EDITORIAL

Taking health seriously: the Senate inquiry into public hospitals

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In July last year, the State and Territory leaders expressed concern over a health system under "unsustainable stress" and suggested that the Federal Government should sponsor a prolonged and detailed inquiry by the Productivity Commission. The Prime Minister rejected the suggestion, and the Australian Senate therefore decided to conduct its own shorter inquiry. Submissions were invited late last year, and the Senate Community Affairs References Committee is conducting hearings at the time of writing. The focus here is on my idiosyncratic impressions of what has happened during the hearings on 11 November 1999 (Canberra), 23 February (Adelaide), 24 February (Darwin), 25 February (Perth), 21 March (Sydney), and 22 March (Brisbane). Transcripts of the hearings are available in Hansard (1999, 2000).

There have been many differences of emphasis and opinion among the individuals and agencies that have made submissions and presented to the Committee, and among Committee members. However, some common themes are emerging. One is that there is no agreed basis in evidence for arguing that either more or less should be spent on health care. The clinical professions (and other parties) have tended to claim that the system is indeed under increasing pressure. On the other hand, New South Wales Health argued that the overall level of funding may be about right – that "... our health system works well but is in need of reform." A similar view was expressed by the Royal Australasian College of Physicians: we should "... try to get the systems better before we start ... looking to provide a lot more money."

In general, members of the Committee have not been provided with a consistent way of defining pressure. Nor have they been convinced about its origins and consequences. Are all health systems always under pressure (because expectations always run ahead of capabilities), is our health care system getting better or worse, or is it better or worse than systems in other countries? Equally important, might the main problem be the way resources are used (with the many structural inefficiencies, lack of equity, claimed inappropriateness of care methods, and so on) rather than the level of funding? The Committee is unlikely to resolve these questions on the basis of the evidence presented thus far.

Submissions have been more consistent in terms of arguing for a better process of deciding how much to spend. For example, the process should involve making sure the community at large is better informed of the consequences of spending more or less, that it can express its views, and that governments become more committed to acting in line with those views. The Health Consumers' Council put it quite bluntly: it would benefit everyone to inform the voters "... how the hell financing arrangements in this country work and who pays for what" and "... about other policy matters."

Another widely held view is that cost shifting is endemic in the Australian health system. Some of the best health professionals spend much time managing cost shifting rather than health care, and consumers bear most of the penalties. There is no way of stopping people from wanting to cost shift. Policing and sanctions are inefficient and often ineffective, and it would make more sense to re-structure the health system so that cost shifting is less harmful to Australia's health. When asked the views on cost shifting of the Health Department of Western Australia, a witness for the Doctors Reform Society of WA suggested there was probably a wide range of views "... ranging from the Commissioner, who will say it does not exist, down through the various levels which enforce it." A representative of the Health Department of Western Australia put it another way: cost-shifting is occurring, but "... it is occurring from the Commonwealth to the State and not necessarily vice versa."

There has been near unanimity with respect to one change that would help reduce the destructive aspects of cost-shifting: that of redefinition of the roles of State and Commonwealth governments. For example, few people believe it makes sense for the Commonwealth to pay GPs and the States the hospitals in different ways and with different financial incentives, or to have private insurers paying hospitals and the Commonwealth the specialists. Most people were aware of the origins of these arrangements and the difficulties in causing all parties to want to change, but were reluctant to accept these as adequate excuses for taking no action for so long. As the Australian Medical Association (AMA) put it, even if health funding were to increase, Australia is stuck with a financing model "... that is a dog's breakfast."

The underlying logic seemed very strong. Consumers are not interested in knowing whether the financing of their health care is by way of the Commonwealth or the State government: the available resources are the community's and not any government's. All parties should work together to give the community what it expects and deserves – a national health care system that does not have the same level of waste as the current one.

A related matter, not specifically within the Committee's terms of reference, has consumed a large share of the hearings: which side (the Commonwealth or the States and Territories) has been behaving the better during the current round of Australian Health Care agreements. It seems to me that the evidence slightly favours the States and Territories, but if so the Commonwealth might legitimately claim they were less guilty in the previous round. Analysis is difficult if only because of the complexity of the Agreements (including the clauses that deal with the interface between the public and private financing and care provider sectors). Better data would also help.

Many submissions promoted the idea of co-ordinated care, and the Commonwealth's Co-ordinated Care Trials were generally supported. One or two submissions criticised the details, such as why it seemed necessary to conduct prolonged tests of what Basil Fawlty would call 'the bleeding obvious', and how it was impossible properly to test a model intended to be all-inclusive by running an optional scheme in which a self-selected subsample of perhaps only 1% of the

community was involved. Several submissions (and one or two Senators) leaned openly towards a demonstration project for an entire community (such as the Hunter Valley or the ACT).

Many witnesses stated or implied the need for transparent rationing, but there were differences of opinion about what that might mean. For example, Dr Brand of the AMA said that "... nobody yet has been honest enough to start to say that we have got to ration health care in this country in the public sector." We need to make sure that "... the waiting lists are not jumped by people who pay money or by people who make the most noise" and that services "... are actually going to people who have the greatest need." In response, Senator Evans asked whether the AMA normally offered quite the opposite kinds of measures. "Don't you usually refer us to price mechanisms, and isn't that really a decision made based on wealth? The AMA are always encouraging us to offer more market driven solutions."

