

The next Australian Health Care Agreements: what clinicians want

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Abstract

For the first time experienced clinicians are to be involved in the development of the Australian Health Care Agreements (AHCAs) (2003-2008). As a result doctors, nurses and allied health professionals are hoping that current impediments to necessary change will be removed. Numerous suggestions to improve the Agreement will come forward from the "front line". All clinicians will argue that the next Agreement must result in a marked increase in the funding available to public hospitals. The new Agreement must remove barriers hindering our capacity to integrate all of our healthcare services. Safe, appropriate and cost effective healthcare delivery must embrace a continuum of care involving patients and their primary care physician, community health services and hospitals. The Agreement must embody arrangements for markedly enhancing our public health efforts in the area of prevention of disease. Australia's clinicians are worried about inequity in terms of access and outcome for their patients and are willing to be partners in health care governance to improve the situation.

Background

Clinicians have long been frustrated by Health Care Agreements between the Commonwealth and State Governments that actually hinder sensible planning for the populations healthcare needs particularly when it comes to the delivery of integrated care. The current, but soon to expire, AHCAS did little to improve matters over the last five years. Intergovernmental cost shifting and the blame game have become an art form. The Commonwealth's failure to deliver sufficient hostel and nursing home beds sees as many as 1500 patients on an average day occupying acute care beds in our hospitals while waiting for more suitable accommodation. They don't need the facilities that support these beds while daily patients who do lie on trolleys in our Emergency Department. Clinicians have been swept into the cost shifting game as they are asked to "bulk bill" all public patients attending for ambulatory services at public hospitals.

Health professionals and their patients agree that urgent and major strategies to improve our healthcare system will require us to concentrate on structural changes to support health promotion while initiatives are funded to provide more care for patients in their home and community rather than hospital. Remuneration by the Commonwealth to general practitioners, unless improved, will thwart both of these important goals.

Traditionally the AHCAs were constructed to ensure that the Federal Government gives State Governments sufficient funding to supply us all with free public hospital care. It has been negotiated by well meaning bureaucrats who, unfortunately, have often been far removed from the frontline where the battle to provide Australians with the healthcare they need is fought. Currently the Agreements give the States about \$7 billion annually. The States don't have to spend that money on health and successive Federal Governments claim that they don't. Our State Governments collectively spend about \$11 billion running their hospitals and

community health services (their responsibility) so that \$7 billion is less than half of their of total expenditure. The Federal Government anticipates that most of the money they provide will be spent on “us” as public hospital patients within a public hospital bed. Such a focus on hospital care rather than integrated care represents poor and outdated conceptual thinking.

Australia has been spending about 8.5% of its Gross Domestic Product (GDP) on health. Recent figures from the Commonwealth suggest that that figure is creeping closer to 9% as a result of inflation and private insurance subsidies rather than any new health care initiatives. While clinicians have no doubt that major improvements in quality, safety and cost effectiveness can be generated from infrastructure reform (including sensible AHCAs) informed opinion looking at the situation at home and abroad suggests that we may need to spend at least 10% of GDP on healthcare. (Kilham 2002)

Currently funding arrangements are derived from figures documenting how many patients use hospital beds. The quality of the service provided and indeed the outcome from the care given are irrelevant and the formula acts as a disincentive to have people cared for out of hospital. The current AHCAs have a built-in adjustment for usage growth of 2.1% per year, but allowances for cost changes are much less than the average 6-8% inflation associated with healthcare spending that has been experienced in recent years. (Reid 2002) Australia is very reliant on the importation of its medical supplies and equipment.

Clinicians hope that in the current negotiations for new AHCAs the Commonwealth will be honest and admit the subsidies provided to boost private health insurance have done nothing to relieve the ever-increasing pressure on Australia's public hospitals. Patients tell their doctors they joined a private health fund because their accountants told them to do so. Many new subscribers have no intention of using their private insurance if that will involve any out-of-pocket expenses. Simplified billing systems have been designed but are poorly utilised. Private insurance is certainly useful if you need relatively simple surgery as beds and theatre time are available in private hospitals. The gross inequity that sees so many patients who must rely on the public hospital system wait years for planned surgery is largely a matter of inadequate funding and must be specifically addressed in the new AHCAs.

