The 2003-2008 Australian Health Care Agreements – an industry perspective

Mark Cormack

Mark Cormack is National Director of the Australian Healthcare Association.

Abstract

This paper presents a public hospital and health care industry perspective on the development of the 2003 – 2008 Australian Health Care Agreements. The Australian Healthcare Association conducted a national industry consultation exercise from June to September 2002 in the lead up to the development of the next round of agreements. While acknowledging that the size of the funding commitment from the Commonwealth to the states will be the central focus of negotiations, health industry representatives identified issues of equal importance. The AHCAs' linkages with other health programs need to reflect that health care has moved beyond the confines of the hospitals. Adjustments and output targets need to provide incentives to improve and reform the industry. The success of private health insurance policy has not yet translated into benefits for the public hospital sector, and any funding contingencies between the two programs cannot be justified at this time. Special priority areas such as health workforce will need specific policy and program responses.

Introduction

The 1998-2003 Australian Health Care Agreements (AHCAs) are in their final year. Development of the next AHCAs is underway. Commonwealth, state and territory health ministers are well advanced in articulating their positions. The formal output to date is a series of detailed analyses of policies, priorities and recommendations emanating from the nine reference groups established by the Australian Health Ministers Conference (AHMC) in April 2002 (Australian Health Ministers Conference, 2002). These were tabled at the September 2002 meeting of AHMC, with further work on their translation into specific strategies to be discussed at the November 2002 meeting of AHMC.

Treasury and central agencies presumably are now sharpening their pencils in expectation of taking charge of the process once the health ideologues have had their say. The AHCAs are collectively a large program, with next one likely to be worth in excess of $ 40 Bn in Commonwealth outlays over five years. With the informal matching of this by state and territory governments, the total sum increases to more than $ 80 Bn. The attention of treasuries and central agencies is therefore expected, and justified on the basis that such vast amounts of money could surely not be entrusted to the big spending health agencies.

Of course the AHCAs are about much more than money. They are about services for people. In many instances services that are life saving, in most cases life altering, and, one expects, life enhancing. The AHCAs are also about the shape, size and future direction of Australia's most complex, professionalised, ubiquitous and valued service industry. Health service provision is better described as an industry than a system. System implies structure and order – terms not typically associated with the complex and idiosyncratic web of programs underpinning the provision of essential health services.

The complexity of these arrangements is exemplified in the current AHCAs (Department of Health and Aged Care, 1998). Features of the current agreements have been described elsewhere (Duckett 2002, Cormack 2002a and Australian Healthcare Association, 2000). AHCAs include funding allocations, principles, policy, rules,

adjustments and special priorities. Since their inception the AHCAs and Medicare Agreements have progressively defined major hospital funding and related policy priorities of the Commonwealth, state and territory governments. They have enabled combined policy attention to priority areas such as mental health, casemix, pharmaceuticals, palliative care and quality. While the reporting of performance under the agreements has been delayed and relatively inaccessible to the general public, anecdotal evidence suggests they have been successful in maintaining the fundamental Medicare principles, funding commitments by both levels of government, and facilitated useful service reforms in some priority areas.

Despite the durability of the AHCAs and Medicare Agreement process, they are generally poorly understood by hospital and health care industry senior managers, let alone the wider community. AHCAs have remained the domain of Commonwealth, state and territory health and central agencies. Input from the industry has historically been ad hoc, despite the fact that it is responsible on a day-to-day basis for the operational delivery of the outputs of the AHCAs, i.e. essential health care services delivered on the basis of clinical need. The AHMC reference group process described above was welcomed as one means of ensuring broader input to the development of the next AHCA. However, its short time frame and closed nature permitted little formal input to the process beyond the members of the reference groups.

Industry consultation from June to September 2002

The Australian Healthcare Association (AHA) in its capacity as the national industry association for the public hospital and health care sector undertook a national consultation program on the AHCAs from June to September 2002. Its aim was twofold. Firstly, to provide senior health sector executives with a detailed overview and understanding of the current AHCAs. Secondly, to gauge industry views on the impact and effectiveness of the current AHCAs, and priorities for attention in the next round.

Eleven half-day workshops were held across the state capitals. Approximately 240 senior health industry executives, and representatives from health and central agencies attended the workshop series. Participants received a package of pre-reading materials including their state's AHCA, associated industry and peer-reviewed commentary. Workshops included presentation of material on the features of the current agreements, with the majority of time allocated to gathering input and discussing priority issues. Participants were requested to individually record a list of priority issues that they felt needed to be addressed in the next AHCA. Responses were collated and analysed on the basis of frequency of mention. They were subsequently allocated to broad content categories.

Analysis of responses from industry participants revealed the following priority issues for attention in the next AHCAs. Under each specific category, objectives were identified for inclusion in the next round of agreements. They are listed in order of frequency of mention and the ranking that participants gave to them.

