

Funding the essentials: the Australian Health Care Agreements, 2003-2008

JOHN DEEBLE

John Deeble is an Adjunct Professor in the National Centre for Epidemiology and Population Health at the Australian National University, Canberra

Abstract

This editorial reviews a number of papers in a special issue of the Australian Health Review covering the Australian Health Care Agreements to be concluded by June 2003. These include a report on consultations by the Australian Healthcare Association with industry representatives from July-October 2002. For hospitals, the agreements will set the main financial parameters for the next five years. Apart from the quantum of Commonwealth grants, the issues seen as most important involved linkages with primary care providers and aged care facilities, the dominance of inpatient work in current arrangements, workforce planning and public/ private sector relationships. The possibility of recent private health insurance changes reducing the sums available for public hospitals was noted. Some estimates are presented of the possible effects of private insurance reform, together with some data from a special AHA survey of public hospital activity this year.

Background

Once every five years the Australian governments indulge in the mixture of cooperation, competition and navel gazing known as 'negotiating the Australian Health Care Agreements'. It formally starts with the Commonwealth making an offer to the States and Territories of operational funding for public hospitals and some associated services over the next five years. The process began nearly 28 years ago with the Commonwealth's first entry into direct public hospital funding in 1975. Despite some changes in content, it has continued ever since. The agreement for 2003 to 2008 will be the fifth since Medicare began in 1984. It will provide about \$40 billion over the five years and although it will be central to all of our health care arrangements, hospital funding will still dominate.

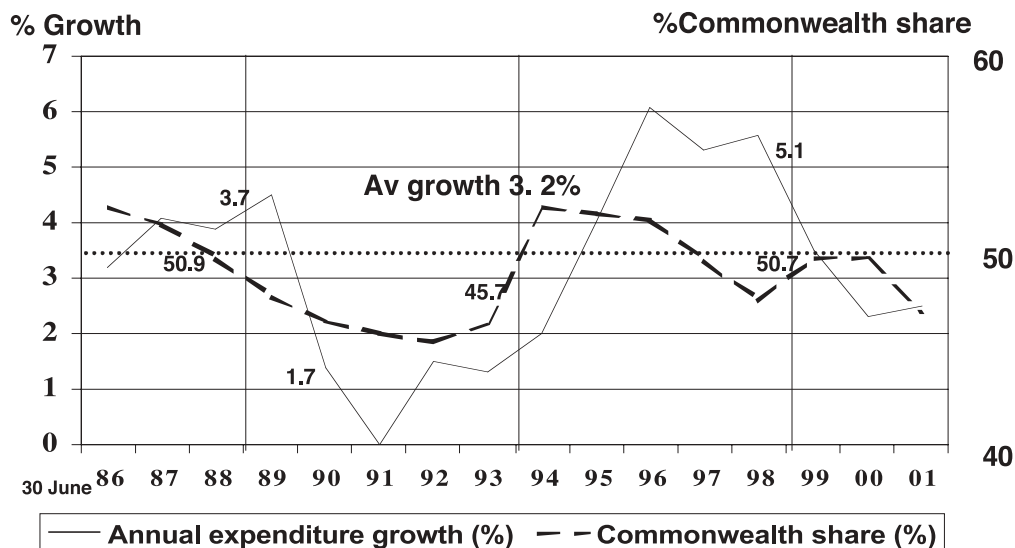
Much of this special issue of Australian Health Review is devoted to the forthcoming agreements. They have some strange features. In a sense, they are not agreements at all. Medicare is a Commonwealth program and the Commonwealth determines its direction. Whereas its benefits for medical services are provided under the Commonwealth's constitutional power over insurance, its hospital care promises can only be delivered by institutions owned and controlled by the States and Territories. Under Section 96, it can make grants to the States on such terms and conditions as the Parliament thinks fit and those conditions are embodied in the Health Care Agreements - essentially, to provide hospital care without charge to all those who seek it, based on medical need rather than ability to pay and with equity in relation to location, although it is almost impossible to say just how the last condition is complied with.

The parties' obligations are thus quite different. On the Commonwealth side it is to pay money, on the State and Territory side to deliver services to acceptable standards, whatever the cost. It is an arrangement guaranteed

to create discord and blame-shifting. The States can reject the offer and need not spend the money but they are so locked in by public expectations and political forces that it is not a realistic long-run option. The financial details have therefore never deviated far from the Commonwealth's first offer. Indeed, the legislation provides that even if a State or Territory does not accept it, the Commonwealth offer will stand. It was well into the term of the 1998 agreements before Western Australia finally signed.

