

Structural barriers to reform of the Australian health and public hospital system

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AUSTRALIAN CENTRE FOR HEALTH RESEARCH

COMMONWEALTH – STATES AND TERRITORIES FUTURE RELATIONSHIPS,
ADMINISTRATIVE ARRANGEMENTS AND IMPLEMENTATION OF PERFORMANCE BASED
FUNDING FOR THE AUSTRALIAN PUBLIC HOSPITAL SYSTEM

NOVEMBER 2009

THE POLITICS OF DEATH

“Health reformers always smash up against two unpalatable truths. We are all going to die. And the demand for interventions that might postpone that day far outstrips the supply. No politician would be caught dead admitting this, of course: most promise that all will receive whatever is medically necessary. But what does that mean? Should doctors seek to save the largest number of lives, or the largest number of years of life? Even in America, resources are finite. No one doubts that \$1,000 to save the life of a child is money well spent. But what about \$1m to prolong a terminally ill patient’s painful life by a week? Also, who should pay?”

‘The Politics of Death’, *The Economist*, 5/9/2009

“At least two of the super Ministries, Education Employment and Training, and Health and Community Services, as it was in 1987, are too big and diversified for any Minister to manage and have never been under control. Having a junior Minister doesn’t help much, especially if he/she is a dill.”

Hon. Sen. P. Walsh ‘*Confessions of a Failed Finance Minister*’,
Random House Australia, 1995

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PROLOGUE

Personal and political concerns about the delivery and funding of health services in Australia (and elsewhere) are, and will remain, a consuming issue for at least the next three decades.

The trend is not new. As this report shows it has been the case since the colony was established. The fundamental issues remain very much the same. The numbers of patients, employees and professionals have increased absolutely and relatively. So have the sums of money and health's proportion of the Gross Domestic Product has climbed steadily – it is now about 9.5%.

At regular intervals when parts of the system have been under severe stress, or on occasions failed, there have been calls for major reforms.

Most politicians, bureaucrats, administrators and health professionals agree change is needed.

However, with a couple of exceptions radical or significant change has not been a feature of the system. The calls for serious reforms have not been matched by subsequent actions.

This report demonstrates that the real reason is that the constitutional, legislative and administrative structures have not kept pace with the growth in and demands of the sector.

Major policy reasons or administrative decisions have been made for the wrong reasons, e.g. NSW's decision to transfer 70,000 health workers into a NSW based legal entity to avoid the operation of the then federal Government's 'Work Choices' legislation is but one example.

Rules and regulations and organisations have been piled on top of each other without the question first being asked – ‘Why are we doing this and what will be the results for the patients and the taxpayers?’

In addition to the long standing rancour between elements within the sector, there has been a high degree of intellectual and political sloth that has resulted in a failure to address a number of fundamental structural issues.

This report outlines ways in which a history of inaction and avoidance of major issues can and must be dealt with.

ACHR REPORT – CONCLUSIONS AND RECOMMENDATIONS

1. The demands of individuals and Australian society place personal and national health as the key political and financial issue for the next three decades – at least.
2. Within the Commonwealth and States' and Territories' legislative, political and bureaucratic structures and systems, it must be accorded a level of recognition commensurate with its political and financial importance and the continuing pressures to deliver a very high standard of services to all Australians.
3. The organisational cultures within the public health sector and parts of the private sector have evolved and been built on since early colonial days and federation. They have not been proactively adapted to anticipate and meet the demands of modern health policy and health care services management. The history of the sector indicates that the culture will not change quickly. Unless radical changes are made in important parts of the 'machinery of the government' serious tangible reform in the Australian health sector will not occur. Specifically the current 'machinery of government' will be a serious constraint on the development of policy, its implementation, the delivery of services and adapting the funding of a modern health care system to more sophisticated demands.
4. In our federal system a combination of clear, resolute political direction from COAG, devolution of responsibilities as close as possible to the users of health services and modernisation of health

funding are fundamental to maintaining health care standards and evolving new policies.

5. Any obsolete, overlapping, dysfunctional and inconsistent legislation governing the implementation of health policy and services needs to be urgently addressed **and** resolved by COAG. Specific timetables should be set for **repeal** of legislation that is out of date, irrelevant, or contradictory as between the Commonwealth and the States and in each of the States and Territories. It should also deal with the regulations and rules flowing from current legislation that do not assist the efficiency of policy development, funding of health services and their delivery.
6. At both a Commonwealth and State level far greater importance needs to be attached to the development **and** delivery of health policy, the funding of health services and implementation and monitoring of policy decisions.
7. At a Commonwealth, States and Territories level urgent attention needs to be given to the roles, responsibilities, objectives and overall performance of Departments of Health.
8. Akin to the Commonwealth arrangements with National Security & Defence there should be a National Health Committee of Cabinet which draws together all the key portfolios involved with the development of policy, funding of health services, implementation of policy and administrative decisions, the monitoring of performance and the management of the relationships between the Commonwealth and the States and Territories in relation to health.

9. At a federal level the Cabinet Committee should be chaired by the Prime Minister or Deputy Prime Minister and should include – The Minister for Health & Ageing, the Minister for Families, Housing, Community Services & Indigenous Affairs, the Minister for Ageing, the Treasurer and the Minister for Finance & Deregulation. The Cabinet Committee should meet regularly and perform in a proactive way. It should reduce the reliance on the adversarial environment of Expenditure Review Committees to determine the allocation of resources and the development of medium to long term policies and service delivery objectives.
10. As part of the process and using the Defence Act as a template the Commonwealth Department of Health should be split into two divisions with a separate Secretary (Policy) and a Chief Executive (Services and Operations) and each position should be subject to written Directives akin to those for the Secretary of Defence and the Chief of the Defence Force under the Defence Act.
11. The regulatory functions of the Department, which potentially pose conflicts of interest for the Policy Divisions, should be transferred to the Department of Finance and Deregulation and all the research bodies should be transferred to the Department of Innovation, Industry, Science and Research.
12. A similar arrangement should be established in each of the States and, in particular, the larger States such as NSW, Victoria and Queensland. The Premier should chair the Cabinet Committee and the Ministers on the Cabinet Committee should be the Ministers for Health, Community Services, Emergency Services (Ambulance in particular) and the Treasurer (and Minister for Finance where there is a separate Minister). (Note the portfolio definitions differ

13. The Productivity Commission should be given the role of **independently** reporting, at least once every two years, to the National Health Committee of Cabinet on the performance of major programmes undertaken or funded by the Commonwealth and ensure that the States provide consistent, strictly comparable performance statistics on the key, fundamental performance indicators (including the financial ones) to the Commonwealth for public hospital services and health activities that it funds.
14. Reduce the administrative demands on the time of Ministers for Health and delegate functions and statutory obligations that do not really require Ministerial involvement.
15. Clarify the roles and relationships of Ministerial officials in Ministers' private offices and reduce the capacity for the exercise of vicarious power by such officials.
16. Where they have not been appointed, arrange for the appointment of a Ministerial/Departmental liaison officer in the Health Minister's office and rotate that position, say, once every two years.
17. Seek to restructure the relationships between the medical professionals and the Minister's offices so that the Minister is not expected to be a continuing authority on a wide range of single issues that are properly the responsibility of public health officials, hospital administrators, clinicians and other hospital staff.
18. Individuals and communities should be provided with incentives to take more interest in their own personal health as well as being

given the opportunity to have a greater interface with, or at a minimum, the understanding of the costs of delivering publicly funded health services – principally public hospitals and similar health care facilities and services.

19. While accepting that there is no perfect model and there are differing requirements between the States, the Victorian model for the governance, management, control and monitoring of the public hospital system has worked better over a longer period of time than any other of the States' systems and should be used as the template for other States and Territories and the Commonwealth (where appropriate).
20. The performance measurements of the public hospital system should be benchmarked against those of the private hospitals. Also a mechanism should be developed which enables the effectiveness and efficiency of public hospitals' expenditure by States' Treasuries to be benchmarked against that of the funders of the private hospital sector.
21. The ever increasing demands on the public hospital system will continue regardless of how the current Commonwealth and States' funding systems are structured and managed. There is little doubt that the States will be continually seeking additional funding from the Commonwealth and on this basis there is a strong argument for:-
 - a. The States, in the short term at least (i.e. 4-6 years), to continue to own their existing public hospitals,
 - b. The Commonwealth to provide the funding (but **not** take ownership) of the public hospitals, and

- c. An effective mechanism be put in place to enable there to be a transfer of patients between both private and public hospitals in the event that one has a temporary shortage while the other has a surplus of beds.
22. It is recognised that the difference between and within the States means there is no single, optimal structure for the delivery of public hospital and associated medical services. The option of letting the current system fester into the future would be consistent with much of the practice in this area over the last 150 years. It is attractive to some politicians and public servants. However it leads to crisis management and ultimately the introduction of harsh measures on the basis that there is no alternative. However, it will not meet public expectations. An approach recommended in this report is as follows:-
- a. Each State should rigorously assess what functions really need to be undertaken, owned, managed and funded by government,
 - b. Consider what legislation and rules and regulations are really needed so that society's expectations about public hospital service can be fulfilled and progressively repeal all those that are not essential and critical,
 - c. Determine what Statutory Authorities, Advisory Boards, Committees etc. really contribute positively to the delivery of services or research and abolish those that do not as quickly as possible,
 - d. Devolve responsibilities for the governance and management of public hospitals to local communities and make the

Boards of each hospital responsible for providing the services and living within budget. Ensure that appointments to hospital Boards are on merit and combine a wide range of skills – especially financial management,

- e. Change the machinery of government to ensure that funding and operation of public hospitals is organisationally separated from centralised departmental control and is as transparent as possible,
 - f. Urgently develop a simple set of data that provides Ministers and the public with succinct, fundamental indicators (financial and operational) of public hospital performance and ensure that they are easily understood,
 - g. Ensure that the funding entity or entities for public hospitals have data that will be simple and enable it to reward those who do well and work with those that are not within budget or meeting operating standards so that they meet the minimum performance criteria, and
 - h. Critically go through the States' and local area health services (where applicable) and individual public hospitals to determine what IT services and systems are **really** needed and will contribute to the national objective of a consistent, comparable nationwide patient health information system.
23. Avoid perpetual line item reviews within Departments of Health but ensure that the National Health Committees of the federal and States' governments conduct regular functional reviews (i.e. why are we doing something and what are the outcomes) of Departments of Health and public hospitals.

PREFACE

In November 2007 the Australian Labor Party Government was elected at the national elections. Prior to and following the election, the now Prime Minister, Hon Kevin Rudd, indicated that Health was a major area on which the new Government would be focusing. He saw it as one of the key priorities for the new Government. At the November 2007 C.O.A.G. Meeting the States and Territories First Ministers agreed with him.

In broad terms the Federal Government committed itself to significantly overhauling the structure, operations and funding of the Australian Health sector. The Prime Minister also argued strongly for a major step forward in health by disbanding “the blame game” which had been a noticeable part of debate in the run up to the Australian federal elections in 2007.

The Australian Government’s proposals come at a time when there had been increasing and considerable focus on the funding, operations, performance and planning for Australia’s public hospitals. These are the hospitals that have been and remain owned and operated by the States’ and Territories’ governments.

Contemporaneously, the election occurred during the run up to the renegotiations of the Australian Health Care Agreements. Since 1993 these quinquennial agreements set out the terms and conditions and quantum of funding allocated to the States and Territories by the Commonwealth.

The States, in particular, had been critical of the previous Coalition Government’s approach to funding of the public hospitals and the decline in real terms of the Commonwealth’s contributions. There were a diverse range of pressures building for major, and possibly radical, changes in the operation and funding of Australia’s public hospital systems.

There is a deep seated concern that the current structure and funding arrangements in Australia (as in other OECD countries) are unsustainable.

The new President of the United States of America has announced and is pushing through a major overhaul of the US health sector. As has been widely reported the proposals have attracted a great deal of interest within the USA and internationally. They are also generating a vigorous and, at times, acrimonious debate to the point of dividing communities.

There is no OECD country in which the operation and funding of the health sector is not a major issue, and in several cases, it is THE political issue. Because of the ageing of the population and an insistence by individuals on higher and higher standards of health care these pressures will increase. There is no objective evidence to suggest otherwise.

In recognition of the enormity of the policy, operational, professional and financial issues that have to be addressed, solutions found and implemented, the new Australian ALP Government established the National Health & Hospitals Reform Commission (the NH&HRC's terms of reference are attached as Appendix 1).¹

The Commission, chaired by Dr. Christine Bennett, presented its report to the Federal Government on 30th June 2009 and two separate, but associated reports – one on Primary Care and the other on Preventative Health Care were subsequently presented to the Government. The three reports are interrelated. In addition, the Government also referred to a report on ageing that had been completed in September 2008.

The Government has announced a number of proposed measures that flow from the Aged Care, Primary Care and Preventative Health Care

¹ National Health & Hospital Reform Commission

reports but at the time of writing this document it is still to respond formally, and in detail, to the NH&HRC report and its recommendations.

It has announced that it would spend until after Christmas 2009 consulting with communities and the interest groups in the health care sector. It would then report to the first COAG meeting in 2010.

Without detracting from the value of the latest reports, the Australian health sector at both National and State levels is littered with reports from Royal Commissions, Committees of Enquiry, Judicial Commissions, Council of Australian Government's (COAG) reports and various reports from committees comprising Commonwealth and States' officials and States' and Territories' officials only. These reports go back to well before Federation in 1901.

Historically, both prior to and post Federation, the overwhelming majority of reports have been reactions to major crises or particular problems. Very few have been strategic and prospective.

The NH&HRC report is one of the few reports in the last 50 years falling into the category of being strategic and prospective. Although considerable parts of the report are reactive.

It has largely been left to the Commonwealth and States' Treasuries to take the medium to long term strategic views. These are included in the intergenerational reports that have become a feature of annual budget papers. The driver for the Treasuries' interest is their deep concern about future adequacy of funding and the capacity and willingness of Australians to meet the costs associated with maintaining current health care standards.

With many of the reactive type reports often there have been a multitude of positive and useful recommendations but they have also contained

impractical, stupid and unhelpful recommendations that mainly reflect particular short term political or vested interests' objectives. Too often it is the short term reports and their recommendations which attract greatest community, political and media attention. However, rarely do they deal effectively with the medium to long term systemic issues.

As will be argued later in this report, it is the current political and administrative structures, processes and relationships within the health sector and between the health sector and the community which reinforce the short term approach to providing and funding public hospital services (as well as other health services). In all cases the major challenge has been, is and will continue to be, the effective implementation of the recommendations from the numerous reports, the continuing development of sensible medium to long term policies by governments and the provision of adequate funding that matches reasonable community expectations, but does not sate the indulgence of those in the community who do not accept that funds are limited and services must be rationed.

It is the implementation aspects with which this report deals. Implementation and the management of inter-government relationships and those between governments and the health sector have been seriously neglected in all of the official reports that have been published to date. At best they have been skated over with motherhood type recommendations about the things that need to be done but very few concrete proposals for what should happen and who will be responsible for its implementation.

The N.H.&H.R.C. report focuses on the public sector and public policy and funding issues in particular. It recognised in a number of its

recommendations the need for structural, legislative and regulatory change.²

Trying to ensure that Australians continue to enjoy the same or better standards of overall health care than they currently receive is a major political, bureaucratic, professional, financial and personal challenge. It is a great deal larger than people assess it to be.

Unlike building a bridge or some other piece of physical infrastructure or introducing a new tax where the opportunity is to start de novo, any new health policy has to be implemented with the whole of the system in motion. There are very few situations where the implementation of a ‘green fields’ solution is practically or politically possible.

In all the published reports that have been released to date there is very little theoretical and practical attention given to the implementation of new policies and changes to schemes and existing infrastructure in the Australian health sector.

This is all the more surprising in light of the size of the health sector. It is extraordinary that more concerted, overall attention is not given to implementation, because the long history of public hospital policies and administration in Australia (and elsewhere) shows it has been a major stumbling block. A deep seated set of cultures have developed that are obstacles to positive and prompt change. The depth of the cultures is often so ingrained that only radical change will secure a positive result.

Additionally, there is a strong perception amongst States’ and Territories’ policy makers and administrators that the Commonwealth does not understand sufficiently what is involved with and how to run a large public hospital or a public hospital system.

