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THE HEALTH CARE AGREEMENTS – WHAT NEXT?

Health is a tempting but frustrating target for the advocates of reform. Health services constitute nearly 10 per cent of Australia's total GDP and are growing fast as the baby-boomers reach 60. Government is responsible for more than two thirds of all health spending through massive programmes such as the Medicare Benefits Schedule costing $10 billion a year, the Pharmaceutical Benefits Scheme costing $6 billion a year, and aged care subsidies costing $5 billion a year.

Costs are increasing, public hospital waiting lists are growing and medical mishaps are a media staple. Even so, the vast majority of patients receive excellent care almost all the time. Health spending has doubled as a percentage of GDP since 1960 but life expectancy has risen by a decade over the same period and Australia's real total wealth per person has more than doubled. On balance, it seems that health spending at these levels hasn't acted as a serious drag on the economy and is providing a fair return on investment.

Regardless of how fiscally justified they might seem, schemes for health reform always have to pass a common sense test. The formulation of health policy is not an academic exercise. The health sector employs close to a million people. Australians, on average, have 10 Medicare-funded visits to the doctor a year and receive eight PBS-funded drug prescriptions a year. Health is not an "industry" so much as an integral part of people's lives.

The fact that health is not just another economic "service", not just a matter of juggling costs and returns, not just another component of GDP like (say) the car or textile sectors makes improving it harder but not less important. Health reform can't be something to "get right on the night". When the consequences of misguided change could be patients missing out on life-saving treatment, there is almost no tolerance for mistakes, however blameless in theory. Sensible health reform tends to be incremental, consultative and, above all else, a response to problems rather than an expression of ideology. It's a never-ending task much better handled through continuous revision than periodic upheavals, always bearing in mind the injunction to "do no harm".

Australia's health systems are not perfect but, on balance, are as good as any in the world. For this reason, the Government has cast itself as Medicare's "best friend" not its impatient critic. The Government has not sought out problems to solve but has tried to deal intelligently with issues as they have presented themselves. Even so, since 1996, the Government has:

- revitalised the private health insurance system,
- rescued the medical indemnity system,
- at least temporarily reined in PBS growth while still listing expensive new drugs,
- boosted GP bulking-billing rates and kept overall bulk-billing rates at historic highs, and
- increased patient affordability within a modified market system through the Medicare safety net.

The renegotiation of the next round of Australian Health Care Agreements, due to begin about the middle of next year, provides a further opportunity for the Government to reinforce its credentials for cautious but effective reform.

The existing Health Care Agreements expire on June 30 2008. Finalising them (two months late in August 2003) took over 12 months' discussion at ministerial, departmental secretary, and executive level, as might be expected for Agreements concerning the spending of nearly $9 billion a year. Hundreds of Commonwealth and state public servants were involved, in some cases on an almost full time basis.

As things turned out, the Commonwealth largely secured some important objectives. The states agreed to provide "step-down" care to patients who were too sick to go home but not sick enough to need acute hospital treatment. The states now supply data about waiting times (unfortunately, sometimes fiddled) for elective surgery and in emergency departments which the Commonwealth publishes annually, including "league tables" comparing the states' performance. As well, the Commonwealth was able to smooth out the quantum of its funding obligations over the life of the agreements and to ensure that the states more than matched increases in Commonwealth funding.

Successfully resisting the states' demand for even more money (they actually received a $10 billion increase over five years) was the great achievement of my predecessor. It enabled the Commonwealth to focus on those parts of the health system it was actually responsible for and to improve them sufficiently to shake Labor's traditional standing as the party best placed to manage health. In this way, the current Agreements helped to set up the platform for the Government's 2004 election win.

If anything, the current Agreements clarified and reinforced the states' responsibility for actually running public hospitals. What they didn't do was limit the states' freedom to manage (or mismanage) public hospitals according to their own political priorities and preferred management values.

The next Health Care Agreements should be about helping patients by providing better treatment rather than turf wars between governments. It seems that the most aggravating feature of the existing health system, certainly the one that most consistently features in the media, is long waits for non-emergency public hospital treatment. These seem largely a by-product of very long chains of command, a tendency to management-by-committee and micro-meddling from ministers' offices producing decision-shy administrators and demoralised health staff. What's really needed is stronger management so that health professionals feel their work is valued, their opinions taken seriously and their time put to effective use.