However as in other constitutional matters, these disparate positions are ultimately reconciled by convention and politics. Whether necessary or not, it is politically important for agreement to at least appear to have been reached. To many people, sharing responsibility means sharing costs and the original agreements included a 50:50 cost-sharing formula. That was later rejected by the Commonwealth on the ground that it could not be expected to accept, without question, all of the costs incurred by others. But the idea has persisted. Although the parties all claim to make their spending decisions independently, their rhetoric is different. If the States do not match any increase in the Commonwealth grant they are accused of neglect. Conversely when, as in the later years of most agreements, costs and service demands rise faster than the Commonwealth grant, it is federal parsimony which is to blame for service difficulties. Both groups implicitly apply a 50-50 cost sharing standard and that is what seems to actually happen. Figure 1 - an updated version of one that I have used before - compares the annual percentage growth in constant-price public hospital expenditures under the Commonwealth-State agreements (left vertical axis) with changes in the Commonwealth's share (as measured on the right axis) over the 15 years from 1985-86 to 2000-01. The agreement periods are also shown, together with the average statistics for each. As can be seen, the relationships were both cyclic and predictable. The Commonwealth share was invariably highest at the beginning of the agreement period, lowest at the end, even under the 1988-1993 agreements when the Commonwealth significantly under-estimated needs. Though slightly lower at end of the period than at the beginning, it averaged almost 50% throughout.

Figure 1 Public hospital expenditures: Growth rates and financing shares, 1985-86 to 2000-01



One might therefore wonder what the fuss is all about. However the figure also shows another feature, namely that the higher the Commonwealth proportion, the higher was the rate of growth in total spending. When it was below 50% the growth in spending declined. That would not be true if the States dominated the system and simply used the Commonwealth funding to supplement their own. The reality is more complex than that. Both parties have reacted to each other. But despite their mutual dependency, all of the evidence suggests that it is ultimately the Commonwealth which 'drives' expenditure growth, not the States. It is not a surprising

conclusion. What other objective do special purpose grants have? It means, though, that the Commonwealth contribution is now a major determinant of public sector health spending generally and that both its level and the conditions it imposes are very important influences on the system's behaviour. Both have been largely left to politicians and bureaucrats to decide. The Australian Healthcare Association's consultations have been the first attempt to seek the views of people who actually provide the services.

What should the new agreements do?

The articles which follow outline the views of a number of interested and expert parties on what the new agreements should contain. The Honourable John Thwaites, Victorian Minister for Human Services, outlines a position which while clearly written from a Victorian perspective, contains much which would be held in common with the other States. Professor John Dwyer puts the wishes and objectives of clinicians working in the public system of a State which has significantly improved its communication with doctors over recent years. Julia Davison writes as the Chief Executive of a major teaching hospital and Professor Stephen Duckett as an academic expert, a former Secretary of the relevant Commonwealth Department and the Chairman of a teaching hospital. Finally, Mark Cormack, National Director of the Australian Healthcare Association, summarises the results of the industry consultations conducted throughout Australia in July-October this year. The Commonwealth Minister for Health, Senator Kay Patterson, was invited to contribute but was unable to do so.

Not surprisingly, the contributions vary in emphasis and detail. Mr Thwaites' article concentrates on the issues which most States will see as significantly affecting their ability to deliver care effectively and economically, namely the quantum of grants and their indexation for cost changes; the funding of hospital emergency departments and their interface with primary medical care; the relationship between the public and private sectors, particularly in relation to the private health insurance rebate; workforce planning (a major current issue) and the interface between acute health services and the largely Commonwealth-funded area of aged care. Similar issues appear in all the other papers. Professor Dwyer argues for the removal of any arbitrary limits on the proportion of GDP devoted to health care, a reconsideration of the effects of the private health insurance rebate and a number of practical changes which would improve both the efficiency and the quality of care, such as pooled area funding, the addition of GPs to hospital staff and the better use of information technology in the management of quality and the reduction of adverse events. Julia Davison mentions similar things but sees the forthcoming agreements as particularly important in reinforcing, rather than diluting, the fundamental principles of equity of access under Medicare; in driving reform in areas like mental health and access to pharmaceuticals; and in establishing a much more transparent system.

