The important feature of both of these compensatory mechanisms was that ultimately the Commonwealth Government reserved the power to decide the outcomes.

Specific concerns: the GST

2.79 Taxation issues, particularly the impact on funding for public hospitals, are of concern to the States and Territories. Although public hospital services are largely GST free, there is some degree of uncertainty on just how the introduction of the GST will affect public hospital services. There are concerns also over the new funding arrangements for the States and Territories which will come into effect from 1 July 2000. The changes to fringe benefits tax (FBT) are also of concern, but the degree of concern varies between the jurisdictions.

2.80 Concerns raised with regard to the GST include its effect on programs such as the isolated patients' travel schemes, whereby patients from remote areas receive financial assistance to travel for necessary medical and surgical attention. These schemes are funded by the States and Territories. The Health Department of New South Wales argued that the GST will increase the price of, for example, a train ticket for an isolated patient and this increase will need to be met by the NSW Government as part of its reimbursement of the patient:

> in this state, we have just put an extra $500 000 into running a program which we announced two weeks ago and all of that and more will be lost through the application of the GST.[49]

2.81 The Health Department of New South Wales also expressed concern over the unresolved nature of the possible effect of the GST on, for example, donations to major public hospitals. Rulings on this and other issues are awaited from the Australian Taxation Office (ATO).[50] An example of how the GST may impact on public hospital services and, therefore, public hospital funding, was provided by the Health Department of NSW and concerned a ruling by the ATO in Western Australia:

> to give one example, in Western Australia the ATO has given a ruling that a nurse ringing a doctor on call for advice about how to manage someone presenting as an emergency is not direct patient care. It is actually a service of the doctor to the hospital and therefore GST is payable on the payment to the doctor. The ATO just does not understand the Australian health system.[51]

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49 *Committee Hansard*, 21.3.00, p.355 (Health Department of NSW).

50 *Committee Hansard*, 21.3.00, p.356 (Health Department of NSW).

51 *Committee Hansard*, 21.3.00, p.356 (Health Department of NSW).

2.82 The South Australian Government raised the issue of the compliance costs which will be required as a result of the introduction of the GST. Preliminary estimates compiled for the State by consultants Ernst and Young indicate a possible first year cost of $20 million for the South Australian Department of Human Services (which includes the South Australian Health Commission) and then ongoing compliance costs of $10 million per year.[52]

2.83 The Queensland Government provided the Committee with some estimates of how the GST may impact on public hospitals in Queensland. The Government estimates that direct costs incurred by Queensland Health for the implementation of the GST are in the order of $1.15 million while possible annualised costs are expected to reach $4 million.[53]

2.84 Following the introduction of the GST on 1 July 2000, the payment of general purpose financial assistance grants (FAGs) to the States and Territories will be replaced by revenue from the GST. The payment of GST revenues to the States and Territories will be as follows:

> Subject to the transitional arrangements and other relevant provisions in this Agreement, the Commonwealth will distribute GST revenue grants among the States and Territories in accordance with horizontal fiscal equalisation (HFE) principles.
>
> The pool of funding to be distributed according to HFE principles in a financial year will comprise GST revenue grants and health care grants as defined under an Australian Health Care Agreement between the Commonwealth and the States and Territories. A State or Territory's share of the pool will be based on its population share, adjusted by a relativity factor which embodies per capita financial needs based on recommendations of the Commonwealth Grants Commission. The relativity factor for a State or Territory will be determined by the Commonwealth Treasurer after he has consulted with each State and Territory.[54]

2.85 It is of concern for the States and Territories that it is likely that there will be no increase in funding under these new arrangements for at least several years. This has been acknowledged by the Commonwealth Government, which has undertaken to ensure that the budgetary position of each State and Territory will be no worse in the initial years following the introduction of the GST.[55] The key issue here is that following the introduction of the GST, there is unlikely to be any extra funding, for at least the initial few years, available to the State and Territories which could be applied

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52 *Committee Hansard*, 23.2.00, p.165 (South Australian Minister for Health).

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

54 *Intergovernmental Agreement on the Reform of Commonwealth-State Financial Relations*, 20 June 1999, p.14.