² Recommendation 90:6 to 90:13, *National Health & Hospitals Review Commission*, June 2009.

The public health sector is the largest employer in the Commonwealth, States and Territories.

The NSW Health Department, the public hospitals under its control and associated institutions employ more people than the Australian Defence Force and the Department of Defence!

Health comprises 7.3% of GDP and is estimated in the Federal Government Treasury intergenerational statements to climb exponentially to over 9% by 2025. It needs to be said there is disagreement about the correctness of these figures – although the mere size means that the difference is not that significant when looking at the overall problem of the sector.

By 2025 the overall cost of Government and private sector spending could reach over 20% of GDP. In contrast defence expenditure in Australia is about 3.0% of GDP and in relative and real time likely to remain at about that level.

The stark difference in the proportions of GDP that Health and Defence comprise says something in itself.

The number of national, international and local companies and organisations involved in and supplying goods and services to the health sector probably exceeds those to whom the Defence Materiel Organisation contracts its work for supplying the Australian Defence Forces.

In addition, the number of people who die in Australian hospitals, other than from natural causes, or are killed through medical accidents or carelessness while in hospital also probably exceeds Defence casualties except in a major conflagration. This is not to lay the blame on hospitals, but rather it is a statement of fact. As well as being places for treatment

and recovery, hospitals are also places where people with terminal illnesses or as a consequence of traumatic incidents will inevitably die. As pointed out in the *Economist* quote (see frontispiece) prioritising decisions about who should live and who should die are inevitable choices by clinicians and administrators in all hospitals and involve significant sums of money. It is an uncomfortable truism but death is part of life and the health system!

In spite of its size and significance to the Australian economy and the community at large, far less attention is given to the development of policies and the coordinated management of the political, bureaucratic, financial and operational interfaces at a national and state level than is given to Defence. At a political level, health on a whole of sector basis gets less attention than it deserves.

Not surprisingly, the published literature relating to the health sector is awash with vast amounts of material on the clinical, professional, educational, research and operational issues associated with preventative, acute, chronic and aged care and the provision of medical services to all four strata. It ranges from the erudite that wins Nobel Peace prizes to the emotional pleas from a distraught mother who has lost a child because of a hospital's mistake.

It is trite to say so but there is no 'quick and easy fix' to deal with the challenges confronting health.

The recent N.H.&H.R.C. report is an important, critical and necessary step in a process of securing and driving change. However, while it is alluded to in the Commission's report, rigorous attention is not given to the 'machinery of government' that is an omnipresent element in developing the details of policies that flow from the N.H.&H.R.C. report and delivering the services that the community expects.

At a Commonwealth and, to a lesser extent, at a States' level, implementation of policy has suffered also because of derision towards and scepticism about what is described extensively in the literature as 'new managerialism'. Key departments such as Finance and Deregulation, supported by the Auditor General, have been committed practically towards results (outcomes), value for money and whole-of-life asset management. The same cannot be said about some other Commonwealth agencies (it applies also to some States' departments).

On the basis of our examination the Commonwealth Department of Health applies very little rigour to analysis of the results of the performance of the Commonwealth's funding to the States for public hospitals. The response from the Department was that it accepted the States' figures without undertaking any continuing analysis and critical assessment. This was reaffirmed by the Commonwealth Auditor-General in his report 'Performance Information in the Australian Health Care Agreements – 2002-2003'³ and reaffirmed in the Australian National Audit Office Report in 2006-2007.⁴

Yet performance was and remains the touchstone of the Federal Government's stated approach to Commonwealth funding for the public hospital system. There was a similar problem in the sanctions based Australian Health Care Agreements that preceded the current funding arrangements.

The purpose of this report is to examine the legislative, regulatory and operating relationships between the Commonwealth, the States and the Territories and the essential roles that policy makers, politicians, Ministers, Ministers' offices and officials in those offices and the

³ Australian National Audit Office, Audit Report No 21 2002-03

⁴ Pp6-7 (2006-07), A.N.A.O. Review of Auditor General's Report No 19, *Administration of the State and Territory Compliance with the Australian Health Care Agreement*, House of Representative Standing Committee on Health and Ageing, August 2007

bureaucracy play in developing policies for and implementing reforms in the health sector, and the legislative and administrative arrangements that support or impede the processes.

It tries to deal also with managing ‘the system’ while new policies and changes are developed and implemented.

While the health sector generally occupies about the same amount of literature and internet information as Defence, it became obvious in the research undertaken for this report that very little has been written about the ‘machinery of government’ as it relates to health. In that respect, it is notably different from Defence.

Machinery of government involves the political and legislative arrangements that are fundamental to making ‘the system’ work; providing it with a strategic and tactical capacity to anticipate changes in society’s demands and accommodate them financially in a way that does not stress the Federal, States’ and Territories’ budgets and ultimately health system users – as taxpayers and users of the system.

The ‘machinery of Government’ deals only peripherally with the private hospitals. There are Government programmes that affect private hospitals (e.g. the private health insurance rebate) but there is not the close connection that arises as a result of governments’ direct funding of public hospitals. However, unless major decisions are made in relation to the way chronic care patients are handled that situation will have to change.

In the future it is increasingly likely the relationship between the public and private hospital sectors will become more important – regardless of ideological views.

In the conduct of the research for this report the Federal Minister for Health, Hon Nicola Roxon, was good enough to write to all her

ministerial colleagues seeking their support. This was provided sometimes willingly, in some cases reluctantly and in one case not at all. In some cases, it was feared that the final report would yield yet another round of criticism about the way in which the Australian public hospital system or parts of it were working or not working. In one case a current Health Minister's response was derisory claiming that there was no need at all for work to be done in this area!

Unfortunately, in Australia there is not an established tradition of senior cabinet ministers maintaining or writing (and subsequently publishing) diaries which detail the substance and personalities of working relationships between Ministers, Cabinet, Ministerial staff, senior public servants and their departments and external parties.

Also in our federal system, while there are formal records of C.O.A.G. meetings and Ministerial Councils, there do not appear to be any formal, published works which adequately outline how policy decisions have been made, the interplay between the Commonwealth and the States and Territories and the attitudes of some individual States, (or in some cases the Commonwealth) which has dragged an optimal solution to being one at the level of the lowest common denominator.

However, the situation is different in the UK. A very senior UK Cabinet Minister, Rt. Hon. Richard Crossman published three volumes of his diaries as a Cabinet Minister. In a research project of this kind, such records are invaluable.

*The Crossman Diaries*⁵ devote a considerable amount of substantive recording and commentary about the interaction at a policy and bureaucratic level that related directly to the health sector and related

⁵ Richard Crossman, *The Diaries of a Cabinet Minister, Vols 1-3* (London: Hamish Hamilton & Jonathan Cape 1981)

sectors in the UK. It particularises the outcomes of the individual relationships and reactions and how policies and programme proposals found their way to Cabinet and ultimately were translated into policies or administrative decisions of the UK government.

In observations that relate as much to the Australian health sector as to the UK, Crossman points out “Too many job changes in three years means a tremendous decline in the power of the politician over the Civil Service machine and a tremendous growth in the power of the Whitehall Departments, both to thwart central Cabinet control and to thwart departmental Ministers’ individual control. It’s the constant fiddling with Ministers and shifting them around which has undermined the central strategy of this government.”⁶

Additionally, he outlines and comments upon the relationships between himself as Minister for Housing and his departmental head Dame Evelyn Sharp.

The Crossman Diaries provide an extraordinarily valuable insight into why Cabinet decided to act in particular ways in relation to significant government decisions, e.g. remuneration of doctors, treatment of the aged, etc. On a major issue such as health, which travels across so many other portfolios and agencies, the insight provided is of value in assessing the situation in the Australian context.

One of those insights, from January 1969 – 40 years ago, is relevant to a significant part of the public hospital debate in Australia today. Crossman chaired a conference of Regional Hospital Board Chairmen and officials on the National Health Service Green Paper. The Department of Health officials had wanted the Health Service to be organised into “some twenty huge areas run by sixteen oligarchs

⁶ Crossman p. 78, Volume Three

responsible to London. It was an astonishing misjudgment of public opinion to think that such a recommendation could go through”⁷. What was agreed was a Regional Planning Board at the top “and the effective management done by much smaller units down below, grouped round district hospitals”⁸. The Minister overruled the Department’s advice and Crossman explained why. It is but one of a number of examples that assist greatly in understanding how our system operates and enables better judgments to be made about whether the system is operating effectively and efficiently.

Regrettably, no such extensive comparisons exist in Australia. In fact, no comprehensive comparison exists.

Hon. Dr Neal Blewett⁹, a former ALP Federal Cabinet Minister (and for a time, Minister for Health) in his diary refers to the Health sector in a limited way. His memoirs are of assistance in that they disclose the frictions he experienced in the portfolio and, in particular, the lack of detailed thought and consideration to health policy by some of his colleagues. This is in spite of the fact that the Whitlam Government had introduced the universal health care scheme ‘Medicare’ and there were significant financial, operational and political pressures for changes to the scheme from a very broad spectrum of the Australian community.

Recently a former Secretary of the Commonwealth Department of Health has written about the future directions of Australian health policies. In the course of so doing, he covered a limited amount of ground about the way in which the relationships within and between governments have operated.

⁷ Crossman p. 329, Volume Three

⁸ Ibid

⁹ Hon Neil Blewett, *A Cabinet Diary*, (Adelaide: Wakefield Press, 1999)

Dr Sidney Sax in his book '*Medical Care in the Melting Pot – An Australian Review*'¹⁰ came very close to dealing with some of the core policy and implementation matters. It is very useful in dealing with the planning for funding and construction of public hospitals. It details much about the relationships between the Department of Health and the hospital administrators and medical professionals. However, it lacks the insights of someone from inside the political policy making processes. Although Dr Sax was very close to Ministers, it was in a period prior to the growth of the Ministerial private offices and the introduction of Medicare and the Australian Health Care Agreements.

Dr. Cummins, a former Director-General of the NSW Department of Health, comes closest to dealing with the legislative and personal relationship issues within a major State department of health (NSW) but unfortunately it did not go beyond 1975 when he retired. His seminal work '*A History of Medical Administration in NSW*'¹¹ highlights the difficult relationships within the NSW Department of Health and between the NSW Department of Health and the key central agencies as well as the Commonwealth.

As an example he wrote:-

“Individual general hospitals were very possessive of their executive authority, and sensitive to any action which might disturb ‘the status quo’. Equally, the medical profession was involved in an acrimonious campaign to protect its independent status, which it saw as being threatened by the National Health Scheme. When faced with the challenge, the profession was not

¹⁰ Dr Sidney Sax, *Medical Care in the Melting Pot. An Australian Review*, (Sydney: Angus & Robertson, 1972). Dr Sax was, at one time, Director of Health services Research and Planning in the NSW Department of Health.

¹¹ Dr C J Cummins, *A History of Medical Administration in NSW 1788-1973* (NSW Dept of Health 1979)

concerned with niceties between Federal and State responsibilities, and the cry of 'nationalisation' and 'socialisation' was easily aroused as a safe defence.”¹²

He also commented on the style and substance of several Ministers of Health for whom he worked and other senior officials in the NSW Department of Health and the Commonwealth. The recent research and interviews for this report revealed that little has changed.

In August 2001 the then Commonwealth Minister for Health & Aged Care, Hon Dr. Michael Woolridge, released a history of the Commonwealth Department of Health¹³ which, while an interesting historical narrative, does not deal with many of the continuing and controversial issues that surrounded evolution of the Australian health sector and especially the shift of powers and influence from the States to the Commonwealth. The author specifically points out that the book “is not an institutional history, although the Commonwealth Department of Health is its main character”¹⁴.

On the basis of the research undertaken in connection with the preparation of this report it would seem that the substance of many of the major issues have changed very little, although the technology and professional skills are much more sophisticated and the clinical and financial costs are much greater. In the introduction to Dr. Sax's book, Prof. G.E.R. Palmer notes: “*The Australian health care system is currently in a state of turmoil and it has become increasingly apparent that a number of far reaching changes must be implemented over the next*

¹² Ibid at page 145

¹³ Francesca Beddie, *Putting Life into the Years – The Commonwealth's Role in Australian Health Since 1901*, (Canberra ACT: Dept of Health & Aged Care, 2001)

¹⁴ Ibid p. 2

few years if a crisis of major dimensions is to be averted.”¹⁵ – That was 37 years ago!

Medicare followed and ranks probably as the most significant, strategic, proactive health policy change since World War II. This was one of the few nationwide, enduring policy and systemic changes that has occurred in the Australian health sector since WW II – although there have been individual decisions such as the introduction of case mix funding and several important, preventative health campaigns that have had a positive impact and, in some cases, have reduced the impact on public hospitals, e.g. the reduction in smoking.

As with other parts of the Australian political system more and more power has shifted to the Commonwealth as it increasingly exercised greater financial control and influence over the States and Territories. There is no sign of that trend being reversed. In the foreseeable future it is unlikely to do so.

Additionally, Kevin Rudd (as Opposition Leader and subsequently Prime Minister) prior to the November 2007 election threatened:

*“A commitment that if elected a Rudd Labor Government will seek to take financial control of Australia's 750 public hospitals, if State and Territory Governments have failed to agree to a national health and hospital reform plan by mid-2009, to eliminate the duplication and overlap which currently plagues the system, and currently wastes billions of dollars”.*¹⁶

While the Commonwealth appears to have ‘softened’ that threat, it is an ultimate weapon in the Commonwealth’s legislative and bureaucratic

¹⁵ Op cit, Sax p. ix

¹⁶ Statement given by Kevin Rudd on *The World Today* ABC Local Radio from Canberra on 23 August 2007

armoury. However, it may not wish to carry the highly charged political responsibility for day to day running of public hospitals, although the Commonwealth may only be funding them directly and not through the States!

As will be discussed in later parts of this report, a great deal of confusion has arisen about funding, owning and operating public hospitals - the boundaries are often blurred. It has been widely assumed that if a government funds a hospital it follows that it owns and operates it. Clarification of the roles and responsibilities is an essential part of having a rational discussion about how policies might best be made and services delivered at manageable costs in the future.

The absence of any substantial body of similar literature to that of the Crossman Diaries and subsequent diaries and commentaries by senior, former Prime Ministers and Ministers, combined with a less sophisticated view of dealing with these issues in Australian society and our political system specifically, presented a dilemma in preparing this report.

We had to look at how we might gain candid assessments about the interactions within the Australian political system and between the Commonwealth and States' political leaders and bureaucracies that are an integral part of attempting to develop and implement future health policies.

Also, how do you gain an understanding of the relationships with and understanding of the tensions between Departments of Health and Departments of Finance and Treasuries, who have to meet stringent management and financial challenges? In some instances the tensions will be positive and in other cases negative.

To try and gain a realistic picture, information would be needed from current and former Ministers, their private offices staff and former Ministerial staff, current and former departmental officials as well as departments that interfaced or are deeply involved with the health sector such as Treasury, Finance, Premier & Cabinet and departments which fall within the category of 'Human Services'.

Also in a number of cases we sought the view of academics who are or had been in the 'system' and retired, or who had studied these particular areas of public administration.

There is a substantial group of public hospital administrators, especially former ones, who were prepared to provide their views, but at senior levels of Health Departments there was reluctance about expressing candid opinions almost solely because of the political risks. The one exception was Victoria.

In addition, talking to the various interest groups that want to influence or are affected by governments' policies and administrative decisions was important. In the limited number of interviews there was a vast range of opinions about 'what the Government should do!'

As indicated above the Minister for Health Hon. Nicola Roxon wrote to her Ministerial colleagues. We separately approached the Commonwealth and States' and Territories Departments of Health, Treasuries and Premier and Cabinet. With very few exceptions we found most of the officials helpful.

In all cases the enormous workload involved with Health departments and Treasuries limited the time available for officials to provide the data necessary for research. In some cases, officials claimed that either the data was unavailable or was not credible.

In the case of agencies that have an ‘interest’ in the funding and outcomes of Departments of Health there was a consistent theme of wanting to maintain Australia’s universal health care system but at the same time rigorously control costs.