Stephen Duckett believes that the last agreements so softened the basic Medicare principles as to be virtually meaningless. He argues for change in three fundamental processes, namely a concentration on funding public inpatient care only (leaving private patient treatment to negotiations between the hospitals and private health insurance funds), a change to Commonwealth casemix payments in lieu of lump sum grants to the States (only work done would be paid for) and a progressive shift to full Commonwealth funding of hospital outpatient services, beginning perhaps in 2005. Participants in the industry consultations identified the same broad problems in administration (and many more) with generally similar solutions. Mark Cormack's report summarises them in eight categories. It is noteworthy though that although aggregate funding and, particularly its indexation, were often mentioned neither these issues nor waiting list problems were given the highest priority. The most highly ranked problems involved segmentation, the lack of flexibility in using funds, the public-private insurance interface and the very poor interactions between acute hospitals and both primary medical services and aged care.

What do these perspectives have in common?

It is a truism that 'what you see depends on where you sit' and attitudes to issues in the agreements illustrate it. The fact that aggregate funding questions did not figure as highly in the ranking of on-the-ground administrators as they did for others was not necessarily because they were satisfied (most were not) but rather from a perception that there was little that they could do and the responsibility for funding decisions which affected them -

Commonwealth or State - was not immediately obvious. Similarly, the priorities of States have sometimes been influenced by local pressures and sometimes pragmatic. No opportunity for extra funding could be missed, whether it was consistent with any long term policy or high on their priority lists or not. As an example dental care, though a relatively small item, may well be a quite high funding priority for several states. It is unlikely to be so for the Commonwealth and so it will probably not figure in any offer. However this round of negotiations will be conducted in a unique situation where all of the State and Territory governments are in the hands of one political party and the Commonwealth is in another. They have for the first time set up a set of joint working parties to report on key areas, chaired by Ministers from each jurisdiction. The reports have been public since September. They may produce more understanding and a more united front, at least as far as the States and Territories are concerned. But the Commonwealth government now has less need to satisfy its State/Territory colleagues and it is free from any immediate electoral pressure, unlike the governments in several of the states.

There are nevertheless some common issues which cannot be avoided. The first is the need to break the dominance of in-patient hospital treatment over the whole funding structure. The current agreements provide for the indexation of grants for cost changes (although its basis has been much disputed) together with adjustments for population growth and composition, especially ageing. These apply to the grants as a whole. The formula also provides for utilisation growth of 2.1% per person per annum, which is almost exactly the historical rate of growth in hospital expenditures in Figure 1 with the effects of population increase and ageing removed. But work is measured entirely in cost-weighted inpatient separations. There is therefore a strong incentive to maximise inpatient use and that has actually extended to the way in which some state governments fund their own hospitals directly. It is easy to see why such a bias has developed. Hospital separations are the easiest event to measure and waiting lists for elective surgery are the indicators of success or failure which both the public and the media understand. One might sometimes think that hospitals did little else. However about 30% all public hospital expenditure is unrelated to inpatient use (outpatients, teaching, research etc.) and overall cost growth embodies quality improvement, technological enhancement and a variety of factors not covered by changes in input costs alone. The 2.1% 'utilisation' factor is not necessarily inadequate. It is the basis of its calculation which needs extension.

At the least, that would require the measurement of non-admitted patient care. Some units already exist (the weighted-outpatient-occasions-of-service used in Victoria, for example) and as Mark Cormack's report on industry consultations points out, they could be improved for a fraction of the investment which has been made in casemix classification for inpatients. Extreme accuracy is not essential and there are well developed systems overseas. However emergency departments, out-of-hours services and other outpatient work are also issues in themselves. None of the hospital representatives saw any real alternatives to public emergency services in trauma etc, although some private hospitals have limited facilities; and most saw some specialist outpatient clinics as essential, particularly in the teaching hospitals. But the 'casual' outpatient attendance has been a funding problem ever since Medicare opened private practitioner care to everyone and it has caused more bureaucratic angst over cost-shifting, etc. than almost any other issue. Of course the patients take no notice of such matters. Outpatient services are both physical and financial alternatives to doctors' care and the less available private out-of-hours services become and the lower the proportion of services bulk billed, the greater the reliance on hospitals. Non-admitted occasions of service rose by about 10% between 1999-2000 and 2000-2001. That equated to an overall cost growth of nearly 3% by itself and the hospitals report that it is continuing. Stephen Duckett's proposal that the Commonwealth take full financial responsibility may be one long-term answer (the current growth is almost all from services for which Medicare would otherwise pay) but until then some other recognition of this component is needed. The present agreements simply assume the status quo.