In Australia, in contradistinction to a country like America, the most sophisticated and technically demanding services are only available in our public hospitals. Everyone in the country may need the services of our major public hospitals no matter how wealthy they are. It is a frustrating anomaly therefore that private health funds provide a lower rebate to public hospitals who care for their privately insured patients than they do to private hospitals. Recent studies suggest that only 40% of Australians with private health insurance declare this to be the case when they enter a public hospital. (Duckett 2002)

The cynicism of seasoned health economists who have been embroiled in negotiating previous Australian Health Care Agreements is disturbing but does not surprise clinicians interested in healthcare reform. Unique promises are on the table from all of our Health Ministers declaring that an analysis of major deficiencies in our public health system that need addressing urgently will be completed before funding issues are examined in the coming months. Nonetheless it is all too common for us clinicians to hear economists declare that the Federal Treasury will have already determined a bottom line figure based on their concept of affordability. This figure will not change no matter what healthcare imperatives are identified.

The contributions clinicians can make to the shape of the next AHCAs depend on Governments following through with their pre-negotiation agreement to de-emphasise jurisdictional boundaries and examine the principles, aims and outcomes required from the new Agreement. There has been an acceptance in principle of the long-standing demand from clinicians that the next AHCAs must address specifically, in addition to public hospital care, prevention, the continuity of care, workforce training and continuing education, the public/private hospital interface, and quality and safety. Clinician involvement will be associated with the applauding of sensible changes and the genuine spirit of partnership involving clinicians, bureaucrat and politicians. But, because expectations are properly high, clinicians will publicly denounce the process if the cynics' views turn out to be correct.

Changes required to the next AHCAs

Funding issues

Clinicians across the country speak with one voice when describing the spartan nature of our public hospitals. Many more conversations are held with administrators about money rather than quality. Workforce shortages are related to insufficient numbers of skilled professionals being available or willing to work in the public hospital system. The problem is compounded by inadequate funding for full time positions in the public health system. The problems are of course intertwined.

Over the course of the next AHCAs Australia should plan to progressively increase spending on health so that it reaches 11% of GDP by 2008. With simultaneous infrastructure reform to achieve greater efficiency, such funding should provide us with one of the finest healthcare systems in the world. The annual inflation factor built into the Agreement should not be less than 6% and ideally should be varied each year based on a careful evaluation of real inflation figures within this particular industry.

Clinicians have been worried that the Commonwealth will argue that increased State revenue provided by GST collections will provide the States with all the funding they need. A number of economists however argue that the full benefit of GST initiatives will not be felt by the State's until at least 2007 on the east coast of Australia and long after that in other parts of the country. (Reid 2002) In the forthcoming negotiations the arguments related to GST must be explored transparently and apolitically. An Agreement based on supposition rather than fact could render entirely inadequate the funding formula that may be agreed upon before June of next year. We clinicians certainly don't want to hear another round of tired arguments about "comparative effort" and the size of the base grant given to the States. We certainly don't want to see individual politicians, sensing some particular advantage for their State, breaking ranks rather than staying true to principles that should guide all State Governments during these negotiations. New South Wales has led the way with the introduction of guaranteed three year budgeting for its Area Health Services. Funding for all health programs should be guaranteed for three years to allow sensible forward planning.

The designers of the next AHCAs should consider the potential advantages of State and Commonwealth health spending being pooled and held by Area Health Services or their equivalents. In any given area (conceptualised by thinking of an Area Health Service or equivalent) the total spending on public health is composed of State dollars for hospitals and community health facilities and Commonwealth spending on the medical and pharmaceutical benefits scheme, nursing homes and hostels etc. The total amount of historical funding for these services, adjusted for inflation as per the terms of the new AHCAs, could be held centrally and used for a networked and truly integrated healthcare plan for that Area's population. Trials of this approach in selected areas of each State should be built into the next Agreement. Intuitively such centralised funding and administration could overcome all the barriers that currently beset efforts to integrate healthcare at all levels.