55 Treasury, *Mid-Year Economic and Fiscal Outlook*, Canberra, Treasury, 1999, p.67.

to their public hospitals. Over the longer term, however, the States and Territories are expected to have greater flexibility as a result of the revenue from the GST.

Specific concerns: FBT

2.86 The possible impact of changes to FBT was raised by each jurisdiction, however some States, notably Western Australia, South Australia and Victoria appear to have much more widespread usage of salary packaging for public hospital staff of all types and levels than other jurisdictions and consequently view the changes with greater concern. Interestingly, South Australia argued that the use of salary packaging and the FBT exemption 'has been used to keep down costs within the public hospital system'.[56] However, these cost savings for South Australia can also be described as cost shifting from the State to the Commonwealth which forgoes revenue from taxation. If it is considered desirable that the salaries of public hospital staff should be further subsidised by other taxpayers, then the subsidy should be transparent rather than hidden within the FBT arrangements.

2.87 Some of the concerns about the FBT changes have been addressed by legislative amendments and, in addition, the Commonwealth Government announced in its 2000-01 Budget that it will provide grants of $240.5 million for public and not-for-profit hospitals over the three year period 2000-01 to 2002-03 to assist with the transition to the new FBT arrangements.[57] It is likely that this funding will be required by the States and Territories because the AHA has estimated that the changes to the FBT arrangements will have a financial impact of approximately $250 million per year on public hospitals, with a disproportionate effect on rural and regional services.[58]

Assessing the adequacy of capital funding

2.88 Capital funding has long been the poor relation to recurrent funding in many areas of government enterprise, but perhaps nowhere more noticeably than in public hospitals. Broadly speaking, capital funding comprises spending on buildings, facilities and equipment, rather than services. It is primarily the responsibility of State and Territory governments and as such needs to be included in any analysis of the adequacy of funding available for public hospitals.

2.89 Several participants in the inquiry raised concerns about the adequacy of capital funding. For example, the RACP stated that serious problems existed with the lack of adequate resourcing for public hospital infrastructure. The College noted that the urgency of the problem varied between public hospitals but that in some public hospitals 'capital equipment has been allowed to run down to the point where it is

56 *Committee Hansard*, 23.2.00, p.165 (South Australian Minister for Health).

57 Health and Aged Care Portfolio, *Portfolio Budget Statements 2000-01*, Canberra, Department of Health and Aged Care, 2000, p.80.

58 Submission No.63, Additional Information, p.2 (AHA, WHA, AAPTC).

creating serious clinical problems'.[59] The Queensland Government pointed to its large investment in capital works for its public hospitals, explaining that part of its objective is to provide more efficient public hospitals.[60] In their joint submission, the RACP, ACA and the Health Issues Centre drew on Professor Stephen Leeder's book *Healthy Medicine* to comment that:

> less than 4 per cent of the total health budget goes to capital works…as a result of this lack of commitment in Australia we have an ageing fleet of public hospitals unable to take full advantage of the new technologies that enable more patients to be treated out of hospital, or more comfortably in hospital if that is the best place for them.[61]

This view indicates that continuing underfunding of the capital requirements of public hospitals may be at the expense of their efficiency.

The consumer perspective

2.90 Several consumer bodies provided consumer input into the inquiry. The Consumers' Health Forum (CHF) drew upon its consultations with members to outline issues which consumers regard as important in relation to the adequacy of funding for public hospitals. The Australian Consumers' Association and Consumers' Council of WA also discussed issues of concern to their members. Key concerns raised by these groups included:

- the current level of funding is not adequate to properly meet existing needs;
- existing funding should be allocated in a way that better targets the needs of consumers, including the promotion of Consumer-oriented care;
- the closure of specific purpose services and long waiting lists for others;
- reduction in public hospital outpatient and allied health services which could be used to prevent hospitalisation;
- the length of waiting lists and last minute cancellations and bookings;
- decreasing length of stay, particularly where patients are discharged without adequate support or into isolated situations; and
- negative effects on patient care of hospital staff with very heavy workloads.[62]

2.91 A consumer viewpoint was also provided by the President of the Deafness Association of the Northern Territory who identified a range of particular problems with regard to the Northern Territory, including:

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59 *Committee Hansard*, 21.3.00, p.372 (RACP).

