

Reform of the Australian Health Care Agreements: progress or political ploy?

Michael A Reid

Having acknowledged problems with previous Australian Health Care Agreements, the Federal and State Health Ministers have established working groups in nine health policy areas, each co-chaired by a clinician and a bureaucrat, and including other clinicians. Involving the medical workforce in health policy discussions is a positive step. (MJA 2002; 177: 310-312)

EVERY FIVE YEARS over the past 15 years, the Commonwealth, States and Territories have negotiated healthcare agreements, and new agreements are about to be signed for the next five-year period (2003–2008). The Australian Health Care Agreements (AHCAs), which are negotiated bilaterally with each State, provide Commonwealth monies to the States in exchange for ensuring the States continue to provide free hospital care.

Previous agreements

If the *negotiations* of previous agreements are any guide, the States will stick together in arguing the overall size of the Commonwealth's contribution to the States, until the Commonwealth courts one State (usually a smaller one or one going into election mode) and offers a very good deal to break from the pack. That State accepts, and the "domino principle" then cuts in.

If the *content* of previous agreements is any guide, the next agreement will be devoid of national health policy, contain perverse performance measures, be largely incomprehensible to all but its authors, and preserve the existing capacity and incentives to shift costs from State to Commonwealth funding sources and vice versa.

Will this one be any different?

Based on the April 2002 Joint Statement by the Commonwealth and State Health Ministers, it will be substantially different. In this statement the Ministers:¹

- acknowledged that previous negotiations had focused more on health funding than on health outcomes;
- acknowledged the long history of "buck-passing" between States and the Commonwealth;
- agreed to a cooperative approach to the 2003–2008 agreement, focused on best care and health gain; and
- identified priority areas for commissioned work to inform the 2003–2008 agreement.

See also page 313

Policy and Practice Program, Institute for International Health, Newtown, NSW.

Michael A Reid, BEcon, Director, and Adjunct Professor, Faculty of Medicine, University of Sydney.
Reprints: Mr Michael A Reid, Policy and Practice Program, Institute for International Health, 144-146 Burren Street, Newtown, NSW 2042.
mreid@iih.usyd.edu.au

The Joint Statement indicated that the 2003–2008 agreement would encapsulate national objectives for providing improved healthcare to all Australians.¹

If these aims are only partially realised, they will substantially change the relationship between healthcare and healthcare financing in Australia.

What are the problems with current AHCA arrangements?

The focus of the existing agreements is narrowly limited to one aspect of healthcare. AHCAs provide money to the States on the basis that the States preserve the core feature of Medicare — the maintenance of universally accessible public hospital care free of charge. The call for the agreements to be used to articulate a national health policy for Australia highlights the fact that there is currently no such policy which is used actively by governments to guide the Australian health system. In the negotiations for the 1993 agreement, an ultimately unsuccessful attempt was made to use the agreements to commit States and the Commonwealth to developing and implementing a national health policy.

To use the AHCAs to articulate national health policy objectives would constitute a major change. It is appropriate that such health policy objectives are incorporated in AHCAs, as the monies provided through the agreements are not specifically earmarked for hospital care. As there is no alternative broad health agreement between the Commonwealth and States, the AHCAs are currently, somewhat undeservedly, viewed as the major vehicle for Federal–State health debate.

If, as Health Ministers have agreed, the "2003–2008 Agreement... [is to] encapsulate national objectives for the provision of improved care for all Australians",¹ the AHCAs will need to extend beyond public hospital issues to incorporate primary care. There will need to be discussion in the agreements on primary care, chronic care, mental health, Indigenous health, aged care, rural health, public health, and, presumably, agreed quantifiable measures to assess achievement of these national objectives, while maintaining flexibility of resource allocation.

The existing agreements have only one performance indicator for which funding is contingent — a commitment by States to provide public hospital inpatient services at an agreed level. For example, the current New South Wales agreement states: "New South Wales commits to provide

services to public patients at an indicative public patient weighted separation rate [ie, public inpatient discharges from hospitals] of 261.21/1000 applicable weighted population.”² The Commonwealth can review its financial commitment to New South Wales if the level of inpatient separations falls below this figure. Other performance measures are reported under the agreement, although these do not affect funding provided to the States.

At present, States are unlikely to significantly reduce hospital care unless other primary or community care programs can be substituted, presumably with Commonwealth approval, for hospital care. The commendable exploration by some States for ways to reduce hospital readmissions of people with chronic and complex conditions through improving community-based care depends on Commonwealth support, directly or indirectly, for care beyond the hospital. It would be good for this to be recognised in the new AHCAs.

