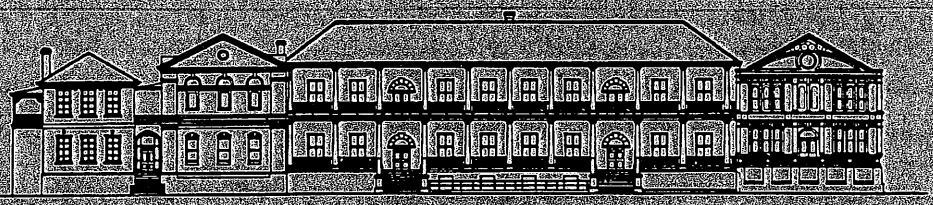
PUBLIC ACCOUNTS SPECIAL COMMITTEE

PARLIAMENT OF NEW SOUTH WALES

Funding of

Health Infrastructure and Services

in New South Wales



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PUBLIC ACCOUNTS SPECIAL COMMITTEE

INQUIRY INTO THE FUNDING OF

HEALTH INFRASTRUCTURE AND SERVICES

IN NEW SOUTH WALES

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FORWARD TO THE FUNDING OF HEALTH INFRASTRUCTURE AND SERVICES IN NEW SOUTH WALES REPORT

This is the second report of the Public Accounts Special Committee set up by Parliament to conduct an inquiry into the Port Macquarie Base Hospital project and wider health issues.

The Phase I Inquiry was conducted and reported to Parliament last year. The Phase II Inquiry has been about looking at a number of issues broadly relating to the current State and Federal funding for Health infrastructure and services in NSW with particular reference to a number of matters enumerated in the terms of reference adopted by motion of the Parliament on Thursday 7th May, 1992.

The consideration of the Phase II terms of reference by the Committee was delayed to a significant extent by the ongoing consideration of the Phase I terms of reference and matters arising therefrom until just before Christmas last year. However, the Committee since then has had the benefit of hearing extensive oral and written evidence.

The Committee has taken a wide interpretation of the term "infrastructure" and considered the overall mechanisms of service delivery in that context rather than restricting it to the bricks and mortar of physical infrastructure. In doing so, the Committee has come to the view that the community should have a greater role in determining the range of services to be provided within the limits set by Government for the overall level of funding of Health Care which determination must remain a right and duty of the Government.

The Committee believes that a programme should be developed for greater ongoing public participation in the strategic planning process and determination of priorities for Health services. Issues papers covering specific topics should be developed and circulated widely with comments sought from expert bodies and the general public.

The Committee also believes that Area Health Boards and District Health Boards should be required to develop a dynamic working relationship with the community in developing policies and programmes to service their communities and that they report on their activities in their annual reports, including their structure and effectiveness.

On these issues and other matters relating to community participation, there was a high degree of unanimity.

However, as I believe was predictable, the Committee was unable to agree on two of the most fundamental issues facing the Health debate in NSW today.

These are:

(1) Whether or not the capacity for the private sector to treat more patients should be utilised for the treatment of public patients

(2) The importance and effect of low and declining levels of Private Health Insurance.

Whilst during the Phase II Inquiry the Committee approached its task in a spirit of co-operation, it was plain from the outset that these underlying differences of opinion were not going to be bridged in this inquiry and report.

Indeed, it seems to me from the beginning of this Inquiry that the results were always going to be modest.

Thus the recommendation that "The NSW Government along with other State and Territory Governments negotiate with the Commonwealth with regard to their respective responsibilities as set out in the Constitution in order to clarify and rationalise their respective roles and responsibilities for the funding of provision and accountability for the Health Services" is clearly overshadowed by the clash between the Federal Treasurer Mr Dawkins and the NSW Health Minister Mr Phillips over the Federal Government's decision to slash $61,000,000 from NSW's annual health budget.

The scope of the terms of reference and the nature of the underlying political debate demonstrated month after month in Parliament indicated that this modest result was inevitable.

As Chairman of the Public Accounts Committee I believe that the best work done by the Committee is done in areas where the issues the Committee considers are not at the heart of fundamental policy divisions within the Parliament.

Quite simply what the Parliament itself cannot resolve to agree on in a fundamental and productive sense, no committee of the Parliament can be expected to agree upon either.

Having said that, I believe that the Public Accounts Committee has done some of the best work ever in this Parliament especially where there is a will all round to tackle an issue of controversy such as the School Student Transport Scheme.

But where there is a pro-active and underlying dispute between the various elements of the Parliament, and fixed policy positions have been adopted by all sides, no committee of the Parliament will subsequently be able to sort the matters out unless the Parliament itself agrees to do so.

I would not like it to be thought from these comments that Committee members did not use their best efforts and tackle their jobs in a way which involved maximum co-operation in the circumstances - they did.

I should also say that the support work done by the Public Accounts Committee staff and by consultants, Joe Scuteri and Jim Hales from KPMG Peat Marwick (Adelaide) was absolutely first-class. It is just that the end product reflects the underlying political dispute far more than anything else.

Andrew Tink MP
Chairman

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GLOSSARY OF TERMS

Average Length of Stay

The average number of days for which patients are in hospital for a given ailment.

Diagnosis Related Groups

A system of classifying inpatients into categories according to their principal diagnosis, complications, co-morbidities and relative cost of resources consumed during their episode of care in hospital.

Division of General Practice

An organisational structure which provides for networking of general practitioners (GPs) and provides an organised interface between GPs and local hospitals, government bodies, Area Health Boards, care agencies, community groups and other health service providers.

Funder/Provider Split

An organisational arrangement by which the funding of health services is separated from the provision of those services. Typically, a government entity is responsible for determining the health care needs of a community, and then contracting with a provider (public or private) of those services.

Home and Community Care Program (HACC)

A program jointly funded by State and Commonwealth Governments aimed at providing a wide range of home-based health and welfare services which prevent inappropriate and/or premature institutionalisation of the elderly and disabled.

Multi Purpose Service

A health care facility which provides a range of hospital and community-based services according to the needs of the local population, using funds from State and Commonwealth Governments.

National Health Strategy Review

A formal review commissioned by the Commonwealth Department of Health, Housing, Local Government and Community Services and which focused on the formulation of strategies for the reform and development of health care services in Australia.

Net Present Value

The value expressed in current dollars of a future cash flow stream discounted by a specified rate of return.

Resource Allocation Formula (RAF)

A formula used by the NSW Health Department to determine the allocation of funds for health care services to regions, having regard to the population, its age/sex distribution and health status differences relevant to the use of health services.

Visiting Medical Officer

A medical practitioner who is paid on a sessional or fee for service basis and has the rights of private practice within a hospital.

LIST OF ABBREVIATIONS

AHIA	Australian Health Insurance Association
AIHW	Australian Institute of Health and Welfare
ATO	Australian Taxation Office
CHA	NSW Community Health Association Co-operative Ltd.
CHF	Consumer's Health Forum
CHSE	College of Health Services Executives
FAG	Financial Assistance Grant
GDP	Gross Domestic Product
HACC	Home and Community Care Program
HCOA	Health Care of Australia
HFG	Hospital Funding Grant
HSA	Health Services Association of NSW
MPS	Multi Purpose Service
NCAC	National Consumers' Advisory Council
NHS	National Health Service
PHA	Private Hospitals Association of NSW
RAF	Resource Allocation Formula
SPP	Specific Purpose Payments

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APPENDICES

1 EXECUTIVE SUMMARY

The approach adopted by the Public Accounts Special Committee in its Inquiry into the funding of health infrastructure and services in New South Wales has been based on a relatively wide interpretation of the term "infrastructure". The Committee has taken the view that infrastructure, in the context of this Inquiry, relates to the overall mechanisms of service delivery, and is not restricted to the "bricks and mortar" of physical infrastructure. By so doing, the Committee has opened the Inquiry to a much wider range of issues than might be considered under a narrower interpretation.

The Committee recognises that the development of new technologies, alternative methods of service delivery, and the changing demography of the population of NSW lead to an complex industry, in which the demand for services will always exceed the industry's capacity to provide. The limits necessarily imposed by governments on the availability of funding for health care require that priorities be set.

It is the Committee's view, whilst acknowledging both the right and duty of government to determine the overall level of funding of health care, that the community should have a greater role in determining the range of services to be provided within these limits. This entails the empowerment of the community in determining the range of health services and outcomes that it considers to be appropriate to its needs and its capacity to pay. This view is consistent with recent trends both internationally and nationally, and a number of overseas cases are cited which may provide insights into alternative approaches and their effectiveness.

The Committee acknowledges that the NSW Health Department has undertaken a number of initiatives aimed at improving the planning and delivery of health services, which provide an important foundation for future strategic planning. However, the principal focus of these efforts continues to be on efficiency enhancement which, while important, is not considered by the Committee to be sufficient to achieve the optimum results from the health care system. Rather, a greater focus on health outcomes and an ongoing appraisal of the best methods for achieving those outcomes, comprising preventative, health promotion and treatment services are important elements which need to be added to the current initiatives. Equally important, the

participation of the wider community in this process and in the setting of priorities is seen as an essential requirement. Once these strategies are in place, then a more informed decision may be made about the facilities required for the delivery of those services.

The planning process advocated by the Committee reflects the view that a more holistic approach to the delivery of services, and a reduction in the barriers which exist between the different forms of care (caused by a variety of factors) may lead to a health care system which is not only more effective in the outcomes achieved, but one which does not rely so heavily on the provision of expensive and largely immobile infrastructure. Such an approach calls for a greater integration of services, rather than the fragmentation which is often found in the current environment.

In the context outlined above, the Committee has addressed each of the Terms of Reference with a view firstly to establish the nature of the current arrangements pertinent to each Term, then seeks to challenge whether or not those arrangements could be improved. The subsequent effects on the demand for infrastructure are then assessed, and finally alternative ways for providing that infrastructure are reviewed. The Committee considers that this approach to the fundamental issue of service delivery has the potential to provide for both a more efficient and effective health care system. Under these circumstances, the options available for the provision of this infrastructure may be viewed in a more informed and constructive light.

Impact of Demographic Trends

Demographic trends and influences on the health care system in New South Wales are generally consistent with those appearing elsewhere in Australia. In NSW, the total population will continue to grow at a slow but steady rate, and in so doing, will have a net (but non-measured) demand effect on health services. Population growth is more rapid in some regions of the State than in others, and will accordingly create larger demands for health services in those regions.

Older persons use health services at far greater levels than younger persons, and as the NSW elderly population is increasing at a greater rate than the

general population, health services will continue to feel the effects. As with the general population, some regions are demographically ageing at much faster rates than in other locations, and with that, the demand for health services profile will differ considerably from region to region. At the same time, however, there is no simple relationship between the demand for health services and ageing, with studies by the Australian Institute of Health and Welfare (AIHW) observing that most increases in the demand for health services occurring in the last two years of life.

Offsetting some of the demand impacts due to demographic factors are processes resulting in shorter stays in hospital, non-hospital options for treatment, better early detection (and possible avoidance of hospitalisation) of disease and illness prevention programs. Some of these trends are quite well understood and relatively easy to quantify - others are less clearly understood in terms of their likely impacts on both the demand for and supply of health services in NSW.

Many observers of the NSW health care system see a trend towards (and indeed argue a need for) more community-based health care services, greater integration of acute hospital services with other services, and greater flexibility in terms of care and treatment options.

The net effect of these various factors on the total demand for health services is unclear, and the Committee is concerned that the NSW Health Department's submission did not attempt to more accurately quantify the direction and magnitude of the range of factors identified as impacting on the NSW health system. The Committee considers that the Department's planning models and information systems should have the capacity to do so. The Committee urges the Department to consider not only the volume of such services, but also alternative methods of service delivery which may be more effective in achieving the desired outcomes.

Impact of Changing Trends in the Provision of Health Services

The Committee has identified several patterns in relation to trends in the provision of health services. Firstly, improved and new technology, together with advances in diagnostic methods, treatment procedures, and a greater emphasis on community-based services, are likely to reduce the demand for

some acute hospital services, and will be reflected in both reduced incidence of hospitalisation and shorter stays in hospital. Overall, the number of hospital beds in NSW is expected to continue to decline over the next decade.

Secondly, the introduction of new technology and techniques is likely to stimulate demand for certain types of health services. This is expected to affect the balance between alternative methods of service delivery, not necessarily the total level of resources required. For example, there is an expectation that more services will be provided on a community basis, and that hospitals will focus more on acute care services. This will lead to a change in the role of hospitals in terms of the nature of services they provide and the manner in which they provide them. To be effective, however, closer links will need to be forged between hospital services and community based services to ensure continuity of care and the cost-effectiveness of the services provided.

Thirdly, there is a need to develop a greater focus on the outcomes of health services. In so doing, however, care needs to be taken that the focus does not concentrate only on those programs whose outcomes are easily measured. In this context, there is a need for more strategic planning into the most appropriate mix of acute hospital-based forms of care and prevention, early intervention, and community-based services. In this regard, the Committee considers there is scope for expert opinion to be applied to the assessment of the various alternatives for service delivery to ensure that the most effective mix of preventative, treatment and rehabilitation services are provided. Community participation in this process is considered to be an essential element. Recent trends in these areas overseas warrant close monitoring to determine the most appropriate model to apply in New South Wales.

Respective Roles of State and Commonwealth Governments and their Relative Financial Contributions

The existing arrangements between the Commonwealth and State Governments specify their respective roles and responsibilities in relation to the provision of health services. Whilst these roles and responsibilities appear to be mutually exclusive, the Committee recognises that in reality, there is overlapping of services, complexities of funding, and unclear lines of

accountability. There is an urgent need for NSW, along with other State and Territory Governments, to negotiate with the Commonwealth with regard to their respective responsibilities as set out in the Constitution in order to clarify and rationalise their respective roles and responsibilities for the funding of, provision of, and accountability for health services.

The Commonwealth contribution towards the recurrent funding of NSW public hospitals has remained at around 35% in recent years. While there has been real growth in the HFGs paid to NSW by the Commonwealth, the rate of growth has been low and for 1992-93, it is estimated at 1% only. It was pointed out to the Committee that Commonwealth funding to the States is declining as a proportion of GDP (and as a percentage of all outlays), and that from the perspective of the States, the relative importance of receipts from the Commonwealth has been declining.

In addition, the Committee notes that Commonwealth funding of State public hospitals has been more tightly controlled by the Commonwealth than other Commonwealth health expenditure (in particular, Medicare reimbursements for community-based medical services and payments under the Pharmaceutical Benefits Scheme). It appears unlikely that there will be any change in this pattern in the foreseeable future.