60 *Committee Hansard*, 22.3.00, p.466 (Queensland Minister for Health).

61 Submission No.45, p.8 (RACP, ACA, Health Issues Centre).

62 Submission No.72, p.8 (CHF); Submission No.45, p.14 (RACP, ACA, Health Issues Centre); Submission No.7, p.2 and *Committee Hansard*, 23.2.00, pp.272-3 (HCC of WA).

- premature discharge from hospital leading to unnecessary readmission–although this may become less of a problem following the introduction of the Transitional Care Project;
- understaffing of the public hospital which may result in, for example, inadequate attention to the dietary needs of older and disabled patients;
- overlong waiting times in outpatient clinics; and
- in summary, 'the public hospital gives a good service for able-bodied people, but for elderly or disabled people the picture is not so rosy'.[63]

Perceptions of a funding 'crisis' in public hospitals

2.92 Discussion in Chapter 1 indicated that the Australian health system generally worked well and that most Australians enjoy a very high standard of health and health care. However, The casual reader of newspaper headlines in 1999 such as 'Hospital held together by chewing gum' could be forgiven for imagining that the public hospital sector was in 'crisis'. Adding to this sense of 'crisis' were highly critical comments contributed at the time by senior hospital clinicians, such as: 'every year you think this is the worst, but no, next year is worse' (Professor John Dwyer, Prince of Wales Hospital); 'it seems to me that we have been coping with a crisis for a long time' (Dr Malcolm Fisher, Royal North Shore Hospital); and 'this place is on a knife-edge' (Professor Rick Kefford, Westmead Hospital).[64]

2.93 It is difficult to distinguish hyperbole from fact in this regard, in part because some public hospitals and their advocates have proven adept at using the media effectively to project their messages. However, it is apparent from some of the submissions and evidence provided to the inquiry that there is a considerable level of concern about the funding situation facing public hospitals. One of the key issues for the Committee, however, is whether greater amounts of funding alone will be an effective and sustainable remedy.

2.94 The Australian Medical Association (AMA) told the Committee that 'we believe that the system is primarily running now on goodwill'[65] and that 'almost everybody who works in the system says we need more dollars'.[66] In addition, the joint submission from the Australian Healthcare Association (AHA), Women's Hospitals Australia (WHA), and the Australian Association of Paediatric Teaching Centres (AAPTC) argued that 'the consensus view is that the absolute level of funding for public hospitals and healthcare is inadequate'.[67]

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63 *Committee Hansard*, 24.2.00, p.228 (Deafness Association of the Northern Territory Inc.).

64 quoted in Ragg, M 'Keeping thorns by your side', *Sydney Morning Herald*, 26.5.00, p.21.

65 *Committee Hansard*, 11.11.99, p.77 (AMA).

66 *Committee Hansard*, 11.11.99, p.78 (AMA).

67 Submission No.63, p.12 (AHA, WHA, AAPTC).

2.95 Evidence of the available resources failing to meet demand may be inferred from the waiting lists and waiting times for elective surgery and the waiting times in emergency departments of public hospitals. However, in its recent report on government services, the Productivity Commission notes that differences in recording practices of waiting times for elective surgery and in the scope of the data collections in the States and Territories affects 'the comparability of reported results'.[68] From 1999-2000 all jurisdictions are to adopt a similar recording practice. With regard to emergency department waiting times, although nationally agreed definitions exist, differences in how the data is collected are apparent between jurisdictions.[69] A recent report from the AIHW provides data on waiting times for elective surgery in 1997-98[70] but again, variations in the data collection methods between the jurisdictions hampers any firm conclusions. Given that the available data appears to require several caveats, the Committee has not presented any data on waiting lists/waiting times because it is unlikely to assist in an evaluation of the adequacy of funding for public hospitals.

2.96 These instances of inadequacies in the available data are indicative of the frustration which the Committee has faced in its attempt to evaluate the position of public hospitals in Australia. While a huge volume of data is collected, and reported on, by agencies such as the Australian Institute of Health and Welfare, there appears to be much about the financing and operation of public hospitals which is either unknown or not particularly useful because, for example, of gaps, or concerns about consistency of data collection across jurisdictions.

