

# The 2003-2008 Australian Health Care Agreements: an opportunity for reform

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## Abstract

*The Australian Health Care Agreements govern the relationship between the Commonwealth and States about public hospital funding. The incentives enshrined in the Agreements can shape policy priorities. Although they provide for the largest specific purpose grant a State/Territory receives, the current negotiations should not be seen as providing the only opportunity for reform of health care for the next five years. This paper argues that the negotiations should focus on two key areas where Commonwealth–State frictions are high but reform is feasible. Specifically it is suggested that the Commonwealth should contribute its funding of public hospital inpatient services on a casemix basis, and secondly, should fund outpatient services directly*

The typical 1998-2003 Australian Health Care Agreement between the Commonwealth and each State and Territory is a document of about 45 pages long with clauses about consultation, roles, formulae, etc. The critical obligations on the State are encompassed in the agreed Principles (clause 13) which provide:

1. Eligible persons must be given the choice to receive public hospital services free of charge as public patients.
2. Access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period.
3. Eligible persons should have equitable access to public hospital services, regardless of their geographical location.

Importantly, Principles 2 and 3 are softened in that it is agreed that these principles are met if the State “is using its best endeavours to achieve the outcomes sought in those principles to the greatest extent practicable”. The result of this softening is that these principles are so vague to be meaningless.

The Australian Health Care Agreement negotiations are often contentious (Reid 2002) and generally do not lead to major reform, despite calls for more dramatic changes (Paterson 2002). The Agreements have evolved over time (Duckett 2002) but the 2003-2008 Agreement presents an opportunity for further reform. I propose that the new Australian Health Care Agreement negotiations should be simplified to focus on reform in two key areas: hospital inpatient and outpatient services.

## Hospital inpatient services

The Australian Health Care Agreement is the mechanism by which the hospital component of Medicare is effected. From the public's perspective, the key component of hospital Medicare is that all Australians can obtain public hospital inpatient treatment without charge. The 1998-2003 Agreement has good provisions for indexation of the health care funding arrangements including indexation for price increases (although the States and an independent arbiter have argued that the indexation arrangements are parsimonious), demographic

change (including growth and ageing of the population), and practice changes (including provision for an expected increase in utilisation of services per head of population). These provisions should be continued in their present form in a new Agreement.

The new Agreement however, should change the basis of funding of hospital inpatient services from a grant to the State to a casemix-weighted payment for public patients treated. Casemix measures have evolved over recent years and robust measures now exist for all types of inpatient activity (acute and sub-acute). The mechanism of payment should be via the Health Insurance Commission direct to health services on the basis of achieved activity. In this way, accountability and information flow would both be improved.

Converting the hospital payment to a payment for services should also mean that the inpatient arrangements could be excluded from Grants Commission equalisation. This will increase the transparency by which payments are made from the Commonwealth to the State and hence further strengthen accountability.

The Commonwealth currently funds roughly 50% of public hospital care across Australia. Under the proposed arrangement the Commonwealth should fix an amount per weighted patient that it will pay in each State and Territory. This would be indexed in line with current provisions. The funding arrangement should incorporate a cap on the number of patients to be paid for in each State, possibly at an age-sex standardised utilisation rate and accompanied by robust performance standards for timely access to care. This cap could also be equalised between States over the course of the Agreement by differential rates of growth of the initial cap. Because the payments would be made on a per patient treated basis, if States reduced funded activity there would be a consequential reduction in Commonwealth payments.

In my view the new Agreement should focus on public patients, leaving payments for private patients as a matter of health insurance policy rather than Commonwealth-State negotiation. Currently, fees for private patients in public hospitals are subsidised by State governments and indirectly by the Commonwealth (Canil 2001). It is proposed that fees for private patients in public hospitals should be negotiated between the States and/or public hospitals and health insurance funds in the same way that fees for patients in private hospitals are negotiated. The “second tier default benefit”, which sets a floor for fees in private hospitals at 85% of prevailing fees in the absence of agreement between hospitals and private health insurance funds, should be extended to overnight patients in those public hospitals which meet the criteria established by government for that benefit. The situation with same day patients is somewhat more variable, particularly because the criteria for admission are less clear. The Commonwealth should remove the requirement for private health insurance funds to pay the second tier default benefit for same-day patients in either public or private hospitals. This would lead to more robust discussions between health insurance funds and hospitals and will reduce the cost of the second tier benefit. The default (first tier) benefit would remain in place for same-day cases in both sectors.