Coordination

Apart from workforce problems, which many hospitals saw as the major short term limit to greater activity, the other highly ranked factors all related to process, in particular the 'silo' approach to separately funding medical and hospital care and the uncoordinated links between acute hospital treatment and the mostly Commonwealth-funded area of aged care. The problems relate not just to efficiency in the freeing of acute hospital beds now occupied by long stay, sub-acute patients, but also to the quality of services they give. Acute hospitals do not handle people with chronic and complex conditions well. They require links with GPs and

other primary care services as well as with the nursing homes that are mostly but not exclusively involved in caring for the aged. All of the hospital representatives cited the lack of any institutional contact with primary care providers and blamed uncoordinated Commonwealth policies for the excessive waiting times for admission to long term facilities. Delay in constructing and commissioning new nursing homes was seen as a major cause, although the population based formula itself was also questioned. However recent initiatives in the Commonwealth funding of some 'transitional' beds in public hospitals were welcomed.

All of the papers which follow identified the same factors. They are also prominent, in different forms, in the recommendations of the AHMAC Working Parties. Many of those involve ways of getting around the jurisdictional and institutional divides. These are in some ways the inevitable outcomes of a federal system, but not entirely. The Coordinated Care Trials were an attempt to avoid them. The results showed that although patients liked the more personal attention and thought that their care had improved, costs did not fall (they almost certainly rose) and there was no clear evidence of better health outcomes or a reduction in the need for acute treatment. The pooling of funds was not enough. Poor management skills, rivalries and professional myopia were equally important obstacles.

Given the hospital focus of the agreements, and their generality, it is doubtful if all of these concerns can be addressed within them. Initiatives like the Coordinated Care Trials were developed outside the mainstream system. However the hospital representatives all supported an increase in the small proportion of Commonwealth's agreement funding reserved for special purposes (now less than 4%) and some earmarked appropriation for programs to improve coordination could be included there. Experience with mental health reform has shown that substantial results can be achieved from relatively small, directed outlays.

The big money question

Finally, there is the question which everyone has in mind but cannot yet answer, namely what the impact of the Commonwealth's Private Health Insurance Rebate will be. Its proponents have argued that by shifting patients to the private hospital sector, it will reduce the pressure on public hospitals. Others have been doubtful on the ground that the two systems treat different types of patient and that the poorest, oldest and sickest patients will still be cared for publicly. The two approaches reflect quite different assumptions. If the demand for hospital care is finite, any increase in one sector must logically involve a decrease in the other. But if demand is not fixed and availability creates its own market, increased private sector use would simply be a net addition to the total. That is what history suggests. All that would have happened is that more money would have been spent and more hospitalisation provided overall.

It is impossible to prove either of these propositions conclusively. However the question is important. In the last agreements the States won a Commonwealth promise of compensation if private health insurance levels continued to fall (at the rate of \$80 million nationally for every 1% fall in the proportion of the population which was insured). That was never paid because the 30% rebate stabilised membership and the campaign associated with 'lifetime health cover' increased it dramatically. However the provision remains, it logically works both ways and the Commonwealth would, on the present formula, now be entitled to withdraw over \$1 billion in hospital grants to the States. It undertook not to do so in the current agreements but they expire in June next year and there are many people who fear that the Commonwealth Treasury and Finance Departments will find the chance to recoup some of the \$2.3 billion in PHI rebates too tempting to resist. Judgements will be made on a priori grounds and payments under the agreements will be cut.

Any reliable evidence is therefore critical. The AIHW data show that between 1998-99 and 2000-2001, total hospital separations rose by 7%, a large increase though not the largest on record. However they rose by only 1% for public patients, with almost no change in 2000-2001. In contrast, private patient separations grew by 16% (19% in private hospitals) with the greatest increase in the year to June 2001. Over three quarters of their overall rise was in same day procedures. A simple extrapolation of past growth would suggest a shift of about 260,000 admissions from public to private patient status, though largely at the low-cost end.

However the process was not that simple. Table 1 shows public and private patient separations per 1000 population in 1998-99 and 2000-2001, split between New South Wales and all the other States and Territories. That takes out the effects of population growth.

Table 1. Separations from acute hospitals, 1998-99 and 2000-2001, rates per 1000 population, by status of patient; New South Wales and other States and Territories.