Although both the Treasury and the Department of Health have expressed concerns about aspects of the indexation methodology in the new Medicare Agreement (claiming that there are health sector-specific factors which are not being taken into account), the NSW Treasury itself has not been able to identify an appropriate methodology for the indexation of payments from the Consolidated Fund for the State health program. The Committee considers that both Treasury and the Health Department should develop a more appropriate indexation basis for recurrent health funding.

Apart from the issue of poor indexation, the NSW Government has other concerns about the Medicare Agreement, particularly in relation to the continuing problem of role uncertainty (overlapping roles), the lack of integration with the National Health Strategy, and the lack of provision for capital funding for infrastructure purposes. The Commonwealth's Hospital Enhancement program has also been substantially reduced.

A further concern from the NSW Government's perspective is the increasing importance of Specific Purpose Payments (SPP) by the Commonwealth to the States. Such payments are tied, and in many cases, require matching by the State. NSW Treasury feels that the increasing importance of SPP is influencing the extent to which the State can use its own discretionary funds. It was argued also that some of the programs funded by the Commonwealth under SPP conditions may not necessarily reflect the priorities for health within the State, although on the other hand the NSW Government argues for more national priority setting.

Within overall NSW Government policy, health is seen as a high priority area, and is exempted from (or treated more leniently under) some of the rigors of the Budget process (e.g., exemption from efficiency dividend payments).

Notwithstanding the relatively privileged position of health within the budget context, the Committee sees few further options and strategies available for significant infrastructure funding from within the existing structure and resource allocation processes operating in the public sector generally, and the health sector specifically. As such, any additional funds which are required will need to be generated through improved effectiveness and efficiency measures in the delivery of services from within the public sector; from changes in government priorities so as to allocate more funds to health care; and/or through greater participation of the private sector in the delivery of services. This will require new and innovative approaches to the issue of physical infrastructure development in the health sector (and perhaps in other sectors).

Private Sector Participation in Health Services

The private sector plays a role in the provision of health care services in New South Wales and Australia. Given the private sector's reliance on private health insurance as the major funder of services, the decline in health insurance participation since the introduction of Medicare is of great concern to the private sector and to the NSW Health Department.

Private hospitals in NSW account for approximately 18% of all acute care bed days in the State, a proportion which is lower than that exhibited in most other States. Bed capacity in NSW private hospitals increased by approximately

10% between 1989 and 1992. There is a general perception that private hospitals offer a narrower and less complex range of services than their public sector counterparts.

Despite the increase in bed numbers, private hospitals currently operate at approximately 57% of their potential capacity, indicating there is capacity within this sector which could be accessed to treat more public patients if desired. The case for so doing was argued by a number of the parties making submissions to the Committee. The Health Department's policy in this regard is to encourage the development of a stronger private hospital sector to complement the services offered in the public sector. In support of this policy, the Department has undertaken a number of initiatives aimed at providing the private sector the opportunity to develop a larger role in the health industry in co-operation with the public sector.

The Health Department and Treasury identified the differences that exist in the different benefit levels paid for the treatment of private patients in public hospitals compared to those received for treatment in private hospitals. They advocate that these differences should be removed, with some adjustments, to provide for a more "level playing field" between the two sectors. At the same time, differences in the taxation liability of for-profit operators and not-for-profit operators in the private sector also result in competitive differences within the private sector itself.

Whilst all members of the Committee acknowledged the capacity for the private sector to treat more patients, there were differences of opinion as to whether or not that capacity should be utilised for the treatment of public patients. Some members were in favour of ultilising this capacity under some form of contractual arrangement, while others were opposed to such proposals. Notwithstanding these differences of opinion, it was agreed that any consideration of the role of the private sector must take account of the overall health strategy for the area.

Impact of Private Health Insurance and Trends on State Health Budgets

Private health insurance is an important element of the funding of the Australian health care system. Since the introduction of Medicare, participation in private health insurance has fallen to approximately 45% of the

NSW population in March 1992, and is continuing to decline. The early period of decline was in the area of basic table cover, but this has now extended to supplementary table cover. The major reasons for the decline were considered by most parties making submissions to be the availability of free treatment in public hospitals together with the increasing real cost of private health insurance.

The indirect effects of Medicare (such as universal access to public hospitals) are impacting on private health insurance levels; the costs of private health insurance, and the revenue and cost structures of public and private hospitals. A number of submissions emphasised to the Committee that if current trends continue, there will be major negative consequences in both hospital sectors. In particular, if current trends persist, the public hospital system would not be able to immediately meet the increased demand for services caused by any widespread closure of private hospitals.

The Committee was divided in its views on the importance and the effect of low and declining levels of private health insurance. Some members of the Committee felt that if private health insurance levels continue to fall, significant stresses would be placed on the public hospital system as occupancy levels decline in private hospitals. Other members of the Committee disagreed with this assessment, and considered that the public hospital system would, in time, be able to respond to the situation. The consequences of a continuation in current insurance trends will also impact on State finances, thus further exacerbating problems of funding health and other programs for the NSW population. The Committee considers that there is a need for this issue to be addressed at a national level.

Anomalies in Current Financial and Organisational Arrangements and their Impact on Effective Health Care Delivery

The submissions to the Committee cited many examples of anomalies that exist within the system which serve to act as perverse incentives to both the funders and providers of health care, and as barriers to the efficient delivery of services.

The health care system itself, like many such systems internationally, fails to provide incentives for many participants. These include:

- clinicians who, despite being among the key drivers of costs, are not participants in the funding decision-making process;

- GPs who are discouraged by the method of remuneration from taking a more active role as advisors to patients on their health care needs, and from acting as gatekeepers to the health system;

- the public sector which is both the funder and provider of services, which some argue creates a conflict between these roles, whereby the provider role gains dominance;

- consumers themselves whose preferences are unknown, and who are uninformed about the real costs of health care; and

- lack of consumer power over the nature of treatment provided and the availability of alternatives.

The respective roles of the Commonwealth and State Governments in both the funding and delivery of health care services is a second source of anomaly. In particular, the following problems were identified:

- complex and confused lines of accountability result in the absence of any final level of accountability across the two levels of government;

- the different sources of funding for many components of the health system provide incentives for cost shifting both between the funding agencies and between the different providers of services;

- duplication of administration across the two jurisdictions;

- structural rigidity in program boundaries which inhibit the delivery of the most appropriate form of care; and

- a lack of integration of services limiting the potential for improved networking of service providers.

The nature of the funding system itself is a further cause for concern. Examples of the causes of the anomalies occurring within this aspect of the system include:

- global budgeting of hospitals on the basis of historical costs leads to managers having to resort to relatively crude measures to control costs, such as closing beds, and provides incentives for the manager to shift costs to community-based services which are outside of his/her budgetary responsibility;

- separation of capital budgets for major capital expenditure items from recurrent budgets inhibits the potential to make optimum use of recurrent savings for the purposes of infrastructure funding;

- the relatively short time frame for budgeting and planning restrict the time horizons of managers and limit the amortisation of capital investment which could lead to greater efficiencies and cost savings;

- centralised financial and asset control leads to delays between the inception of a plan and its implementation, often resulting in the loss of the potential savings originally foreseen.

Finally, at the local management level, several anomalies were identified:

- lack of management information and control;

- inadequate management structures in hospitals which inhibit the drivers of costs being accountable.

In summary, it is clear to the Committee that problems and anomalies in financial and organisational arrangements are impacting on the effectiveness and efficiency in provision of health care services in NSW. There are clear issues which need to be addressed. In particular, there is a need to simplify and clarify lines of accountability; to remove incentives for cost shifting; to eliminate duplications in administration; to provide for increased flexibility in defining program boundaries; to ensure that health services are better integrated; and to minimise or remove funding system anomalies. Each of these issues involves complex actions and in some cases, fundamental

changes. The Committee has made several recommendations in regard to some of these specific issues.

At a more global level, the Committee believes that many of the problems identified within the health sector could be addressed through a re-orientation of the health system focus towards achieving health outcomes. As previously stated, however, the Committee reinforces the need to ensure that the focus does not become only those programs for which outcomes are easily measurable, and that the effects of services on patients remain paramount. The Committee's attention was drawn to the discussion paper on accountability in health prepared by Professors Baume and Nutbeam in conjunction with the NSW Health Department. The Committee sees merit in a number of the suggestions made in this discussion paper, and has incorporated them in the strategies proposed in this report.

Social and Economic Costs and Benefits of Alternative Ways of Providing Physical Infrastructure and Health Services

Many of the submissions to the Committee considered that the dilemma facing the NSW hospital system in regard to physical infrastructure is the large proportion which is in poor physical condition and inappropriately located to meet current and future needs. The Health Department has identified that an accelerated capital investment program would not only alleviate this problem, but that it would prove cost-effective by reducing the level of recurrent funding due to inefficiencies associated with the existing infrastructure.

The difficulty in implementing this program, however, is in the formulation of the State budget to adequately cater for funds across all government program areas. Some members of the Committee considered that an increase in the total funds provided to health was appropriate, while others considered that an approach which focused on alternative methods of funding and service delivery from within existing capacity was appropriate.

The Health Department has explored a number of alternative avenues for funding, particularly from the private sector. A review of the alternatives necessarily requires consideration of the respective roles of the private and public sectors in the funding and provision of health services.

The view of Treasury and the Health Department is that the fulfillment of the public sector's role does not necessarily require the public sector to be both the funder and the provider of all services. Several models of the funder/provider split have been suggested, based on those recently introduced in the UK and New Zealand. The underlying concept behind these models is that increased competition results in improved efficiency and hence savings in the delivery of services. They also resolve the inherent conflict claimed by some to exist between the provider and regulatory roles of the public sector in the current system. This view was not ascribed to by some other parties making submissions to the Committee, who considered that such arrangements require excess capacity in the system to be effective, and that such excess capacity does not exist within NSW.

Examples of the funder/provider split already exist in NSW, the most well-known example being the contract for services at Port Macquarie Base Hospital. Other examples also exist in the contracting for support services at a number of public hospitals. In general, however, the private sector's participation in the health industry has traditionally centred upon the treatment of privately insured patients in private hospitals.

Whilst members of the Committee agreed that an essential element of the private sector's role has been a strong reliance on private health insurance, there was a divergence of opinion on the importance of the recent trend of declining participation in such insurance since the introduction of Medicare on the private hospital industry. However, the possible development of co-operative arrangements with the public sector, in whatever form, would see a change in the source of funding for private hospitals, which may further exacerbate the decline in private health insurance. The potential effect of this on the private hospital industry was again a matter for difference of views between Committee members.

There are numerous alternatives for the private sector to participate in the development of health infrastructure and the delivery of health services in co-operation with the public sector. When assessing these alternatives, both their economic and social implications must be taken into account. In so doing, it is essential that the perspective taken is that of the community as a whole, and not that of an individual sector.

In considering the relative economic merits of the alternatives, the potential for cost-shifting between the public and private funders of health care, and between different levels of government must be taken into account. Typically, all suggested alternatives for co-operative ventures involve the shifting of some costs of service delivery from the public purse to private insurance funds. The financial effects of this shift on the private funds could potentially be unbearable.

In regard to the extent to which economic gains might be made through greater collaboration between the public and private sectors in the health industry, the Committee was divided in its opinion. Some members considered that these prospects warranted further investigation in order to determine their relative merits. Others considered that the prospect of private participation was, of itself, inappropriate.

The social ramifications of each of the alternatives is also of paramount concern. The elements of universality, equity, the comprehensiveness of services, and access to services each require specific consideration. Any proposal for co-operative ventures must demonstrate its capacity and intent to address each of these issues, to the betterment of the affected population.

The Committee considers that, if co-operative ventures between the public and private sectors are to be considered, it is not feasible or appropriate to classify the range of alternatives into those which are inherently "bad" or inherently "good". There is too little experience in the alternatives on which to base any empirical judgement of their relative merits. Rather each case will need to be evaluated individually, based in its own merits. However, a framework for such evaluations is presented which considers the essential questions:

- Does the proposal lead to improved resource utilisation?
- Does the proposal support the underlying objectives of the health system?
- Does the proposal protect or enhance the rights of individuals and their access to health care services?

Whilst this framework has been proposed as a basis for consideration of alternatives by which the private sector might participate in the provision of services, it might be equally applied to consideration of any proposal, regardless of private sector involvement. The ultimate assessment of any alternative will depend upon the relative weights applied to the answers to these questions. However, the application of this framework will help to ensure that all aspects associated with the proposal are addressed in a comprehensive manner, and that a community perspective is applied.

Finally, the Committee considers that there may be potential to re-allocate or re-use some of the existing physical infrastructure currently owned by the State but managed and used by different agencies involved in providing human services. The potential financial and service delivery benefits to NSW residents may be considerable.

Costs of Alternative Ways of Providing Physical Infrastructure and the Extent to which Costs are Recoverable

Sources of funding health infrastructure from traditional public sources are relatively limited, and are expected to remain so for the foreseeable future. Such sources include State revenue sources, savings on recurrent expenditure, retained own source funds, proceeds from the sale of assets, and Commonwealth capital contributions.

Of these sources, savings on recurrent expenditure appear to offer the greatest potential for additional funds, with the Health Department estimating that additional savings of the order of $300 million per annum could be achieved through continued efficiency gains. The Committee considers that the Department should give a high priority to the pursuit of these gains as a matter of urgency. At the same time, the effectiveness of alternative methods of service delivery should be monitored on an ongoing basis to ensure the most cost effective mix of services.

The borrowing of funds is regulated by the Australian Loan Council, with the global borrowing limit for NSW having reduced in real terms over the past two years. Treasury emphasises that any borrowings do not act independently of the Budget, as all repayments are reflected in the Budget. It has indicated

that, under current government policy, there is little capacity within the Budget to expand current borrowings.

The constraints in existing public sector sources of financing infrastructure have led to the investigation of opportunities for the private sector to assist in this regard. Such opportunities are affected by the policies of the Australian Loan Council in regard to the nature of any contracts between the public and private sectors, and by taxation policy. To be excluded from the global borrowing limit, Loan Council requires any contracts to comprise genuine service contracts (whereby the majority of risk is transferred to the private sector), rather than an agency agreement (where the majority of risk remains with the public sector). Taxation policy also affects private sector participation through its ruling on tax-deductibility for projects where the end user is the public sector. Generally the Taxation Office requires 100% of risk to be transferred to the private sector, which is often both inappropriate and not feasible in many heath care projects. In addition, the different approaches of Loan Council and the Taxation Office represent a "double hurdle" to be overcome in such ventures. The Committee considers that a uniform approach to this issue should be actively pursued by Treasury and the Health Department in negotiations with Loan Council and the Taxation Office.

A number of alternatives for private participation in the provision of health infrastructure have been considered. In so doing, the Committee recognises that such arrangements do not necessarily require additional infrastructure development, but may avoid such expenditure through improved utilisation of existing resources across the two sectors.