A logical extension of such an idea would see a trial of salaried positions within the public health system being made available to general practitioners working within these designated areas. "GP's" are increasingly attracted to "employment" arrangements of various kinds, usually with private sector companies. Many GP's are so poorly remunerated that an adequately funded salaried position would be most attractive. Only in such an arrangement is it likely that the services required from GP's for new paradigms of healthcare delivery will be available. We want general practitioners to be involved in delivering more care at home to patients with chronic and complex disease, rather than having such patients remain overly dependent on hospital care. Current practice models utilised by primary care physicians make their participation in such a scheme difficult indeed.

Subsidised prescription costs (PBS) are available to patients in private hospitals. With the exception of the high-cost (\$100) drugs this is not the case in public hospitals. Extending PBS coverage to public hospitals in the new AHCAs would have numerous advantages. Better understanding of drug utilisation in hospitals, drug purchasing efficiencies and the standardisation of appropriate drug use would be some of the advantages. Currently the delays in the funding back to hospitals of the money they must spend at State level on purchasing expensive \$100 drugs creates cash flow problems for public hospitals. Built into the next Agreement must be incentives for doctors to prescribe more sensibly, with money saved on drug budgets being retained for the enhancement of other services.

Private health insurance

The aim of the Federal Government subsidy to participants in private health insurance schemes was to relieve pressure on the public hospital system. This has not occurred. Indeed it must be recognised that the aging of the population and a reduction in services from underfunded general practitioners has seen demand on public hospitals steadily increase. Indeed there is an irony in the fact that public hospitals are increasingly unable to offer the services most often supplied in the private sector (for example planned surgery) and yet their waiting lists for such surgery continue to grow and grow. Obviously such patients have not been able to afford private health insurance. Many private hospitals are under-utilised and we certainly need to explore for the next AHCA's better ways of fostering a partnership between public and private sector delivery of hospital care.

An enormous improvement in the financial viability of our public hospital system could flow from the very significant increase in the number of Australians who have enrolled in a private health fund – currently 44.1%. As subscription to private health insurance was a response to the financial penalties that would follow failure to do so, particularly in the case of the young, private health insurance should be seen as an additional contribution by those who can afford it to the public hospital system. This real benefit to the public health system would follow if (a) the new AHCA's mandate that rebates for privately insured patients in public hospitals must equal those given to patients in private hospitals and (b) it became compulsory to declare and use your private health insurance when admitted to a public hospital. Public hospitals are more than willing to guarantee to privately insured patients that they will not leave hospital with a bill for either their hospitalisation or the care they received from their doctor.

Currently public hospitals caring for private patients, no matter how serious their illness, receive, on average, \$150 a day less than would a private hospital caring for the patient with perhaps a minor problem. Public hospitals cannot provide the service required for the dollars available from the rebate. The current AHCA's allow the States to charge private patients within public hospitals whatever they like (Clause 57 AHCA's) but the Commonwealth Government controls the rebates paid by insurers.

Given that 70% of patients admitted to public hospitals no matter what their insurance status require admission through an emergency department, costs for care are going to be much higher than is the case with the average admission to a private hospital. A majority of doctors would be more than willing to claim only scheduled benefits if this scheme were enacted, especially if the State Government extended indemnity coverage to all doctors caring for both private and public patients in public hospitals. Uniform acceptance of this initiative should be built into the AHCA's. Economic models show that the above changes would see millions of dollars become available to public hospitals. The insurance subsidy by the Commonwealth would then, at last, really benefit public hospitals.

Quality issues

While many worthwhile initiatives at both the State and Federal Government level are allowing clinicians to concentrate more on quality and safety issues, funding for such ongoing programs must be strengthened in the new Agreement. National standards for adequate performance criteria must be developed. Most importantly data collection systems and analysis must be integrated into all quality programs so that outcome data are available for all to see and respond to. Relatively few data management positions are available in the public health system and outcome data are significantly inadequate for what, in other ways, is a very sophisticated health care system. Quality and safety are central issues to be addressed as we try to reduce the extraordinary burden currently associated with indemnity costs.

All the issues involved with improving quality and safety in our hospitals cannot be covered here but it is widely accepted that we need to raise expectations that clinicians will regard, as normal practice, continuing education, peer review, sentinel event testing and morbidity/mortality meetings. Appropriate funding of such activities in the AHCA's is essential to achieve this goal. Ongoing research into system reforms to minimise human error should also be funded. 50-80% of adverse events occurring in our hospital system are thought to be preventable. Inappropriate use of drugs results in 80,000 admissions per year and costs taxpayers \$350 million. The total cost of unsafe care in Australia is estimated to be between one and two billion dollars per year. Many of the improvements needed will require not only greater funding but also much better use of information technology.