In some of the States there was a concern, at an official level, that the politicians do not understand the policies needed to meet the medium to long term demands of Australia’s ageing population and the serious financial limitations imposed by Australia’s current tax system and financial situation. There was also a view that a number of States’ Ministers and their Opposition counterparts do not adequately understand the old A.C.H.A’s or the new I.G.A. on health funding.

Interestingly, one current State Minister holds the view that public health services will not need to be rationed and the “funding can be found if really needed.”

There was a view from many of the former Health Ministers, Federal and State, that they had been overawed and in some cases intimidated by the size of the portfolio and the policy and management tasks that they faced. Several of the former Ministers interviewed claimed that of all the portfolios in which they had served, Health was the most challenging, the most time consuming and at both a Federal and State level had what seemed to be an unusually large amount of paperwork that had to be signed or personally dealt with by the Minister compared to other portfolios in which they had served.

There was also a very widespread view that because of the size of the Health portfolio at a Federal and State level all but a few Ministers were captured by their Department. There were three distinct cases between the Commonwealth and the States where this had not happened.

As with Crossman, the majority of former Ministers felt they did not have the information, capacity or adequate time to contest Departmental views.

This view was strongly disputed by some officials in Departments of Health but supported by most central agencies. A number of senior officials in States' Departments believed a number of former and current Ministers were not interested in the detail. They were more interested in "keeping health off the front page".

There are widespread views among middle level Treasury and Finance officials at a Commonwealth and States' level who deal with the Health portfolios that all current and recent Ministers have been captured by their departments, regardless of their political affiliation.

The only major exception was in one State where the political management of the health sector was driven by very short term imperatives and the Department was attempting to keep the Minister at arms length, from deep, daily intervention in administrative matters. At a Commonwealth level the view was that since 1975 only two Health Ministers had not been captured by their Department.

In one State, there was a view that a professional, workable relationship had been developed between Senior Ministers, central agencies, the Human Services Minister and the Department.

There was also widespread concern, verging on cynicism, about the data that flows from the public hospitals, through the States' Departments to the Commonwealth and how that data was interpreted and used by the Commonwealth Department of Health. The timely availability and credibility of data, especially for an evidence based performance assessment financial rewards system, remains a critical issue. It is being

addressed but far more high level attention needs to be paid to ensuring that the data will enable comparison of ‘apples with apples’!

The completion and publication of this report presented a real dilemma. Scholarship and intellectual integrity depends upon sources being cited and being appropriately quoted.

However, even in light of the Commonwealth and the States supported by the NH&HRC claiming that it is “time to end the blame game” health is still a highly politically charged arena. It is highly charged at a party political level as well as at a bureaucratic and professional level.

While the ‘blame game’ between the Commonwealth and the States has diminished, the same cannot be said for relations between central agencies and Health Departments and between Head Offices of Health Departments and individual public hospitals. In at least two of the States the ‘blame game’ between Ministers and departments and vice versa still exists.

There is also a great readiness for individuals in the community to blame individual hospitals. In some cases, serious mistakes have been made by a hospital, but in others the patient or guardian is at fault. The media focus on these individual incidents make rational, medium to long term management and planning very difficult.

Most Ministerial staff in Health Ministers’ offices are more concerned about ‘protecting the Minister’ from the political impact of immediate one off incidents and promoting good news stories to try and offset the publicity over adverse events. There is a deep seated defensiveness that was evident in all Ministers’ offices - with two exceptions.

Within Ministerial offices there is a deep seated concern for a Minister’s longevity in the portfolio. Although Health is not in the category of the

Corrective Services or Department of Community Services portfolios, which are regarded as “poisoned chalices”, a number of Ministerial staff, at a State level, see Health as now falling into that category. If this ‘state of mind’ becomes pervasive, it does and will continue to affect the attitudes of health bureaucrats who spend disproportionate amounts of time dealing with short term problems and crises.

Currently, there is certainly a much higher degree of cooperation between the Commonwealth and the States and Territories. There is a concerted attempt to find national solutions – especially in the funding arena.

In some cases there was a willingness to be quoted or views attributed. However, in the majority of cases, at both Commonwealth and State levels, it was a condition of participating in this project, that the participants involved not be quoted or remarks attributed.

The degree of political concern about health matters in two of the States made it more difficult to gain ‘frank and fearless’ opinions. In some instances officials and Ministerial staff asked that meetings be held privately and away from their offices.

At all levels there was a concern that remarks about how relationships that operated between Cabinet, Cabinet committees, Ministers, their private staff and senior officials and between Federal and State officials would be treated. They thought they would be misinterpreted and lead to witch hunts. As many of the participants asked for guarantees of anonymity before proceeding, we decided to treat all sources identically. Except where there has been specific agreement to be quoted or cited anonymity has been granted.

We also provided guarantees that the intention of the report was not to trawl back over and revive criticisms arising from earlier Commissions of

Enquiry or similar investigations that had dealt specifically with mainly clinical, management and financial problems in individual public hospitals, departments or with practitioners.

It is our view that the subjects of this report are very important elements of public policy and administration and that they have been seriously neglected for a long period of time.

Massive sums have been spent by the Commonwealth and States governments over the last 50 years attempting to improve the development of policy and the medium and long term implementation of changes in some parts of the system. However, little or no funding has been provided to deal with the implementation of recommendations or on the ‘machinery of government’ that underlies successful public administration.

This study touches just the edges of what will be the major challenge for the Federal and States and Territories governments in implementing the recommendations of the NH&HRC as well as developing future policies, determining the allocation of funding for the health sector and raising the funds to pay for it from taxation, fees and charges.

We greatly appreciate the time and effort that has been contributed by a very large number of people in completing this report.

In particular we also want to place on record our appreciation of the assistance from the librarians of the NSW State Library, The City of Sydney Library, the College of Physicians, The Commonwealth, NSW, Victorian and Queensland Archives, the Offices of the Auditor – Generals and staff at various medical schools and teaching hospitals around Australia.

We would also like to thank the individuals in government departments and agencies, former Ministers, Ministerial staff and officials who gave a considerable amount of their personal time to discuss the issues.

Chapter 1 – Terms of Reference.

The terms of reference for this report are as follows:-

1. To examine the current constitutional, legislative and administrative arrangements between the Commonwealth and the States and Territories for the provision of funding by the Commonwealth and the States and Territories to the Australian public hospital system (and ancillary operations).
2. To outline, analyse and assess the administrative arrangements and systems for provision of funding to the Australian public hospital system (and ancillary operations).
3. To outline the current performance incentives and/or sanctions in the Australian Health Care Agreements and assess their efficiency and effectiveness in achieving the Federal Government's policies and objectives.
4. To examine the data that is supplied by individual hospitals, area health services (or other regional administrative arrangements) and States and Commonwealth Departments of Health (and Treasuries) on which any system of 'sanctions' or performance incentives has been and will be based.
5. To make recommendations for any changes that would improve the legislative, institutional and administrative arrangements at a Commonwealth, States and Territories level to enable a performance based system of public hospital funding to meet the demands for high quality, accessible public hospital services and care. This would include the benchmarks for assessing the quality of the public hospital system.

Chapter 2. Colonies to Commonwealth – a prolonged era of incrementalism.

In terms of the delivery of public hospital services, a wide range of other medical services and preventative health programmes, 'health' has traditionally been the province of local Government bodies and the States since Australia's early colonial days.

For a long period of colonial administration, hospital services were provided by private organisations – most not for profit bodies and the others private institutions operating for profit.

For lower income and needy socio-economic groups, hospital and related health services were provided by what was described as the 'charitables'. Many of the hospitals that are now public hospitals and are owned and operated by the State were owned, operated and initially funded by a wide range of charitable, benevolent and church organisations – especially those of the established religions.

Many of the services that are now provided by public hospitals or were ancillary to hospital services were provided by local Government. In both cases, there were low levels of charges, but in many instances fees were either not charged or, if charged, remained unpaid. Many doctors provided their services on an honorary basis to the hospitals run by the charitable institutions.

As the population grew and expanded geographically, combined with a series of recessions and a major depression and drought in the 1880s and 1890s, the financial ability of the 'charitables' to provide services diminished. Many of them were unable to continue and the States' Governments started to provide financial assistance.

In many cases the States' Governments provided some funding and subsequently became the operators, financiers and ultimately the owners of these hospitals.

Many of the local Government services followed the same route.

However, what did not change was a culture of close relationships between the hospitals and their staff and the communities and socio-economic groups they served.

Even at the time of Federation in 1901, travel was not easy and hospitals and health services were regarded as basic parts of local communities.

That culture became deeply ingrained and although travel and communications have improved markedly it remains a strongly held view of many people within a wide range of communities both metropolitan and regional, that hospital services should be community based and focused. There is a strong resistance to centralized control of the operational side of hospital services.

As the States' Governments became more financially involved and, ultimately, became owners and operators of hospitals, Acts of Parliament were passed to deal with specific hospitals. This occurred mainly in the capital cities and in some of the regional cities. Legislation was introduced also to deal with sexually transmitted diseases and wider public health measures.

The legislation for individual hospitals reinforced the communities' views of them as separate entities.

Federation did not bring with it the immediate formation of a Commonwealth Department of Health. Thus the legislative basis for many of the hospitals and related functions continued at a States' level until after World War I and in a number of cases after World War II.

The Constitution Act of 1900 did not provide the Commonwealth with exclusive powers to deal with health.

Even though the Commonwealth had the ‘Quarantine power’, its scope was not widely or extensively used until 1921 when the Commonwealth Department of Health was created.

The power on which the Commonwealth relied for the administrative basis of the Department was Section 51(1)(xxxix) of the Constitution – the Quarantine power!

The initial plan for the new Department was “to broaden its administrative base from a quarantine service to initiating research and treatment of medical problems in the tropical north, establishing a national chain of public health laboratories and surveying the problems of industrial disease and hygiene”.¹⁷

In 1921 when the Commonwealth Department of Health was established the pressures of post World War I reconstruction, including considerable migration to Australia from Europe were dissipating. Things were more settled and the Commonwealth and the States continued on more or less parallel paths up until the Great Depression of the early 1930s.

The financial pressures of the Depression on individuals and families put considerable pressures on the provision of health services. The ‘charitables’ were unable to obtain the funds to adequately run the hospitals. Progressively, responsibility for funding ‘charitable’ hospitals transferred to the States. In some cases the non-government organisations continued to own and staff the hospitals but the States’ Governments increasingly funded them, or provided operating subsidies.

¹⁷ ‘Putting Life into Years’ – *The Commonwealth’s Role in Australia’s Health Since 1901*: Francesca Beddie, Department of Health & Aged Care, 2001

Up until World War II the Commonwealth's activities in the health sector continued to deal with the main objectives set out in 1921 when the Department of Health was created.

The outbreak of World War II brought with it significant changes. The Commonwealth was omnipotent under the wartime regulations and many hospitals were requisitioned or voluntarily dedicated to treating military personnel and the victims of war.

As with other parts of the Australian economy and society the Commonwealth gained greater financial powers and that in turn resulted in greater policy and operational controls.

Towards the end of World War II, the then Attorney General, Dr. H.V. Evatt, introduced the Constitution Alteration (*Post War Reconstruction Bill* 1944).

The Bill followed extensive consultations between the Commonwealth and the States. In October 1942, the Commonwealth Government summoned a special Constitutional Convention. It comprised all Parties in the Commonwealth Parliament, the Government **and** the Opposition in each State Parliament. The Convention ran from 24th November 1942 to 2nd December 1942.

As a result of that Convention, "*the convention, on the motion of the Premier of Tasmania, Hon. R Cosgrove, unanimously reached the following resolution:-*

That ...

- (a) Adequate powers to make laws in relation to post-war reconstruction should be conferred on the Parliament of the Commonwealth.....*

- (c) *For this reason, legislative power with respect to suitable additional matters in relation to post-war reconstruction should be referred to the Parliament of the Commonwealth by the parliaments of the States under section 51 (xxxvii) of the Constitution.*
- (d) *Such reference should be for a period of not less than five years and not more than seven years from the cessation of hostilities and should not be revoked during that period.*
- (e) *At the end of such period, or at an earlier date, a referendum should be held to secure the approval of the electors to the alterations of the Constitution on a permanent basis.*¹⁸

The resolution was unanimously passed.

Included in the fourteen powers to be referred was the power over health.

Evatt went on to refer specifically to health and the reasons for including it:-

“I come now to national health. During the war it has become even more evident that the health of the people is a matter of national and not merely of local concern. Considerations of nutrition, health and hospital facilities, and preventive medicine, do not differ from State to State and the services to the people made available by the great hospitals, both public and private, should be extended throughout Australia with practical Commonwealth support.....

*.....it is essential that the Commonwealth shall have the power of leadership in the field of national health.”*¹⁹

¹⁸ Hansard; proceedings of the House of Representatives, 11 February 1944 at p. 137.

¹⁹ Ibid at p. 151

Significantly, he went on to observe that “*The only corner of the field of public health which belongs to the Commonwealth is that of quarantine.*”²⁰

The proposal in relation to the transfer of the fourteen powers was put to referendum and lost! While the Premiers and Leaders of the Opposition had all agreed they were unable to persuade the electors that the power should be transferred to the Commonwealth.

It would appear that in terms of the legislative arrangements, no significant structural progress has been made since 1944. Most of the shift in power and influence over the health care system has largely been brought by the funding arrangements and to a much lesser extent regulation.

It is foreboding that in 1944, not only had the Commonwealth secured the agreement of the Federal opposition, but it had also secured the agreement from all the States’ Governments and States’ Oppositions to agree to the transfer of powers in relation to health. Although the circumstances under which the ‘fourteen powers’ transfer were discussed were very different to what they are today, the importance of health in budgetary, political and operational terms looms larger in our society than it did at the end of World War II.

As the following table (at page 32) shows the health sector remains a mixture of legislative and regulatory arrangements with the Commonwealth and States having powers in their own right, operating conjointly under various agreements and arrangements and in other areas, especially service delivery, acting on their own.

²⁰ Ibid at p. 151

The Commonwealth legislation and regulation that has been introduced since 1944 has fallen into three main categories:-

- (1) Financial - legislation that enables benefits to be paid or schemes to be established that relate to a wide range of benefits,
- (2) Regulatory - legislation and regulation that introduces controls or establishes standards, and
- (3) Establishment of National entities – this deals mainly with research, advisory or other organisations that will implement international treaty obligations.

Current Roles & Responsibilities

	State	Commonwealth	Joint
<i>Fund</i>	<i>Community health</i>	<i>Private medical care (incl primary care)</i>	<i>Public hospitals</i>
	<i>Capital infrastructure and service planning</i>	<i>Residential and flexible aged care services</i>	<i>Public health programs</i>
	<i>Ambulance services</i>	<i>Subsidise Private Health Insurance</i>	<i>Mental health services</i>
	<i>Food safety and regulation</i>	<i>Education of health professionals</i>	<i>Sub-acute care</i>
	<i>Environmental health</i>	<i>Veterans health services</i>	<i>ATSI health services</i>
	<i>Travel assistance</i>	<i>Pharmaceuticals</i>	<i>Home and community care</i>
	<i>Pharmaceuticals in public hospitals</i>	<i>Vaccines</i>	<i>Health research</i>
		<i>Community-controlled ATSI primary healthcare</i>	<i>Health workforce training</i>
			<i>Emergency responses</i>
			<i>Blood and blood products</i>
Regulate	Regulate health services and professions	Private health insurance industry	Health service safety and quality
		Pharmaceutical industry	Health service safety and quality
		Alternative medicines and non-pharmacotherapies (thru the TGA)	Quality and supply of workforce
			Food regulatory arrangements
<i>Deliver</i>	<i>Public hospital services</i>	<i>Vocational training for GPs</i>	
	<i>Independent complaints body</i>	<i>Data on key programs as well as data for agreed national minimum data sets</i>	
	<i>Clinical training for undergraduates and specialists</i>		
	<i>Public health</i>		
	<i>Community health</i>		
	<i>Public dental</i>		
	<i>Vaccine distribution</i>		
	<i>Health promotion programs</i>		
	<i>Home and Community Care program</i>		
	<i>National minimum data sets</i>		

This is an extract from a speech delivered by Murray Watt MP, Queensland Parliamentary Secretary for Health on 5-6 November 2009

The National Health & Hospitals Review Commission Report does not address, in any detail, the essential simplification of the legislative and regulatory arrangements that should form the basis of medium to long term health care in Australia. In parts of its report, it alludes to areas where legislation and regulatory change may be needed, e.g. “The Healthy Australia Accord in 2010”.²¹ However, while the Accord proposes a high level agreement there is no suggestion in the Report that it might require ‘mirror’ legislation in the Commonwealth and the States to provide the necessary powers and give effect to the recommendation.