Dr Brand clarified the point very well by noting that "... waiting lists are one option to ration health care in our public hospitals (but) it is not necessarily the best system. There are other ways of looking at managing access to health care. One of those is a means test."

I interpreted this debate to mean that, when the AMA talks about rationing, it is mainly referring to denial of access to public hospitals to those people who can afford to pay for private hospital services. Senator Evans was envisaging a rationing system like that in (say) New Zealand or Oregon where an individual's access to care is prioritised on clinical grounds and is largely independent of the level of his or her contribution to financing. In one respect, Dr Brand is nearly correct in implying that few people are talking about the AMA's model of rationing, but this may be because it is a discredited idea in some people's eyes. Dr Brand was surely overstating the extent to which the idea of means-tested public hospitals is new. It has been advocated by the AMA for at least 60 years, off and on, for good reason. The well-off are potential customers, and it would be helpful to private medicine if they were to be weaned off tax-funded services in the public health care sector.

A few submissions argued in favour of more and better competition between providers. A typical comment was that competition between public and private hospitals was demonstrably imperfect, given that most private hospitals could not (or would not) bid for public patients and most public hospitals were similarly unwilling or unable to maintain their share of the privately insured sector. Perhaps more obvious, competition is bound to be flawed when governments mandate prices for one type of hospital and not the other, or mandate different prices depending on the owner. Much needs to be done to ensure that ownership of the health care facility becomes less important than cost-effectiveness. As observed by the Royal Australasian College of Physicians, there are good and bad hospitals in both the public and private sectors. The aim should be to ensure good hospitals are rewarded, whether they are public or private.

There were patterns of agreement on the quality of health care. It was frequently argued that Australia's health system is excellent, and (as the Prime Minister said recently) who would want to be treated anywhere else than here? However, hardly any evidence was presented to support this view. Some submissions were much more critical, and the findings of the Quality in Australian Health Care study were commonly quoted (Wilson *et al*, 1995).

As one submission said, we currently know a little about costs and virtually nothing about value because there are few rewards for delivering value. It was argued that "... the dismissal or other form of censure of health system managers on the grounds of quality is virtually unknown in Australia. The system is still being run largely on the basis of ability to control costs, rather than the provision of high quality care and value for money."

One matter on which there has been less agreement is the effect of the 30% rebate on private health insurance (PHI). A few parties (and particularly those which were strong advocates, such as the Australian Medical Association and the Australian Private Hospitals Association) have argued that the change has been helpful (in that it prevented a disaster) and more changes of the same style are needed now – such as individual health savings accounts, transferable Medicare entitlements, the means-testing of public hospitals and other ways of putting pressure on those who can afford to 'do the right thing' and insure themselves.

The influence of some of these parties may be less today, at least on this particular matter, because their claims have not been fully borne out in practice. For example, the AMA had told the government that the rebate would increase membership to 40% or more (when it is currently at about 32.5% in spite of the additional incentives including lifetime community rating), and the APHA had argued that the rebate could totally eliminate public hospital waiting lists (when the effects are so small as to be unmeasurable throughout most of Australia).

The submission from the University of New South Wales (for which I shared responsibility with all academic staff) presented an analysis of the likely impact of the rebate on public hospitals over the period from June 1999 to May 2000. There were six steps, as presented in Figure 1.

Figure 1: Computation of the annual effects of the 30% rebate on public hospital expenditures

1 Retained members	
Population	18000000
Without rebate	29.0%
Upper estimate with rebate	34.3%
Lower estimate with rebate	30.5%
Retained members (upper)	954000
Retained members (lower)	270000
2 Gross transferred inpatient days	
Upper (900 per 1000 popn)	858600
Lower (813.6 per 1000 popn)	219672
3 Net transferred inpatient days	
Upper (10% in public hospitals)	772740
Lower (15% in public hospitals)	186721

4 Transferred costs

Upper (at $625 per day)	$482,962,500
Lower (at $625 per day)	$116,700,750

5 Transferred costs as % public hospital expenditure

Annual expenditure	$12000000000
Upper estimate	4.02%
Lower estimate	0.97%

6 Annual growth in public hospital admissions

Year	Total admissions	Growth rate
1993–94	3296000	
1994–95	3420000	(3.76%)
1995–96	3568000	(4.33%)
1996–97	3622000	(1.51%)
1997–98	3748000	(3.48%)
1998–99 (estimated)	3870560	(3.27%)
1999–00 (estimated)	3997127	(3.27%)

The first step involved estimating the number of people having PHI as a consequence of the 30% rebate. It was assumed that coverage would have been 29% by May 2000 without the rebate. High and low rates were used for membership with the rebate, ranging from 30.5% to 34.3%, thus giving upper and lower estimates of 954,000 and 270,000 people. These 'retained members' included both new members and continuing members.