Alternatives considered for co-operative ventures with the private sector included

- contracting for support services,
- contracting for clinical services,
- joint ventures involving co-location of public and private hospital facilities, and
- the development of competitive health services markets.

In regard to their respective capacity to assist in the funding of infrastructure, the Committee considers that, whilst useful in some circumstances, the contracting of support services and co-location of facilities offer limited opportunities for a significant contribution. Nevertheless, such opportunities warrant investigation where they are considered to be appropriate. Contracting for clinical services, either on a case by case basis or through the creation of a wider competitive market system, provides a greater opportunity either for a significant injection of funds, or the avoidance of capital expenditure by the public sector.

The State's narrow tax base provides limited opportunity for cost recovery via the tax system in the various forms of co-operative venture with the private sector. The most likely form of recurrent funds recovery is payroll tax paid by a private operator, although this may not apply to not-for-profit private operators. In the case of co-location, some opportunity for cost recovery may exit under a lease arrangement with the private operator. Other options for cost recovery are largely in the form of one-off payments. The potential for the State to recover costs will therefore need to be evaluated on a case by case basis, having regard to the particular circumstances of each case.

Health Education, Preventative Health and Community Involvement in/and Responsibility for Health of the Community

There is an increasing trend internationally and nationally towards a greater focus on the achievement of health outcomes, and for greater community participation in determining the priorities for health care services. A number of examples of this trend have been identified, particularly in the UK and USA, which provide valuable lessons in pursuing this direction in Australia.

Within Australia, there have been a number of reports at the national and State levels which have acknowledged the need for reform on these areas, and which have proposed strategies for the implementation of reform. The National Health Strategy Review has published a series of Issues and Background Papers which deal specifically with the problems to be addressed and which call for new initiatives to be undertaken.

In NSW, the Health Department has implemented a number of organisational changes aimed at greater devolution of decision-making in the planning and delivery of health services to the local level. It has also indicated that a greater focus on the achievement of health outcomes is a major priority for its future activities, and that it is developing a program for greater community participation in the planning process. The Committee acknowledges these developments, and has identified a number of strategies which could serve to facilitate this process.

A range of views are presented on ways by which health services might be planned with greater participation by local communities. Clearly, there is a considerable body of expertise within the community, in academia and in the Health Department itself which, collectively, has the capacity to develop and implement a program for reform which will maximise health outcomes. The challenge is to establish a forum by which that expertise may be accessed. The importance of health education in promoting greater community participation in the planning for, and delivery of, health services among local communities, and in facilitating the integration of services is also recognised.

The Committee has included a number of specific recommendations which provide examples of ways in which approaches to these issues might be initiated. In addition, the Committee considers that an ongoing program of pilot projects should be maintained which explore and evaluate alternative methods by which the objectives of community participation and program evaluation may be furthered.

In regard to the participation of the private sector in the area of community health services, virtually all parties making submissions to the Committee recognised these services as traditionally falling largely in the province of the public sector. The private sector is involved to a lesser extent through the activities of some charitable, community and religious organisations and the work of volunteers. Many of the submissions argued strongly that such services would be adversely affected by the for-profit private sector becoming involved in service delivery. There were differing views, however, as to the appropriate approach for involving the private sector.

The Department of Health considered that a shift in the provision of infrastructure might alter the balance in the way such services might be

delivered, but not the fundamental way in which the State and Commonwealth Governments fulfilled their respective responsibilities in fostering the development of appropriate services.

Some submissions to the Committee were strongly opposed to the for-profit private sector being involved in these services. They referred to an inherent conflict of interest between the provision of acute hospital services and those of community health services, which manifests itself in a variety of ways. For example, community services and hospital services often compete for the same clients - one to prevent hospitalisation and the other to "capture admissions". Similarly, the argument was put that there would be a tendency to divert resources under a private operator to the more tangible services (such as surgery) rather than the more intangible services (such as mental health, rehabilitation etc.). Equally important, the capability of the private sector to provide community services across the range of jurisdictions often involved in these services was also challenged.

Other views expressed to the Committee were less opposed to private sector involvement in this sphere, but advocated a cautionary approach. The Health Services Association (HSA) proposed a mechanism for private sector involvement in community health services which would help to protect these services and their consumers from potential abuse. Their approach revolves about the appointment of a Director of Public Health and Community Health who would be responsible for all community health services in the area, and would advise the District Health Board on the most appropriate allocation of resources between inpatient and community health services.

There is little doubt that any changes to the nature of funding health infrastructure will bring about a number of changes, not all of which will necessarily be in the general public interest. These changes will require a new form of structure to ensure the quality, consistency, integration of services and accountability to the community. It is essential, therefore, that this structure provides appropriate mechanisms for the active participation of the community in the planning for, delivery of and monitoring of services.

List of Recommendations

4.1.1 That the Health Department extend its current planning models and information systems to better quantify the projected impact of demographic trends and technology developments on the demand for health services.

4.2.1 That the Health Department's Health Outcomes Program Demonstration Projects be extended, focusing on projects which develop the link between the achievement of health outcomes and the allocation of resources. Such an approach should not be limited to those programs where outcomes are most easily measured, and should also have regard to the processes of service delivery. The approaches taken overseas in this area should be examined as part of the development of a suitable strategy in New South Wales.

4.2.2 That an expert panel be established to investigate alternative methods of service delivery covering the spectrum of health services which maximise the achievement of health outcomes. The panel to comprise representatives from both community based and hospital based services, and be multi-disciplinary in its membership.

4.2.3 That a program be established for trialling integrated methods of service delivery in order to formally evaluate their effectiveness in achieving specified health outcomes and their potential impact on health infrastructure requirements.

4.2.4 That a program be established for the formal evaluation of new technologies, their costs and their effectiveness in improving health outcomes relative to other treatment methods prior to their wider adoption.

4.3.1 That the NSW Government, along with other State and Territory Governments, negotiate with the Commonwealth with regard to their respective responsibilities as set out in the Constitution in order to clarify and rationalise their respective roles and

responsibilities for the funding of, provision of, and accountability for health services.

4.4.1 That any use of excess bed capacity in either the private or public sectors must be in harmony with an effective community health and preventative health strategy.

4.5.1 That the NSW Government, in conjunction with other States, hold discussions with the Commonwealth on the issues facing private health insurance and their potential effects on the public health system.

5.1 That the Health Department develop resource allocation processes which more closely link funds provided to services delivered, covering both hospital and community based services.

5.2 That early discharge programs be formally trialled and evaluated to determine their effectiveness on achieving health outcomes, their costs, and the nature and level of resources required.

5.3 That NSW Treasury and the Health Department further investigate strategies for the funding of physical infrastructure through more flexible arrangements between the recurrent and capital budgets.

6.1.1 That the relative merits of alternative methods of service delivery be evaluated on a case by case basis, based on the following criteria:

- **Does the proposal lead to improved resource allocation?**
- **Does the proposal support the underlying objectives of the health system?**
- **Does the proposal protect or enhance the rights of individuals and their access to health care services?**

6.1.2 That the Government establish an inter-agency working group involving the human services departments to review, and where appropriate to reallocate, public physical infrastructure.

6.2.1 That the Health Department clarify the basis on which the additional savings it has identified in recurrent health funding may be achieved, specify the procedures by which it plans to realise those savings, and implement a program for their realisation.

7.1 That a public education program be developed and implemented into the nature and costs of health services, as a precursor to greater public participation in the planning for health services. This may include the publication of particular State-wide and regional issues such as waiting times, surgery rates, admission rates etc.

7.2 That a program be developed for greater ongoing public participation in the strategic planning process and determination of priorities for health services. Issues papers covering specific topics should be developed and circulated widely, with comments sought from expert bodies and the general public.

7.3 That a program be developed for greater decentralisation of community health services planning and delivery to facilitate community participation in these processes.

7.4 That Area Health Boards and District Health Boards be required to develop a dynamic working relationship with the community in developing policies and programs to service their communities, and that they report on their activities in their Annual reports, including their structure and effectiveness.

7.5 That the position of Director of Community Health at the Area and District level be adopted universally, with representation at the level of the Area and District Executive.

7.6 That area and District Chief Executive Officers develop programs to facilitate the integration of general practice, community health and inpatient services.

7.7 That the Health Department, through its Area and District structure, support and encourage the development of the family medicine program by expanding its role in the integration of health services.

2 INTRODUCTION

2.1 TERMS OF REFERENCE

On Thursday 7 May, 1992, on a notice of Motion by the Minister for the Environment, the Honourable Mr Moore, the Legislative Assembly of the New South Wales Parliament resolved that the following terms of reference be adopted by the Select Committee of the Public Accounts Committee:

(1) Committee to report to Parliament by 16 October 1992 concerning current State and Federal funding for Health infrastructure and services in New South Wales. In particular, the Committee is specifically asked to consider:

(a) impact of changing trends in the provision of health service;

(b) impact of demographic trends;

(c) identification of social and economic costs and benefits of alternative ways of providing physical infrastructure and health services;

(d) costs of the alternative ways of providing physical infrastructure and the extent to which costs are recoverable;

(e) respective roles of State and Federal Governments and their relative financial contributions;

(f) impact of private health insurance levels and trends on the State Health Budget;

(g) anomalies in current financial and organisational arrangements and their impact on effective health care delivery;

(h) private sector participation in public health services.

(2) The effect of the alternative ways of providing infrastructure on:

(a) health education and preventative health;

(b) community involvement in/and responsibility for the health of the community.

(3) The same general principles will apply to this inquiry as to Inquiry One: that is:

(a) commercial confidentiality will be protected and dealt with in camera;

(b) duplication of previous enquiries and the National Health Strategy Review to be minimised;

(c) focus to be on NSW issues.

2.2 METHOD OF INQUIRY

The Committee considered information presented to it by written submission and by examining witnesses. Written submissions from interested parties and the general public were invited in newspaper advertisements published on 3 October 1992. Submissions were sent to the Director, Public Accounts Committee, and were due by 23 October 1992 although late submissions were considered. A total of 45 submissions were received. A list of persons and organisations making submissions is contained in Appendix A to this report. The Committee also considered additional written information as requested during the course of the inquiry.

In addition, a series of public hearings were held on 11 December 1992 and 16, 17 and 18 March 1993 in Sydney. A list of witnesses and, where applicable the organisation they represented, is contained in Appendix B to this report.

3 SETTING THE CONTEXT FOR THE COMMITTEE'S CONSIDERATIONS

The Committee has examined the Terms of Reference for the Inquiry at considerable length in order to ensure that its approach to the Inquiry is consistent with the expectations and requirements of the Legislative Assembly of the Parliament of New South Wales. At the same time, however, the Committee is aware that the nature of the wording of some of the Terms of Reference lends to them being interpreted in different ways.

Central to this dilemma is the interpretation of the term "infrastructure". Many of those making submissions to the Committee have interpreted this term as relating solely to the physical facilities from which health services are delivered. Others have interpreted it more widely as encompassing the overall mechanisms for service delivery, of which "bricks and mortar" are but one element. As a result of these differences, many of the submissions to the Committee addressing the Terms of Reference differed markedly in their focus and content. Whilst the Committee was encouraged by the diversity of views expressed by many of the parties presenting both written submissions and verbal evidence, such diversity of views in regard to the intent of the Terms of Reference has required the Committee to assess its own direction to the Inquiry. It is the Committee's intent that this report should make a positive contribution to the debate on the future directions for funding and delivery of health care services in New South Wales.

Accordingly, the Committee has adopted the wider interpretation of the term infrastructure, that is, the mechanisms for health service delivery. By so doing, it has opened the Inquiry to consideration of a much wider range of issues than might be considered under a more limited definition. The Committee has taken the view that a clearer understanding of the fundamental mission of health services and the community's expectations of these services, is an essential precursor to any consideration of how those services may be best funded.

As a starting point, the Committee recognises that the demand for health care services is in essence insatiable. The capacity of medical technology to expand health care to new horizons, the longer life span of our population, the increasing proportion of the population who are aged, together with the

community's expectations that access to services should be unfettered, combine to place an impossible onus on the health care system to fully satisfy these demands. The prospect of simply providing more money is simplistic, and has been shown not to solve the problem. In the USA, where over 12% of GDP is spent on health care annually, there continue to be large segments of the population who are unable to readily gain access to health care services.

In Australia, the availability of funds for health care is ultimately determined primarily by Governments at the Commonwealth, State and Local levels, although the private sector also plays a role. The private sector is, however, affected greatly by government policies, as has been demonstrated in Australia since the introduction of Medicare. The limits necessarily imposed by governments on the availability of funding for health care require that priorities be set. In essence, this entails finding a balance between those services which technology could provide given unlimited funds and those which the community is both willing and has the capacity to pay for, albeit through the use of government funds.

In New South Wales, the determination of this balance is currently made by the Department of Health and the service providers themselves. In itself, this can lead to conflict within the system where the government seeks to balance its own economic targets and its duty of health care provision, while clinicians seek to meet the needs of individual patients. The impression gained by the Committee is that the primary focus of the existing health planning process is on efficiency improvements in regard to the range of services currently provided. However, the fundamental questions of what range of services the community requires, and which alternative methods for delivering those services are the most effective in their outcomes, remain unanswered under this approach.

It is the Committee's view, whilst acknowledging both the right and duty of government to determine the overall level of funding of health care, that the community should have a greater role in determining the range of services to be provided within these limits. This entails an empowerment of the community in determining the range of health services and health outcomes that it considers to be appropriate to its needs and its capacity to pay.

At the international level, the World Health Organisation (WHO), together with an emerging movement in public health, has been instrumental in a growing emphasis on greater community participation, control and ownership of health services and the decision-making processes. In particular, the adoption of primary health care, health promotion and community development strategies have emerged as increasingly important models for the improvement of the community's health status. The WHO has stressed the importance of informed opinion and the active co-operation of the public in the improvement of the population's health status. These aspects have been central to the statements made in the Alma-Ata Declaration from the 1978 Conference on Primary Health Care, and the Ottawa Charter for Health Promotion (1986).

There have been a number of examples overseas where this approach has been adopted. Two such examples, in Wales and Oregon are described in section 7.2 of this report. Although the approaches taken in these regions differed in their methods, and neither has as yet been tested for their long term effects, they provide some important lessons for Australia, which the Committee considers to be of particular relevance to this Inquiry.

Firstly they illustrate the need for a strategic direction to be defined for health care services which focuses on the outcomes of health care as well as the processes of service delivery. The focus on health outcomes also promotes consideration of the relative effectiveness of alternative methods of service delivery, and provides incentives for greater investment in preventative and health promotion activities.