Information technology

The Australian healthcare system is well behind many other OECD countries in the use of modern information technology. Increasingly, it is becoming apparent that investing in this technology is cost effective. Progress is being made in our efforts to develop a nationally useable patient held electronic record but the acceptance and application of information technology in routine daily clinical life is distressingly slow. Modern public hospital wards should have available to them computer literate ward secretaries rather than ward clerks. Medical histories are ideally suited to being gathered by house staff using pre-programmed hand-held computers with the information later being downloaded to produce a readable hard copy. Surely tests should now be ordered by touch screen technology that displays costs and indications and indeed details alternatives that may be more appropriate and cost effective. The digitalisation of diagnostic images is now likely to be highly cost effective as well as providing the healthcare system with greater efficiencies. Film is expensive, CD technology is cheap. The AHCAs should look at a five-year plan for diagnostic imaging and remote reporting. Computers can be used to help implement critical pathways and analyse outcome data so that they can be continuously improved. The AHCAs should embrace funding arrangements that will allow our healthcare system to increase spending on information technology from less than 2% to 5% of budget.

Care of the seriously disabled younger person

Significant numbers of younger disabled Australians particularly those with significant mental and physical disabilities are disadvantaged by the current uncertainty related to responsibility for care. Clinicians, patients and their families have long been frustrated by the jurisdictional squabbling that interferes with both the adequate delivery of service to patients and hinders proper planning to the care of this disadvantaged sector of our community. In the new AHCAs clinicians wish to see the Commonwealth accept financial responsibility for the care of the younger disabled Australian, whether that care is provided in the community or in an institution.

Workforce issues

The critical shortage of nurses is a worldwide problem and one that must be solved. It needs to be addressed in the AHCAs as well as issues surrounding a critical shortage of other much-needed professionals. While not providing the complete answer money is at the centre of any solution. Nurses need more than a better base salary. Dedication to hospital ward nursing (the area where there is a critical workforce shortage) requires life-style sacrifices many young people are not willing to make. Altruism and vocation must be supplemented with financial packages for a largely female workforce to provide everything from accommodation allowances in high cost areas, subsidisation of child care and improvement in the availability of such a service while accepting the need to improve allowances for onerous duties. HECS relief would be an important strategy. The AHCAs should see Canberra being asked to relinquish control of determining how many University places for nursing students should be made available while the appropriateness of current educational models for nursing are reassessed. Medical educationalists feel that nurses and nursing education (and certainly hospitals) would benefit from more “learning on the job” as is commonplace for medical students.

Australian hospitals are also suffering from a critical shortage of a number of other health professionals including pharmacists, radiation technologists, radiographers and physiotherapists. This extends to doctors with certain specialties including obstetrics and anaesthetics. While the number of training places in Colleges and Universities are important issues, many of these needed professionals are only absent from the public health scene because of the enormous differential in remuneration between our private and public sectors. Unless the AHCAs address these realities, the already very serious problems must inevitably become worse.

Indemnity

Planning to solve the numerous problems caused by our current indemnity crisis is beyond the scope of this article but one initiative is certainly worthy of much detailed discussion as the new AHCAs are prepared. Patients found to have been injured by negligence have dollars awarded by Courts to cover all their lifetime medical expenses related to that negligence. Most often if we are talking about serious injury or illness, such care will only be available in the public health system (for example rehabilitation after severe brain injury). If Australians would accept as part of our Medicare agreement that such patients could have their care paid for

within our public health system, indemnity costs would be very much reduced. This would be a pragmatic sacrifice that taxpayers would make to ensure that the clinicians we need are actually there when we need them.

Dental care

Clinicians are frustrated by our Medicare system's inadequate funding of dental care to those who must rely on the public health system. The aging of our population coupled with the use of fluoride as a successful public health measure has actually seen older Australians develop unique problems with dental health not experienced by previous generations. Dental health is as important a determinant of quality of life as is health for any other organ system. This is an area where there is gross inequity and indeed represents, in many ways problems associated with the growing divide between wealthy and less advantaged Australians. Clinicians want this inequality addressed in the new AHCA's with public funding extended to dental care being similar to that made available through the MBS.