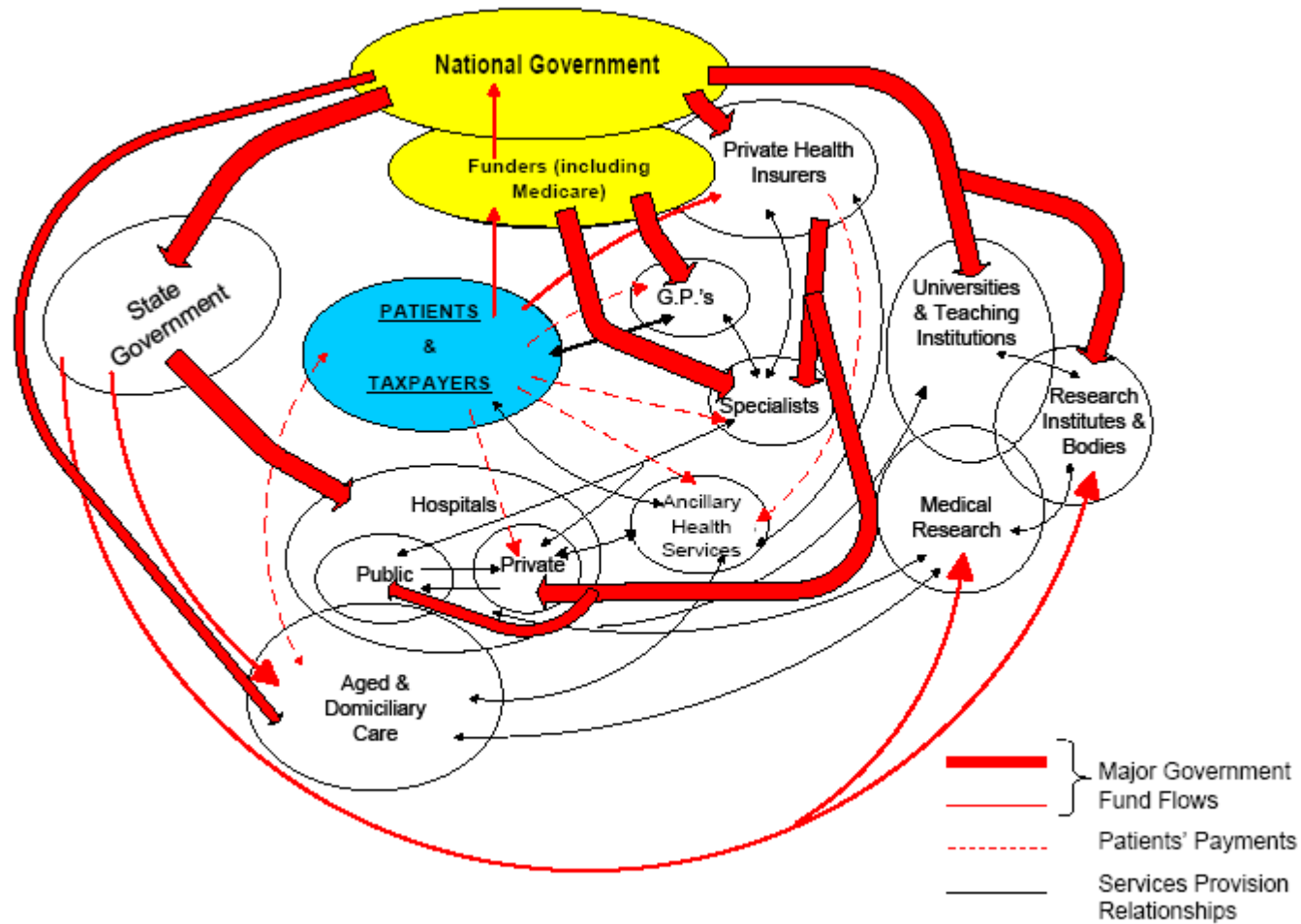
In addition, it does not flesh out the legislative, regulatory and administrative structures that would be needed to support the proposed funding options – especially ‘Medicare Select’.

The attached diagram illustrates the convoluted relationships between the various components of the health sector. It also shows the flows of funds which, in turn, brings with it accountabilities and responsibilities. Each recipient of funds reflects a vested interest group in the Australian health sector.

Based on past history, any major changes in funding, responsibilities and accountabilities will bring either cries of anguish and/or opposition to changes. These will include significant and powerful elements of the Commonwealth and States’ Departments of Health. History in Australia, the United Kingdom and, to a lesser extent, North America illustrates that implementing major changes will face massive obstacles and inertia.

²¹ NH&HRC Report; Recommendations at page 13

The Australian Health Sector



It was in the immediate post World War II period that significant changes started to occur. The Commonwealth's taxing powers were strengthened both by High Court decisions and the reluctance of the States to return to levying personal income tax. In spite of continual complaints from the States, none of them were or are prepared to impose additional state income taxes. That position has not changed and is unlikely to change.

In dealing with the health sector into the foreseeable future, it has been assumed in this report that there will be no return to additional, personal or corporate income taxation by the States and that the current horizontal, fiscal equalisation arrangements as recommended by the Commonwealth Grants Commission will remain in place as well, without any major variations.

If these assumptions are correct and health expenditure continues to climb exponentially as a proportion of GDP, the only options are:

- (i) dramatically improved productivity and reductions in overhead costs (which must include the costs of the Commonwealth and States' health bureaucracies) and,
- (ii) an increase in Commonwealth taxation to cover the increased costs, or
- (iii) increases in the Medicare levy, or
- (iv) expanded use of the private sector both in the funding and delivery of services, or
- (v) a combination of the first four, or
- (vi) a decline in the range and level of health services.

Option (vi) is unacceptable to the Australian community, although if governments and society do not make serious decisions about the health sector, it will happen by default.

The history following the defeat of the ‘fourteen powers’ referendum is not encouraging, except, perhaps, to note that Medicare was introduced and has successfully operated in spite of initial and continuing opposition from sections of the medical profession.

Taxation became one of the main drivers of change in the Australian health sector (as it was, and remains, in other key parts of the Australian economy) and inexorably was the major weapon that the Commonwealth used actively and positively through income redistribution, corporate taxes and more recently the Goods and Services Tax. It is clearly the simplest vehicle for the Commonwealth to use in securing changes by the States in the operation of the public hospital system. However, in itself it does not provide a solution to the systemic problems.

The Commonwealth also strengthened and widened its involvement through successive amendments to the *National Health Act*. This culminated in the most significant overall change to the Australian health system – the introduction of Medicare and the introduction of the Medicare levy that every Australian taxpayer pays. However, these changes were based mainly on funding by or via the Commonwealth. The social objectives of Medicare depended, for their success, on financial support.

The language between the two tiers of Government also shifted. The Commonwealth talked more openly and aggressively about overall provision of services and the necessity to have a national system. Also of considerable noteworthiness are the words used by Sir Earle Page, the

Minister for Health in the Coalition Government in 1953. They bear remarkable similarity to those of the current Prime Minister in 2007 – 54 years later.

Introducing *The National Health Bill* 1953, the then Minister in his second reading speech said, inter alia:-

*“I hope that this measure, like other measures of first class importance, with which I have been associated with the object of bringing about close cooperation with the States and with industrial organisations will have a long life.....I hope this charter on national health will have a similar long life, and the same experience of general approval, especially as many attempts which have been made over the last 30 years to crystallize this health problem in legislation have just failed within sight of the finishing post.”*²²

No doubt he had in his mind Prime Minister Curtin’s ‘fourteen powers’ referendum of 1944, when the electorate voted against giving the Commonwealth additional powers, including over health.

Page said of the Bill, that it:-

*“...would consolidate within the framework of one statute the health services which would lay the foundation for a national health scheme for the Commonwealth.”*²³

He went on to say that the Bill: *“...has endeavoured to bring into being a national health scheme that will remove from the people worry and*

²² Sir Earle Page, Minister for Health Commonwealth, 2nd Reading Speech, *National Health Bill* 1953, Hansard at page 1755

²³ Ibid at p. 1755

*anxiety caused by the costs of sickness, and give confidence in the permanence and solvency of the scheme.”*²⁴

Especially in light of statements that have been made by the current Federal and States’ Governments, he said:-

*“The establishment of a partnership with State Governments, the professions and insurance organisations on a long term basis give all the parties that sense of security needed to develop and provide a satisfactory and comprehensive cover against sickness for the whole of the community.”*²⁵

Later in the second reading speech, he added:-

*“In addition, the action of the Government in encouraging people to insure, and adding to the amount available to them in times of illness, had the direct affect of making available a very substantial additional amount of income to the hospital system. A couple of weeks ago I was informed that the deficits of the Royal Prince Alfred Hospital and the Sydney Hospital, which had reached such alarming proportion last June as to cause the authorities to consider the closing of several hundred beds.....”*²⁶

The cynics would say on reading these statements and comparing them to today’s challenges, that very little has changed!

(Ironically the *National Health Bill* was followed immediately by the *Queensland Tobacco Leaf Marketing Board Guarantee Bill 1953*).²⁷

²⁴ Ibid at p. 1755

²⁵ Ibid at p. 1756

²⁶ Ibid, at pages 1760 & 1761

²⁷ Ibid at page 1762

The post World War II era was also the time when States' Treasuries appear to have started to take a more detailed interest in expenditure by larger departments.

There were particular areas such as medical research, tropical diseases and preventative health care where the States, for a variety of reasons, were looking at what should be kept on a State basis and what could be moved to the Commonwealth and be dealt with on a national basis. The dominant reason for wanting to move roles and functions was a lack of adequate funds.

It was in the mid-1950s with high levels of inflation and increasing demands for better services, that the costs of providing public hospital and other related services started to grow exponentially – both in notional and real terms.

While individual professional and clinical issues, both positive and negative, maintained a high level of public interest and Australian medical research institutions were making considerable international impact, the elephant in the room then was, as it is now, 'funding – its adequacy and effectiveness'!

There were widespread political and societal concerns that blocs of society were not getting access to proper health care. Although there were massive improvements in dealing with vaccinatable diseases and key indicators such as child mortality were showing falling death rates, evidence was growing that access to health services and hospital services in particular were diminishing.

While many doctors argued that the 'honorary system' was providing the best service levels, evidence was growing that the system needed a major overhaul.

Simultaneously overhead costs were rising and Treasuries were attempting to reduce overall, real costs and increase productivity. Their task was not made any easier by the legal and regulatory arrangements and as Dr. John Deeble observed “.....in Australia high administrative expenses are inevitable because of the complexity and lack of co-ordination of health service arrangements.”²⁸

Deeble addressed the issue of overheads, mainly with a hospital administration and clinical approach. But he did not deal in detail with the burgeoning overhead costs associated with the health bureaucracies.

On the basis of the limited literature and academic research in this area, the tension levels between doctors, nurses and hospital administrators on one hand and government health departments on the other, were frequently difficult and acrimonious. The situation was and still is the case in some of the States. It remains a difficult area because of the complexities, blurred lines of accountability and budget constraints.

Dr Cummins, a former Director-General of the NSW Department of Public Health observed: - *"The Office of the Director-General of Public Health contributed the greater variety of services, although not the greatest numbers of staff, to the Ministry. The latter was provided by the Office of the Inspector General of the Insane and the staffs of the mental hospitals. Although their administrations were separate, that of the Director-General assumed a superior status within the Ministry, due to his official endorsement as Chief Medical Officer of the Government. There was very little interaction between the two major professional sectors. Their seniority lists were separate and staff feeling was one of veiled hostility, or at the best indifference, each to the other. This had*

²⁸ Deeble J, (1967) 'The Cost and Sources of Finance of Australian Health Service', The Economic Record, Vol 43, at p. 109.

*not altered substantially when I joined the Department of Public Health in 1950.”*²⁹

Likewise, the relationships between the Departments of Health and the Treasuries ranged, and continue to range, from workable to acrimonious and even outwardly hostile.

From interviews with former States’ and Commonwealth Health Ministers, senior officials, hospital administrators and unions, the overwhelming cause of the problems was, and remains, fundamental structural matters, funding and remuneration. Following closely behind was, and remains, blurred lines of responsibility and accountability and inadequate legislative clarity.

Interestingly, since World War II the States started to build a raft of Acts and regulations that dealt with health and a wide range of related matters that were brought under the umbrella of Health departments, e.g. food outlets regulation and inspection.

In summary, the views and actions across all the States is best summarised by the approach that: ‘if it moves regulate it!’ Some of the causes of this approach were:-

- to deal with increasing community pressures for Governments “to do something” to fix actual and perceived problems, although in many cases incidents were ‘one off’ and minor in the total scheme of things,
- greater reliance by Treasury and Finance Departments on regulation to try to control both direct and indirect costs in public hospitals in particular,

²⁹ Cummins, Dr CJ, *A History of Medical Administration in NSW*, NSW Dept of Health 1979, at p. 134

- with increased Commonwealth funding, mainly in preventative care, an increasing demand for reporting on expenditure and results, but with different criteria between the two tiers of Government, and
- reactions by Ministers in an attempt to keep health off the front pages of the media or the evening news broadcasts.

One consequence was an increase in the numbers of both administrative and clerical staff and from the mid 1970s an exponential growth in IT and MIS staff. After 1973, this was accompanied by an exponential growth in ministerial staff engaged in Ministers' private offices.

There was an increasing, noticeable and ready willingness by politicians to react to short term, adverse events when media and political pressure was exerted. Mostly it resulted in amending existing legislation or passing new regulations with additional controls. In some cases penalties were introduced. In many cases the results were ineffective and consumed a considerable amount of time and administrative action that did little for improving services to patients.

Very few of the reactions were to examine and test why government was in the field and was control and regulation necessarily the best approach?

Prof Peter Wilenski in his Review of NSW Government Administration observed “... *it is in this area of policy development and analysis and priority setting that the structures of the administration supporting Ministers in NSW are often weakest. While there is a strong emphasis in many departments and authorities on technical competence and getting*

the job done, there has not always been the same concern with thinking deeply about what the job itself should be.”³⁰

This report was followed in 1982 by “Further Report – Unfinished Agenda” also by Prof Peter Wilenski, in which he reiterated but in stronger terms the points he had set out five years earlier. They were:-

“The Interim Report pointed to the administration’s serious lack of capacity in policy development and policy analysis. Too often, Ministers were not presented with a reasonable range of policy options, while the political and social implications of what appeared to be technical or administrative decisions were overlooked. Policies frequently evolved as a result of case-by-case decision making and were sometimes at variance with overall government priorities. In addition, longer term planning and the anticipation of emerging problems tended to be neglected.”³¹

In terms of the other States, Prof Wilenski’s observations generally apply. The lack of a cadre of highly intelligent and skilled people at the senior health policy levels in central agencies and Departments of Health has been one of the main reasons for some of the continuing structural problems.

At a Commonwealth level there is no published evidence, with the exception of Andrew Podger’s³² recent articles and speeches, to suggest that the Commonwealth Department of Health since World War II has

³⁰ ‘Directions for Change - Interim Report – November 1977.’ Review of NSW Government Administration, Prof Peter Wilenski pp 3-4

³¹ ‘Further Report - Unfinished Agenda’, Review of NSW Government Administration, Prof Peter Wilenski, p 22.

³² Andrew Podger, President of the IPAA (National) and former Secretary of the Commonwealth Department of Health 1996-2002.

seriously addressed “what the job itself” should be - what should be its roles and functions?

Several former Commonwealth Ministers acknowledged they had not been rigorous enough in questioning and testing the Department’s roles, responsibilities and accountabilities and had allowed administrative overhead creep!

The experiences have varied between the States and Territories. In Queensland, the public hospitals were free and the geography and demography of that State added a dimension to health policy and service delivery that did not exist in the other States, until more recently in Western Australia.

