Submission to the

National Commission of Audit

18 November 2013

Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission to the National Commission of Audit.

We are Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Medicare Locals and primary healthcare providers, universities, and individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

We endorse the guiding principles for the Commission's review and note that these broadly underpin the AHHA position on a range of health policy issues. Our submission addresses the terms of reference as they apply to the health sector. In particular, we provide comment on the structural changes to the health sector over the past 6 years through the National Health Reform Agreement (and the related National Partnership Agreement on Improving Public Hospital Services and the National Healthcare Agreement 2011). These changes include:

- activity based funding for public hospitals
- a focus on reduction of emergency department and elective surgery waiting times
- increased transparency and accountability, new national governance bodies and reporting against national performance targets
- establishment of Local Hospital Networks responsible for local service development and delivery; and
- establishment of Medicare Locals to support a stronger primary care system.

While some aspects of these reforms have made important improvements to the Australian health system, many require evaluation and some are of questionable value. The review being undertaken by the Commission of Audit will provide useful guidance to the additional work which needs to be undertaken nationally to further refine health reform.

We note and endorse the Abbott Government's commitment to ensuring a strong health sector, with a renewed focus on delivery of frontline services, and a streamlining of bureaucratic processes and infrastructure to ensure that maximum value is achieved from the health budget.

The AHHA would be pleased to provide additional information or comment if required.

Scope of government

The Australian health system is built on a solid foundation, with Medicare and a world class public healthcare and hospitals sector providing the basis for universal access to quality health care services, complemented by a strong and vibrant private health sector spanning hospitals, health services and health insurance. However, increasing costs, demand pressures particularly in emergency departments and for elective surgery, workforce issues and uneven distribution of services are amongst the challenges facing Australia's public health system, and more broadly, the health sector.

Reforms which foster equity, efficiency, transparency and universal access to quality care, within an affordable context, must be the focus of the Commonwealth government in coming years. To this end, transparency and accountability are important to ensure effective and efficient resource use and service delivery by a high-performing public health sector.

The private health sector plays an important role in maintaining a balanced system where people have a genuine choice. However there is no logic to a system that sees private hospitals contracted to treat public patients while public hospitals compete for private patients.

There are strong arguments that the private health insurance (PHI) rebate is not an efficient use of resources. However, we acknowledge that rebates have been needed in the past to ensure the viability of the PHI sector. To avoid repeating mistakes of the past, the AHHA believes that a broader review of Australia's health insurance arrangements should be undertaken before any decisions are made about the PHI rebate. Such a review would mean that decisions could be taken with a better understanding of the dynamics of the PHI market in relation to Medicare, and ensure that public funds are used as efficiently and effectively as possible to improve people's health.

National governance and consistent reporting are necessary in a high-performing health system. However, duplication of agency functions and service provider reporting needs to be addressed. Exemplifying such duplication are the raft of new Commonwealth health agencies introduced over the past 6 years, often without much buy-in or support from the states and territories, which undertake work which could as readily be undertaken by long-established agencies with well-developed infrastructure, administrative architecture, and processes in place. Many functions overlap across agencies; the reporting burden on healthcare providers and the jurisdictions may be unnecessarily onerous; and there is significant waste in the development of administrative infrastructure such as human resources, information technology, communications systems, property and the like. This is further complicated by the decentralised nature of many of the new agencies. It would be timely to review and evaluate the functions and performance of each of these agencies to ensure that the value of taxpayer investment is maximised.

The AHHA is strongly of the view that health promotion and disease prevention must be resourced and evaluated effectively, irrespective of the agency which has responsibility for this function, and this work must take place in an integrated way across the nation. Evidenced based promotion and prevention programs have the potential to significantly reduce disease and disability and contain costs. As such, this is a critical component of the overall health budget.

The achievement of improved outcomes and increased value from government expenditure in some of the activities currently undertaken by the Commonwealth in the health and related sectors may in part be dependent on the extent to which it contracts and invests in the not-for-profit sector. The AHHA believes there is considerable scope to make real savings, while also achieving increased community value from government expenditure, by adopting a less bureaucratic government-centric approach to areas such as program evaluation, translation of research into an evidence base for health policy, health prevention and promotion services, and administrative functions which focus on integration across the diverse parts of the health sector.