Secondly, they demonstrate the need for responsibility for the achievement of health outcomes for a given population to be vested with a specific authority. Within New South Wales, the various Regions, Area Health Services, and the more recently created District Health Authorities have the potential to act as vehicles for this purpose. It has been suggested that the separation of the purchaser of services from their provider also facilitates this process.

Thirdly, the implementation of such programs relies on effective management information systems together with education of both managers and health professionals in using the information to best effect. Whilst outcomes measures for hospital services are comparatively well advanced, comparable

measures in the areas of primary care and rehabilitation services clearly require much more work.

Fourthly, there is a need for greater community education in the costs of health services and the outcomes achievable as an essential precursor to the community's active participation in setting priorities and deciding on strategies for the health system.

Finally, the implementation of such an approach will of necessity require a change in the culture in the existing health system. A shift to an outcomes focus, and a wider consensus approach to health care planning will of necessity require a change in attitudes among many managers and health professionals in the system.

The principles outlined above have been recognised in a number of reports published in Australia in recent years. These include "Health for All Australians" (Health Targets and Implementation Committee, 1988), "National Better Health Program" (National Centre for Epidemiology and Population Health, 1992 and 1993), and "Improving Australia's Health: the Role of Primary Health Care" (National Centre for Epidemiology and Population Health, 1992).

The National Health Strategy Review has also considered the above issues in the course of its activities. In particular its published reports "The Australian Health Jigsaw: Integration of Health Care Delivery" (Issues Paper No. 1, July 1991), "Pathways to Better Health" (Issues Paper No. 7, March 1993) and "Healthy Participation - Achieving greater public participation and accountability in the Australian health care system" (Background Paper No 12, March 1993) address these issues in detail.

In the context of this Inquiry, the Terms of Reference require the Committee to minimise duplication of the National Health Strategy Review. However, the Committee believes that some consideration of the broader issues of the type outlined provides a more meaningful context for the assessment of alternative means of funding them. Equally important, the setting of health outcomes priorities and the investigation of alternative methods of achieving those outcomes must have an effect on the types of facilities and level of capital funding required for their construction and maintenance.

The Committee acknowledges that the Health Department has already undertaken a number of important initiatives aimed at improving the planning and delivery of health services. There is no doubt that these initiatives provide an important foundation for future strategic planning. However, the principal focus of these efforts continues to be on efficiency enhancement. Notwithstanding the importance of these initiatives, the Committee considers that of themselves, they are not sufficient to achieve the optimum results from the health care system. Rather, a greater focus on health outcomes and an ongoing appraisal of the best methods for achieving those outcomes, comprising preventative, health promotion and treatment services are important elements which need to be added to the current initiatives. Equally important, the participation of the wider community in this process and in the setting of priorities is seen as an essential requirement. Once these strategies are in place, then a more informed decision may be made about the facilities required for the delivery of those services.

The planning process advocated by the Committee reflects the view that a more holistic approach to the delivery of services, and a reduction in the barriers which exist between the different forms of care (caused by a variety of factors) may lead to a health care system which is not only more effective in the outcomes achieved, but one which does not rely so heavily on the provision of expensive and largely immobile infrastructure. Such an approach calls for a greater integration of services, rather than the fragmentation which is often found in the current environment.

Given the context outlined above, the Committee has considered how responding to the Terms of Reference may assist in pursuit of this direction. Accordingly, the Committee has addressed each of the Terms of Reference with a view firstly to establish the nature of the current arrangements pertinent to each Term, then seeks to challenge whether or not those arrangements could be improved. The subsequent effects on the demand for infrastructure are then assessed, and finally alternative ways for providing that infrastructure are reviewed. The Committee considers that this approach to the fundamental issue of service delivery has the potential to provide for both a more efficient health care system and a reduced demand for infrastructure. Under these circumstances, the options available for the provision of this infrastructure may be viewed in a more informed and constructive light.

4 MAJOR TRENDS AND ARRANGEMENTS IN THE HEALTH SYSTEM

This section describes the major trends affecting the anticipated demand for health services in New South Wales, together with the respective roles of the State and Commonwealth Governments and of the private sector in the funding and delivery of health services. These issues are discussed under headings corresponding to the Terms of Reference.

4.1 IMPACT OF DEMOGRAPHIC TRENDS (TERM OF REFERENCE 1B)

4.1.1 Background

In the context of the demand for health services, the demography of the population is recognised as a major influencing factor. While there is no single or simple relationship between demographic changes and the demand for health services, there is no doubt that the structure, level and expectations of the population have had, and will continue to have, significant consequences on the use of health services. A number of submissions to the Committee addressed this issue, and are discussed below.

4.1.2 Major demographic influences

Four main demographic factors have been identified as having a major effect on the demand for health services.

- **Population growth**

  The New South Wales population is currently growing at the rate of approximately 1.25% per annum, although this rate may slow due to a continued deferral of births and cutbacks in immigration. Overall, the NSW population is expected to rise by approximately 12.5% between 1991 and 2001.

  The Health Department has suggested that this growth is likely to result in a corresponding increase in demand for services. This implies that if population increases by 12.5%, demand will rise also by 12.5%. However, the interaction between simple arithmetic changes in population, and the various other demand and supply side factors has not been fully explored.

Treasury, by comparison, estimates a similar growth in population, but a marginally lower growth rate in the demand for services associated with this factor, of the order of 1.0% to 1.25% per annum. Notwithstanding these differences, the Committee recognises the importance of population growth as a major determinant of the demand for health services.

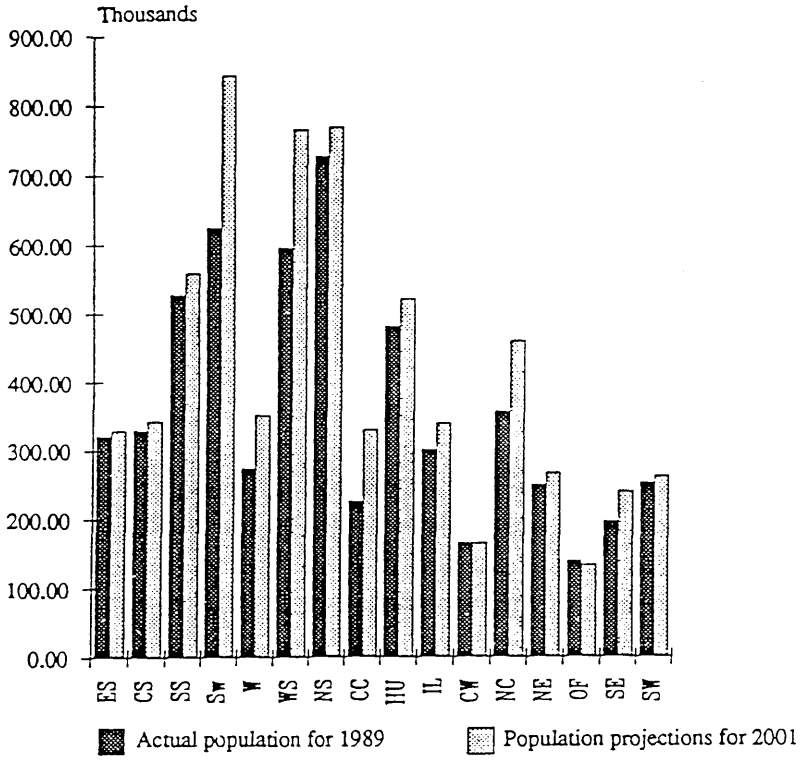
- **Population distribution**

The second major demographic factor relates to uneven demographic change within the State. In some areas, population growth will be minimal, and in other regions, growth will be rapid. The Committee understands that the Health Department undertakes planning at the Area or Regional level for future health services, and that the planning process includes demographic factors.

Figure 1, overleaf, shows the uneven population increases anticipated for each Area and Region in New South Wales between 1989 and 2001. The main areas of growth are projected to be in the South-West, Wentworth and western suburbs of Sydney. This uneven distribution is likely to have a significant effect on the demand for infrastructure development and require relocation of many services.

It is Treasury's view that the total capacity of the hospital sector is more than adequate to meet the demands of the population, but the maldistribution of those services among regions requires additional infrastructure development. Whilst the former view was not necessarily endorsed by other parties in their views to the Committee, the issue of maldistribution was widely supported.

FIGURE 1 - POPULATIONS 1989 AND 2001
NSW AREAS AND REGIONS



Key:				
	ES	Eastern Sydney AHS	HU	Hunter AHS
	CS	Central Sydney AHS	IL	Illawarra AHS
	SS	Southern Sydney AHS	CW	Central Western Region
	Sw	South West Sydney AHS	NC	North Coast Region
	W	Wentworth AHS	NE	New England Region
	WS	Western Sydney AHS	OF	Orana & Far West Region
	NS	Northern Sydney AHS	SE	South Eastern Region
	CC	Central Coast AHS	SW	South Western Region

Source: NSW Health Dept. Submission to the Public Accounts Special Committee, pp 3.1

- **Ageing of the population**

The third demographic factor identified as impacting on the demand for health services is the effect of an ageing population. It is expected that the NSW population over the age of 65 years of age will increase by 160,000 or 23% by 2001, a much faster than the general rate of population increase.

Some areas of the State will age much more rapidly than others - for example, the largest increases in the elderly population will be in the North Coast (59% increase), Central Coast and Wentworth (53% increase in each). Other areas are expected to show only moderate ageing of their population (such as the Illawarra and the South Western Regions, where increases of 30% are projected), while others will display a comparatively low growth rate in the aged population, such as Northern Sydney and Eastern Sydney, where increases of 9 to 10% are projected.

In its submission, the Health Department has not quantified the effects of an ageing population on the use of health services in NSW, other than to comment that people over 65 years of age use health services at about four times the rate used by the general population. However, the relationship between ageing and the demand for health services is not simple. In a recent paper titled "Economic and Social Consequences of Australia's Ageing Population - Preparing for the 21st Century", John Goss of the Australian Institute of Health and Welfare (AIHW) suggests that the projected blowout in health costs due to an ageing population is not likely to occur. Although there is a growing number and proportion of elderly Australians, Mr Goss claims that, according to US data, health care costs are largely confined to the last two years of life. Thus, until the last two years of life, health care costs for an 80-year old would not differ greatly from those of a 65-year old. The caveat to this projection, however, is the uncertain effect of perceived disability on health care costs. If people live longer but with a greater degree of disability in the future, an increase in the demand for health care services may be expected.

AIHW suggests that the ageing of the population is expected to contribute approximately 0.5% per annum to the growth in demand for health services over that attributed to the general growth in the population. NSW Treasury, in its submission to the Committee, adopted a similar growth factor for New South Wales.

- **Community expectations**

In addition to the above three "pure" demographic factors, increased community awareness of health issues has been identified as a significant demand-side factor. In its submission, the Health Department stated:

> "...the community's expectations for health services, particularly advanced technology services, are high and continually increasing".

To a certain extent, this may be considered to be a supply-driven increase in demand (i.e., the availability of the new technology of itself induces a demand for its application). The overall impact of this feature on demand is extremely difficult to quantify, and can only be guessed.

Professor Peter Baume, Professor Don Nutbeam, and the NSW Health Department (in a 1992 NSW Health Department discussion paper on accountability for health outcomes), see demand for future health services rising more rapidly than in the past because of two main processes - medical science offering new treatment possibilities, and population ageing. They see the first of these processes as a demand-side factor also:

> "A further stress within the system comes from altered community perceptions and increased community demands for services. This is fed, in part, by better general education and by better understanding of the medical tools available, and is influenced considerably by the press treatment of medical and hospital issues. As a consequence, the financial management pressures on those who fund and administer the sector are great and increasing."

Given the importance of community expectations of health care, the Committee is conscious of the need for greater community awareness and understanding of the capacity of the health system to cater for the community's health needs and the associated costs of service delivery. It is the Committee's view that a more informed community is better placed to make appropriate judgments on the types and levels of health care services to be provided. This issue is explored further in section 7 of this report.

4.1.3 Quantifying the effects of these changes

Efforts to quantify the effects of these changes on the demand for health services are fraught with difficulty, and few of the submissions to the Committee sought to do so. In its submission, Treasury presents a broad estimate of possible effects, but acknowledges that the figures need to be suitably qualified and treated as only broadly indicative. Their indicative estimates of the net effects of the factors previously identified as impacting on the demand for and cost of health services are shown in Table 1 below:

TABLE 1 - INDICATIVE ESTIMATES OF DEMAND AND COST TRENDS

Nature of factor	Indicative Impact (% per annum)
Demand Factors	
Population growth	1.0 - 1.25
Population ageing	0.3 - 0.5
Private sector market share	(0.5) - 0.5
Net effect of new treatments	n.a.
Total demand effects	0.8 - 2.25
Cost Factors	
Cost pressure from additional demand at 75% marginal cost	0.6 - 1.7
Efficiency gains	(1.5) - (1.0)
Length of stay and service restructuring	(1.0) - 0
Net Cost Impact	(1.9) - 0.7

Source: NSW Treasury Submission to the Public Accounts Special Committee, pp 28

Treasury warns that their indicative estimates should be treated with caution because the relationship between population growth and demand is complex, as is the relationship between falling length of stay and costs. Notwithstanding these caveats and uncertainties about what might happen in the private sector, Treasury considers that:

> "...the overall assessment of the net impact of the demand and supply factors on the cost structure of the health system is that these pressures can be absorbed without substantial additional resources".

This assessment is consistent with the findings of the National Health Strategy in regard to the projected overall demand for hospital beds. However, the Committee is also conscious of the current maldistribution of resources relative to needs, the difficulties associated with relocating those resources, and the costs associated with physical infrastructure development and upgrading. Each of these factors will contribute towards costs rising even without an increase in the total demand for services or efficiency gains in the delivery of services.

A number of other submissions to the Committee echo some of the Health Department and Treasury views, although some offer slightly differing views as to the likely magnitude of the effects of some of the factors identified above. In addition, a change in the nature and the mix of health resources is also anticipated.

4.1.4 Summary

Demographic trends and influences on the health care system in New South Wales are generally consistent with those appearing elsewhere in Australia. In NSW, the total population will continue to grow at a slow but steady rate, and in so doing, will have a net (but non-measured) demand effect on health services. Population growth is more rapid in some regions of the State than in others, and will accordingly create larger demands for health services in those regions.

Older persons use health services at far greater levels than younger persons, and as the NSW elderly population is increasing at a greater rate than the general population, health services will continue to feel the effects. As with the general population, some regions are demographically ageing at much faster rates than in other locations, and with that, the demand for health services profile will differ considerably from region to region.

Offsetting some of the demand impacts due to demographic factors are processes resulting in shorter stays in hospital, non-hospital options for

treatment, better early detection (and possible avoidance of hospitalisation) of disease and illness prevention programs. Some of these trends are quite well understood and relatively easy to quantify - others are less clearly understood in terms of their likely impacts on both the demand for and supply of health services in NSW.