The agreements do not include the total value of Commonwealth contributions to the States for healthcare provision, much less the total value of health expenditure that is incurred by States, regardless of the source of funding. Other health monies which are expended in the State health sector are provided to States through their share of the goods and services tax (GST) revenue, and there remain a number of specific health programs and payments which are funded outside the AHCAs. These include payments for highly specialised drugs, Commonwealth subsidies to privately insured patients in public hospitals, payments for eligible veterans and their dependants, and payments for residents in State-owned residential-care facilities.

Solving the cost-shifting problem

Can the renegotiated agreement limit “the buck-passing between the States and the Commonwealth”?¹ Clearer lines of financial management of care and appropriate incentives are needed if this problem is to be solved. Assuming the 2003–2008 agreement maintains the existing arrangements of the Commonwealth and States in co-financing the provision of healthcare, it is difficult to see how cost-shifting will be fully removed.

Aged care provides a good example. The Commonwealth Government has responsibility for residential aged care. In the absence of what is generally taken to be an adequate residential capacity for infirm elderly people, some are inappropriately accommodated in public hospitals. In many cases, the care they receive in hospitals is inappropriate — better care could be more efficiently provided in purpose-built residential-care settings. Solving this problem will require a combined approach from the Commonwealth and the States, and a willingness by both to shake off an unhappy history.

Several initiatives have led to a reduction of cost-shifting. The different funding streams for pharmaceuticals — whereby the States subsidise pharmaceuticals provided in hospitals, but generally under capped budget allocations, while the Commonwealth subsidises those provided through community pharmacies on an open-ended basis — has

sometimes resulted in hospitals not providing adequate pharmaceuticals for patients at hospital discharge. So, the cost is shifted to the Commonwealth and also to the patients. Arrangements are now in place in some States for the Commonwealth to accept funding responsibility for pharmaceutical products dispensed in both hospitals and the community.

How has the Ministers' April 2002 statement been carried forward?

The strategy adopted by Ministers of tackling important health policy issues by involving the clinical workforce was initiated at the meeting of the Australian Health Ministers Council in April 2002 by the New South Wales Health Minister, Craig Knowles, and is based on a similar process introduced in New South Wales. Nine national reference groups have been formed to address the following policy issues:

- the continuum between preventive, primary, chronic and acute models of care;
- the interface between aged and acute care;
- collaboration on workforce, training and education;
- hospital funding and private health insurance;
- improving Indigenous health;
- improving mental health;
- improving rural health;
- quality and safety; and
- information technology, research and “e-health”.

Each reference group has about 12 members and is co-chaired by a clinician and senior bureaucrat. Each of the nine groups has clinicians as members, an endeavour designed to forge greater interaction between bureaucrats and clinicians.

The terms of reference for the groups are ambitious given the short timeframe for reporting. The documentation guiding the reference groups³ states: “The reference groups will develop and implement a workplan, the outcomes of which will enable the next agreements to identify:

- national objectives for the provision of best care and health outcomes regardless of jurisdictional boundaries;
- opportunities to improve health service delivery; and
- linkages to other relevant health strategies.

The reference groups will provide guidance to health ministers:

- on opportunities to improve the performance of service provision in relation to each group’s designated segment of the health system;
- on how best to minimise the barriers which impede improved performance.”

The documentation then sets the scene for dampening overly high expectations from the process by stating:

“The reference groups will consider:

- the primary focus of the AHCAs being an agreement between the Commonwealth and the States/Territories on funding for the provision of free public hospital services, and secondarily of services at the interface of hospitals and the greater community;

- the capacity of the AHCAs to generate significant health system reform in and of themselves;
- mechanisms outside the AHCAs through which to take forward the identified policy objectives;
- existing work by other bodies in the above areas, including subcommittees of the AHMC and AHMAC; and
- the requirement on all governments to be fiscally responsible".³

The Australian Health Ministers meeting in Darwin in July 2002 received progress reports from each of the nine national reference groups. There was then discussion by Ministers only, behind closed doors, as to whether they would allow the final reports to be collated and summarised by Commonwealth Health Department officials, or whether the Ministers themselves would meet again in September to personally receive the final reports from each group. They opted for the latter. Informal feedback to me from group members about the usefulness of the process to date is variable. Some report lively debate, while other groups are reportedly traipsing unproductively over old worn pathways. There is consensus that the time constraints for completing the documents will seriously limit the quality of the product.

Most participants in the reference groups I spoke to supported the process, but many saw little prospect of the groups making any meaningful contribution to the 2003 AHCAs. One co-chairperson indicated that it would be more realistic to see the process as input to the 2008–2013 agreement!

National health policy discussions involving key groups and individuals are both useful and overdue. That these discussions involve both clinicians and bureaucrats is valuable as well. These and other clinicians, and presumably the Australian Medical Association, will expect that this process is not merely window dressing.