Transition care

Clinicians are increasingly concerned at the inadequacy of our healthcare system to manage, in an appropriate way, the medical problems of adolescents. While this is undoubtedly true in the area of mental health, that is at least the subject of intensive efforts to improve the situation. We now however have a "nice" problem to solve. Many children with previously incurable diseases that would cause their early demise are so much better managed that they will outgrow paediatric care and need to be cared for in our adult health system. Children with cystic fibrosis, thalassemia, immune deficiencies and storage diseases would be examples. The AHCA's must recognise this reality and work with State Governments to finance transition programs and units for this population. It is entirely unacceptable to have a child (by definition an adult in some States after just 14 years and 9 months) cared for in a hospital environment where the average age of patients is above 60 years.

Advanced planning

Our public health system, unlike private industry, is poorly adapted to handle the replacement in a timely fashion of expensive but outdated equipment. Crisis after crisis develops when, for example, a linear accelerator or an expensive angiography unit breaks down and must be replaced. The new AHCA's must address as never before forward planning and incorporation in a business, rather than a conceptual sense, depreciation economics. It is obvious already that over the next five years advances, at a cost, will see us able to better treat leukemia, rheumatoid arthritis and coronary artery disease just to mention a few problems. Studies tell us that the quality of life for patients on dialysis would be improved if we could afford to give them longer times on an artificial kidney. Routine colonoscopy for all over the age of 50 would certainly save many from premature death from bowel cancer. (Ransohoff 2002) All these realities need to be addressed in the AHCA's, which must establish an appropriately funded bureau for forward planning and the ground rules for determining whether we will or will not make specific advances available to the Australian public. Much more emphasis must be placed on examining long-term economic benefit. Cost effectiveness and better patient outcomes are often gained at the expense of one cost centre while another benefits handsomely.

Prevention

This time the AHCA's must seriously examine and embrace structural changes that will allow us to keep Australians healthier for longer. Here is the obvious "win-win" strategy. While private sector economics have sullied the reputation of many American-style health maintenance organisations (HMOs) the concept is unassailable. New agreements should see, at last, adequate funding to address our big three public health nightmares, tobacco addiction, alcohol abuse and obesity. Only a fraction of the taxes collected from cigarette and alcohol sales are actually ploughed back into education that might see people avoid the nicotine trap and use alcohol wisely.

Too few Australians have a primary care physician they consider to be the co-ordinator of their "medical orchestra". Consideration should be given in the planning of the new AHCA's to a differential in the medical rebate available for seeing a general practitioner. With the exception of emergency visits, individuals might be required to make a co-payment if seeing other than "their" general practitioner. This initiative needs to be

linked to a new payment system for general practitioners engaging in “routine maintenance” and health education. Patients would be able to change their designated GP if they desired but the concept of individuals having a long-term relationship with one primary care physician is crucial for health maintenance strategies. Leaving aside the pain and suffering involved in osteoporosis, the disease costs our country more than \$800 million per year yet should be regarded as a preventable condition. Education that motivates a lifestyle change provides the answer.

Clinical Governance and Networks:

Physicians welcome the efforts of NSW Health Minister Craig Knowles to make sure that knowledgeable clinicians are involved in the planning of the next AHCA. The acceptance by State Governments and the Federal Health Minister of the appropriateness of such a move is much appreciated. As a result we may see the next AHCA being the best yet. More and more clinicians understand the realities of health economics, they understand that no country can do all it would wish for all its people and accept, as never before, that they must be responsible and informed when they spend healthcare dollars. Peer review and the need to embrace quality issues and document the outcomes of the effects of their treatment are being accepted as necessary and inherent in their professionalism. They also appreciate that the networking of our hospital system with appropriate attention to role delineation is as important as is the horizontal integration of our continuum of care. They do however expect that the AHCA will result in a new era of partnership, a first among equals approach, between clinicians and health bureaucrats. Inherent in this must be efforts to depoliticise healthcare decisions as compassion, evidence, forward planning and consumer consultation provide us with the very best healthcare system we can afford.

References

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