Most observers of the NSW health care system see a trend towards (and indeed argue a need for) more community-based health care services, greater integration of acute hospital services with other services, and greater flexibility in terms of care and treatment options. Given the relative inexperience of the private sector in the field of community-based services, its future role in these likely developments is unclear.

The net effect of these various factors on the total demand for health services is unclear, and the Committee is concerned that the NSW Health Department's submission did not attempt to more accurately quantify the direction and magnitude of the range of factors identified as impacting on the NSW health system. The Committee considers that the Department's planning models and information systems should have the capacity to do so. The Committee urges the Department to consider not only the volume of such services, but also alternative methods of service delivery which may be more effective in achieving the desired outcomes.

RECOMMENDATIONS

4.1.1 That the Health Department extend its current planning models and information systems to better quantify the projected impact of demographic trends and technology developments on the demand for health services.

4.2 IMPACT OF CHANGING TRENDS IN THE PROVISION OF HEALTH SERVICES (TERM OF REFERENCE 1A)

4.2.1 Background

Many of the factors which impact on the demand for, and supply of health services in New South Wales have been clearly in evidence over the last few years. These factors have had significant measurable impacts, and are expected to have further influences into the future. In addition, a number of newer factors are emerging, and while most observers in the health sector agree on the nature and direction of their impacts, the magnitudes of the effects are less certain.

Some of the demand and supply factors that are changing have underlying causes that are not easily influenced by government policy or actions. Others may be more easily controlled - for example encouraging or accelerating change, or through delays that ameliorate their impacts on the health system.

4.2.2 Trends in the provision of health services

Many of the submissions to the Committee identified a number of trends which are impacting on the provision of health services. These are summarised below, although no attempt has been made to quantify their effects, individually or collectively, on the demand for, and supply of, health services. The absence of such quantification reflects the difficulties associated with isolating the cause and effect relationships of the multitude of inter-related factors at work within the health system.

- **Disease prevention**

  Improved disease prevention strategies may be expected to decrease demand on the hospital system. Such strategies include immunisation, health education and research, and health promotion campaigns in such areas as anti-smoking and alcohol abuse. The benefits of such programs are often long term in their nature, and in some instances may be less tangible. For example, immunisation programs tend to have an immediate and measurable impact on specific illnesses. Other programs, such as weight loss or anti-smoking programs tend to be more long term in their

impact, and their effects subsumed in an overall improvement in the community's health status. Notwithstanding these differences, there is a need to ensure that an appropriate balance is found between disease prevention programs and treatment and rehabilitation services.

- **Improving health status**

  Longer life spans arising from improved health status (which are in turn due to many factors such as better nutrition, education, housing and employment) produce an older population, which creates additional and different types of demands on both acute and non-acute services. The challenge facing the health system is to anticipate the effects of these changes on the demand for health services, and to ensure that the appropriate mix of services is provided in the most cost-effective manner.

- **Changes in medical procedures and technology**

  New technology provides more effective diagnostic techniques and treatments, with more patients seeking these services. Such techniques enable the earlier detection of diseases, simplify treatment and improve outcomes. Other examples, such as telemonitoring, as suggested by the Health Services Association (HSA), will facilitate the treatment of patients in the community rather than in hospitals. The technology required to support these processes, is often expensive and requires additional infrastructure funding. Technology, however, is a facilitator of change in the methods of service delivery, and provides one of the greatest opportunities for the health system to meet the increasing demand for services. The adoption of new technology may require changes in attitudes among both service providers and the community in the way in which services are provided, and the settings in which they operate.

- **Same day treatment**

  Increasing numbers of patients are treated on a 'same-day' basis, without the need for an overnight stay in hospital, and this trend will continue. There is a trend also towards more free-standing day procedure facilities, and more procedures undertaken outside hospital (for example, in doctors' rooms). The Department of Health estimates that day only work could be

increased from the 1988 level of 25% (32% in 1991/92) of acute admissions (public and private) to around 45% by 2001.

The Health Services Association (HSA) of NSW considered that the Health Department's estimates of falling bed requirements may be conservative because of the rapid increase in the number of day surgery procedures. They estimated greater reductions in bed capacity over time.

- **Decreasing average length of stay**

Average length of stay for acute inpatients is expected to continue to fall from the present 6.4 days to under 6 days by 2001. If day-only patients are included, the respective values would be 4.8 and 3.6 days.

- **Reduced supply of acute hospital beds**

Public hospital bed numbers in New South Wales have been declining for some years and are likely to continue to fall over the next few years. Private bed numbers, on the other hand, have remained relatively constant at about 5,000. The expectation of reduced bed numbers is consistent with the findings of the National Health Strategy, which projects that bed numbers could be reduced to less than 3.5 beds per 1,000 residents by the year 2001.

- **Non-inpatient services and community care**

Consistent with overseas trends and those exhibited in Australia in recent years, it is expected that more services will be provided to people in their homes, in the community or on an ambulatory basis. This in turn will require improved facilities for outpatient and community health services. At the same time, improved linkages will be required between hospitals and community-based services to ensure continuity and adequacy of care.

Most submissions to the Committee see a trend towards greater integration of community-based services with acute hospital services, and an increasing emphasis on ensuring a "continuum of care" for patients. The Health Services Association of NSW (HSA) sees this as a major future trend, and because of this, there is a significant need to give

> "...attention to community related infrastructure that needs to be put in place for the large numbers of patients who are returned to the community and to their homes following their acute episode of care".

This view was also supported by the Evatt Foundation, which highlighted three major issues:

- An increased emphasis on preventive health services and education;
- a move away from lengthy hospital stays to an emphasis on home and community care; and
- demographic factors, particularly uneven population growth and population ageing,

each of which are likely to have particular demand effects. Overall, the Evatt Foundation's assessment of demographic changes and distribution is similar to the views of the Health Department and Treasury.

In relation to the trend towards shorter hospital stays and longer periods of community-based care, the Evatt Foundation warned that dangers lie in the privatisation of community health services, believing that private operators would focus on throughput from hospital early discharges rather than on prevention issues.

As the health care environment changes over time to reflect greater community-based care, and perhaps changes in funding sources, it was stressed in a number of submissions to the Committee that a flexible approach would be a key factor in ensuring the delivery of high quality (and as a continuum) care - flexibility in terms of health care delivery settings, procurement of funding, and in other ways. This would be particularly necessary as the population ages and a wider range of treatment, care, and residential options are required.

- **Nursing homes, aged hostels, and multi-purpose services**

The use of hospitals as focal points for the co-ordination, as opposed to the delivery, of a wider range of services is expected to see them expand their traditional roles, particularly in country areas. This view was reinforced in the submission from the Health Department which stated:

> "Small country hospitals increasingly find themselves having to care for hostel and/or nursing home type patients in an acute care environment and, as a result, function as de facto nursing homes. However services needed by such patients cannot always be easily provided within the acute hospital setting. For these small country hospitals development into a Multi Purpose Service (MPS) has many benefits. The MPS concept involves pooling available resources from the State and Federal Governments ..... so that the provision of an appropriate range of viable health services and community services can be co-ordinated, co-located, and tailored to meet local needs".

- **Managed access**

There is some inappropriate use of services, and for example, many patients who could be treated in a general practitioner's surgery attend hospital emergency departments. This problem calls for improved networking of local and community health support services to enhance the accessibility of hospital services to patients in need of acute care. The establishment of Divisions of General Practice represent an important vehicle for the development of closer links between those services provided in a community setting and those provided in hospitals.

- **Increased private health sector market share**

For decades the private hospital sector has operated at average occupancy rates of about 60% compared to current occupancy rates just under 80% in public hospitals. Better utilisation of the private system is considered desirable by the Health Department because they believe it would allow a smaller public infrastructure with lower capital, operating and maintenance costs. The issues of costs incurred under different forms of private participation are discussed further in Section 6 of this report.

- **Service networks**

  Smaller hospitals cannot provide a full range of comprehensive services, calling for an increasing emphasis on networking of services. In this context, the roles of referral hospitals and country base hospitals will be to provide the increasingly sophisticated services and backup required. A 'Guide to the Role Delineation of Health Services' has been developed by the Health Department which describes the support, such as X-ray, staff profiles, and other requirements necessary for safe and appropriate clinical services.

- **Restricted number of tertiary centres**

  It is expected that complex services, such as those dealing with more unusual conditions, will be concentrated at a limited number of tertiary centres to provide them with the volume of work necessary to justify the capital investment required, and guarantee quality of care. In concept, this strategy is similar to the Nationally Funded Centres (NFC) Program which provides funding for certain high-cost, low volume services on a national scale, such as heart and liver transplant services.

- **Consolidation of services**

  The difficulties associated with achieving cost-efficiency in operating some small hospitals with low occupancy rates is of concern to the Health Department. In these instances, the consolidation of services at fewer, larger sites is considered by the Health Department to be desirable. The need for consolidation must, however, be balanced by the needs of rural communities.

- **Quality improvement**

  There is an increasing emphasis being placed on quality management programs and the use of statistically based quality improvement techniques. Greater attention to quality improvement will allow more effective use of available resources.

- **Focus on treatment outcomes**

  As outlined previously in this report, there is an increasing need for, and a response to, a greater focus on the outcomes of treatment in the health arena. According to the Health Department's submission:

  > "The rates at which some procedures are performed vary significantly between hospitals without measurable effects on overall health status. This suggests that some treatments may be ineffective or unnecessary. The Department is developing new measures for treatment outcomes in order to improve patient quality of care and possibly lower costs".

  The Committee recognises the difficulties associated with the measurement of health outcomes and the risks of focusing only on those programs where outcomes are measurable. Nevertheless, the Committee believes that the Department should expand its outcomes measures into all forms of health services. Section 7 of this report identifies several initiatives taken overseas and elsewhere in Australia in developing a greater focus on health outcomes as an essential element of determining the strategic direction of, and setting priorities for the health industry. The Committee considers that such an approach in New South Wales is an essential step to enhancing the effectiveness of health services.

- **Health education and community consultation**

  The Committee has previously identified the need for greater community consultation on the issue of planning health services, together with improved education on the costs of health care. Such consultation needs to address not only the traditional aspects of hospital care, but also the integration of services across all areas of the community.

4.2.3 Summary

The Committee has identified several patterns in relation to trends in the provision of health services. Firstly, improved and new technology, together with advances in diagnostic methods, treatment procedures, and a greater emphasis on community-based services, are likely to reduce the demand for some acute hospital services, and will be reflected in both reduced incidence

of hospitalisation and shorter stays in hospital. Overall, the number of hospital beds in NSW is expected to continue to decline over the next decade.

Secondly, the introduction of new technology and techniques is likely to stimulate demand for certain types of health services. This is expected to affect the balance between alternative methods of service delivery, if not the total level of resources required. For example, there is an expectation that more services will be provided on a community basis, and that hospitals will focus more on acute care services. This will lead to a change in the role of hospitals in terms of the nature of services they provide and the manner in which they provide them. To be effective, however, closer links will need to be forged between hospital services and community based services to ensure continuity of care and the cost-effectiveness of the services provided.

Thirdly, there is a need to develop a greater focus on the outcomes of health services. In so doing, however, care needs to be taken that such a focus does not concentrate only on those programs whose outcomes are easily measured. In this context, there is a need for more strategic planning into the most appropriate mix of acute, hospital-based forms of care towards prevention, earlier intervention, and community-based facilities. In this regard, the Committee considers there is scope for expert opinion to be applied to the assessment of the various alternatives for service delivery to ensure that the most effective mix of preventative, treatment and rehabilitation services are provided. Community participation in this process is considered to be an essential element. Recent trends in these areas overseas warrant close monitoring to determine the most appropriate model to apply in NSW.

RECOMMENDATIONS

4.2.1 That the Health Department's Health Outcomes Program Demonstration Projects be extended, focusing on projects which develop the link between the achievement of health outcomes and the allocation of resources. Such an approach should not be limited to those programs where outcomes are most easily measured, and should also have regard to the processes of service delivery. The approaches taken overseas in this area should be examined as part of the development of a suitable strategy in New South Wales.

4.2.2 That an expert panel be established to investigate alternative methods of service delivery covering the spectrum of health services which maximise the achievement of health outcomes. The panel to comprise representatives from both community based and hospital based services, and be multi-disciplinary in its membership.

4.2.3 That a program be established for trialling integrated methods of service delivery in order to formally evaluate their effectiveness in achieving specified health outcomes and their potential impact on health infrastructure requirements.

4.2.4 That a program be established for the formal evaluation of new technologies, their costs and their effectiveness in improving health outcomes relative to other treatment methods prior to their wider adoption.

4.3 RESPECTIVE ROLES OF STATE AND COMMONWEALTH GOVERNMENTS AND THEIR RELATIVE FINANCIAL CONTRIBUTIONS (TERM OF REFERENCE 1E)

4.3.1 Background

The health care system in Australia is complex, both in terms of its operation and how it is funded. Much of the complexity is related to the nature of Commonwealth-State roles and responsibilities. In addition to the complexities inherent in a federal system of this type, there have been many changes in roles, responsibilities, and funding strategies in recent years. Before discussing specific issues relating to Commonwealth-NSW roles and financial contributions, a broad overview of the Australian health system is presented below.

4.3.2 Overview of Commonwealth and State roles and responsibilities for health care

In broad terms, the Commonwealth is responsible for:

- overseeing the Health Insurance Commission and the administration of Medicare;
- funding of general practitioner and specialist medical services delivered in the community;
- funding of medical services provided to private patients in hospitals;
- funding of pharmaceutical services outside hospitals (through the Pharmaceutical Benefits Scheme);
- payment of nursing home and hostel benefits (for public and private nursing homes);
- payment of domiciliary nursing care benefits;
- funding and (currently) provision of health services for veterans and their dependents; and

- regulation of private health insurance.

State Government health care responsibilities are as follows:

- provision of acute public hospital services;
- provision of acute and long-term mental health services;
- provision of nursing home and hostel services through public (State) nursing homes and hostels;
- regulation of private hospitals, nursing homes and hostels;
- provision of community health services;
- public health services, including immunisation, food inspection; and
- registration of health professionals.

This division of funding responsibilities has led to a number of anomalies in both the funding for and management of health services. These are discussed further in section 5 of this report.