1. Linkages between programs funded via the AHCAs, and other primary and community care programs (including general practice)

Health care has moved beyond the boundaries of the hospital institution. It is increasingly dependent on adequate access to GP services, community based care, and viable and accessible outpatient services. Hospital outpatient services have changed over the years. There has been diminishing access to multidisciplinary care especially for persons with chronic and complex conditions. Effective health care services require a greater degree of co-ordination of programs and integration of care across a range of settings.

The AHCAs provide little incentive for investment by the public sector in outpatient, ambulatory and community based care. This is because there is minimal measurement of performance, apart from admitted care, and payment to the sector is dependent on maintaining a high and annually growing utilisation of inpatient care. The Commonwealth has invested heavily in the measurement of acute hospital activity (DRGs) over a 15-year period of time. Similar extensive investment in the methodology of measuring primary care, sub acute, other health care modalities and outcomes is required to improve linkages across program areas.

Objectives identified from industry consultation

- Establish incentives to encourage investment in primary health care and ambulatory care models that keep people out of hospital.
- Encourage program, service and planning linkages between Commonwealth and state funded primary care services, and the acute care sector.
- Invest in the development of measurement methodologies for health interventions beyond acute hospital care, and of broader health outcomes.

2. Linkages between the acute care sector (state) and aged care programs (Commonwealth & state)

Inadequate provision of Commonwealth funded residential aged care places (especially high level care), has led to an increase in acute hospital bed days allocated to nursing home type patients (NHTPs). Waiting times for admission to residential high level care for older patients are excessive. This results in sub-optimal interim care arrangements for older people and capacity problems in public hospitals for other acute care services such as elective surgery.

Planning ratios adopted by the Commonwealth to guide the allocation of new aged care places are not being met in some high growth metropolitan and selected regional areas. The ratios themselves are also questionable. Approved aged care places take a long time to become operational (phantom beds) due to delays in sourcing capital and building new facilities. In some regions the Commonwealth has funded the states to establish transitional beds in hospitals to deal with demand for NHTPs. This initiative has attracted widespread support.

Objectives identified from industry consultation

- Commitment by Commonwealth to fully meet its planning targets at a regional level (not just aggregate state and national level), and maintain these annually.
- In regions/areas where there is shortfall in places, the Commonwealth to fund the public and non-government sector to operate innovative, transitional care programs to cater for the placement and care needs of NHTPs, currently unable to be discharged from hospitals.
- Introduce a three-year forward planning cycle for allocation and distribution of Commonwealth funded residential aged care places.

3. AHCAs should not contain any clawback provision (or alternative provision), which reduces public hospital funding based on increased levels of private health insurance (PHI) coverage

Current agreements provide for a reduction (clawback) in Commonwealth funding to the public hospital sector based on increased levels of PHI coverage in each state. As PHI coverage increases above a set threshold (expressed as a percentage of the total population who are insured), public sector funding can be decreased. Conversely, funding can be increased if PHI coverage declines, which was the circumstance when the provision was first introduced. This provision in the current AHCAs has not been implemented, and a commitment has been given by government to not do so in the life of the agreements that end in June 2003.

The relationship between the proportion of the population with PHI, and the pressure on the public hospital sector remains unclear. Despite massive increases in PHI coverage following Commonwealth policy initiatives, pressure on the public sector has not diminished. There is little evidence of any sustainable benefit to the sector, or its patients. Analysis of the latest available national hospital data (AIHW, 2002, & Cormack 2002b) reveals no significant improvement in public hospital waiting times.

At the same time there has been a major increase in utilisation of the private sector due to the $ 2.2 Bn investment in PHI subsidies and other policies of the Commonwealth. There is little control over growth, the nature of the services purchased, the quality of care delivered, and standards of access under which the additional private hospital services have been delivered.

There is no formal requirement for the public and private sectors to collaborate, jointly plan or develop hospital and health care services despite the Commonwealth funding approximately 50% of the public sector, and 30% of the private sector through tax funded programs.

Objectives identified from industry consultation

- Remove any implicit or explicit connection between the amount of funding delivered by the Commonwealth to the public hospital sector via the AHCAs, and the private sector via the PHI programs i.e., no clawback.
- Provide funding incentives in the AHCA for the public and private hospital sector to jointly plan, develop and deploy hospital and healthcare infrastructure. The aim of improved planning would be to ensure more equitable distribution of scare resources, and improve access to services funded partially or fully by Commonwealth and state governments.
- Implement national standards of access and quality applicable to both public and private hospital sectors. Provide incentives for both sectors to achieve a manageable set of minimum standards.

4. Health workforce

Workforce planning has lacked a long term, consistent approach. The Commonwealth and states have separate but overlapping responsibilities in this area. Workforce shortages exist for medical practitioners, nurses and allied health professionals. The Australian Medical Workforce Advisory Committee (AMWAC) and Australian Health Workforce Advisory Committee (AHWAC) provide a national framework, workforce intelligence information and indicative targets to inform the workforce training and deployment efforts of the Commonwealth and state government agencies. Despite this there appears to be less evidence of commitment by the parties to implement strategies that will address the chronic and worsening workforce shortages besetting the public hospital and health care system.

