Reforming Australian health care: the first instalment

John S Deeble

Starting with the basics of public hospitals and federal–state financial relationships

The Australian Government's policy statement of 3 March 2010[1] is the first of what will be a series of announcements on health policy and funding. It is nearly all about public hospitals and federal–state financial relationships. We will have to see if and how the later announcements interact. However, access to hospitals is the biggest single issue in the public mind.

The basic issues are clear. The states and territories own and operate public hospitals under 5-yearly cost sharing agreements with the federal government. The initial shares were 50%–50%, but the Australian Government portion had steadily fallen to a low of 42% by 2007–08, and will be only slightly higher by the end of the current agreements in 2012–13. The policy report correctly identifies the major problem as the inability of the states to fund their share from their own resources. The Australian Government has the money and it must pay more; but that has been obvious for years.

The Australian Government's response is the one that, short of a complete takeover, gives it most influence and power. It intends to increase its contribution to 60% of "efficient cost" for all public hospital services, initially for inpatients but later also for outpatient and emergency department visits. Hospitals would be paid directly, not through the state health departments. For inpatients, payment would be determined by casemix, and for outpatients and emergency visits by some as yet unknown formula. The states would meet the remaining 40%. To recover the cost, the federal government has signalled a reduction of 30% in the states' and territories' Goods and Services Tax (GST) revenue, leaving the status quo intact.

For the first time, the Australian Government will share in actual utilisation growth. But none of this will happen quickly. Until 2013–14 — two elections ahead — total funding will be the same as in the current Australian Health Care Agreements. The so-called $50 billion reform package is largely spin, derived by summing the higher federal government share of specific service payments over 15 years, and ignoring the fact that it is already paying that money through the distribution of the GST. The projected gain of $15 billion to the states and territories may be an overstatement too, because shortening waiting times for elective surgery — as the government is promising — will require more admissions and more money, of which the states will have to find at least 40%. The same basic problem, redefined.

How does the reform plan hope to get more out of the system? Shorn of all the hype, there are only two measures available — casemix payment and the devolution of administration. Casemix payment is the new health economics religion. It is supposed to reward hospitals that treat most patients for a given amount of money and penalise those that treat fewer patients. Financial incentives rule. However, casemix numbers are only an approximate indicator of hospital output, and no large system, here or overseas, has ever paid hospitals exclusively on the basis of casemix. There is always a block grant component — for some hospitals, almost entirely. That is where the state administrations come in. They moderate the casemix evidence with other information and, unless the Australian Government intends to also prescribe how they must pay their 40% share, they will continue to do so. Casemix is a very useful analytical tool — it is not a panacea.

The second measure is the creation of Local Hospital Networks that would be independent statutory authorities with which the state health departments would contract for the delivery of services. The arguments are much the same — this would encourage innovation and arrangements that suit the local community. However, that is not the main purpose. The whole thrust of this part of the plan is to assure health professionals, particularly doctors, that their positions would be restored and enhanced under more local arrangements. The barely concealed objective is clear — restructuring the state hospital administrations, particularly the two most centralised ones in New South Wales and Queensland. The idea is probably popular there, although I doubt if it has anything like the same trenchancy elsewhere.

There is a good case for more administrative devolution. All organisations atrophy; periodic shake-outs are no bad thing, and it would satisfy many vocal groups. However, the proposed Local Hospital Networks are both vaguely defined and impractical. They would be absurdly small. Contiguity is not the prime consideration — structural relationships are, and every state has well defined referral patterns of a vertical kind. The small-scale model might make some sense in rural areas, but it is impossible to see it working in the major cities where 70% of Australians live, the big teaching hospitals dominate, and the whole city is effectively a region on its own.

Will all this reduce the blame game? Of course not. This policy document is full of it. There is some conflict with the concept of federalism agreed by the Council of Australian Governments (COAG) in 2008, under which the federal government would set outcome targets for broad programs only, leaving the states free to manage them. The new proposals will retain state management but force some organisational changes on them. However, that may well be inevitable and the consequences would be much less radical than the political rhetoric on both sides suggest. It is a significant bureaucratic change though, and, with the next COAG meeting scheduled for 11 April, it is a big ask to seek acceptance in a month.

Competing interests

I have performed consultancy work for the NSW Department of Health on the Productivity Commission inquiry into public and private hospital costs.

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References

1 Australian Government Department of Health and Ageing. A National Health and Hospitals Network for Australia's future. Canberra: Commonwealth of Australia, 2010. http://www.health.gov.au/internet/main/publishing.nsf/Content/nhhn-report/$FILE/NHHN%20-%20Full%20report.pdf (accessed Mar 2010).

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