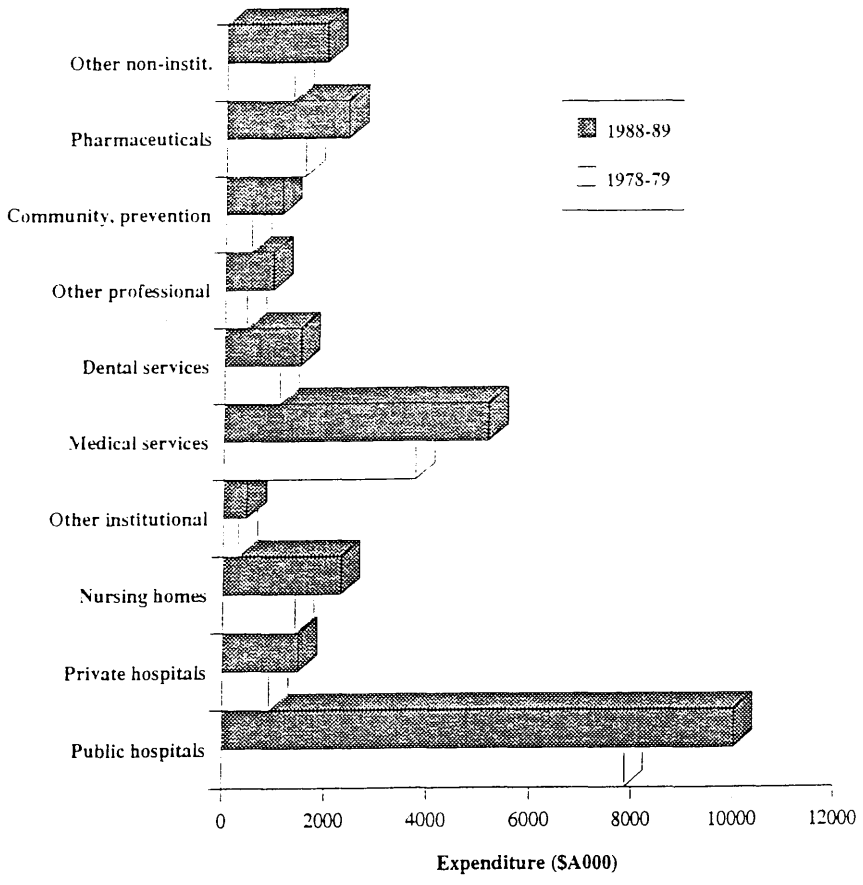
4.3.3 A brief overview of funding of health services in Australia

As a proportion of Gross Domestic Product, total expenditure on health care has remained at a stable level for some years, representing around 8 percent of GDP. Australia's expenditure is greater than in the United Kingdom (stable at around 6% of GDP), but is well below that of the United States (rising and around 12% of GDP) (AIHW, "Australia's Health 1992", Table S43, pp. 340). In 1990-91, total health expenditure in Australia was around $30.9 billion.

Although overall health expenditure as a proportion of GDP remained steady throughout the 1980s and early 1990s, there has been a steady annual rate of growth both in total and per capita health expenditure during this period (AIHW, "Australia's Health 1992", Tables S44 & S45, pp. 340-341).

The largest single component of recurrent health expenditure is on public hospitals. In 1978-79, expenditure on public hospitals accounted for 41% of all health expenditure. By 1988-89, although public hospitals expenditure had risen by 27% over the decade, it represented a lower proportion of total health expenditure (down to 37%) (AIHW, "Australia's Health 1992", Table S47, pp. 342). The components of health care expenditure in Australia for 1978-79 and 1988-89, at constant 1990-91 prices are shown in Figure 2 below:

FIGURE 2 - COMPONENTS OF RECURRENT HEALTH EXPENDITURE, AUSTRALIA, 1978-79 AND 1988-89 (CONSTANT 1990-91 PRICES)



Source: AIHW, "Australia's Health 1992", Table S47, pp 342

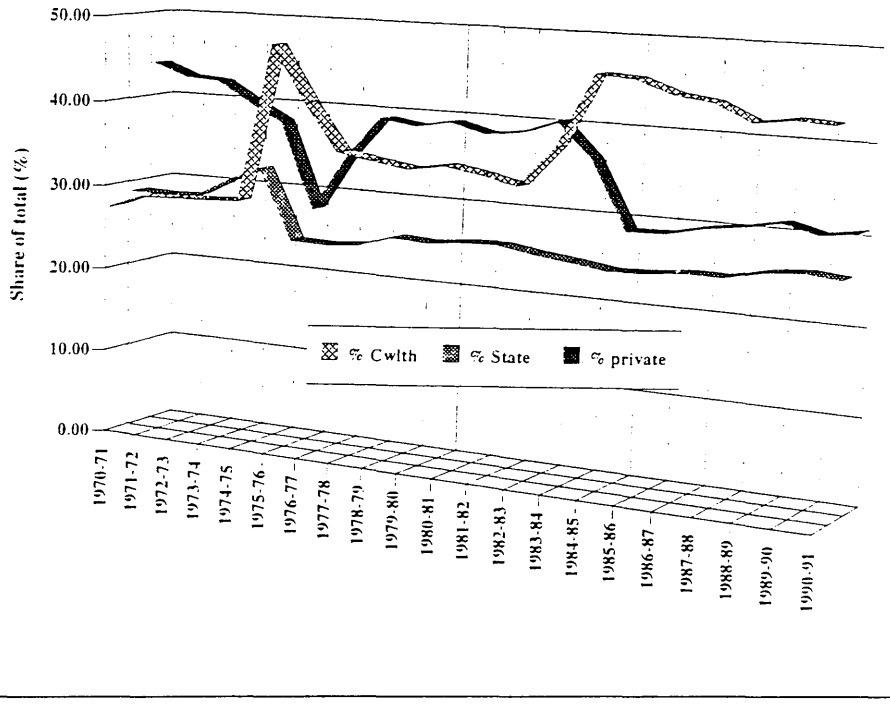
Between 1978-79 and 1988-89, total real recurrent health expenditure in Australia rose by 43% (at constant 1990-91 prices), the largest rises being in

non-medical professional costs, community and preventive health, private hospitals, and nursing homes. Public hospitals expenditure rose by the smallest fraction over this period. (AIHW, "Australia's Health 1992", Table S47, pp. 342).

Since the early 1970s, there have been significant changes in the sources of funding health expenditure in Australia. In 1970-71 for example, the Commonwealth share of the total health bill was approximately 27%. Private sector sources represented 44%, and State/local government, 29% of the total. By 1990-91, the Commonwealth share had risen to 43%, the private sector share had substantially dropped (31%), and the State/local government share was slightly down (to 26%). Throughout this period however, the relative proportions shared by the sectors fluctuated considerably, largely driven by Commonwealth Government policies. For example, the Commonwealth sector share jumped dramatically between 1974-75 and 1975-76 (Medibank introduced), then fell to a 1980s low of 34% in 1982-83. By 1984-85, the Commonwealth share had again peaked at just under 47% following the introduction of Medicare. Since then however, the Commonwealth sector share has steadily fallen and by 1990-91 was below 43% (AIHW, "Australia's Health 1992", Table S48, pp. 343).

The respective proportions of total health care expenditure contributed by the Commonwealth and State Governments and the private sector from 1970-71 to 1990-91 are shown in Figure 3, overleaf.

FIGURE 3 - HEALTH EXPENDITURE BY SECTOR, AUSTRALIA, 1970 TO 1991



Source: AIHW, "Australia's Health 1992", Table S48, pp 343

4.3.4 NSW perceptions of the Medicare Agreement

The Medicare Agreement is the basis for the Commonwealth's contribution to the funding of State public hospitals (through the Hospital Funding Grant - HFG). Since 1984, there have been two Medicare Agreements, with a third to take effect from July 1993. The respective contributions of the NSW and Commonwealth Governments to Health Areas and Hospitals under Medicare agreements since 1985-86 are shown in Table 2 below. The Commonwealth's contribution has fallen from approximately 41% in 1985-86, to about 35%, at which level it has been relatively constant since 1990-91.

TABLE 2: RESPECTIVE LEVELS OF NSW AND COMMONWEALTH CONTRIBUTIONS TO HEALTH AREAS/HOSPITALS, 1985-86 TO 1992-93

Year	State Support		C'wealth Support[a]		Total[b]
	($M)	% of Total	($M)	% of Total	($M)
1985-86	1,364	58.1	984	41.9	2,348
1986-87	1,613	60.8	1,040	39.2	2,653
1987-88	1,749	61.0	1,117	39.0	2,866
1988-89	2,122	66.2	1,085	33.8	3,207
1989-90	2,226	65.3	1,185	34.7	3,411
1990-91	2,413	65.6	1,268	34.4	3,681
1991-92	2,464	65.0	1,324	35.0	3,788
1992-93 (est)	2,533	65.0	1,365	35.0	3,898

(a) Funding actually provided under Medicare arrangements
(b) Total payments to Areas/Hospitals, less actual Commonwealth Specific Purpose Payments other than those included in (a).

Source: NSW Treasury Submission to the Public Accounts Special Committee, supp Table 4.

In real terms, the contributions by both the Commonwealth and State Governments under the HFG have increased in recent years, but at considerably different rates. The comparative figures are shown in Table 3 below:

TABLE 3: PAYMENTS BY NSW AND THE COMMONWEALTH GOVERNMENTS UNDER THE HFG, 1988-89 TO 1992-93.

Year	NSW Government		C'wealth Government	
	Payments ($1993)	Real Growth (%)	Payments ($1993)	Real Growth (%)
1988-1989	2,433	-	1,244	-
1989-1990	2,404	-1.2	1,280	2.9
1990-1991	2,506	4.2	1,317	2.9
1991-1992	2,516	0.4	1,352	2.7
1992-1993 (est)	2,533	0.7	1,365	1.0

Source: NSW Treasury Submission to the Public Accounts Special Committee, supp Tab 3

Over the four year period to 1992-93, the Commonwealth's contribution has increased by 9.7%, compared to 4.1% by the State. In addition to the HFG, which is a specific purpose payment, the traditional untied Financial Assistance Grants (FAGs) by the Commonwealth to the States declined by 17.2% between 1984-85 and 1991-92. FAGs are a major source of funds used by the States for a wide range of programs including health programs.

Other information provided by the Department to the Committee (based on Victorian Treasury analysis) is that between 1984-85 and 1989-90, the Commonwealth's payments to the States (as a percentage of GDP) steadily declined; that Commonwealth outlays to States as a percentage of total outlays steadily declined; and receipts from the Commonwealth are declining as a percentage of total States' receipts.

The NSW Health Department's submission emphasised that while the Commonwealth was maintaining tight control over HFGs to the States (in fact declining as a percent of Commonwealth health outlays), other Commonwealth-funded areas are expanding as a proportion of the health budget. In particular, Medicare payments for medical services, payments under the Pharmaceutical Benefits Scheme, and payments for nursing home benefits have all substantially risen in recent years. The submission to the Committee by the Health Services Association of NSW (HSA) puts a similar view:

> "It is contended that the federal government has through its fiscal policy, managed to put considerable constraints on the public hospital system, which it has not done to other sectors of the health care system".

While the facts relating to recent trends in Commonwealth funding of health services have been presented to the Committee, the Committee recognises that these patterns may have arisen from changes in the underlying demand for health services, and are not exclusively the result of Commonwealth fiscal policy (or they may be a function of both).

Notwithstanding that the NSW Government has signed the third Medicare Agreement with the Commonwealth, there remain a number of areas which

are of concern to both the Health Department and Treasury. In particular, the following issues were identified in the Treasury submission :

"• a need to establish a mechanism to address the overlapping roles and responsibilities between the Commonwealth and State as identified in the National Health Strategy plan;

- a need to establish a national health policy to provide a framework for the development and management of health services;

- a lack of attention to the level of base funding provided to take account of increase in demand and an inappropriate means of distributing the non-base grant funding;

- a lack of capital funding for public hospitals."

In addition to the Treasury's concerns, the Health Department submission discusses in more detail the issue of funding indexation and other matters. Of major concern to the Department is the penalty which the State incur if the percentage of public bed days in the State falls below 55.85%.

The declining level of private health insurance participation since the introduction of Medicare was also identified as a factor of concern in many of the submissions to the Committee. The Commonwealth no longer provides direct financial support either to the State to compensate for this increase in public patient levels, or to health funds to assist with the larger proportion of elderly people remaining in private health funds.

Indexation of the HFG over the five year agreement period is also a significant issue for the NSW Government. The HFG is indexed according to growth in the population adjusted for age and sex weighted hospital utilisation. Notwithstanding this allowance, the States bear costs of increased utilisation, but also benefit from any efficiencies gained, from factors other than population growth and ageing. The inflation index is inadequate, being calculated on the basis of 75% of the Award Rates of Pay Index and 25% of the Consumer Price Index. The Award Rates of Pay Index does not take into account increases in State awards (which cover most health professionals). Again, States bear the full burden of wage negotiations. In addition, the

inflationary index does not take account of cost increases from improved salaries and conditions, particularly for nurses; the development of new procedures; cost pressure from increased productivity, for example, higher average bed day costs as length of stay decreases; and the cost of (largely imported) medical technology.

The Committee was informed also that the increasing use of Specific Purpose Payments (SPPs) by the Commonwealth has had a major impact on the ways in which State discretionary funds can be used because of the requirement for the matching of Commonwealth funds by the State. Furthermore, the services targeted by the Commonwealth with its SPPs may not necessarily accord with the State's own health priorities. The Committee notes the need for State priorities to be determined within the context of national priorities, but to also take account of the particular needs of the people of New South Wales.

Finally, the issue of diminished access to Commonwealth funds for capital purposes is of major concern to the NSW Government, for two main reasons. Firstly, the Commonwealth's Hospital Enhancement Program, which provided $25 million in its first year and $50 million in each of 1989-90 and 1990-91 to assist States in enhancing clinical services was reduced to $30 million in 1991-92. Secondly, there is no provision for additional infrastructure funding by the Commonwealth. The Department stated that:

> "...as the State is providing a service on behalf of the Commonwealth, the price of the service should include a component for a return on capital investment. However, no such payment is made by the Commonwealth".

The Committee notes, however, that under the Australian Constitution, States are responsible for the provision of health services, although the Commonwealth can influence these services through the funding arrangements.

4.3.5 Health financing arrangements in NSW

Within the NSW budget, there are three types of funding for health:

- **Consolidated Fund support for recurrent payments;**

  The general process for determining the allocation for recurrent payments is based on the previous year's allocation (plus indexing and approved enhancement funding), less productivity dividends and portfolio savings.

  The Treasury submission to the Committee highlights the privileged status of NSW Health within the NSW Budget process. They pointed out that while the Health sector received substantial enhancement funding over the period 1988-89 to 1990-91 totaling $112 million per annum, difficult budget conditions have meant that enhancement funding for 1991-92 has been virtually eliminated.