Since World War II experiences in all the States except Victoria have been mostly much the same.

Victoria is different because its serious financial and administrative situation in 1993 precipitated massive changes to the ‘machinery of government’ and the restructuring of many departments and the delivery of services.

The other States have wrestled with similar issues. Some of them have embarked on ambitious programmes of positive change that are consistent with the statements that have been made by the Prime Minister, the Commonwealth Minister of Health and the States’ Premiers at C.O.A.G. South Australia consistently and Queensland more recently, have attempted to assess “what the job itself should be” and Western Australia has had episodic forays into trying to be innovative in health policy and delivery of health services. While it is unpopular to say so, the attempts at innovation in Western Australia have been constrained from time to time by the public service oversight bodies that were

established in that State following the activities and actions of a relatively small group of people who had failed to observe proper process in relation to public administration.

However, in several of the States, the short term political imperatives have inevitably forced the reaction of fixing the immediate problem and getting it off of the front pages of the newspapers!

Attempts by several of the States' Ministers to think seriously about "what the job itself should be" supported by several Departmental Secretaries and occasionally actively supported by important central agencies' Departmental Heads have secured some positive changes and they have endured.

Victoria stands out as the State that over the last 15 years has seriously attempted, and succeeded, in grappling with the 'machinery of government', financial and operational challenges in developing health policies and the delivery of services. Victoria, under both ALP and Coalition Governments, has been far more comprehensive, enterprising and rigorous in its approach to the wide range of issues that are involved in the health sector. Regrettably, the starting point was the financial crisis of 1992-93. But on all the evidence available, it is difficult to argue that Victoria is not significantly ahead of the Commonwealth and the other States in its approach to the structure and operations in the health sector.

Queensland has more recently followed in Victoria's wake. However, the evidence suggests that its actions were initiated not by a basic desire to fundamentally review what would be the best health system for Queenslanders but rather by a series of highly publicised incidents at

Also over the period before and after federation, there have been a small dedicated group of academics and medical practitioners who have written about, promoted and implemented positive changes. However, with a few exceptions there has been little detailed attention to the ‘machinery of government’ that forms the basis of the existing structures, funding and services in the health sector.

Most of the former Ministers for Health at both Federal and States’ levels were of the view that opportunities had been missed at the time of the introduction of Medicare, at the commencement of each of the Australian Health Care Agreements and during the reform period of the mid 1990s to significantly overhaul and simplify the legislative and regulatory regime in the Commonwealth and States and as between the two tiers of Government.

All the former Ministers (Federal and State), the former departmental heads and a number of hospital administrators were strongly of the view that powerful sections of the medical profession, especially the surgeons and anaesthetists, adamantly opposed legislative and regulatory reform.

One former Coalition Federal Minister, whose views were independently supported by two of his former State colleagues (each from a different State) strongly held the view that: “it was a great shame that the Liberal Party was so beholden to small, but powerful, sections of the medical profession, that they did not see that Rt. Hon. Barbara Castle (a U.K. Health Minister) was correct when she described some of the profession as being “the building workers in white coats”.

However, in trying to conquer the gargantuan task of controlling and efficiently spending the vast sums of money involved in the sector, the array of negative, vested interests have dominated and seriously impeded a great deal of the proposed reforms over the last 100 years.

One of the major reasons why this is the case is that the complexity of the legislative and administrative arrangements is an almost insurmountable roadblock.

Also it is a fertile field for obstruction by departmental officials. Although it is difficult to verify there appears to have been a long standing culture of obfuscation and opposition to major reform from middle level management in the Commonwealth and States health bureaucracies. The deeply ingrained culture does not provide the platform for real flexibility and positive changes.

Every time a new set of regulations are put in place it usually increases the number of bureaucrats and creates a hurdle for positive change.

Several of the former Commonwealth Ministers and a number of their former State colleagues, supported by former and current senior health officials in the States, were critical of the structure and operation of the Commonwealth Department of Health. The former Ministers came from each major political party. All of them took the view that if blame was to be apportioned, it was to them for not “taking on the Department and contesting their views and overcoming their inertia and resistance to major reforms”.

One of the former Ministers admitted that because he believed he was being obstructed by the Department he had knowingly consented to one of his Ministerial office staff using his power vicariously to canvass issues from parts of the health sector in a way that deliberately

circumvented the Department. (It should be noted that based on our experiences and knowledge, such behaviour is not confined to Health Ministers and the Health Departments).

Although there were differing degrees of emphasis the main views were:-

- (1) The current legislation and administrative orders in relation to the Commonwealth Department of Health are not structured to deal with rapidly evolving policy, service delivery requirements and negotiations with the States and Territories for the best policy, operational and financial outcomes,
- (2) At a minimum, the Department has inherent conflicts of interest and should be structurally separated into 'policy' and 'services delivery' with its regulatory roles being moved elsewhere in the public service,
- (3) The Department and its breadth of responsibilities and financial commitments are too large for a single Minister³³ to handle effectively. In addition, in any system where services have to be 'rationed' there is an inherent conflict between Child Care and Youth on one hand and Ageing on the other,
- (4) With one exception, the view of the former Ministers at both Commonwealth and States' levels was that Assistant Ministers and Parliamentary Secretaries do not solve the structural and operational issues and often form another layer of administration that impedes change, as well as confusing lines of accountability and responsibility,

³³ Note: The principal Minister in the portfolio is the Minister for Health and Ageing. There are three subsidiary or related portfolios: 'Indigenous Health, Rural and Regional Services Delivery'; 'Ageing' and 'Early Childhood Education, Child Care, Youth and Sport'. There is a Minister for each portfolio. In addition, there is a Parliamentary Secretary for Health.

- (5) There is insufficient mobility between the Commonwealth and States' departments of Health and related agencies (the same observation applies more widely between Commonwealth and States' public services),
- (6) That the Commonwealth Department of Health does not pursue a rigorous performance based approach to the services that the Commonwealth is either funding in the States or delivering itself, and
- (6) There is a need for major changes in the 'culture' of the Department and especially in its relationships with other Commonwealth agencies and its States and Territories counterparts.

On the premises that:

- (i) the Commonwealth will continue to increase expenditure on the overall health sector that will include funding to the States for public hospitals, and that health's proportion of the GDP will continue to grow exponentially, more and more power will accrete to the Commonwealth,
- (ii) inevitably the Commonwealth will be forced to consider and implement some form of funder and provider model for health care, and
- (iii) productivity and expenditure efficiency will be a continuing demand within the health system and significant structural changes are needed initially at the Commonwealth level to ensure that happens. Concomitant, but not necessarily identical changes will then flow to the States.

And that:

- (i) it is also assumed that the control of taxation revenue and the current constitutional powers given under Section 51(i)(xxxix) of *The Constitution Act* provides the Commonwealth with sufficient power to act without threat of a High Court challenge, and
- (ii) if the Commonwealth ever contemplated a referendum on constitutional powers in the foreseeable future, it may warrant incorporating health as a specific power rather than continuing to rely on the quarantine power. However, the history of referenda in Australia are not encouraging.

The recommendations are:-

1. A National Health Committee of Cabinet should be established. It would be similar in nature to the National Security Committee and would be chaired by the Prime Minister and include the Treasurer along with the Minister for Finance and Deregulation.

It should also include the Ministers for Health, Ageing and Indigenous Health.

It should meet regularly and, in addition, meet prior to COAG every time health policy and provision of health services is on the COAG agenda. There is a strong argument for Health being a standing item on the COAG agenda.
2. With significant health policy and funding issues being elevated to COAG, the Health Ministerial Council, as it is currently constituted, should be discontinued. However, it appears that

meetings between Health Ministers (including the New Zealand Health Minister) have been productive and they should continue.

3. Meetings of the Secretaries and Directors-General of Departments of Health have not been as productive. The concerted view of the States and Territories is that the Commonwealth Department of Health officials have attempted to limit the scope of both the agenda and discussion. If, as recommended, the Commonwealth Department of Health is structurally separated, the Heads of States and Territories' Health Departments should meet regularly and, in particular, deal with major policy and funding issues and performance measurement and reviews.
4. Using the *Defence Act* as a template, the Commonwealth Department of Health (which currently has an establishment of over 4,444 full time positions) should be structurally separated.

It should be broken into two main divisions and the regulatory and research functions moved into the Department of Finance and Deregulation and the Department of Innovation, Industry, Science and Research.

The two divisions should be:-

- (i) National health policy and it should probably comprise no more than 250 people of a high intellectual calibre and administrative capacity who provide the Minister in the first instance and the National Health Committee of Cabinet with high level policy advice, and
- (ii) The Services and Operations Division which deal with implementing the funder-provider or purchaser-provider

recommendations of the N.H.&H.R.C. Report. It would be associated with but administratively separate from the Policy Division or Department.

To implement the proposed rearrangement:-

- (i) The Administrative Orders and, if necessary, the regulations would be structured similar to those in the *Defence Act 1903* (as amended). It provides for Directives which are the Government's expectations of the Secretary and Chief of the Defence Force. Part II, Section 8 of the *Defence Act 1903* (as amended) provides:

“the Minister shall have the general control and administration of the Defence Force, and the powers vested in the Chief of the Defence Force, the Chief of Navy, the Chief of Army and the Chief of Air Force by virtue of section 9, and the powers vested jointly in the Secretary and the Chief of the Defence Force by virtue of section 9A, shall be exercised subject to and in accordance with any directions of the Minister.”

The Minister issues formal written Directives to the Chief of the Defence Force and the Secretary of the Department of Defence.

“Section 9A, Administration of Defence Force” also provides for instructions to be issued with the authority of the Secretary and the Chief of the Defence Force in pursuance of the powers vested in them jointly by virtue of

Subsection (1) shall be known as Defence Instructions.³⁴ They flow down through the Defence Force and the Department.

In addition, the Secretary of the Department of Defence is subject to the *Public Service Act* 1999 (as amended) and the *Financial Management and Accountability Act* 1997 (as amended).

While there has been criticism of the structure of Defence, a major advantage is that the legislative basis provides a very clear, published statement of the relationships, roles and accountabilities.

In contrast the Department of Health and Ageing is a Department of State, some of whose powers are reliant on Section 51 (xxxix) of the Constitution but for its general operations relies on the *Public Service Act* 1999 and the *Financial Management and Accountability Act* 1997. This legislation is, of necessity, broad in nature. Additionally, there are 70 principal Acts that are administered by the Department. Some of these Acts derogate powers and functions, e.g. *Therapeutic Goods Act* 1989, others enable the Department to act on behalf of international agencies, e.g. *World Health Organisation Act* 1947 and a significant number deal with funding or funding relating matters.

In this case, it would be Directives from the Minister for Health to the Secretary of the Department of Health Policy and the Secretary of the Department of Health Services and

³⁴ Section 9A(2) *Defence Act* 1903 (as amended) at page 6

Operations. The Directives would carry with them key performance indicators that would be independently reviewed annually. In addition, the Department of Finance and Deregulation's annual Compliance Statement would make their completion mandatory and provide the basis for external assessment of the Department's performance against published objectives.

- (ii) All the regulatory functions such as the Therapeutic Goods Administration would be transferred to the Department of Finance and Deregulation.
- (iii) Institutions, such as the National Health and Medical Research Council, should be transferred to the Minister for Innovation, Industry, Science and Research and be subject to the same governance arrangements as the C.S.I.R.O. and other research institutions.
- (iv) Any professional regulation and accreditation procedures would be handled by the States as part of their health services delivery responsibilities and the mutual recognition arrangements between the Commonwealth and the States would ensure national coverage and consistency. There is no reason why a national register cannot be maintained by a State under the mutual recognition agreements.
- (v) The current Department of Health would differentiate its priorities between major policy issues and services delivery issues, e.g. the National Public Toilet Mapping Project (which is a service delivery, not a policy issue). It raises also the issue as to whether or not projects of this kind are a

real policy priority for the Commonwealth Department of Health.

- (vi) The quarantine services functions executed by the Department of Health (as against the policies that should apply under the *Quarantine Act* 1908) would be transferred to the Department of Customs and in the medium to long term be melded into a Department of Border Security. This would apply also to the *Quarantine (Validation of Fees) Act* 1985.

It is highly likely that a proposed reorganisation of this kind would not only clarify the roles, responsibilities and accountabilities of the Commonwealth Department of Health, but would also assist the States to implement similar, necessary, structural reforms.

It would also shift the intellectual (sic), financial and operational focus that concerns many of the entrenched vested interest groups that have become an integral part of the milieu of the health caravanserai.

Based on the advice and opinions of former health Ministers and officials and the experience in other Westminster systems, the current Commonwealth Department of Health will find a multitude of reasons why there should be no changes and will claim that everything is operating satisfactorily.

Combined with service deficiencies and inadequacies in much of the data coming to the Commonwealth from the States and Territories, a lack of radical reform would mean that:-

1. Many of the N.H.&H.R.C.'s recommendations will not, and cannot, be implemented successfully, and

2. The Federal Government's totally appropriate vision of an evidence based funding system is likely to be, at best, a pipe dream.

Achieving legislative, regulatory and administrative restructuring of the kind suggested above will be essential if real, enduring reform is also to be instituted at a States and Territories' level.

While much of the core legislation and regulations in the States preceded that in the Commonwealth, a great deal of it now relates to, or is influenced by, the Commonwealth legislation and the financial arrangements between the Commonwealth and the States.

A preferred position would be for legislation in the proposed Health Services and Operations Department to be mirrored by legislation, regulations and performance data in the States and Territories.

It has been demonstrated in a wide range of areas where national objectives are desirable but the constitutional powers are divided between the Commonwealth and the States that 'mirror' legislation can be devised, passed and operated satisfactorily, e.g. the *Corporations Law*.

In health policy there is a need for consistency and commonality between the Commonwealth and the States.

In contrast, in the Health Services and Operations areas there will be common themes and funding streams, but geographic and demographic differences between the States, e.g. Aboriginal and Torres Straits Islander needs in Queensland, will need capacity for meeting particular needs.

Underlying the first stages of reform that have been recommended by the N.H.&H.R.C. report will also require major cultural changes.

This will not be easy because the existing Departments of Health are large. The Commonwealth has 4,444 permanent staff and 482 “non-ongoing” staff (presumably temporaries) as at 30th June 2009.

In contrast, NSW has 99,815, many of whom are in operational areas. However, it is extraordinarily difficult to find accurate, consistent definitions of what constitutes the administrative overheads of running a health system.

As has been pointed out elsewhere in this report, there are a large number of vested interest groups involved, some of them are deeply entrenched in the current ‘system’. It is likely that the only way to create the platform for establishing a health system that will meet the demands of the next 25-30 years is to start at the sources of legislative powers and funding and institute radical change – incremental changes will become mired in a bog of competing self interest.

Chapter 3. The Way Forward - Carrots, Sticks and Money.

Between the years of 1993 and 2007, both A.L.P. and Coalition Governments have been in power in Canberra.

Since the federal election in November 2007, other events have overtaken the negotiation and funding processes for health (and a number of other sectors where the Commonwealth provides funds to the States and Territories for the provision of services).

There have been three Australian Health Care Agreements:-

1. 1993 – 1998,
2. 1998 – 2003, and
3. 2003 – 2008.

The Agreements covered the provision of Commonwealth funds for the States and Territories owned and operated public hospitals. They determined the quantum of funding that would be provided by the Commonwealth, set out a requirement that there be matching funding from the States and Territories, and provided for the withholding of funds by the Commonwealth if the States and Territories did not meet certain conditions.

All of the agreements ran for five years, although the last year of the 2003-2008 Agreement was a transition period, when:-

- (i) Immediately after the election of November 2007, the Commonwealth made some one off, ad hoc allocations to the States and Territories to provide short term funding for

major problems, e.g. \$150m to help shorten waiting lists for elective surgery, and

- (ii) Concomitantly, the Federal and States' Treasuries were negotiating and successfully concluded arrangements to radically change the arrangements for Specific Purpose Payments (SPPs) to the States. These new arrangements covered Health.

It should be noted that most of the former Secretaries and Directors-General of Health and some of the current Heads of the Health Departments regard the Treasuries' approach to public hospital funding as "lacking understanding of the dimension of the personal issues and being a narrow bean counting" approach. This is consistent with a view that has existed for over 100 years.