2.97 Transparency of financial reporting by the different levels of government leaves much to be desired as does the availability of data which may be of use to patients such as waiting times for elective surgery. The overall situation was summed up by Qual-Med's Dr Wilson, who concluded that 'the information systems are poor'[71], and the Sydney Teaching Hospitals Advocacy Group, who argued that 'we were a long way behind in information technology in hospitals–a long, long way behind'.[72] The Queensland Nurses Union acknowledged that Queensland 'is getting a little better' in this regard but were concerned that 'the systems are still not out there to accurately measure anything else other than costs'.[73]

2.98 The Sydney Teaching Hospitals' Advocacy Group (which draws its membership from senior clinicians such as those quoted earlier in this section) argued

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68 Steering Committee for the Review of Commonwealth/State Service Provision 2000, *Report on Government Services 2000*, Canberra, AusInfo, 2000, p.293.

69 Steering Committee for the Review of Commonwealth/State Service Provision 2000, p.294.

70 Australian Institute of Health and Welfare, *Waiting Times for Elective Surgery in Australia 1997-98*, Canberra, AIHW, 2000.

71 *Committee Hansard*, 21.3.00, p.319 (Dr Wilson).

72 *Committee Hansard*, 21.3.00, p.396 (Sydney Teaching Hospitals Advocacy Group).

73 *Committee Hansard*, 22.3.00, p.439 (Queensland Nurses Union).

that more funding needs to be spent on patients, which is not exactly the same as spending more on public hospitals. The analogy was used that a large amount of funding could be put in at the top and by the time it filtered down to the patient 'there is not much coming out'.[74] Professor Hindle took this approach even further by arguing that:

> ..simply adding $2 billion to the budget of the public hospitals would produce no significant impact that people would recognise. The reason for this is that the boundary between what is appropriate care and what is not is ill-defined.[75]

2.99 Professor Hindle's argument is that any increase in funding would eventually be absorbed by the system as it adjusted to the new level of funding. The real need, in his view, is for any available funding to be spent on structural change.[76] This and other options for reform are discussed in the next chapter.

Public hospital sector efficiency

2.100 The Health Department of New South Wales drew upon the findings of the recent report of the NSW Health Council to state that 'there were limited gains to be had in terms of efficiencies within our public hospital system'.[77] The Centre for Health Program Evaluation (CHPE) argued, however, that it is only once adequate quality assurance mechanisms are in place that informed decisions can be made on efficiency in public hospitals. CHPE made the point that merely placing a budget cap on the funding for public hospitals may create undesirable outcomes in the short term, such as a decline in quality.[78] This would appear to indicate that the Victorian Government's policy of a '1.5 per cent productivity improvement requirement each year',[79] which was drawn to the Committee's attention by ACHSE, may not be a desirable or efficient practice in the absence of adequate quality assurance mechanisms.

2.101 Another view of the efficiency of public hospitals was provided by some States and Territories, which asserted that efficiency could be judged on the basis of the cost per casemix-adjusted separation.[80] Thus, Victoria argued that its 'hospitals are

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

75 *Committee Hansard*, 21.3.00, p.325 (Professor Hindle).

76 *Committee Hansard*, 21.3.00, p.325 (Professor Hindle).

77 *Committee Hansard*, 21.3.00, p.359 (Health Department of NSW).

78 *Committee Hansard*, 23.3.00, p.592 (CHPE).

79 *Committee Hansard*, 23.3.00, p.550 (ACHSE).

80 The cost per casemix-adjusted separation is a measure of the average cost of providing care for a patient admitted to hospital, adjusted for the relative complexity of the patient's condition and of the hospital services provided. It does not take account of the quality of care provided nor of the health outcomes achieved (Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98*, Canberra, AIHW, 1999, p.222).

extremely efficient. They spend less per casemix than other states'.[81] Queensland, meanwhile, claimed that the available costing of separations data indicated that it had the most efficient hospital services.[82] The latest available data indicates that Queensland has the lowest cost per casemix-adjusted separation at $2354, followed by South Australia ($2458) and Victoria ($2462), the only other jurisdictions below the Australia-wide average.[83]