In many of these areas, organisations such as the AHHA and other like bodies have infrastructure in place which can be utilised at relatively low cost to achieve government goals, as a result of our lower administrative overheads and our ability to access highly skilled personnel from within our member constituents. For example, the AHHA's academic members have invested in its research arm, the Deeble Institute for Health Policy Research. This independent Institute draws together health policy researchers from a number of universities to undertake research relevant to the policy agenda. Similarly, we are able to draw on the expertise of many highly qualified members to provide low cost consultancy services to government. Recent examples of cost-effective, policy-relevant work undertaken on behalf of Government through competitive bidding processes or direct commission include evaluations of the reporting burden on Aboriginal Controlled Community Health Organisations and of maternal and child health telephone triage systems; community needs analyses; and horizon scanning exercises for the National Lead Clinicians Group.

We encourage the Commonwealth Government to look to organisations such as AHHA in the not-for-profit sector to provide input to policy and evaluation where relevant, rather than funding high cost government infrastructure at the expense of delivering frontline services.

Efficiency and effectiveness of government expenditure

Australia has a long and proud history of universal access to health care. Achieving and maintaining it, however, can be difficult. With ageing populations, growing burdens of chronic disease and escalating health care costs, the health system is under pressure. Bulk-billing rates for GPs are currently relatively high, although not evenly distributed across the

country. Despite this, out of pocket costs for health care in Australia are also quite high and pose a major barrier to accessing care for some people.

For many people living in rural and remote Australia, gaining access to timely care, especially specialist care, can be difficult. And, in some specialty areas, waiting times for care in the public system can be very long: much longer than they are in the private sector, which raises some concern about the equity of the system and balance between the public and private sectors.

In the search for reform options to ensure efficient and effective government expenditure in the health budget, it is important that we build on the strengths of the existing system and preserve the principles that Medicare was founded on: equity, efficiency, simplicity and universality.

Medicare should be preserved and remain compulsory for all citizens, and should continue to be funded, in part, through the taxation system. However, Government should give greater consideration to finding an equitable and fiscally sustainable way of operating Medicare alongside the private health insurance system. A focus on developing health care financing and payment methods that are better able to ensure patients receive seamless care in and out of hospital is needed.

Both MBS and PBS programs would benefit from a review to determine opportunities for disinvestment, for example of redundant treatments and technologies, particularly at a time when there is an ever-increasing demand to add new treatments and technologies to these schedules.

Through Medicare, ideally funding arrangements should be patient-centred, supporting the right care in the most appropriate environment. Bundled payments options for patients with chronic or complex conditions should be implemented as soon as possible.

The development and expansion of programs and bundled funding packages that support safe, appropriate and cost-effective home-based alternatives to hospital admission must be a priority for Government. Funding for programs such as Hospital in the Home (HITH) is an example of the innovations that can assist in making better use of an already stretched health budget. HITH programs can reduce unnecessary admissions to hospital, releasing resources to care for those for whom hospital admission is the only option. Decreasing avoidable admissions can reduce 'bed-block', which in turn helps hospitals achieve emergency department and elective surgery performance targets. While hospitals currently fund a range of HITH programs, other primary care and community-based providers need a defined funding source to encourage further expansion of services. With increasing pressure on the health system's financial sustainability, the transition of HITH from small locally led "innovations" to a sophisticated component of the overall health system structure is essential.

Integration across allied health, primary health and hospitals should be supported by strong policy and incentives. The current disconnect across these sectors is problematic to efficient resource utilization, and the contribution of Medicare Locals to improving this is yet to be fully realised (and evaluated).

The effective and efficient provision and coordination of primary health care services is a critical component of a comprehensive health system which can significantly improve health outcomes and reduce overall health care costs and out-of-pocket expenses. The finalisation of bilateral National Primary Health Care Strategic Framework implementation plans must be a priority for the Commonwealth, states and territories.