  In further explanation of the relatively favorable treatment of Health in the Budget process, Treasury informed the Committee that

  > "...the general approach taken with health is to provide no additional funding for new health facilities that come on stream. The reason for this is that in view of the surplus hospital capacity position, it is expected that there will be offsetting savings occurring through lower per unit operating costs and the reduction in the level of older, less efficient and poorer located facilities".

  There are no health-sector specific indexation factors applied in determining the recurrent funding allocation for health. The indexation factors used across the system are applied to health. While it has been often argued that health sector cost pressures have distinguishing characteristics, no satisfactory methodology has been found to better reflect specific health cost factors.

  Health (and education) differ from other NSW Government programs in that these agencies are not required to provide a productivity benefit to the Budget. In the case of Health, all efficiency savings can be applied to areas of high priority within the health sector. Similarly, there are no

portfolio savings (targeted reduction in programs) applied to the health sector.

It is clear to the Committee that the recurrent funding of the NSW Health Department is either exempted from certain austerity measures or is treated more leniently than many other agencies in the allocation of recurrent funds. That this will continue is by no means clear, although current State Government priorities for health are likely to provide flexibility in the short term at least.

- **Consolidated Fund support for capital payments;**

Capital fund allocations across sectors are determined by the Ministerial Capital Works Committee. Treasury comments that

> "Once again health is accorded a privileged position relative to other agencies. Health Consolidated Fund Support was set at $250 million in 1990-91 and has since been indexed in line with cost increases. For 1992-93 the capital allocation is $273 million. This approach has provided a reasonable level of budget support and has avoided any cutback in funding reflecting the deteriorating overall budget position".

- **Own source revenue.**

The major sources of revenue include patient fees, fees for compensable patients, asset sales, and other sources.

4.3.6 Allocating funds within the public health sector in NSW

The NSW Health Department recognises that recurrent funds need to be allocated to Areas and Regions on the basis of need, rather than arbitrary per capita or other distribution methods. There are significant geographic variations in demographic structure, health status, socio-economic status, and other factors affecting the demand for health services.

In order to allocate resources for health services on a more rational and equitable basis, the Department has developed its Resource Allocation Formula (RAF). The RAF uses projected population distribution and takes

into account age/sex and health status differences relevant to utilisation of health services.

A basic principle built into the RAF is that areas and Regions should be self sufficient in the delivery of routine health services to their residents. Re-allocation of resources from older established Areas to growth Areas and Regions of the State is being undertaken gradually to achieve this self sufficiency. The process is welcomed by its beneficiaries but resisted by communities whose service base is reduced by it. Professor Ian Webster, in his submission to the Committee, agrees that while the RAF is sound in principle, there is still a major problem with the uneven distribution of health resources between regions. He cites the example of the South Western Sydney Area Health Service which is under-provided for in terms of most health resources, and in particular, the skills of allied health professionals.

The Department's submission stresses that the RAF redistribution system which aims to give rise to new or expanded services where needed cannot take place unless the necessary infrastructure has been provided. There is therefore a critical interdependence between re-allocation of recurrent funding and planning of the Capital Works Program.

4.3.7 Summary

The existing arrangements between the Commonwealth and State Governments specify their respective roles and responsibilities in relation to the provision of health services. Whilst these roles and responsibilities appear to be mutually exclusive, the Committee recognises that in reality, there is overlapping of services, complexities of funding, and unclear lines of accountability. There is an urgent need for NSW, along with other State and Territory Governments, to negotiate with the Commonwealth with regard to their respective responsibilities as set out in the Constitution in order to clarify and rationalise their respective roles and responsibilities for the funding of, provision of, and accountability for health services.

The Commonwealth contribution towards the recurrent funding of NSW public hospitals has remained at around 35% in recent years. While there has been real growth in the HFGs paid to NSW by the Commonwealth, the rate of growth has been low and for 1992-93, it is estimated at 1% only. It was

pointed out to the Committee that Commonwealth funding to the States is declining as a proportion of GDP (and as a percentage of all outlays), and that from the perspective of the States, the relative importance of receipts from the Commonwealth has been declining.

In addition, the Committee notes that Commonwealth funding of State public hospitals has been more tightly controlled by the Commonwealth than other Commonwealth health expenditure (in particular, Medicare reimbursements for community-based medical services and payments under the Pharmaceutical Benefits Scheme). It appears unlikely that there will be any change in this pattern in the foreseeable future.

Although both the Treasury and the Department of Health have expressed concerns about aspects of the indexation methodology in the new Medicare Agreement (claiming that there are health sector-specific factors which are not being taken into account), the NSW Treasury itself has not been able to identify an appropriate methodology for the indexation of payments from the Consolidated Fund for the State health program. The Committee considers that Treasury and the Health Department should develop a more appropriate indexation basis for recurrent health funding.

Apart from the issue of poor indexation, the NSW Government has other concerns about the Medicare Agreement, particularly in relation to the continuing problem of role uncertainty (overlapping roles), the lack of integration with the National Health Strategy, and the lack of provision for capital funding for infrastructure purposes. The Commonwealth's Hospital Enhancement program has also been substantially reduced.

A further concern from the NSW Government's perspective is the increasing importance of Specific Purpose Payments (SPP) by the Commonwealth to the States. Such payments are tied, and in many cases, require matching by the State. NSW Treasury feels that the increasing importance of SPP is influencing the extent to which the State can use its own discretionary funds. It was argued also that some of the programs funded by the Commonwealth under SPP conditions may not necessarily reflect the priorities for health within the State, although on the other hand the NSW Government argues for more national priority setting.

Within overall NSW Government policy, health is seen as a high priority area, and is exempted from (or treated more leniently under) some of the rigors of the Budget process (e.g., exemption from efficiency dividend payments).

Notwithstanding the relatively privileged position of health within the budget context, the Committee sees few further options and strategies available for significant infrastructure funding from within the existing structure and resource allocation processes operating in the public sector generally, and the health sector specifically. As such, any additional funds which are required will need to be generated through improved effectiveness and efficiency measures in the delivery of services from within the public sector; from changes in government priorities so as to allocate more funds to health care; and/or through greater participation of the private sector in the delivery of services. This will require new and innovative approaches to the issue of physical infrastructure development in the health sector (and perhaps in other sectors).

RECOMMENDATIONS

4.3.1 That the NSW Government, along with other State and Territory Governments, negotiate with the Commonwealth with regard to their respective responsibilities as set out in the Constitution in order to clarify and rationalise their respective roles and responsibilities for the funding of, provision of, and accountability for health services.

4.4 PRIVATE SECTOR PARTICIPATION IN HEALTH SERVICES (TERM OF REFERENCE 1H)

4.4.1 Background

The private sector plays an important role in the overall provision of health services in New South Wales and Australia, and has been significantly affected by Commonwealth policies over the years. This effect is demonstrated by the reduction in the coverage of private health insurance since the introduction of Medicare from a level of approximately 64% of the population to about 40%. Most of the early decline was in the area of basic insurance (i.e. insurance to be a private patient in a public hospital), with supplementary insurance (i.e. that which provides coverage for treatment in a private hospital) remained relatively constant. More recently, the latter form of coverage has also declined, dropping from 37.2% to 36.4% of the population in the twelve months to March 1993. This latter decline necessarily reduces access to private hospitals, with a corresponding increase in demand for public hospitals.

Given the strong nexus that exists between supplementary cover private health insurance and the private hospital industry, any deterioration in the former will have serious repercussions on private hospitals, and the contribution they make to the overall provision of health services within New South Wales.

4.4.2 Private hospitals in New South Wales

Historically, larger private hospitals in Australia and New South Wales have been operated by religious and charitable bodies, often located in close proximity to large public teaching hospitals. The for-profit hospitals were typically much smaller, and, according to the submission by Health Care of Australia (HCOA), were more akin to a "cottage industry". In the mid-1980's, however, a number of new "for-profit" operators emerged, some of them from overseas (e.g., Hospital Corporation of America and Hospital Affiliates). Whilst many of these groups have since withdrawn, their effect on the industry was significant. There are now a number of for-profit hospital chains in Australia, the largest being HCOA which operates 24 private hospitals in NSW, Victoria and Queensland, covering a total of over 2,100 beds.

Private hospitals in New South Wales account for approximately 18% of all acute care bed days in the State. This is a considerably lower proportion than that exhibited in other States, where in Victoria, Queensland and South Australia, the proportion is over 25%. Bed capacity in NSW private hospitals increased by approximately 10% between 1989 and 1992. The Health Department, in its submission, referred to the results of a survey of private hospitals in 1989, which indicated that:

- private hospitals generally provided a narrower and less complex level of services than public hospitals, and

- larger, better equipped private hospitals had higher occupancy rates than the average for all private hospitals.

The average occupancy of private hospitals in New South Wales is currently of the order of 57%. The reasons for this occupancy level are complex and have their roots in the history of private hospital development. However, the capacity exists for the private hospital sector to treat more patients. The Private Hospitals Association of NSW (PHA) expressed its support for greater co-operation with the public sector in pursuing this direction. The PHA stated:

> "It is argued that there is a role for both the public and private sectors in the delivery of health/hospital services - the challenge is to achieve the appropriate balance.
>
> PHA-NSW is not in any way suggesting an enormous shift toward the private sector, but it is strongly suggesting that the potential of the private sector is far from fully realised".

The Health Department has also advocated a larger role for the private sector in the delivery of hospital services. In its submission to the Committee, the Department stated:

> "The main thrust of the Government's policy in developing a more effective private health care service has been to provide the opportunity for the private sector to deliver comprehensive and high quality services.

> A better private hospital sector will provide a more viable choice for the people of NSW, and will complement the already strong public system and provide a more competitive environment with the efficiencies that environment promotes."

Both Treasury and the Health Department make the observation that private hospitals could perform more effectively in NSW even under the current health financing arrangements through an increase in their occupancy levels.

A number of submissions to the Committee highlighted the disadvantages private hospitals suffer relative to public hospital sectors under the existing Medicare arrangements. The fact that public hospitals can charge a schedule fee for private patients while public patients are treated free provides a strong incentive for them to attract private patients. In addition, the medical costs at public hospitals are free to the patient, while a fee is normally charged for these services in private hospitals, making public hospitals more attractive to patients. Finally, the fee charged for private patients at public hospitals is currently $189 per day, compared to a fee of the order of $400 per day in private hospitals. Thus there are also strong incentives for private health insurers to favour treatment in public hospitals.

Treasury, in its submission, states:

> "A more rational approach would be for the Commonwealth to set the private patient fees in public hospitals broadly in line with efficient cost and private sector charges. This would of course, without corrective action, produce a windfall gain to the States and a significant increase in health insurance rates which would further exacerbate the decline in health insurance coverage. The higher revenue generated and hence the higher cost to the health funds could, however, be completely offset by an arrangement whereby the windfall revenue was distributed to the insurer".

Over the past four years, many private hospitals have experienced financial difficulties, and two major private hospital groups have been placed in receivership in this period. The major reasons cited for these operators include low occupancy rates, high borrowings, the high cost of bed licenses,

the inability to attract equity capital and depressed asset values. The Health Department states that :

> "Rates of return on private hospitals would need to increase to around 20% to attract institutional and other private investment capital. Good prospects for capital gain in the value of assets employed would also be needed. The absence of land ownership and the limitations of specific purpose zoning of hospital land reduce the capital gain potential of private hospital developments on public hospital campuses."

Religious and charitable organisations enjoy a tax advantage over the for-profit operators, since they are not required to pay income, payroll or sales tax, and their "not-for-profit" philosophy is often more acceptable to local communities.

4.4.3 NSW State Government support for private hospitals

The New South Wales Government has sought to redress the imbalance between the public and private hospital sectors through three means:

- Reforming the legislative and institutional environment

  The Private Hospitals and Day Procedure Act (1988) reduced the regulatory processes associated with the approval of new private hospitals or the expansion or upgrading of existing private hospitals. The Act has also sought to encourage the development of larger hospitals and to expand the range of facilities and services. Since March 1988, five new private hospitals have opened, ten existing private hospitals have been expanded and upgraded, and two public hospitals have converted to private hospitals with upgrading of services and facilities. In addition, free-standing day surgery centres have grown, with 35 such centres licensed at the end 1991.

- Encouragement of contractual arrangements

  The Health Department has contracted with the private sector for the treatment of public patients in a number of areas, particularly in the

Northern Sydney, Hunter and Illawarra Health Services and the North Coast region. For a contract to be acceptable, the private provision of services must be more cost-effective than the provision of those services in the public sector at marginal cost. However, marginal costs are very difficult to measure.

- Private sector participation in new health infrastructure

  The private sector has been encouraged to develop new hospitals associated with the major teaching hospitals in a number of locations. Approval for developments of this type has been given at the campuses of Royal North Shore, Royal Prince Alfred, St George and Westmead Hospitals.

4.4.4 Non-hospital services in the private sector

The private sector's most obvious form of participation in the delivery of non-hospital health services is that of private medical practitioners and allied health professionals. Treasury also highlight the fact that the majority of community services provided under the Home and Community Care (HACC) program are provided by the private sector, including both for-profit and not-for-profit organisations.

Notwithstanding these instances, it is generally accepted that community health services and preventive programs have traditionally been the province of the public sector and voluntary organisations. According the Private Hospitals Association of NSW (PHA), this

> "... has been principally because of tradition and the fact that the issue of how to finance such service has not been addressed."

A number of submissions to the Committee emphasised that community involvement in the planning and delivery of community-based services is a critical factor to their success, and that private sector ownership and management of these services fail to adequately cater for community participation.

4.4.5 Summary

The private sector plays a role in the provision of health care services in New South Wales and Australia. Given the private sector's reliance on private health insurance as the major funder of services, the decline in health insurance participation since the introduction of Medicare is of great concern to the private sector and to the NSW Health Department.

Private hospitals in NSW account for approximately 18% of all acute care bed days in the State, a proportion which is lower than that exhibited in most other States. Bed capacity in NSW private hospitals increased by approximately 10% between 1989 and 1992. There is a general perception that private hospitals offer a narrower and less complex range of services than their public sector counterparts.

Despite the increase in bed numbers, private hospitals currently operate at approximately 57% of their potential capacity, indicating there is capacity within this sector which could be accessed to treat more public patients if desired. The case for so doing was argued by a number of the parties making submissions to the Committee. The Health Department's policy in this regard is to encourage the development of a stronger private hospital sector to complement the services offered in the public sector. In support of this policy, the Department has undertaken a number of initiatives aimed at providing the private sector the opportunity to develop a larger role in the health industry in co-operation with the public sector.

The Health Department and Treasury identified the differences that exist in the different benefit levels paid for the treatment of private patients in public hospitals compared to those received for treatment in private hospitals. They advocate that these differences should be removed, with some adjustments, to provide for a more "level playing field" between the two sectors.