2.102 In its recent Budget for 2000-01, the ACT Government announced that it is to introduce a four-year 'efficiency improvement' program which is expected to save $25 million over four years[84], from the 2 ACT public hospitals, with $2.5 million in savings expected in 2000-01. Savings 'will be achieved through a process of continuous improvement in hospital and acute care services'.[85]

2.103 It will be interesting to see where the $25 million in savings accrue. A glance at the mix of costs which comprise the cost per casemix-adjusted separation indicates that the ACT has costs which are well above the Australian average for salaried/sessional staff, Visiting Medical Officer (VMO) payments, nursing costs, diagnostic/allied health costs, administrative costs and superannuation. The cost of medical supplies is a further area of difference.[86] If the ACT does succeed in lowering its cost per casemix-adjusted separation closer to the Australian average, presumably the average itself (and therefore the measure of efficiency) will also fall, if the costs of the other jurisdictions do not increase.

2.104 A problem with using the cost per casemix-adjusted separation in this way is that at best it is only informative in a relative sense, that is, how different jurisdictions perform relative to others. It takes the average of the existing performance and uses that as a benchmark. Accordingly, this measure of efficiency may tell us little more than the average amount which each jurisdiction is prepared to pay for its public hospital services. For example, the Health Department of Western Australia explained that as a purchaser of public hospital services from the Metropolitan Health Service, it specifies the volume of services required in various diagnostic groupings, quality indicators and 'the price that the department will pay for those services'.[87]

2.105 The cost per casemix adjusted separation does not assist in measuring optimal efficiency. As Qual-Med's Dr Wilson put it: 'there is no real costing of the product'.[88]

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81 *Committee Hansard*, 23.3.00, p.511 (Victorian Minister for Health).

82 *Committee Hansard*, 22.3.00, p.468 (Queensland Minister for Health).

83 Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98*, Canberra, AIHW, 1999, p.10.

84 ACT Government, *Budget 2000: Budget estimates: Budget paper No. 4*, Canberra, ACT Government, p.104.

85 ACT Government, *Budget 2000: Budget paper No. 2*, Canberra, ACT Government, 2000, p.11.

86 Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98*, p.10.

87 *Committee Hansard*, 25.2.00, p.275 (Health Department of Western Australia).

88 *Committee Hansard*, 21.3.00, p.315 (Dr Wilson).

The knowledge about public hospital efficiency which is really required would explain why, for example:

> a hip replacement in one hospital can cost up to 1.5 times more than in another hospital of similar size and function without any discernible difference in quality of care or severity of condition.[89]

Unfortunately, much evidence presented to the inquiry on the adequacy of data collection systems in public hospitals indicates that there is some considerable way to go before any factually-based assertions can be made about the efficiency of the public hospital sector.

Adequacy of funding in rural Australia

2.106 Generally speaking, people living in rural and remote areas of Australia have poorer health status than people living in metropolitan areas. They have lower life expectancy and experience higher rates of hospitalisation for some causes of ill-health. People living in rural and remote areas also have less access to health care compared to their metropolitan counterparts.[90]

2.107 Table 3 provides an overview of the number of hospitals and available beds in each of the rural, remote and metropolitan areas (RRMA) classification.[91] Data in the Table is instructive to the extent that it provides an indication of the available beds per 1000 of the population in each of the RRMAs. This reveals that 'other metropolitan centres', such as Newcastle and Geelong, have the lowest number of available beds, at 2.2 per 1000 population, while 'other remote areas', such as Cloncurry Shire and Coober Pedy District Council, have the highest at 5.1 beds per 1000 of the population.

2.108 While this data may appear surprising, some possible reasons for these differences include: greater availability of private hospitals in metropolitan areas; hospitals in remote localities provide services to their surrounding areas; a higher percentage of nursing home type patients in the remote areas compared to metropolitan areas (ie fewer nursing home beds in remote areas); higher morbidity in remote areas; and differences in medical practice.[92] It is important to remember also that the data in the Table represents the average for each region and as such, while useful in a comparative sense, it is not actually informative about the experience of individual locations.