Totals	NSW				Other States / Territories			
	1998-99	2000-2001	Change		1998-99	2000-2001	Change	
Status	(No)	(No)	(No)	%	(No)	(No)	(No)	%
Public	172.5	159.2	- 13.3	- 7.7	188.0	189.4	+ 1.4	+ 0.7
Private	116.5	130.0	+ 13.5	+ 11.2	126.0	144.0	+ 14.0	+ 11.4
Total	289.0	289.2	+ 0.2	-	314.0	333.4	+ 19.4	+ 6.2

Sources: calculated from AIHW, *Australian Hospital Statistics, 1998-99 and 2000-2001*.

As can be seen, at just over 11% per person the rise in private patient separations was almost uniform across the country. But all of the reduction in public patient work occurred in New South Wales, which was also the only state in which the total rate of separations did not change. There may have been a number of good reasons for this, including better coordination and a better management of complex cases. The New South Wales result may nevertheless give some indication of what the maximum shift in underlying usage might have been. If nothing else had changed, it would have implied a notional reduction of about \$700 million in gross public inpatient costs Australia-wide, which would have fallen to about \$600 million when the additional medical and pharmaceutical costs of private treatment were met. That would have equalled only 26% of the health insurance rebate's cost and only 4% of total public hospital expenditures, even less at marginal costs. Most of the Commonwealth's outlays went to people who were already being treated privately.

But that conceptual reduction did not occur in cash. Public patient admissions rose in the rest of the country, in constant prices public hospital outlays increased by nearly 5% and as will be shown later, these rates of growth appear to be continuing. It would thus be very hard to justify any clawback of Commonwealth funding through the agreements. Improving access for public patients was one of the key arguments advanced for the whole private health insurance program. It would be self-defeating to take back any of the money which might make that happen. It is already being spent.

Current trends

Given these results, it was important to know what the trend in public hospital activity might now be. Official figures will not be available until well after the agreement negotiations end. The reports from the hospitals were varied. Many reported increased activity in 2002 with differing experiences in terms of the proportion of public patient work but most of the accounts were anecdotal.

We therefore surveyed, through the AHA, a sample of 30 hospitals in all states and territories covering their activities for the two four-monthly periods of April to July, 2001 and 2002. The sample was stratified by hospital type and size. The surveyed hospitals accounted for nearly 20% of all public hospital separations in 2001, which clearly leaves room for sampling error. However it was a large sample statistically and on such key indicators as the average length of stay, the proportions of same-day and overnight admissions, and the proportions of public and private patients the results for 2001 were remarkably close to the national data.

Details will be reported in a later issue of this journal. The main results are summarised in Table 2. They suggest that public hospital separations had resumed their growth in 2002, at about 1.6% over the same period in 2001. The increase was almost entirely in public patient separations, which rose by 1.8% compared with only 0.6% for private patients. However that made very little difference to the private patient proportion nationally. Average cost weights were unchanged.

Table 2. Sample hospital separations, by patient status, April-July 2001 and 2002.

	Public	Private	Total	% private	cost weight
2001	242,762	22,238	265,100	8.4	1.02
2002	247,028	22,367	269,395	8.3	1.02
% change	+ 1.8	+ 0.6	+ 1.6	- 0.1	-

It is now four years since the private health insurance rebate was introduced and over two years since 'lifetime health cover' came into effect. The membership of private insurance has changed very little and any waiting periods imposed on the rush of new health fund members expired a year ago. Most of the effects should thus be evident by now and the system appears to have stabilised with;

- (a) almost no change in the composition of public hospital work,
- (b) about the same level of public patient separations as before, growing at about the same rate as that which applied in most of the country over the two transitional years. It is a higher rate than population growth but less than the target figure for utilisation increases in the current agreements. However several States have not been meeting that target anyway.

It is hard to see why these results would change. They suggest some reduction in the growth of inpatient admissions, but these are very early days. All of the experience, here and overseas, is that although financing changes of this kind can produce one-off pauses in expansion, they do not alter long term trends. About two years of public inpatient growth may have been moved to private funding, but that is likely to be all. And inpatient separations are only one measure of hospital activity and a limited indicator of expenditure changes generally. As pointed out earlier, outpatient demand has moved quite sharply in the opposite direction - particularly in NSW - and by 2000-2001 at least, waiting times for public elective surgery had apparently not changed.

Both of these issues should be treated separately. However given the backlogs, all of the arguments for broadening the scope of the Australian Health Care Agreements, the continuing pressure for technological enhancement, equipment upgrading and the completely open-ended nature of the private insurance subsidy, maintaining something very like the present growth factor in monetary terms would seem to be both prudent, justified and equitable.