Commonwealth health programmes generally work better than state ones because public servants write cheques, set standards, and monitor compliance but don't actually run health services. The Commonwealth Government funds the PBS but the drugs are supplied by private manufacturers and delivered by private pharmacists. The Commonwealth Government funds medical services but they're actually delivered by private doctors on a fee-for-service basis. The Commonwealth Government funds nursing homes but they're actually run by independent bodies. Some are for-profit businesses, some community-run institutions and some religious charities. Mostly, the

Commonwealth has earned the respect of the health professionals and organisations it deals with because it decides what it wants and trusts the professionals to deliver it. This is one of the reasons why many health professionals would like a Commonwealth takeover of public hospitals and think that would be the best possible outcome of the next Health Care Agreements.

To their understandable frustration, this is not going to happen. It's not realistic to expect the states to surrender their public hospital responsibilities to the Commonwealth, despite the apparent common sense of having one level of government with responsibility for the overall health system. Also, as the Prime Minister has said, there's no certainty that Commonwealth public servants would be any better than their state counterparts at running hospitals. A Commonwealth takeover of the states' existing health responsibilities (currently about a quarter of their spending) would have enormous legal and administrative ramifications, require wholesale renegotiation of existing Commonwealth-state financial arrangements and could even trigger calls for the states' complete abolition.

Almost equally unrealistic would be a Commonwealth hand-back of full responsibility for public hospitals to the states. These days, on every key issue, voters expect leadership from the highest level of government to which they have access, namely the Commonwealth Government. Whatever its theoretical merits, voters would regard adding major health responsibilities to the states as an abdication of leadership on the part of the Commonwealth Government. Almost inevitably, full state government funding for public hospitals would only last till the next perceived crisis and the almost certain appearance of a new Commonwealth funding programme to help.

Because the urge to improve is part and parcel of western culture and because the modern instinct is to change structures rather than undertake the harder task of changing people's minds, commentators and politicians with little to lose are instinctively drawn to big reform programmes. In this case, however, it's almost certainly better to fine-tune the existing arrangements than to contemplate structural upheavals that could produce their own problems in the long run and high transition costs in the meantime. Hypothetical possibilities are certainly worth speculating about provided we then focus on what’s actually achievable. The best realistic outcome from the next Agreements is a clearer distinction about who’s responsible for what and better patient transition between Commonwealth and state-run health programmes. My vision is Health Care Agreements that actually lead to better health rather just focus on hospital funding.

As far as the Commonwealth Government is concerned, Health Care Agreements expose the Commonwealth to blame for a state’s mistakes without providing any real capacity to make a practical difference. The Commonwealth’s only practical remedy is to give more money, sometimes to the people who caused the crisis in the first place. Under the existing Agreements, the Commonwealth can penalise non-compliance by withholding from the offending state up to 4 per cent of its payments. These sanctions have never been invoked for the very good reason that they would almost certainly make a bad situation worse.

As far as the state governments are concerned, the Agreements impose serious limits on their freedom to run public hospitals without, they claim, securing enough money to cope with increased hospital use. For instance, it would have been illegal for Premier Beattie to force privately insured patients to go private in public hospitals or to charge public patients a co-payment, as he proposed last year.

Regardless of any further funding conditions that the Commonwealth might want to impose, renegotiating the next Agreements will almost inevitably involve a huge fight over the amount of Commonwealth funding and the indexation factor applied. It would be a pity if the inevitable argy-bargy achieved no improvements in the way the system treats patients. On the other hand, it's also important to avoid "improvements" that ultimately add to perceptions of buck-passing and management paralysis. The basic choice for the Commonwealth is more capacity to influence a state's decisions versus enhancing the likelihood that the states will make the right decisions in the first place.

The Opposition is already talking about the Health Care Agreements as an issue in next year's federal election. In September, in his only speech on health policy since again becoming leader, Kim Beazley said that: "Genuine debate on the issue of a single public funder for health care certainly has a place on my reform agenda… (It) is a complex area of national policy but it shouldn't be put in the too hard basket". In her Earle Page lecture in August, Julia Gillard also said that Labor was "prepared to genuinely discuss the arguments for and against a single funder for health care" but has not provided any detail about what the single funder might be or what it might fund.

She was much more forthcoming prior to the last election. In 2004, she told an AMA conference that an incoming Labor government would establish an Australian Health Reform Commission which would determine how existing Commonwealth and state health funds should be spent. "The principal characteristic of a unified national health system", she said, "must be that existing Commonwealth money, Medicare, the PBS, payments to nursing homes and payments made under the Australian Health Care Agreements are combined with existing state and territory money for hospital communities and mental health populations, of dental care and the like, and the combined pool of money is then applied to the population's health needs".