There was skepticism, which still remains, about the actual and potential effectiveness of financial 'sanctions' in any funding agreement relating to the provision of health services and especially for public hospitals. Some of the skepticism is based on the politics of health and a major component is the assessment that it is very difficult to provide effective and timely sanctions under the umbrella of joint Federal and States' funding arrangements for public hospitals. An additional complication is the significant difference in administrative structures and processes between and within the States and Territories.

On the basis of the history of the three AHCAs, it would appear that the relationships described by Dr Sidney Sax and Dr. Cummins have not greatly changed and that although sanctions were written into the Agreements, they were ineffective.

The initial ad hoc payments immediately after the 2007 election to the States and Territories fulfilled specific commitments given by the incoming A.L.P. Government. They were largely a response to demands from the States to either provide the additional funds to enable them to fulfill increasing demands for public hospital and related services or to fill funding gaps caused by poor financial management (by some States and their public hospital administrations) or a combination of the two. They were also a temporary measure until the Commonwealth and the States had considered the recommendations of the National Health and Hospital Review Commission and the replacement for the former AHCAs.

The new SPP arrangements represented a none too subtle shift of power from being between large line agencies (such as Health, Housing and Education) to the Commonwealth and States' and Territories' Treasuries. This shift is understandable in light of the size of the Health budgets of the Commonwealth, States and Territories and the 'contingent liabilities' that exist because of Australia's ageing population.

At all tiers of government the Treasuries for some time have been warning about the financial impact of increased demands for services caused largely by an ageing population and the wider impact of inter-generational change. Similar concerns are shared by Departments of Health but with a different emphasis. At a State level, meeting the immediate demands for service delivery are the political and operational imperatives.

In the course of our investigation all the Treasuries (and in some cases central agencies) expressed serious reservations about the willingness and

capacity of Health Departments to maintain effective control over both recurrent and capital expenditure.

The Treasuries' views and those of several of the former Federal Health Ministers are that the AHCAs were not an effective means of providing funding and certainly not a consistent vehicle for maintaining financial control.

Some former Health Ministers (Federal and State) and States' Health and Treasury officials argued there had been a serious disconnect between the Ministerial Health Council and the Treasuries. The majority view is that the new C.O.A.G. arrangements are a positive step in overcoming that problem.

The 'sanctions' under the former AHCAs were meaningless because no Federal Minister would accept a recommendation from the Department of Health to implement sanctions provided for in the AHCAs and likewise no political party would have the courage to do so.

Commonwealth officials interviewed for the report and former Ministers could not recall between 1993 and 2007 the Commonwealth Department of Health recommending to either the Health Minister or to the Expenditure Review Committee of Cabinet that sanctions should be imposed.

All the former States and Territories' Ministers interviewed regarded the AHCAs as being unusually one-sided. In real terms, the proportion of Commonwealth funding declined during each five years operation of the Agreements. None of the former States' Ministers could recall the Commonwealth threatening to use the sanctions in the Agreements, although several Premiers and Treasurers recall there being a "lot of

political static being around just prior to and during the renegotiations of each AHCA.”

All of the former States’ Health Ministers interviewed regarded the negotiations associated with each outcome and the negotiations of each quinquennial agreement as unsatisfactory and not conducive to resolving what were, and remain, serious policy, financial and operational issues.

As an example, two former Coalition Premiers and one former A.L.P. Premier regarded the processes and outcomes of the 1998-2003 AHCAs as “farcical and unsatisfactory”. Three former A.L.P. Premiers expressed similar views about the negotiations and outcomes associated with the 2003-2008 AHCAs.

The sums of money involved have been large:

2005 – 2006	Federal payments	\$9.296 billion
	States & Territories payments	\$12.301 billion
2006 – 2007	Federal payments	\$8.8 billion
	States & Territories payments	\$9.953 billion
2007 – 2008	Federal payments	\$9.7 billion
	States & Territories payments	\$9.758 billion

In the 2008-2009 Federal budget, the provision for payments to the States and Territories for public hospitals was \$13.123 billion.³⁵

In the 2009-2010 Federal budget, the appropriation by the Commonwealth to the States and Territories for public hospital expenditure was \$12.153 billion.³⁶

³⁵ Source – Final Budget Outcomes, (tables referring to SPPs to and through the States) Australian Government, 2006, 2007, 2008, 2009

During the course of each Agreement, there were allegations exchanged between the Commonwealth and the States of cost-shifting, manipulation of data and attempts to load various schemes with costs that should have been attributed to the public hospitals or Commonwealth benefits payments scheme or vice versa.

The issue of sanctions has been recognised by the ALP Government. In statements made since November 2007 it has talked about providing ‘incentives’ rather than imposing sanctions.

One kind of incentive has been the ‘Competition Policy’ type payments that were made to individual States for meeting objectives agreed between the Commonwealth and a State for achieving real reforms arising out of the 1996 Competition Policy agreed to by the Commonwealth and States. If the reform was not implemented or delayed this payment would not be made, e.g. the opening up of the NSW rice market.

Several of the States regarded the difference between ‘sanctions’ and ‘incentives’ as semantic. If the funds are not paid up front by the Commonwealth to a State, it is regarded by the State as withholding of funds and thus a ‘sanction’. If the incentive is in the form of a performance payment the States, with one exception, do not have an adequate performance management and assessment system.

There was also a view from most of the States’ Departments of Health and the Treasuries that the Commonwealth Department of Health does not have the necessary experience, knowledge or capacity to rigorously and effectively analyse and interpret individual States’ performance data

³⁶ Source – Forward Estimate, Australian Government 2009/2010 Budget

– where it exists. This was confirmed in reports by the Australian National Audit Office.

The consensus of views amongst the States is that for a performance based incentive to have the decided impact, it has to be supported by a credible, consistently applied performance review system.

At individual public hospitals the lack of clarity about responsibilities and accountabilities, plus serious practical limitations on the ability to introduce an effective performance review system, constrains the reliability of aggregated financial and clinical performance data. This point has been confirmed by States and Territories Auditors-Generals reports.

Casualty and emergency wards are the first point of entry for many patients. They are also an area with highly variable patient loads and costs. The very nature of casualty or emergency wards is such that many incidents are poorly recorded or not recorded at all. In addition, many of the casualty and emergency wards are substituting for GPs. Unless the triage nurses or the sheer length of waiting times actively discourages patients from waiting, there is no incentive. A consequence is a high level of complaints about waiting times at public hospitals. Waiting times are recorded and consolidated. Instead of developing the incentives to keep people, who do not need emergency treatment out of emergency wards, the figure for acceptable waiting times are increased or decreased to give an acceptable or manageable political outcome.

In addition, the only effective ‘incentive’ or ‘sanctions’ for individuals is to keep them waiting as long as possible in the hope they will go elsewhere or just give up waiting and come back at another time. This has adverse effects on disadvantaged groups within society.

There are groups of community based GPs who object to the construction of 'super' clinics. But there is a very strong operational and broader economic argument that the availability of 24 hour GP clinics adjacent, or nearby, to public and private hospitals provide the opportunity, convenience and incentive for non trauma cases to be transferred from emergency or casualty wards.

In N.Z. there is a charge for patients presenting at public hospital emergency and casualty wards.

All the evidence suggests that the sanctions that were contained in the Australian Health Care Agreements were ineffective. Even if they had been exercised by the Commonwealth in relation to one or more of the States, the political consequences would have resulted in them being overruled or worked around.

The current complexity of the administrative arrangements between the Commonwealth Treasury, Departments of Finance and Deregulation and Health and the States' Departments of Health and Treasuries (and in some cases separate Departments of Finance) and individual hospitals (and in some cases with area or regional health administrations in between) strongly suggests that macro-economic bloc funding incentives will not be effectively translated into individual public hospitals' finances and clinical operations.

This does not suggest that individual hospitals or States' departments should not introduce and manage rigorous financial and clinical performance measurement and management systems. On the contrary, they are essential. But they do not greatly influence the patients' behaviour – the demand side. If the pressure is to be eased on emergency and casualty wards, a combination of pricing and education applying to

individuals are more likely to be effective. Such methods are outside the capacity of Commonwealth, States and Territories' funding agreements.

'Competition Policy' type incentives may have limited impact, but to implement them at a patient and individual hospital level would, most likely, result in increased administration costs and clerical support (bureaucrats).

Prima facie, there is an argument for introducing price incentives so that the message is given to people that can afford to pay to go elsewhere so that casualty or emergency wards come back to dealing with trauma cases.

As much as a proportion of locally, community based GPs resent or have reservations about the construction of super GP clinics adjacent to public hospitals, they are likely to be a means of transferring non-urgent cases out of Casualty and Emergency Wards of public hospitals.

Chapter 4. Performance and Evidence – the Statistical Chameleon.

When elected in November 2007, the new A.L.P. Government stated very clearly that its policy decisions and funding arrangements would be ‘evidence based’. Both the Prime Minister and other senior Ministers indicated that they were pursuing major reforms and allocating funds would be as a result of “evidence based” assessments and reviews and that performance would be a major criterion – especially in the health sector.

In the health sector, individual related data is collected by general practitioners, paramedics, hospitals and the various range of medical practitioners in those hospitals, ward nurses and a wide range of people involved in post operative work. In addition, pharmacists maintain records of prescriptions medicines provided to individuals.

In a series of tiers, the information comes together either through Medicare, aggregated hospital clinical data or procedures, financial data which records operating costs as well as the ‘hotel’ type costs associated with running a hospital or other patient related institution.

Over the last 100 years that data has evolved from simple paper based records that originated and remain as patient based records.

As the technical and professional standards of health care improved, both the clinical and financial records became more complex and comprehensive.

The development of mechanical and ultimately computer based clinical and financial recording and analytical systems provided the means for administrators, clinicians, Treasuries and health sector insurance

organisations to gain a far more comprehensive view of what was happening in the sector and how much it costs.

As the funding of public hospitals shifted from the 'charitables' to the Commonwealth or States or both, with provision of subsidies or financial accommodation and governments' significantly increased financial support to preventative health care programmes, the requirement for accountability grew.

Consistent with the financial pressures facing all Australian governments from 1970 onwards, the demand for 'value for money' and performance assessment also grew. Simultaneously, there was a growing need to prioritise or ration public funding in order to deliver various governments' policies and programmes.

Concomitantly, as smaller community public hospitals have reduced in number and large public hospitals have dominated the hospital sector, responsibilities and accountabilities have shifted to the Chief Executives of the large hospitals, the Secretaries and Directors-General of Departments of Health and ultimately, Ministers for Health.

An exception is Victoria where, to a significant degree, responsibility and accountability for public hospital management and performance has been kept largely at the local hospital's board level.

For a variety of reasons, many Ministers for Health have felt the need to become more and more involved in public statements about the performance of individual hospitals or single events in public hospitals. In many cases, it has been involvement with incidents or financial matters that would be normally dealt with by a hospital Chief Executive, a senior clinician or medical superintendent. Rather than seeking a sensible solution to what is usually a systemic problem, Ministers resort

to the headline catching “heads will roll” response. The reaction is not evidence based and is a strong disincentive for managers or clinicians or both to avoid decision making and push responsibility elsewhere.

During the same period, and more especially, since the commencement of the first Australian Health Care Agreement in 1993, the Commonwealth as a major funder of public hospitals has taken greater interest in the overall performance of the public hospital system in each State and Territory.

In one sense, the States’ and Territories Ministers for Health have become squeezed between three pressure points - the individual patients who have a predominant interest in the performance of one hospital; States’ Treasuries which have an interest in the performance of individual hospitals or area or regional health services, and the consequent implications for a State or Territory budget as a whole and the Commonwealth Treasury, Department of Finance and Deregulation and the Department of Health which have interests in the overall public hospital system in a State or Territory and the performance of the health sector nationally, especially in relation to preventative health programmes and the financial position of Medicare and the Pharmaceutical Benefits Scheme.

As the health sector expanded, so did the data collected by it. It falls into five main categories:-

- (i) patient related data that is received by GPs, specialists and individual hospitals;
- (ii) hospital data that has several sub-categories:-
 - a. clinical performance in relation to patients;

- b. categories of procedures which feed into the decision making process for allocation of hospital resources. Similar data is also used by Medicare and the health insurers on an aggregated basis for each procedure;
 - c. economic and financial data which contributes to making assessments of trends in demand for services and the supply.
- (iii) financial data – both recurrent and capital (revenue and costs) which enables State and the Federal governments to allocate funding. Although it needs to be said that Deeble's 1962 observations about there not being accurate data on overheads (ie. bureaucrats involved in administration) still apply,
 - (iv) politically oriented data which have been 'ad hoc' and mostly is in response to one off incidents or an attempt to find 'good news' to offset adverse events, and
 - (v) macro economic and sector/programme wide data that feeds into medical research, innovation, teaching or a wide range of activities that hang off or are related to the health sector.

Physically, masses of data are collected and a quick perusal of the Australian Institute of Health and Welfare website and that of the Commonwealth and States' Departments of Health, the Health Insurance Commission and the National Health and Medical Research Council illustrates that the data is encyclopedic in volume. In addition there is a massive amount of data collected by universities, research institutes and the private sector.

The real issue is not the volume collected, but what is its value in making sensible decisions about the future operation and funding of the public hospital system (in this case)?

Also based on the way in which Commonwealth, States' and Territories' negotiations are conducted, what is the key fundamental operational and financial data that will quickly and accurately provide a current overview of the real, up-to-date status or financial position of the States' and Territories public hospital system?

For Ministers and senior bureaucrats to make informed judgments it is essential they have access to succinct, relevant, up-to-date performance data and that the data has relevance.

In undertaking this project we worked with the international accounting and consultancy firm Deloitte to assess performance reporting in Australia. The Deloitte work, which was undertaken by professional staff working in the Australian Health Sector, illustrated very clearly that the amount of data collected is massive.

However, a recurring theme of Commonwealth and States' Auditor Generals' reports is that the data may not necessarily be accurate, is often not relevant and when aggregated may not convey an accurate picture of the real state of the 'health system'.

In a separate exercise that Deloitte Touche Tohmatsu has undertaken for the NSW 'Independent Panel – Caring together: the Health Action Plan for NSW – Stage 1 Progress Report, October 2009' it made several major, critical observations which go to the basis of any credible evidence based, performance management system.

At page 2 of its report Deloitte observed:-

“The definitions adopted for rating progress under the NSW Health reporting system, and the definition of the Actions themselves, leave scope for similar progress to be rated differently in Health Services across NSW. In particular:

- There appears to be little difference between ‘Commenced’ and ‘Partially Achieved’ in circumstances where for example, a project group is established to develop a revised policy/protocol or to prepare and publish information on costs or budgets. So Health Services may report the same progress under either.
- The rating of progress is open to considerable interpretation where pre-existing arrangements may (go some way to) satisfy the principle of the action if not the letter. On other Actions, policies/protocols may exist but are not always followed/needed (e.g. for emergency department clinicians to admit patients to wards; or for the induction of overseas trained nurses). Again, the reporting of progress varies depending on whether these are viewed as, in the former, *Commenced or Partially Achieved*, or, in the latter, *Achieved or Not Applicable*.
- Progress on the same action can be rated differently in the same Health Service as well as between Health Services”³⁷

These observations are part of a very detailed examination of the implementation of the Garling Report. In spite of the detail they deserve reading in full because they demonstrate that although there is

³⁷ Deloitte Touche Tohmatsu letter, 30th October 2009 to Ms Caitlin Francis, Independent Panel – Caring together; The Health Action Plan for NSW (established following the NSW Government’s response to the Garling Report presented to the NSW Government in November 2008.

a nucleus of good intentions the structural, cultural and systemic constraints mean that the data or evidence that ultimately reaches the State Minister and then the Commonwealth Department of Health and its Minister is unlikely to accurately reflect what is happening at the ‘coalface’.

The Independent Panel report, as with the Deloitte work that was done for this report and a series of Auditor Generals’ reports, demonstrates also that Commonwealth, States’ and Territories’ Ministers, Departmental Heads and other key decision makers:

- May not be receiving succinct, critical data that enables them to distinguish the wood for the trees, and
- Much of the data that is received may not be credible or sufficiently reliable to base major operational or financial decisions upon.