Whether the outcome of this process can achieve Health Ministers' objectives "that the 2003–2008 agreement would

encapsulate national [health] objectives"¹ is yet too early to judge. There is considerable danger, particularly to the Commonwealth, if, by the time the financial aspects of the new agreements are being negotiated (probably later this calendar year or early in 2003), there is little linkage between the "products" of the nine reference groups and the content of the agreements.

The role of the Commonwealth and State Treasuries between now and 1 July 2003 will be critical. State Treasuries may be reluctant to accept increases in the numbers of performance measures with the agreements. The Commonwealth may cite such factors as the positive impact of the GST on State coffers and the increase in the proportion of the population holding private health insurance as reasons for not substantially increasing Commonwealth contributions to the States.

Health Ministers have started down a pathway of significant involvement of Australia's clinical workforce in policy discussions, with a clear public focus on fundamentally reshaping the next AHCAs. The purpose is admirable. From it may come a new expression of national health policy on which funding decisions can be based. This would be good for everyone's health.

References

1. Joint Statement from Commonwealth, State and Territory Health Ministers. Australian Health Care Agreements (AHCA), 2003–2008, 2002 (available from the NSW Health Minister's office, Level 33, Governor Macquarie Tower, 1 Farrer Place, Sydney, NSW 2000).
2. Australian Health Care Agreement between the Commonwealth of Australia and the State of New South Wales, 1998. <<http://www.health.gov.au/haf/docs/hca/nsw.pdf>>
3. Development of 2003–2008 Australian Health Care Agreements. Terms of Reference for AHCA Reference Group Process. Attachment C, 2002 (available from the NSW Department of Health, LMB 961, North Sydney, NSW 2059).

(Received 26 Jul 2002, accepted 9 Aug 2002)

□

books received

All about heart bypass surgery. Trahair R. Melbourne: Oxford University Press, 2002 (xi + 132 pp \$24.95) ISBN 0195513053. **Atlas of clinical dermatology.** du Viver A. Edinburgh: Churchill Livingstone, 2002 (748 pp \$523.57) ISBN 044372205.

Basic surgical techniques. Kirk RM. Edinburgh: Churchill Livingstone, 2002 (viii + 189 pp \$104.50) ISBN 0443071225.

Beyond the clinical: survival skills for ophthalmologists. Moseley MJ, Murray PI. Oxford: Butterworth-Heinemann, 2002 (x + 199 pp \$73.70) ISBN 0750644877.

Clinical medicine. Kumar P, Clark M (eds). Edinburgh: W B Saunders, 2002 (xvi + 1446 pp \$110) ISBN 0702025798.

Community paediatrics. Polnay L (ed). Edinburgh: Churchill Livingstone, 2002 (xv + 617 pp \$140.38) ISBN 0443063486.

Evidence-based on call acute medicine pocketbook. Ball CM, Phillips RS (eds). Edinburgh: Churchill Livingstone, 2002 (xii + 203 pp \$53.90) ISBN 0443071780.

Genomics and world health. Report of the Advisory Committee on Health Research. Geneva: World Health Organization, 2002 (241 pp \$51.55) ISBN 9241545542.

Handbook of women's health. An evidence-based approach. Rosenfeld JA (ed). Cambridge: Cambridge University Press, 2001 (xi + 613 pp \$160) ISBN 0521788331.

Investment in health. Social and economic returns. Washington DC: Pan American Health Organization (WHO), 2001 (xi + 157 pp \$38.80) ISBN 9275122881.

Motor neuron disease. Kuncl RW (ed). London: W B Saunders, 2002 (xiii + 198 pp \$175.56) ISBN 0702025283.

Notable names in anaesthesia. Maltby JR (ed). London: Royal Society of Medicine Press, 2002 (xiii + 254 pp \$78) ISBN 1853155128.

Practical guide to range of motion assessment. Gerhardt JJ, Cocchiarella L, Lea RD. Chicago: AMA Press, 2002 (xii + 108 pp \$124.80) ISBN 157947263X.

Skin pathology. Weedon D. London: Churchill Livingstone, 2002 (vii + 1158 pp \$622.50) ISBN 0443070695.

Sepsis and multiple organ dysfunction: a multidisciplinary approach. Deitch EA, Vincent J-L, Windsor A (eds). London: W B Saunders, 2002 (497 pp \$351.21) ISBN 0702021652.

Travellers' health. How to stay healthy abroad. Dawood R (ed). Oxford: Oxford University Press, 2002 (xxxii + 730 pp \$39.95) ISBN 0192629476.

You are the target. Big tobacco: lies, scams – now the truth. Lovell G. Vancouver BC: Chryan Communications, 2002 (200 pp \$19.20) ISBN 0973067004.