There have been a number of inquiries into health workforce planning. Most recently the National Review of Nursing Education (Department of Education Science and Training, 2002) presented its final report. The report recommended strategies to address the long-term workforce problems. These were grouped under the headings of

- Building a sustainable nursing workforce
- Maximising health outcomes
- Capacity building

A number of recommendations relate to the scope of professional practice, transition to the workplace, and retention strategies at the hospital and health care provider level. These initiatives will require varying degrees of change in industry practice and culture, and their outcomes will directly impact on the provision of public hospital and health care services.

Objectives identified from industry consultation

- Commonwealth and states to develop a national approach to workforce planning, and program development aimed at eliminating health workforce supply problems.
- Workforce initiatives relating to transition to the workplace, clinical training, scope of practice and retention be specifically identified and funded within the AHCA.

5. Annual base grant adjustments for utilisation growth to take into account activity provided in an inpatient, outpatient or community settings

Base grant payments to the states under the AHCAs are adjusted annually based on the growth in per capita utilisation. Because this is measured in terms of inpatient separations only, states are effectively encouraged to increase their separations per person every year, or at a minimum, to maintain a targeted level of use. That has the positive effect of ensuring that capacity in the acute care sector is maintained but has the disadvantage that no other activity is formally recognised. There are insufficient incentives to stabilise or reduce inpatient use by the substitution of outpatient or community care or by better pre/post admission treatment and better links with primary health care. Australia already has a high rate of hospitalisation by international standards and it is continuing to increase.

Objectives identified from industry consultation

- Maintain the present base grant adjustment for utilisation growth. However this should not be measured by inpatient separations only. At the least, outpatient work should be included but there should also be a recognition of measures to substitute appropriate community programs for hospital care, including preventive ones. Although some indicators of these already exist, resources should be invested in their improvement.

6. Increase the specified program proportion of total AHCA grants payable to the states and territories

AHCAs contain a number of sub-programs or specific schedules. These are designed to focus Commonwealth and state effort on agreed areas for reform or specific program development. The current agreement identifies priority areas including mental health, palliative care, quality improvement, information management, pharmaceutical policy, and casemix. Identifying specific program areas ensures a degree of fund quarantining, focussed planning and improved reporting of performance. Under the current AHCAs less than 5% of total Commonwealth grants paid to the States and Territories are specified to priority programs. The balance (95%) of the grant has minimal reporting and accountability requirements.

The current AHMC reference group process has identified specific areas for reform and attention. Some of these overlap with others identified by the industry in this paper. They include a specific emphasis on workforce initiatives. This will require a commitment to fund additional registered nursing tertiary places (outside of the scope of the AHCAs), clinical training and transition to workforce programs, also identified in the National Review of Nursing Education.

Capital stock was also identified as a priority. Deeble (2002) reviewed the funding and consumption of capital in the public hospital sector. He concluded that almost all capital expenditure has been directed towards replacement of existing stock, despite major technological change and growth in throughputs. Participants in the consultation exercise identified the inadequate funding of capital as a major limiting factor in the provision of quality care in the public hospital sector. Information management and high technology interventions were two examples of under investment. There are precedents for the Commonwealth to fund specific capital programs as they did with the teaching hospitals enhancement programs of the early 1990s.

Quarantined or specified funding within the next AHCAs is one means of ensuring that these priorities can be given specific attention, funding and reporting frameworks to assess their outcomes.

Objectives identified from industry consultation

- Increase the specified program proportion of total AHCA grants to 10%.
- Direct specific funding to address identified problems in
    - Health workforce
    - Hospital capital stock
    - Interface between acute care and primary care programs and service provision.
    - Interface between acute care and aged care programs and service provision.
    - Co-ordination of planning, development and deployment of services across the public and private sectors.

Conclusion

The 2003-2008 AHCAs provide a special opportunity for the industry, professions, community and government to maintain the best features of our public hospital and health industry. It is also provides an opportunity to progressively improve, and reform health service provision through adjusting the core policy and funding settings.

Health care has moved beyond the walls of the hospital, and it is appropriate that the next five-year funding agreement better reflects this change. It can be achieved, in part, through improving program and funding linkages with a broader range of other Commonwealth and state programs and services. Attention needs to be paid to the incentives needed to make this happen, and to measurement of a broader range of outputs and outcomes. Priority areas identified by a consensus of industry and other stakeholders need to be backed up by specified program structures and funding arrangements to translate good ideas into good policy and outcomes. Workforce is but one of these priorities long overdue for action.

Above all, the base funding grants need to incorporate adjustments for growth in both costs and outputs. Despite the increased level of individual choice for private health care that the Commonwealth has created through its PHI policies, there is at present no evidence that it is translating into any durable benefit for the public sector and its consumers. Until this becomes evident, there should be no contingent link between the number of people holding PHI, and the funding to the public hospital and health care sector through the AHCAs.

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