Presumably, this meant that the Commonwealth and the states would maintain their existing funding but cede control to a new independent organisation to decide how taxpayers' money would be spent. Almost certainly, a new single funder's first decision would be that the Commonwealth and the states should provide more funding. It's hard to see how subjecting the market-oriented, demand-driven parts of the health system such as the MBS and the PBS to the kind of bureaucracy that strangles public hospitals could be an improvement. This could easily become a classic illustration of the axiom that few situations are so bad that misguided reform can't make them worse.

Labor's single funder option could also contribute to the perceived democratic deficit by giving elected politicians less say over what actually happens in public hospitals but no less political responsibility for anything that goes wrong. The states would no longer be in charge but it's not clear that the Commonwealth would be in charge

either. Labor owes it to voters to provide much more detail and can’t hide behind the Shadow Health Minister’s despairing platitude that “anyone who has made up their mind exactly about what governments should do in this area just hasn’t thought through all the difficult issues”.

Any situation where one level of government is responsible for funding but another level of government is responsible for service delivery is fraught with potential for cost blow-outs and service failures because neither level of government is ever clearly in charge and fully accountable. Calls for more cooperation between governments always draw applause. It's a fine aspiration that the lion should lie down with the lamb but it rarely works as planned because the interests of funder and service deliverer diverge and neither can realistically sack or penalise the other (unlike the situation that exists in public-private partnerships).

The problem with the Commonwealth seeking any specific performance outcomes from state-run public hospitals is that the Commonwealth would be regarded as co-responsible for any failure to deliver. Seeking state guarantees on emergency department waiting times, elective surgery waiting lists or rural obstetric services means that the Commonwealth will be blamed for the states' inevitable failure to deliver but will lack any realistic means of compelling better performance.

Instead, as a condition of continued funding, the Commonwealth could require much more access to information about the actual performance of public hospitals. This could involve comprehensive, timely, month-by-month data about the numbers of people presenting at each emergency department and their subsequent history of public hospital treatment. It could involve detailed information about the number of specific procedures performed at particular public hospitals, their costs and failure rates. The need to provide this information, especially adverse event information, should lead to better management systems in public hospitals and its publication should lead to more pressure to perform. Providing more information to the public, I suspect, is more likely to lead to beneficial structural change than another round of negotiation between Commonwealth and state officials.

The Commonwealth could consider relaxing some requirements that may now work against optimal treatment outcomes. For instance, the requirement that hospitals maintain late 1990s service standards means that dialysis and chemotherapy services continue to be provided in hospitals rather than, more conveniently and less expensively, in homes or in doctors' rooms. Some of the most common episodes of hospital care, dialysis, chemotherapy, colonoscopy, gastroscopy and cataract removal, can readily be performed outside hospital. Dialysis and chemotherapy alone are about 13 per cent of all in-patient admissions.

The states are already shifting some services (such as outpatient consultations and diagnostics) from public to private provision and thereby accessing Commonwealth MBS funding at least for the medical services provided by staff specialists. Shifting more services from the traditional hospital setting could provide more access to the MBS and should also make it much harder for the states to claim, in future, that the Health Care Agreements have ripped them off.

Demanding more information from the states while permitting more evolution of health service delivery could further reinforce people's understanding that the states provide free health services to public patients while the Commonwealth subsidises medical services, drugs, aged care services and the private sector. It would potentially increase the states' use of clinically and economically preferable forms of treatment but it would leave decision-making entirely up to them. Management changes to enable information to be provided and to try to ensure that it revealed strong and improving hospital performance could involve more contracting out of services and even further privatisations of public hospitals but this would be entirely up to the states.

Health Care Agreements along these lines wouldn't solve the cost-shifting problem but perhaps, for health administrators, this is the equivalent of the vagaries of weather and market for farmers: an inevitable, unavoidable part of any system with multiple funders that just has to be factored in and lived with.

Because health matters so much to so many people, it would be wrong for the Government to establish priorities for the new Health Care Agreements without the benefit of wide community debate. As always in health, the challenge will be to face up to the deficiencies of the present system as well as the perils of change; to accept that no system is perfect and to avoid conscripting patients in political campaigns. Because the current Agreements expire on June 30 2008, considering options for change is no longer academic speculation or ideological indulgence. People with a track record of contributing to sensible policy development should now have their say and make their difference.