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89 New South Wales Health Council, *Report of the NSW Health Council: a better health system for NSW*, Gladesville, NSW Better Health Centre, 2000, p.xxi

90 Australian Institute of Health and Welfare, *Health in Rural and Remote Australia*, p. vi-viii.

91 Details of the composition of each area in the Rural, Remote and Metropolitan Areas (RRMA) classification can be found in: Australian Institute of Health and Welfare, *Health in Rural and Remote Australia*, Canberra, AIHW, 1999, pp. 115-130. This publication contains a listing, by State and Territory of the statistical local areas which comprise each area of the classification.

92 Australian Institute of Health and Welfare, *Health in Rural and Remote Australia*, p.79.

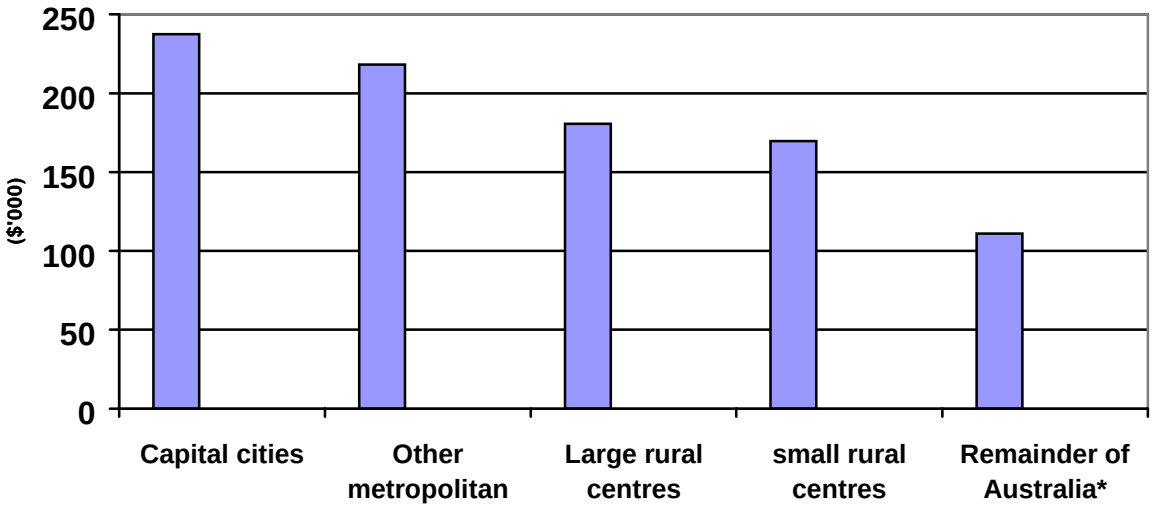
Table 3: Number of hospitals and available beds per 1 000 population by RRMA, public acute and psychiatric hospitals, 1997-98

Hospitals	
Capital cities	176
Other metropolitan centres	21
Total metropolitan	197
Large rural centres	28
Small rural centres	52
Other rural centres	324
Total rural	404
Remote centres	26
Other remote areas	137
Total remote	163
Total all regions	*764*
Available beds per 1 000 population	
Capital cities	2.8
Other metropolitan centres	2.2
Total metropolitan	2.7
Large rural centres	4.3
Small rural centres	3.5
Other rural areas	3.3
Total rural	3.6
Remote centres	4.2
Other remote areas	5.1
Total remote	4.7
Total all regions	*3.0*

Source: AIHW, *Australian Hospital Statistics*, table 3.4

2.109 The data in Figure 10 can be contrasted to that in Table 3. The data indicates that although rural and remote areas, on average, have a higher provision of available public hospital beds than metropolitan areas, the expenditure per bed is much higher in the capital cities and other metropolitan areas, declining as the degree of rurality increases. This largely reflects the mix of services provided in the different regions, with, for example, more complex cases treated in the larger metropolitan public hospitals. The expenditure on public hospitals is a State and Territory responsibility.

Figure 10: Expenditure per available public hospital bed 1995-96 ($'000)



*****Remainder of Australia includes 'other rural areas', 'remote centres', and 'other remote areas'.

Source: Australian Institute of Health and Welfare, *Health in rural and remote Australia,* Canberra, AIHW, 1998, p.80.