The clinical and administrative expertise of Medicare Locals enables an important role in population health planning and in addressing inequities in health service access and health outcomes. However, the diversity of the environments in which Medicare Locals operate (including geography, population size and characteristics, local government and local health network structures) requires flexibility and innovation in organisational structure and service delivery. A simplification of funding arrangements and reporting requirements would assist in reducing the administrative burden on Medicare Locals.

The Boards of Medicare Locals must have autonomy and independence from all levels of Government and must be free to make informed decisions, in the best interests of their community, in relation to the range of programs and services they provide. However, it is important that the Government retain an overall view of the success or otherwise of its investment in primary health care. The absorption of advice and program accountability into the functions of the line departments such as the Department of Health is preferable to the current arrangements where responsibility is transferred to a variety of proliferating agencies, for whom the objectives are sometimes unclear (for instance, is the purpose of public reporting to better inform consumer choice, improve clinician or hospital performance, improve health outcomes, ensure fiscal responsibility, or a mix of some or all of these?). To ensure some clarity around program accountability for Medicare Locals, the Government must provide overarching governance arrangements and take direct responsibility for performance, in order to ensure value for taxpayer investment.

The AHHA notes the Health Minister's public statements querying the role of Commonwealth agencies in health prevention and promotion activities. There is a substantial evidence base to support early intervention and prevention as being the most effective approach to reducing both the burden of disease and the cost of care, particularly for complex and chronic conditions which are increasingly a challenge for Australia's health sector. A continued investment in health prevention and promotion can be justified in the context of the longer term benefits, including fiscal savings, and the AHHA contends that this investment should continue, albeit subject to regular evaluation. However cost savings

may be achieved by unwinding the current investment in administrative infrastructure which duplicates, to an extent, investment occurring in other agencies..

Public sector performance and accountability

The National Health Reform Act 2011 established the Independent Hospital Pricing Authority to develop a Pricing Framework and National Efficient Price to support the implementation of Activity Based Funding (ABF) as the basis for the Commonwealth's contribution to the funding of hospital-based activity from July 2014. The intent was that this would deliver better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for Australia's health system.

Shortcomings include the National Efficient Price being based on the current average cost and not incorporating components of effectiveness or quality. Also, while it determines Commonwealth funding for public hospital services, it does not require the states and territories to fund at the NEP. Under the Agreement, states and territories have autonomy as to the level of funding they choose to invest in public hospital services. States and territories may choose to provide hospitals with a higher or lower share of the NEP funds.

While activity-based funding can be an effective mechanism to achieve consistency and transparency in health service funding, through-put based funding models can create inappropriate incentives to provide treatment and favour throughput at the expense of quality care.

The current ABF model is a cost reduction model which values technical efficiency (cost reduction) above improved allocative efficiency (equity and clinical outcomes). As a hospital centred model, it may create perverse incentives to provide inpatient care instead of more effective community based options. The AHHA contends that ABF must accommodate unavoidable cost variations relating to the location of service, availability of services and the clinical and social characteristics of client groups.

More broadly, there is a mismatch between the reporting burden in the health sector and the funds provided by Government, whereby the reporting requirement can at times be as onerous for a project funded for $50,000 as it is for a $5 million project. Likewise, minor variations in reporting requirements within and between agencies creates unnecessary duplication and burden, for example, where there are small differences in definition of effectively the same data item, or a requirement to report the same thing for different contracts but with different time periods.

Reducing unnecessary red tape and reporting in relation to contracting, particularly with not-for-profit entities, is important to reduce waste, to allow a proper focus on program delivery, and to ensure that public-private partnerships are a sustainable model in the health sector.

Conclusion

While many positive reforms have been implemented in the health sector over the past several years, it is now time to evaluate the success or otherwise of the reforms, and the many agencies created to implement and support change to ensure that investment in the health sector is appropriately targeted, achieves better health outcomes for Australians, and is sustainable into the future. The AHHA welcomes the current review process and would be pleased to provide further commentary to support the views outlined in this submission.

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