## **Outpatient services**

Outpatients is one of the key frictional problems in Commonwealth/State relations where consultant physician services provided in a physician's room attract a Medicare rebate but if the same service, provided by the same physician, is performed in an hospital outpatient clinic it is funded through State and Territory public hospital arrangements. This provides an unhealthy incentive on States to shift costs to the Commonwealth, regardless of whether this leads to an overall efficiency improvement (provision of services in outpatients may be in cheaper than in physicians' rooms) or enhances continuity of care. The 2003-2008 Australian Health Care Agreement should address this problem.

In the 1998-2003 Agreement the Commonwealth at last accepted responsibility for pharmaceutical services provided to outpatients and on discharge from public hospitals. New funding arrangements for pharmaceuticals are now being implemented in a number of States (Victoria, Queensland and Western Australia). This harmonisation of policies may lead to improved efficiency by obviating the need for recently discharged patients to visit specialists or general practitioners to obtain continuation prescriptions.

Overall system efficiency would be approved if the Commonwealth assumed similar responsibility for payment for hospital outpatient services. An additional funding stream for these services would provide an incentive on hospitals to continue these services which would have both short and long term benefits. In the short term,

consumers would benefit from improved access to medical services without payment at point of service. There are currently high out-of-pocket costs for many specialist services and hospital-based provision would facilitate more equitable access to these services. The collapse of bulk-billing and after hours general practice in outer metropolitan areas would also be addressed in this policy as hospital emergency department services could afford to establish primary care clinics to meet this need. Since most clinician training occurs in hospitals, the policy would also have long term benefits by facilitating training opportunities for new generations of clinicians.

Given the need to plan the implementation of this, it is proposed that the new Health Care Agreement include a clause that the Commonwealth will assume responsibility for payment of hospital outpatient activity from 1 July 2005 on such basis as is agreed between the Commonwealth and the States. The clause should also provide that Commonwealth payments for outpatients may, for the term of the Agreement, be capped.

In the absence of agreement between the Commonwealth and States on the basis for outpatient payment, the Health Care Agreement should provide that as from 1 July 2005 public hospitals would be able to bulk-bill Medicare for outpatient services provided by medical practitioners. This would ensure no out-of-pocket payments for patients for this important service but also provide a fall back funding mechanism in the event that a better funding approach could not be agreed.

Ideally, outpatient payments should be on a bundled visit basis as is common in most States. Assuming responsibility for hospital outpatients would give the Commonwealth experience in this payment basis which could provide a useful precedent for other specialist services. It would also encourage a situation where the choice of treatment locale would be on the basis of quality and efficiency, not who pays.

## Conclusion

There would be three main effects of my proposals. First, a major simplification of the Australian Health Care Agreements would occur, reducing their complexity and clarifying the core public interest components of the Agreement. Secondly, the refocusing of the Agreement on public hospital inpatients through casemix payment would increase transparency and accountability for this aspect of health care. The Commonwealth contribution would be clear and direct without the obfuscation involved in equalisation through Grants Commission arrangements. Thirdly, a phased implementation of the transfer of responsibility for outpatient activity would reduce the scope for cost shifting and also clarify responsibilities. Together, these changes would represent a significant simplification of Commonwealth/State relations in health care, and improve accountability for hospital services.

Although there are a myriad other aspects of the Australian health care system which could be reformed, achieving improvements in the two areas I have specified would represent a significant simplification of responsibilities resulting in improved accountability and reduced scope for cost and blame shifting. Focussing on two areas for reform may mean that reform in at least these two areas is achieved. Policy attention could then move on. The Australian Health Care Agreement should not be seen as the only opportunity to achieve policy change in Australian health care. A quinquennial burst of funding and activity is a poor substitute for the collaborative, strategic planning that is needed to address other important areas of policy such as Indigenous health, workforce supply, safety and quality, and continuity of care.

## References

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