2.110 The data in Table 4 contains, for regions in each State and Territory, data on per capita benefits paid for Medicare services which include: GP and specialist consultations, pathology and diagnostic imaging services (out-of-hospital) and in-hospital services and procedures for private patients. These benefits are the responsibility of the Commonwealth Government.

2.111 Data in the Table indicates that, generally speaking, per capita benefits from Medicare are lower in non-metropolitan areas compared to metropolitan areas. However, some care needs to be exercised when interpreting the data. It can be observed, for example, that the average per capita benefit for residents in the ACT is lower than the average benefit in each State and is lower also than the per capita benefits in non-metropolitan regions in New South Wales, Victoria and Queensland. There are a range of reasons why per capita benefits vary across regions and, as with the data presented earlier, no one set of data presents the whole picture. Missing from the data in this section is, for example, expenditure on Indigenous health services, nursing homes, and Multipurpose Services (pooled funds from the Commonwealth and States and Territories).

Table 4: Medicare Services By Region 1997-98

Region	Services per capita (number)	Benefits per capita ($)
New South Wales		
Metropolitan	13.7	430
Non-metropolitan	10.5	330
Total NSW	12.3	386
Victoria		
Metropolitan	12.5	394
Non-metropolitan	9.7	305
Total Victoria	11.5	363
Queensland		
Metropolitan	12.2	377
Non-metropolitan	10.4	318
Total QLD	10.8	341
South Australia		
Metropolitan	11.7	376
Non-metropolitan	8.6	277
Total SA	10.6	342
Western Australia		
Metropolitan	11.2	340
Non-metropolitan	7.3	221
Total WA	10.0	304
Tasmania		
Metropolitan	10.8	340
Non-metropolitan	9.4	280
Total Tasmania	9.9	304
Northern Territory		
Non-metropolitan	4.3	126
A.C.T.		
Metropolitan	9.3	288
Australia		
Metropolitan	12.5	392
Non-metropolitan	9.8	304
Total Australia	11.2	354

Source: Calculated from: Commonwealth Department of Health and Aged Care, *Electorate Profiles*, May 1999.

2.112 An assumption which is evident in the submissions and evidence from the Queensland and Tasmanian Governments is that some parts of metropolitan Australia (notably Sydney and Melbourne) are overserviced and much of rural and remote Australia is underserviced with regard to their respective access to medical and diagnostic services. However, precise knowledge is lacking because this is not an area which has received much research attention. If spending on health bore some relationship to health status then it could be expected that residents of Sydney and Melbourne would be, on average, far healthier than the rest of Australia. This is clearly not the case and many other variables are involved, such as average age of people in particular regions and the proportion of people with private health insurance.

2.113 A similar concern with regard to rural and remote areas was raised with the Committee by CHPE and Professor Richardson. A study of certain hospital procedures in Statistical Local Areas (SLAs) in Victoria revealed 'something like a 500 to 800 per cent variation in how much is being given between SLAs that cannot be explained by population, by age or by sex'.[93] Professor Richardson concluded that the findings were:

> quite stunning in terms of the implications for bad allocation of resources. It strongly implies that either some areas are massively underservicing or some other areas are massively overservicing, and we do not research that in Australia.[94]

2.114 Assumptions can be made about the location of doctors or practicing preferences as some of the reasons behind these differences. The Committee has been surprised about how little appears to be known or understood about the public hospital sector and the health system more broadly, particularly in light of the vast resources which are spent.

2.115 More than 25 per cent of submissions to the inquiry discussed the adequacy of funding to meet demand for public hospital services in rural Australia. None of these submissions judged the level of funding to be adequate. The National Rural Health Alliance (NRHA), which comprises 22 member organisations and represents both consumers and providers of services, argues that people living in rural and remote areas of Australia should receive a 'fair' share of health expenditure, which would be in the order of 30 per cent of that expenditure. The NRHA acknowledges that data is not completely adequate in this area 'but there is a great deal of anecdotal evidence to support the intuitive judgement that this criterion is not met where public hospitals are concerned'.[95]

2.116 However, the NRHA argued in evidence presented to the inquiry that funding for public hospitals in rural areas is not really the issue:

> the right question is not how much money is going to hospitals in rural areas but how much money is going to health services in rural areas.[96]

This view encapsulates the dilemma inherent in assessing the adequacy of funding for public hospitals both in rural areas and metropolitan areas. Public hospitals are a part of the health system and, as such, it is difficult to separate the sector completely from the broader health system.