In other cases the question also arises as to whether or not senior departmental officials, Ministers and Ministerial staff really know how to use the data – even if it is credible.

It has been a long tradition of bureaucracies to stifle reform by deluging Ministers with masses of data.

In a system the size of the Australian public hospital sector margins of statistical error are expected. However, in many cases not only are the statistics within a State not strictly comparable but the statistics collected in one State’s hospitals are not comparable with those from another State. This appears to be the case especially to areas such as overheads.

The problem is not new and as Prof. John Deebie observed in 1962:-

*“Apart from problems of consolidation, there are major differences in coverage, both between the States and between institutions within them. Since public intervention in this field has always been combined (and often confused) with charity and the relief of poverty, the titles and classifications attached to various institutions and services differ enormously.”*³⁸

Several other points made in Deeble’s 1962 paper are still relevant:-

*“...policies differ considerably between States, so that major issues in one State may be of little or no importance in another”*³⁹ e.g. Aboriginal and Torres Strait Islander health issues have a significant impact on the Queensland health budget (a fact that was recognised in the AHCAs) but a very minor impact in the Victorian and Tasmanian health budgets.

As the capital budgets have risen and will continue to rise exponentially Deeble’s statement that *“There appears to be no clear connection between expenditures and the methods used to finance them”*⁴⁰ applies as much today as when he made the original observations.

The point most relevant to this report is his observation that *“The formal structure of administration has altered little over the past thirty years, despite considerable and important changes in financing.”*⁴¹ The result of our research is that the same observation applies with the substitution of 77 years for 30!

³⁸ Ibid of page 522

³⁹ Ibid at page 524

⁴⁰ Ibid at page 534

⁴¹ Ibid at page 526

As Deloitte's work (both for this report and the NSW Independent Panel) has amply illustrated, the "ad hoc arrangements" and "complexity of the system" has amplified the challenge of providing policy makers, Ministers and Treasurers with comparable up-to-date data that will enable optimal resource allocation decisions to be made.

Much of the data that ultimately ends up with the Australian Institute of Health and Welfare and central agencies involved with health funding, policy development and implementation is interesting and adds to the mosaic of what constitutes the Australian health sector. However, in terms of governments understanding what should be done and how it should be done, much of the data is either peripheral, irrelevant, inaccurate or a combination of all three.

Initially, any change will depend upon Ministers and senior officials asking the basic questions – why are we collecting this data, is it really useful and does it really provide the basis for making decisions about the performance of the health systems that governments are funding?

As has been argued earlier in the report much of the problem lies with out dated legislative, administrative and bureaucratic structures. If these are fixed many of the problems with data collection, credibility and analysis will diminish and ultimately disappear.

APPENDIX 1

National Health and Hospitals Reform Commission

Terms of Reference

Australia's health system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.

The Commonwealth Government will establish a National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address these challenges.

- By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care.
- By December 2008, the Commission will provide an interim report on a long-term health reform plan to provide sustainable improvements in the performance of the health system.
- By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:
 - reduce inefficiencies generated by cost-shifting, blame-

shifting and buck-passing;

- better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;
- bring a greater focus on prevention to the health system;
- better integrate acute services and aged care services, and improve the transition between hospital and aged care;
- improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;
- improve the provision of health services in rural areas;
- improve Indigenous health outcomes; and
- provide a well qualified and sustainable health workforce into the future.

The Commission's long-term health reform plan will maintain the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through her to the Prime Minister, and to the Council of Australian Governments and the Australian Health Ministers' Conference.

The Commonwealth, in consultation with the States and Territories from time to time, may provide additional terms of reference to the

Commission.

The Commission will comprise a Chair, and a number of part-time commissioners who will represent a wide range of experience and perspectives, but will not be representatives of any individual stakeholder groups.

The Commission will consult widely with consumers, health professionals, hospital administrators, State and Territory governments and other interested stakeholders.

The Commission will address overlap and duplication including in regulation between the Commonwealth and States.

The Commission will provide the Commonwealth Minister for Health and Ageing with regular progress reports.

Appendix 2 - Deloitte

This appendix includes work that was done specifically by Deloitte in dealing with the terms of reference for this project. At a national level, the findings of the work done for this project are consistent with the observations and findings of the work done specifically for the NSW Independent Panel referred to in the body of the report.

In terms of the overall system the Australian Institute for Health and Welfare (AIHW) data indicates that Australians enjoy one of the longest life expectancies in the world and falling incidences of many major diseases.ⁱ This reflects the quality of Australia's broad social policy framework as well as the quality of its healthcare system.

Nevertheless, available data also indicate that there is significant variability in the accessibility, quality, safety and efficiency of health services provided across States and Territories. It has been found that:

- More than 50 per cent of doctors do not follow best practice guidelinesⁱⁱ,
- Between 30 and 50 per cent of patients with chronic disease are hospitalised because of inadequate care managementⁱⁱⁱ,
- Fewer than 14 per cent of people with chronic disease are placed on care plans and less than one per cent of patients are tracked to see if they adhere to care plans^{iv},
- Up to 18 per cent of medical errors are estimated to be due to the inadequate availability of patient information^v,
- Between two and four per cent of all hospital admissions, and up to 30 per cent for patients over the age of 75 years, are

medication-related, and up to three-quarters are potentially preventable^{vi},

- Approximately 25 per cent of a clinicians' time was spent collecting information rather than administering care^{vii},
- Long waiting lists are reported for public hospital care, which, while not comparable in all cases, create concerns around the equity of and access to quality healthcare among Australians, and
- Reports of significant variability across jurisdictions in the types of procedures and care performed raise questions about overall system efficiency and compliance with clinical best practice.^{viii}.

This data and research suggest healthcare is not being delivered as well as it could be or more precisely, it is not meeting the community's expectations for universal access to safe, high quality and sustainable care.

Simultaneously, the demands on the system are increasing.

To close the gap between community expectations for its healthcare system and current healthcare delivery, it is first necessary to articulate the outcomes and objectives for the healthcare system.

Australian communities' vision and expectations for the Australian healthcare system have been specified most recently by the NH&HRC^{ix} and COAG^x, which are shown in Box 1.

Box 1: Australian community expectations for the Australian healthcare system

NHHRC outcomes and objectives for the healthcare system

The NHHRC was convened in February 2008 and subsequently developed a set of principles aimed at informing reform strategies for the whole health and aged care system. The principles were organized into proposed design principles, generally what Australians as citizens and potential patients want from the system, and governance principles, generally how the health system should work.

Design principles

- People and family centred
- Equitable
- Shared responsibility
- Strengthening prevention and wellness
- Comprehensive
- Value for money
- Providing for future generations
- Recognise broader environmental influences which shape our health

Governance principles

- Taking the long term view
- Safety and quality
- Transparency and accountability
- Public voice
- A respectful and ethical system
- Responsible spending on health
- A culture of reflective improvement and innovation

COAG outcomes and objectives for the healthcare system

In November 2008, COAG established the following outcomes and objectives for the Australian healthcare system:

- Australian children are born and remain healthy
- Australians manage the key risk factors that contribute to ill health
- Australians have access to the support, care and education they need to make healthy choices
- the primary healthcare needs of all Australians are met effectively through timely and quality care in the community
- people with complex care needs can access comprehensive, integrated and coordinated services
- Australians receive high-quality hospital and hospital related care
- older Australians receive high-quality, affordable health and aged care services that are appropriate to their needs and enable choice and seamless, timely transitions within and across sectors
- Australians have positive health and aged care experiences which take account of individual circumstances and care needs
- Australia's health system promotes social inclusion and reduces disadvantage, especially for Indigenous Australians
- Australians have a sustainable health system.

Following the development of these objectives, both COAG^{xi} and the NH&HRC^{xii} have made initial recommendations for performance indicators that can be used to drive quality performance. It is expected that these draft recommendations will be further refined before being incorporated into a new National Healthcare Partnership agreement in

2009 that will underpin future funding arrangements between the Commonwealth, States and Territories over the short to medium term. It needs to be noted that none of the COAG or NH&HRC objectives are financial.

If the new arrangements are to be successful it is necessary that lessons are learned from previous ‘reforms’ that have had limited success: The requirement of States and Territories to report against an agreed set of indicators to drive better outcomes in healthcare is not new. The 2003-2008 Australian Health Care Agreement (AHCA) stated that “the Commonwealth [and the States] agree that the publication of performance information against agreed indicators should occur to improve the transparency of the performance of the public hospital system.”

At the conclusion of the five year agreement, very little progress has been made since the Agreement’s original conception in improving transparency and accountability for outcomes.

The chief reasons for the poor effectiveness of the AHCA reporting regime are the same problems that plague the private sector in the implementation of performance management frameworks: lack of hard, objective data, poor accountability for outcomes and poor definition of the processes that governments were seeking to manage. Specifically: -

- Performance measurement was limited to the public hospital system only and ignored other care settings that have a material influence on the quality of life and sustainability of Australia’s universal healthcare system, including most significantly the primary care sector,

- There was a poor articulation of the roles and responsibilities of key stakeholders for the delivery of key outputs and outcomes, which led to a lack of accountability for achieving KPIs,
- The KPIs in the AHCA were focused on levels of activity and inputs rather than outputs and outcomes,
- Where indicators were outcome-focused, including most significantly waiting list indicators to measure timely access to care, there was a lack of hard, objective and comparable data available to measure progress, which rendered the indicator meaningless and served only to impose costs on the system and waste taxpayer dollars, and
- Information was provided infrequently, and at a level that was of limited use to the community (aggregated at a State level as opposed to provider-level reporting).

These are similar to the problems raised by Prof. Deeble in 1962 and referred to earlier in the report. Through the efforts of the NH&HRC and COAG, there is an opportunity to remedy these historic problems and to establish a reporting framework that will drive the reform objectives and strategies being developed by the NH&HRC and COAG.

It is appropriate to establish a list of indicators by first considering the strategic objectives Australian Governments want to achieve. Given the wide range of expectations that the community has for the healthcare system, however, it would be possible to develop lists of potentially hundreds of indicators of performance.

The key challenge is to identify the core indicators that will drive efficiency and effectiveness against the critical strategic objectives of the healthcare system.

As shown by the initial performance indicator frameworks released by both the NH&HRC and COAG, there is an increased recognition today that the hospital is only one possible node in a patient's journey through the healthcare system and, accordingly, there has been an increased focus on driving strategies for better preventative care and hospital avoidance through stronger primary care service delivery. There is also a stronger focus on outputs and outcomes relative to previous performance reporting frameworks. Common to both the COAG and NH&HRC frameworks, for example, are the following measures for hospital performance:

- Waiting times for selected public hospital services,
- Measures of the number of adverse events, and
- Measures of the number unplanned/unexpected readmissions within 28 days of selected surgical admissions.

Both frameworks, however, largely ignore measures of hospital performance that are necessary to drive improved efficiency and access. These patient flow and process indicators are essential to driving improved access to hospital beds (increasing supply in light of growth in demand), quality performance in hospital care and a more sustainable healthcare system:

- Emergency Department Access Block measures,
- Emergency Department average length of stay measures,
- Relative stay index,

- Number of referrals to home based or community care,
- Number hospital patient days by those eligible and waiting for residential aged care,
- Recurrent and total cost per case mix adjusted separation,
- Recurrent and total cost per non-admitted occasions of service,
- YTD operating result as a percentage of revenue - variance to budget.

The notable omissions in the NH&HRC and COAG indicators are the financial components. Some of the reasons are likely to be those raised by Prof. Deeble 47 years ago. These indicators immediately above are critical for driving accountability for outcomes and improved performance in Australian hospitals within the broader healthcare framework.

Other critical measures of quality in care that need to be included, which are not included in the COAG list, include:

- Measures of patient satisfaction, which will enable better purchasing by patients in the future,
- Indications of primary care provider contact, which drive better quality outcomes for patients through more connected care,
- Rates of hospital acquired infections, and
- Indicators of specialist clinical workforce appropriately credentialed and privileged, which ensure patients, are given appropriate care by the right people at the right time.

Considering Australians' expectations for the healthcare system, and the hospitals within that system, the following indicators represent the

critical indicators that need to be reported as part of a National Healthcare Agreement.

Table 1: Recommended hospital indicators a National Healthcare Agreement

Hospital performance indicator	Rationale for selection
Timely access	
Emergency Department Access Block: % patients waiting beyond threshold for Emergency Department care	Emergency Department Access Block measures the time a patient needs to wait to access emergency department care. The threshold should be set at a length of time considered to be an 'excessive' length of time to wait. In general 8 hours is the prescribed threshold.
Elective surgery waiting times: waiting time at 90 th percentile and % long waits for elective surgery	This measure should ensure there is equitable and timely access to care across all States and Territories. Waiting list measures should also provide a signal for investment where the supply of services is not meeting demand.
Efficiency	
Percentage of patients seen within recommended Emergency Department Length of Stay period	This measure should ensure there is efficient patient management in all emergency departments and drive quality performance through provider comparisons to a national benchmark or prescribed threshold. Convention is for a threshold of 4 hours (the so-called '4 hour rule'). Efficient management of patients in the emergency department and appropriate referral of patients into other wards ensures optimal access for other patients to emergency department care.
Relative stay index (actual number of acute care patient days divided by the expected number of acute care patient days adjusted for casemix)	This measure drives quality performance in the hospital system, ensuring that on average patients are treated in line with clinical guidelines and national best practice.
Number of referrals to home based or community care	This measure drives sustainability in the healthcare system by encouraging the care of patients in lower cost care settings.
Number hospital patient days by those eligible and waiting for residential aged care	This measure drives sustainability in the healthcare system by encouraging the care of patients in lower cost and more appropriate care settings for aged care patients. It also drives improved access to care for the community through the release of beds for other patients.
Recurrent and total cost per casemix adjusted separation	This measure will drive sustainability in the healthcare system by driving efficiency in care. A significant deviation in the cost of care among peer provider comparisons will signal the potential to improve models of care or other cost structures to improve the operational efficiency of inpatient care.
Recurrent and total cost per non-admitted occasions of service	This measure will drive sustainability in the healthcare system by driving efficiency in care. A significant deviation in the cost of care among peer provider comparisons will signal the potential to improve models of care or other cost structures to improve the operational efficiency of outpatient care.
YTD operating result as a percentage of revenue - variance to budget	This measure will drive sustainability in the healthcare system by driving efficiency in care. It also enables Chief Financial Officers within individual hospitals, Departments of Health and Treasuries to gain a far better understanding about a hospitals performance.
Safety & Quality	
Number of sentinel and adverse events	This measure drives quality performance in the hospital system, ensuring that on average patients are treated in line with clinical guidelines and national best practice. A significant deviation from national averages in the number of sentinel and adverse events will provide a signal to governments and the community that

Hospital performance indicator	Rationale for selection
	investment needs to be made to improve clinical practice at a particular provider. At the same time the community and patients can be confident of the safety and quality of care they are receiving at providers in their jurisdiction.
Unplanned and unexpected hospital readmissions within 28 days for selected surgical admissions	This measure drives quality performance in the hospital system, ensuring that on average patients are treated in line with clinical guidelines and national best practice. A significant deviation from national averages in the number of unplanned and unexpected hospital readmissions will provide a signal to governments and the community that investment needs to be made to improve clinical practice at a particular provider. At the same time the community and patients can be confident of the safety and quality of care they are receiving at providers in their jurisdiction.
Number of patients with Staphylococcus aureus (including MRSA) bacteraemia	This measure drives quality performance in the hospital system, ensuring that on average patients are treated in line with clinical guidelines and national best practice. A significant deviation from national averages in the number of hospital acquired infections will provide a signal to governments and the community that investment needs to be made to improve clinical practice at a particular provider. At the same time the community and patients can be confident of the safety and quality of care they are receiving at providers in their jurisdiction.
Outcomes of standardised patient satisfaction surveys	This measure drives quality performance in the hospital system. A significant deviation from national averages in patient satisfaction will provide a signal to governments and the community that investment needs to be made to improve clinical practice at a particular provider. At the same time the community and patients can be confident of the safety and quality of care they are receiving at providers in their jurisdiction.
Connecting care	
Proportion of patients who are discharged with evidence of contact with primary healthcare provider	This measure will drive improved continuity of care across care settings, which was an objective identified by both CoAG and the NH&HRC.
Workforce sustainability	
% of specialist clinical workforce appropriately credentialed and privileged	This measure will drive quality performance and sustainability in healthcare, providing a signal to governments and communities of potential risks to care where there is a low level of appropriately skilled staff and the need to develop strategies to manage the risks as appropriate.