In the next step, usage of public hospitals was estimated as a range from 813.6 inpatient days per 1000 population per annum (the ABS statistic for 1997–98) to 900. The range took account of the possibility that retained members might be higher users than the average. This gave upper and lower estimates of 858,600 and 219,672 for the number of inpatient days in public hospitals that would have been consumed by the retained members, called the 'gross transferred days'.

Step 3 involved splitting the gross transferred days between public and private hospitals, since people with private health insurance make use of both public and private hospitals. The ABS statistic for 1997–98 was used – that 10% of hospital episodes for privately insured patients occur in public hospitals. This gave 'net transferred days' of 772740 and 186721 for the upper and lower estimates respectively. The authors noted that some people would still elect to be treated as public patient in public hospitals, but they chose to be conservative and set this volume at zero. Incidentally, some members of the Committee were interested to hear the statement by New South Wales Health that, in NSW at least, of the patients with private health insurance who are admitted to public hospitals in the State "... only 39% declare their private health insurance ... and the other 61% come in as public patients."

Step 4 involved estimating the cost of the transferred care. The authors used $625 as the average cost per day of treatment in a public hospital, taken from the 1997–98 National Hospital Cost Data Collection of the Commonwealth Department of Health and Aged Care. This gave upper and lower estimates of costs lost from the public hospital system of $483 million and $117 million respectively. This represented between 4.02% and 0.97% of total recurrent costs.

Finally, the impact of the transferred costs was simply illustrated by noting two factors. First, public hospitals continue to experience increases in the number of admitted patients as a consequence of many factors including increased efficiency, growing expectations, and demographic changes. Between 1993–94 and 1997–98 hospital admissions grew by an average of 3.27%. The underlying factors are robust, and the authors chose not to define a range. Second, it was argued that there is considerable unmet need and therefore, if spare capacity emerged it would quickly be filled by those who had been in waiting (whether on formal waiting lists or not).

Thus it was concluded that, even in the best case scenario, there could not possibly be any significant reduction in public hospital activity levels. In their presentation to the Committee in March 2000, the authors noted that the predictions were being confirmed by actual statistics. Some States and Territories had experienced a small decline in admission rates to public hospitals, and others a small increase. As Queensland Health put it, the rebate arrangements "... do not appear to be delivering a tangible benefits to the public hospital system." The demand for its services "... continues to grow."

The University of New South Wales submission also noted that "... the rebate may have been a sensible taxation policy (but) it was entirely unhelpful to the health care system." It involved spending around $1.7 billion per year, of which the larger part would never find its way to health care providers. Moreover, the effect would be to transfer patients from the public sector into the private sector, which is more costly for reasons such as higher insurance overheads and fewer controls on utilisation. The authors claimed that "... 3 to 12 times more health care" could have been provided for the same cost if it had been allocated instead directly to public hospitals (or even better made available for competitive tendering by both public and private hospitals).

One observer noted sotto voce at this stage that, if the figures were correct, then the opportunity costs were staggering – perhaps $6000 for each additional bed-day freed by this mechanism. All hospitals, public and private, would no doubt welcome being paid at a tenth of this rate. In reality, few private hospitals or private insurers are likely to be feeling that their lot has significantly improved – very little of the new money is reaching them.

It appears that the forecast of an annual cost of $1.7 billion was an underestimate. During the questioning of the Commonwealth Department of Health and Aged Care by the Committee, as recorded in Hansard (Community Affairs CA–76 to CA–91), it became evident to all that the decision to introduce the rebate had been based on rough analyses at best. At least some members of the Committee concluded that the level of analysis was poorly matched to the size of the change. The Department's latest estimate for the cost in 2002–2003 is $2.2 billion.

This leads to one more general impression that is worthy of note: the Senate Committee members have been taking a remarkably serious and careful approach. Compared with other recent hearings, there has been much less politicking, and much more willingness to recognise and deal with the complexity. This is illustrated by the members' frequent questioning of witnesses about what should be done, and several have suggested that a one-off investment in structural change

would be more beneficial than a minor increase in expenditure on existing processes of care. The comments of a former Australian Minister for Health in this issue of AHR (Blewett 2000) are relevant here: that "... the chief advantage of the (private health insurance) rebate is that it provides a really wonderful nest egg for a reforming government to do something really creative within the health system."

The health policy debate has largely been hijacked in Australia and many similar countries over the last decade or so. The quick fix has become the norm, driven by Treasurers rather than Ministers of Health. It is therefore encouraging to see some serious and considered debate again.

Finally, my impression is that most Senators have been frustrated by the general lack of data on costs, cost-shifting, quality of care, under-servicing and over-servicing, and so on. At least, we might therefore hope that information systems will be improved with the deliberate intention of informing future policy debates. I am optimistic we will get this and more.

References

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Hansard, 1999, 2000. Electronic copies of transcripts of the inquiry into public hospitals may be accessed on www.aph.gov.au/hansard. Requests for hard copies may be made to <<community.affairs.sen@aph.gov.au>> or by telephoning 02–6277–3515.

Wilson RM; Runciman WB; Gibberd RW; Harrison BT; Newby L; Hamilton JD 1995, 'The Quality in Australian Health Care Study', *Med J Aust*, 1995 Nov, 163:9, 458–71.