2.117 It is difficult, therefore, to consider the adequacy of funding for public hospitals in rural areas in isolation from other health services. The next chapter

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93 *Committee Hansard*, 23.3.00, p.589 (Professor Richardson).

94 *Committee Hansard*, 23.3.00, p.590 (Professor Richardson).

95 Submission No.66, p.21 (NRHA).

96 *Committee Hansard*, 11.11.99, p.116 (NRHA).

discusses a range of options aimed at providing remedies for the problems and challenges facing Australia's public hospital system, including particular issues relating to rural and remote areas. Also discussed are existing models such as the Multipurpose Services[97], emerging models like the Regional Health Services, and the trials of coordinated care, all of which aim to overcome the shortcomings of the existing system. The Committee is aware that a joint project is underway between DHAC and the NRHA, which is investigating new options for health financing in rural and remote areas. The project is expected to report in mid-2000.

Patient travel assistance schemes

2.118 It is important to note that people living in rural and remote areas do have access to public hospital services in larger centres and the capital cities. It is estimated, for example, that around 25 per cent of services provided by the public hospitals in the ACT are provided to residents of the south-east region of New South Wales. Consequently, the issue of patient travel has also been raised by participants in the inquiry. A Commonwealth-funded program, the Isolated Patients' Travel Accommodation and Assistance Scheme, began in 1978 and ceased in 1987. Since then, patient travel has been the responsibility of the States and Territories. The NRHA argues in its submission that:

> following the devolution of these schemes to the States and the Northern Territory, they have developed in different ways and there has been a lack of national uniformity and focus….difficulties with travel for health purposes are becoming a major and pervasive problem for rural and remote people.[98]

2.119 The NRHA is concerned that the variability of the patient travel schemes in different jurisdictions has and is disadvantaging rural people and limiting their access to public hospital services beyond their immediate region of residence. As an indication of this concern, the NRHA has called for a national review into the schemes.[99]

Concluding comments

2.120 One of the central difficulties for this inquiry has been the lack of available data upon which to base informed decisions. With regard to assessing the adequacy of funding for public hospitals, a key obstacle is that 'there has really been no process put in place for assessing and determining what that right level should be'.[100] The task

97 Multipurpose Services (MPS) are usually small hospitals where (Commonwealth) aged care funding is cashed out to enable the provision of both aged care and acute hospital care in the one facility. More recently, the Regional Health Services (RHS) have been introduced and are to be established only where there is demand from the local community. The emphasis of the RHS is on health services, rather than aged care services, with a broader range of services able to be offered than in the MPS (including, for example, primary care services). The exact mix of services is negotiated with the local community.

98 Submission No.66, p.26 (NRHA).

99 Submission No.66, p.27 (NRHA).

100 *Committee Hansard*, 11.11.00, p.98 (AHA, WHA, AAPTC).

for the Committee would be immeasurably easier if all that was required was to conclude that the Commonwealth needs to do more or that the States and Territories need to lift their performance and one or the other should simply provide more funding for public hospitals. Unfortunately the issue is more complex and unlikely to be addressed through simple measures.

2.121 A cautionary note was adopted by the AHA, WHA and the AAPTC in their joint submission to the inquiry. The groups argued that resolving core issues such as securing adequate funding for public hospitals was not possible 'until such time as there is a comprehensive reform of intergovernmental arrangements'.[101]

2.122 The first term of reference of this inquiry requires the Committee to assess and report on the adequacy of current funding levels to meet future demand for public hospital services in both metropolitan and rural Australia. It is unlikely that demand for public hospital services will decrease due to factors such as ageing of the population, developments in technology and increasing consumer expectations. In order to address current problems and to equip Australia's public hospitals with sufficient resources to confidently approach the future, the following chapter canvasses a range of options for reform.

101 Submission No.63, p.5 (AHA, WHA, AAPTC).