These indicators ideally need to be collected and reported at an individual hospital level to drive improvements in performance. Hospitals should be benchmarked against a national average of their peers in order to identify underperformers and provide assurance to the community in the quality of care across hospitals.

Provider level reporting has been adopted in a number of overseas jurisdictions, including the United Kingdom and the United States,

and recommended by the Australian National Audit Office in 2008 for the next National Healthcare Agreement.^{xiii} In the United Kingdom and the United States provider level reporting underpins pay for performance funding models as well as more informed purchasing of healthcare by patients. In the United Kingdom, for example, provider level data are collected against a comprehensive list of indicators and hospitals are scored relative to prescribed thresholds; the hospitals' score against each indicator contributes to an overall score that governs its funding levels. In Australia, Victoria operates a similar model.

Moreover, the publication of more comprehensive indicator summaries also enables private 'healthcare brokerage' firms to enter the market and assist patients in the purchase of healthcare services; major examples include Dr Fosters in the United Kingdom and Health Solutions and Solucient in the United States.

Although States and Territories do not report against these indicators publicly, most jurisdictions do collect data that would enable these to be reported (Table 2).

Table 2: Summary of current data collections by mainland State jurisdictions and impediments to national data reporting

Key indicator		Data collected in each State and Territory?						Impediments to national data reporting
		New South Wales	Victoria	Queensland	South Australia	Western Australia	Tasmania	
Access								
Ensuring timely access to emergency care: % patients >8h in Emergency	✓	✓	✓	✓	✗	✓	Incomplete coverage Subject to significant variation	
Ensuring timely access to surgery: % long waits for elective surgery	✓	✓	✓	✓	✓	✓	Subject to significant variation Waiting list coverage not complete for all surgery categories or require synthesis of multiple datasets (example: waiting times for orthopaedic specialists, cancer surgery)	
Quality & Safety								
Ensuring safe care: Number of sentinel and adverse events	✗	✓	✓	✓	✗	✓	Sentinel events collected nationally, but adverse events not defined in patient classifications (ICD 10 codes) in development by National Health Information Standards and Statistics Committee (NHISSC)	
Driving quality performance: Unplanned and unexpected hospital readmissions within 28 days for selected surgical admissions	✓	✓	✓	✓	✓	✓	Unplanned and unexpected not defined in patient classification codes (ICD 10 codes)	
Driving quality performance: Number of patients with Staphylococcus aureus (including MRSA) bacteraemia	✓	✓	✓	✓	✓	✓		
Driving quality performance: Outcomes of standardised patient satisfaction surveys	✓	✓	✓	✓	✓	✓	All states and territories collect data but no nationally consistent patient satisfaction survey developed	
Connecting care: Proportion of patients who are discharged with evidence of contact with primary healthcare provider	✗*	✗*	✗*	✗*	✗*	✗*		
Workforce quality and sustainability: % of specialist clinical workforce appropriately credentialed and privileged	✗	✗	✗	✗	✗	✗	Definitional discrepancies between States and Territories	
Efficiency								
Driving quality performance in emergency care: <4h total ED LOS	✓	✓	✓	✓	✓	✓	Incomplete coverage in all States and Territories Subject to significant variation	

Key indicator	Data collected in each State and Territory?						Impediments to national data reporting
	New South Wales	Victoria	Queensland	South Australia	Western Australia	Tasmania	
Driving quality performance in inpatient care: Relative stay index (actual number of acute care patient days divided by the expected number of acute care patient days adjusted for casemix)	✓	✓	✓	✓	✓	✓	
Connecting care: Number of referrals to home based or community care		✓	✓			✗*	
Connecting care: Number hospital patient days by those eligible and waiting for residential aged care	✓	✓	✓	✓		✗*	
Driving quality performance: Recurrent and total cost per casemix adjusted separation	✓	✓	✓	✓	✓	✓	Significant variation in costing methodologies between States and Territories DRGs provide common classification unit even in jurisdictions where no casemix funding models in place – data currently collected through NHCDC
Driving quality performance: Recurrent and total cost per non-admitted occasions of service	✗*	✗*	✗*	✗*	✗*	✗*	Significant variation in patient classification between States and Territories No official registers of outpatient data in most jurisdictions
Driving quality performance: YTD operating result as a percentage of revenue - variance to budget	✓	✓	✓	✓	✓	✓	

*Data collection processes in development, but costing can be undertaken

There are a number of barriers to the implementation of this reporting framework. These issues derive mainly from the lack of consistent, comparable, objective data, particularly with respect to waiting lists, and the need to develop national definitions for some indicators.

Data credibility and waiting lists

Waiting lists are imperfect indicators with the potential for significant variation in reporting by providers.

With respect to elective surgery, waiting lists do not provide information on how much elective surgery is being provided, and they do not take into account the time that patients may need to wait before they are placed on a waiting list.

In some States and Territories a person's waiting time from one hospital to another is not added. For example, in Western Australia and the Northern Territory, when a patient that is waiting for elective surgery is transferred from a list managed by one hospital to that managed by another, the time waited on the first list is not included in the waiting time reported, which has the effect of shortening the reported waiting time compared with the time actually waited by these patients

Persistent inconsistencies in reporting across States and Territories make it effectively impossible to compare across jurisdictions and adverse incentives often arise for providers to change the rate at which patients are added or removed from waiting lists. Waiting list data against the current NMDS list is not complete in four jurisdictions and the list of elective surgeries in the NMDS needs to be updated to ensure that it reflects current elective surgery practice and areas of policy interest.

Similarly, with respect to emergency department waiting list information (triage times), data is not collected in all States and Territories, and there is variation among the States and Territories in the point that ED presentations are recorded as completed.

Nevertheless, waiting lists represent the only potential method for measuring demand relative to supply. No other measure is available to measure the time to access care.

This suggests that more rigorous auditing and verification processes need to be developed to ensure methods for adding patients to waiting lists are on average nationally consistent. One option could be for a national patient satisfaction survey be developed to include questions that require the patient to identify when they first reported the problem to the doctor, when they were listed for surgery and the date of the surgery. De-identified patient surveys should inform national audit processes of waiting list times.

Data definitions and thresholds

For some indicators, nationally consistent definitions need to be developed. Key issues that would need to be addressed include:

- There is currently no clear definition of ‘unplanned readmissions’; ICD 10 codes require development to ensure correct identification for readmission and the codes need to be developed so that these readmissions are truly ‘unexpected’ readmissions,
- While there are eight national sentinel events defined, ICD 10 codes would need to be developed nationally so that adverse events can be accurately captured; some States and Territories

collect more information about adverse events than others, however, national definitions need to be developed,

- National thresholds to measure efficiency in patient treatment, including Emergency Department Access Block and Average Length of Stay measures would need to be identified; for example, while the ‘4 hour rule’ is the general convention applied for Emergency Department ALOS, in the United States lower measures have been recommended (including 1 hour for example),
- Accounting rules for cost indicators would need to be agreed, which could build on AIHW. Currently the Department of Health and Ageing collects cost per casemix data through the annual National Hospital Cost Data Collection. There is variability in the methods applied to calculate the cost per casemix unit, with some States and Territories applying a ‘bottom-up method’ (Patient Costed) and others applying a ‘top down method’ (Cost modelled). There is continued variation in the treatment of leasing costs, corporate overheads, payroll tax, hotel services, and so on. There is no reason to think that with national leadership, however, that national standards and rules could not be developed. However, the fact that the problem has existed for over half a century and has not been fixed suggests that it is either intractable or there is not the political will, or that the Commonwealth Department of Health in assessing the individual States’ and Territories’ performance found it too difficult, or a combination of all three. If it is not resolved it undermines the integrity of any performance assessment of

public hospitals. In turn it diminishes any evidence based approach to funding,

- More rigorous national standards and data collection processes need to be developed for non-admitted occasions of service,
- While some jurisdictions currently conduct patient satisfaction surveys for national reporting to be undertaken a national patient survey would need to be developed to enable comparisons across States, Territories and providers, and
- Referral to home based care would require identification of all relevant home based care programs in each jurisdiction (e.g. Home Based Acute Care Services in Queensland).

ⁱ OECD and Australian Institute of Health and Welfare (AIHW) data indicates that at an average of 81.4 years, Australians enjoy one of the longest life expectancies in the world and falling incidences of many major diseases. Australia ranked 7th in terms of overall healthy life expectancy according to OECD statistics published in 2006. Whilst cardiovascular diseases, cancers and respiratory diseases remain the leading causes of death overall, death rates are falling for many of our leading health concerns, such as cancer, heart disease, strokes, injury and asthma. See OECD Health Statistics 2006 available at www.ecosante.org. See also mortality data for diseases at www.aihw.gov.au.

ⁱⁱ Australian Centre for Health Research Limited, *E-Health and the Transformation of Healthcare*, 2007

ⁱⁱⁱ *Ibid*

^{iv} *Ibid*

^v Australian Institute of Health and Welfare, *Australia's Health 2002*, 2002. Other data includes: in 2005 NSW public hospitals were asked to report to the NSW Department of Health all serious incidents, mishaps or events resulting in preventable patient harm; poor communication was identified to be the root cause in 25% of all preventable errors – See NSW Health 2006, *Patient Safety and Clinical Quality Program: First report on incident management in the NSW public health system 2005–2006*, NSW Department of Health. Within intensive care units, an Australian study found that poor communication was the primary reason for errors in 37% of all cases. Donchin Y, Gopher D, Olin M, et al 1995, 'A look into the nature and causes of human errors in the intensive care unit', *Crit Care Med*, 23: 294-300. A 1998 study of adverse events in Australia found that approximately 50% of all adverse events detected by general practitioners were associated with communication difficulties. Bhasale AL, Miller GC, Reid S 1998, 'Analysing potential harm in Australian general practice: an incident-monitoring study', *Medical Journal of Australia*, 169: 73-76.

^{vi} William B R, Elizabeth E R, Susan J S and Robert J A, 'Adverse drug events and medication errors in Australia' *International Journal for Quality in Healthcare* 15:i49-i59, 2003

^{vii} Although this is relatively old data, there is little reason to assume matters have improved markedly in many parts of the health sector in the intervening years. Australian Audit Commission, *For Your Information*, 1995

^{viii} See the Productivity Commission, 2007, *Report on Government Services 2007*

^{ix} The NHHRC was convened in February 2008 and subsequently developed a set of principles aimed at informing reform strategies for the whole health and aged care system. The principles were organized into proposed design principles, generally what Australians as citizens and potential patients want from the system, and governance principles, generally how the health system should work.

Design principles

- People and family centred
- Equity
- Shared responsibility
- Strengthening prevention and wellness
- Comprehensive
- Value for money
- Providing for future generations
- Recognise broader environmental influences which shape our health

Governance principles

- Taking the long term view
- Safety and quality
- Transparency and accountability
- Public voice
- A respectful and ethical system
- Responsible spending on health, and
- A culture of reflective improvement and innovation

^x In November 2008, CoAG established the following outcomes and objectives for the Australian healthcare system:

- Australian children are born and remain healthy
- Australians manage the key risk factors that contribute to ill health
- Australians have access to the support, care and education they need to make healthy choices
- the primary healthcare needs of all Australians are met effectively through timely and quality care in the community
- people with complex care needs can access comprehensive, integrated and coordinated services
- Australians receive high-quality hospital and hospital related care
- older Australians receive high-quality, affordable health and aged care services that are appropriate to their needs and enable choice and seamless, timely transitions within and across sectors
- Australians have positive health and aged care experiences which take account of individual circumstances and care needs
- Australia's health system promotes social inclusion and reduces disadvantage, especially for Indigenous Australians
- Australians have a sustainable health system.

^{xi} In November 2008, CoAG announced the following set of indicators will be used to measure the performance of the healthcare system:

- preventable disease and injuries;
- timely access to GPs, dental and other primary healthcare professionals
- life expectancy, including the gap between Indigenous and non-Indigenous Australians
- waiting times for services
- net growth in the health workforce
- reduced incidence and prevalence of sexually-transmitted infections and sentinel blood borne viruses (for example, Hepatitis C, HIV) for Indigenous and non-Indigenous Australians
- increased immunisation rates for vaccines in the national schedule
- reduced waiting times for selected public hospital services

- a reduction in selected adverse events in acute and sub-acute care settings compared to 2008-09 levels
- a reduction in unplanned/unexpected readmissions within 28 days of selected surgical admissions compared to 2008-09 levels
- increased rates of services provided by public hospitals per 1,000 weighted population by patient-type compared to 2008-09 levels
- timely access to GPs, dental and primary healthcare professionals
- a reduction in selected potentially avoidable GP type presentations to emergency departments.

This initial reporting framework has been further developed. In 2009 the AIHW published a further developed performance framework, Performance Indicators for the National Healthcare Agreement, which included more than 60 indicators aimed at measuring performance across the continuum of care, including prevention indicators, primary and community health indicators, hospital and related care indicators, aged care indicators, social inclusion and indigenous health indicators and indicators for system sustainability.

^{xiii} The NHHRC also recommended a series of performance indicators in its April 2008 report, *Beyond the Blame Game: Accountability and Performance Benchmarks for the next Australian Healthcare Agreements*, aimed at driving improvements in the quality, safety, access and prevention in healthcare in Australia. The Report recommended the following set of indicators for the next AHCA:

- Comparative life expectancy at birth
- Potentially preventable hospital admissions per 1,000 population
- Immunisation rates for vaccines in the national schedule
- Proportion of women in 50-69 year age group who have had a breast screen in the last two years
- Proportion of babies who are low birth weight
- Proportion of children who have received all developmental health checks
- Proportion of pregnancies with an antenatal contact in the first trimester
- Waiting time at the 90th percentile from referral to aged care assessment.
- Number of nursing home type bed days per 1,000 population >70
- Waiting time at the 90th percentile for access to subacute inpatient care
- Proportion of patients discharged from an emergency department with evidence of communication to a primary healthcare service
- Patients with psychosis seen by a community mental health professional within 7 days
- Waiting time at 90th percentile from referral to radiation oncology for first treatment
- Primary care patients seen in emergency departments per 1,000 population
- Proportion of people with asthma with a written asthma plan
- Proportion of people with diabetes mellitus who have received an annual cycle of care within general practice
- Proportion of people with diabetes mellitus with HbA1c below 7
- Waiting time for admission to a support mental health place in the community
- Waiting time for admission to a supported drug and alcohol place in the community
- Waiting time for mental health emergency community service support
- Patient experience with being treated with dignity
- Waiting time for access to public dental services
- Elective surgery waiting times (90th percentile for cardiothoracic, median waiting time for all other surgery, waiting time at 90th percentile for all other surgery)
- Waiting time for patients by triage category
- Family experience with care process
- Number of emergency department visits and hospital days in the last 30 days of life per person
- Investigation of hospital separations with a diagnosis from agreed national list of complications
- Appropriate prescription of antibiotics by GPs for upper respiratory tract infections
- Appropriate safety and quality measures for primary and community care
- Indigenous rate relative to the non-Indigenous rate (access to services)
- Rate in lowest quintile by socioeconomic states (access to services)
- Rural and remote areas (access to services)
- Patients reporting deferring needed treatment because of financial barriers
- Proportion of GP services bulk billed
- Patient experience with being provided adequate information Proportion of hospital discharge summaries that are provided electronically to the patient identified GP or other health service
- Proportion of referrals made to specialists that are undertaken electronically
- Number of graduating students in health professionals relative to requirements
- Number of new graduates employed in their field of training immediately following post graduation
- Number of accredited and filled clinical training positions
- Number of undergraduate placement weeks for medicine, nursing and other health service professions per 1,000 population relative to the national average.
- Research performance

^{xiii} '5.10 The committee strongly supports the publication of public hospital performance information and urges the Government to include a similar publication requirement in the 2008-2013 AHCA's, and to encourage states to go further, as shown by Victoria and Queensland, by publishing additional information on the performance of individual hospitals.' See: www.aph.gov.au/house/committee/haa/auditreport/report/chapter5.pdf

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