At the same time, variations in the taxation liability of for-profit operators and not-for-profit operators in the private sector also result in competitive differences within the private sector itself.

Whilst all members of the Committee acknowledged the capacity for the private sector to treat more patients, there were differences of opinion as to

whether or not that capacity should be utilised for the treatment of public patients. Some members were in favour of ultilising this capacity under some form of contractual arrangement, while others were opposed to such proposals. Notwithstanding these differences of opinion, it was agreed that any consideration of the role of the private sector must take account of the overall health strategy for the area.

RECOMMENDATIONS

4.4.1 That any use of excess bed capacity in either the private or public sectors must be in harmony with an effective community health and preventative health strategy.

4.5 IMPACT OF PRIVATE HEALTH INSURANCE AND TRENDS ON STATE HEALTH BUDGET (TERM OF REFERENCE 1F)

4.5.1 Background

Private health insurance is an important element of the health care system. In its submission to the Committee, the Australian Health Insurance Association argues that private health insurance is fundamentally important in that it funds around 50 percent of total hospital bed days (in public and private hospitals).

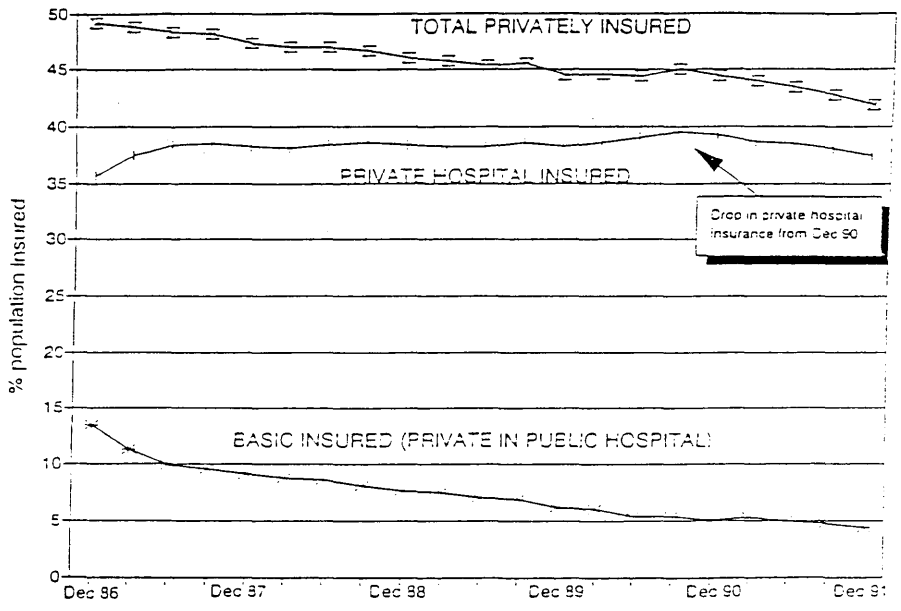
Private health insurance has been an integral part of the overall health system for decades, but its relative importance and position has altered significantly with the introduction of Medicare. A number of submissions to the Committee addressed the topic of private health insurance, its importance, the threats posed to it and the health care system, and other related issues.

4.5.2 Trends in private health insurance participation

Since the introduction of Medicare in the early 1980s, private health insurance levels in NSW (like Australia generally) have significantly fallen. Evidence supplied by the Health Department shows that in December 1983, around 64% of the NSW population had basic private table insurance. By March 1993, this had fallen to approximately 43%. Most of the early decline was in the area of basic table cover, although more recent evidence indicates that this decline has recently extended to supplementary table cover. The proportion of Australians with private health insurance cover, and the type of cover provided from 1986 to 1991 is shown in Figure 4 overleaf.

In its submission to the Committee, the Health Services Association of NSW stated that in a recent survey of a small group of public hospitals, the average number of privately insured bed days had fallen to a level of around 31%. The NSW Health Department considers also that private insurance levels are continuing to fall and that the system is not yet in equilibrium.

FIGURE 4 - PROPORTION OF AUSTRALIANS WITH PRIVATE HEALTH INSURANCE, 1986 TO 1991



Source: APHA Submission to the Public Accounts Special Committee. Appendix A, pp 5.

4.5.3 Impact of private health insurance on the State health budget

The NSW Health Department is concerned that the continuing fall in private health insurance levels (attributed to the introduction of Medicare) could seriously impair the State's ability to carry out its responsibilities under the terms of the Medicare Agreement. Furthermore, the Department stated that:

> "If governments succeed in reducing waiting times for public admission, private health insurance membership could be further eroded".

The reduction in private health insurance participation not only increases the number of public patients seeking free treatment in public hospitals, but also reduces the revenue to the State from those who were previously privately insured. In its submission to the Committee, the Department provided the

results of a simulation model based on the continuing decline in private health insurance levels. The model suggests that if private health insurance levels fell by a further 15 percent (over 8 years), the total cost to the NSW health budget would be $377 million per annum.

The Health Services Association of NSW sees dire consequences for the health system if insurance levels continue to fall. It sees major consequences for the public hospital system if low insurance levels force some of the major private hospitals to close.

> "If those beds (i.e., the 25% of total beds which are in the private sector) were closed and those patients were forced into the public health sector, there is no way the current capital stock, available services and financial resources would be able to meet the flow of additional patients".

Most submissions to the Committee addressing the issue of declining private health insurance levels agreed that availability of free public hospital treatment was the major explanation for the trend (i.e., the consequences of Medicare). In addition, the real cost of private health insurance has risen, this being due to a variety of factors including healthy people dropping out of funds thus skewing fund membership to higher risk (and hence more expensive) members. In addition, the NSW Health Department comments that

> "The impact of a number of additional Commonwealth policies has caused a cost shift from the Commonwealth on to the private health funds".

The Australian Health Insurance Association (AHIA) argued that a further significant development is driving up the cost of private health insurance premiums, and as a consequence, healthy people are leaving, thus further driving up premiums in a vicious cycle. The AHIA presented evidence to the Committee that a number of schemes have been established which are designed to avoid the provisions of the National Health Act as it relates to health insurers. In particular, some employer-based schemes have emerged which are structured so that they are not legally defined as "insurers" (by paying benefits on a discretionary basis), and accordingly, can avoid both the

"community rating" concept in premium setting, and re-insurance arrangements, both of which are provided for in the National Health Act.

4.5.4 Summary

Private health insurance is an important element of the funding of the Australian health care system. Since the introduction of Medicare, participation in private health insurance has fallen to approximately 43% of the NSW population in March 1993, and is continuing to decline. The early period of decline was in the area of basic table cover, but this has now extended to supplementary table cover. The major reasons for the decline were considered by most parties making submissions to be the availability of free treatment in public hospitals together with the increasing real cost of private health insurance.

The indirect effects of Medicare (such as universal access to public hospitals) are impacting on private health insurance levels, the costs of private health insurance, and the revenue and cost structures of public and private hospitals. A number of submissions emphasised to the Committee that if current trends continue, there will be major negative consequences in both hospital sectors. In particular, if current trends persist, the public hospital system would not be able to immediately meet the increased demand for services caused by any widespread closure of private hospitals.

The Committee was divided in its views on the importance and the effect of low and declining levels of private health insurance. Some members of the Committee felt that if private health insurance levels continue to fall, significant stresses would be placed on the public hospital system as occupancy levels decline in private hospitals. Other members of the Committee disagreed with this assessment, and considered that the public hospital system would, in time, be able to respond to the situation. The consequences of a continuation in current insurance trends will also impact on State finances, thus further exacerbating problems of funding health and other programs for the NSW population. The Committee considers that there is a need for this issue to be addressed at a national level.

RECOMMENDATIONS

4.5.1 That the NSW Government, in conjunction with other States, hold discussions with the Commonwealth on the issues facing private health insurance and their potential effects on the public health system.

5 ANOMALIES IN CURRENT FINANCIAL AND ORGANISATIONAL ARRANGEMENTS AND THEIR IMPACT ON EFFECTIVE HEALTH CARE DELIVERY (TERM OF REFERENCE 1G)

5.1 Background

This section of the report describes some of the anomalies, their causes and their implications for health service delivery. Many submissions to the Committee identified a range of anomalies in both the financial and organisational arrangements for the provision of health care services. Some of these problems may be found in health systems throughout the world, while others are unique to Australia and its system of government. The causes of these anomalies and their effects are summarised in the following sections.

5.2 System anomalies

Several submissions to the Committee argued that there are a number of anomalies and distortions which are essentially a function of the nature of the health system itself. These include:

- **Unclear objectives and lack of incentives for the system**

  The combining of the roles of both funder and provider of health services creates an inherent conflict of interest. In NSW, these roles are undertaken by Area and Regional Health Authorities, where they are responsible for both maintaining the health status of their resident populations and for managing the provision of health care services. Treasury submits that:

  > "the tendency is that where the two roles are combined, the emphasis is placed on the provider role at the expense of the purchaser role. In fact the two roles are in inherent conflict and their combination effectively mitigates against the effectiveness of undertaking either role."

  The Committee notes, however, that no evidence has been provided as to the basis for this assertion and the conclusion it implies.

- **Lack of appropriate incentives for clinicians**

  Clinicians are one of the key cost drivers of the health care system, with direct influence over admissions, length of stay, the costs of treatment and the outcome of treatment. Typically, however, clinicians are not required to consider the cost of services, since these are funded by the Commonwealth, the State, the insurer or the patients themselves. Within this framework, the range of remuneration methods for clinicians results in distortions and affects their behaviour. For example, VMO payments may be based on a fee for service or a sessional basis. The former method encourages over servicing, while the latter method encourages inadequate treatment. However, it is questionable as to whether these same "perverse incentives" apply to salaried medical officers.

- **Lack of incentives for GP's to act as gatekeepers**

  In many countries, GP's have an advisory role to patients in regard to their health care needs, as well as monitoring treatment and generally acting as a gatekeeper to the rest of the health care system. In Australia, this role is limited by the method of remuneration which, being fee-for-services which are consultation-based, encourages relatively short consultations and hence referral to specialists. At the same time, the remuneration system makes no provision for the advisory and health monitoring role. The Commonwealth is reviewing remuneration methods for GP's as part of a larger review of the future role of the GP in primary and preventive health care.

- **Absence of information on consumer preferences and the cost of treatment**

  At a general level, there is limited information available on measures of health outcomes and their relationship to health inputs and outputs. Treasury commented that

  > "it is only by the availability of such information that it is possible to develop a rational health strategy in the context of limited resources and competing demands. Work is proceeding on addressing this deficiency, but there is a considerable way to go."

- **Lack of consumer power**

  Patients themselves are able to exert only limited power over the decisions made on their behalf in regard to the nature of treatment provided. Whilst approval of the patient is required before treatment may commence, patients generally are ill-informed about alternative treatment methods, and their rights to seek additional information. In this regard, medical practitioners continue to be the primary power holders.

5.3 Commonwealth and State Government responsibilities

The respective roles of the Commonwealth and State Governments have been outlined previously in this report. These responsibilities have led to a range of distortions, duplications and confusion which impact on the efficiency and effectiveness of the health system, which include:

- **Complex and confused lines of accountability.**

  The involvement of multiple tiers of government involved in the funding, purchasing, provision, regulation and monitoring of services has resulted in the absence of a final level of accountability for service provision and its outcomes. The Health Department states:

  > "Because different levels of government have responsibility for different components of service provision, there are significant barriers to achieving major efficiency gains through substitution of more cost-effective ambulatory, community or home based care for more expensive institutional services."

  In its submission, Treasury cited difficulties of a similar nature resulting from the Commonwealth's introduction of a range of specific service programs, each with its own reporting and accountability requirements which further confuse and complicate the management and co-ordination of services.

- **Incentives for cost-shifting**

With different components of the health care system funded by different levels of government, there are strong incentives to shift services to those funded from another source. Examples of this include:

- Commonwealth funding of community medical and pharmaceutical services, while states fund similar services provided at casualty and outpatient departments at public hospitals, provides an incentive for the hospitals to de-emphasise outpatient services.

- Incentives for hospitals to discharge patients early, given that the Commonwealth provides funding for community services through the joint Commonwealth-State Home and Community Care (HACC) Program.

- HACC emphasises that the priority is for frail aged at the expense of post-acute services.

- Geriatric assessment services operated by the Commonwealth are separate from both HACC programs and public hospitals, limiting both their coverage and potential benefits.

The Health Department summarised the effects of cost-shifting as follows:

"The issue of cost-shifting is not that it represents a large burden financially in that the total amounts involved are relatively small. It creates a problem in the system because it provides perverse incentives in the delivery of care, which impede efficient, effective and appropriate delivery:

- energy is directed (by State and Commonwealth) to exploiting this potential, which is inefficient for the system

- appropriateness of care is jeopardised

- continuity of care is jeopardised

- incentives exist to set up ways of delivering services which minimise financial burdens in the short term. In the longer term, this may result in a less efficient system."

- **Duplication of administration**

In such areas as nursing homes and the HACC program, the involvement of multiple levels of government provides the potential for the duplication of administrative arrangements. This in turn leads to duplication of and potentially inconsistent reporting, and complex lines of accountability.

- **Structural rigidity in program boundaries**

Typically, State and Commonwealth programs are rigidly defined in terms of criteria for access to their services. The Health Department cites the case of the no-growth provisions in HACC which reduce access to post-acute care, thereby creating the risk of patients being admitted to nursing homes when they might have adequately been cared for at home. The rigid nature of these boundaries thus creates the potential for either duplication of service provision or discontinuity of care, as well as inefficiencies on the provision of services.

- **Lack of integration of health services**

The varying responsibilities of the Commonwealth and State Governments for different elements of health care are shown in Table 4 below. The division of funding and responsibility for different elements of the health care system between the Commonwealth and the State Governments provides few incentives and little potential for the establishment of effective networking of services. According to the Health Department,

"not only can this result in inconsistent care which may be detrimental, it also inhibits the potential to package appropriate groups of services for particular individuals".

TABLE 4 - RESPONSIBILITIES OF THE COMMONWEALTH AND STATE GOVERNMENTS FOR ELEMENTS OF HEALTH CARE	
Sector	**Commonwealth/State Role**
Prevention and public health	State
Primary health care	Mainly Commonwealth, but with State involvement in outpatients and community health
Secondary and tertiary health care	State
Rehabilitation	Commonwealth and State
Nursing home	Mainly Commonwealth, with State involvement
Community care	Commonwealth and State

Source: NSW Treasury Submission to the Public Accounts Special Committee pp 16

5.4 Anomalies induced by the funding system

The nature of the funding system used to finance the delivery of health services, independent of those caused by the different sources of funding referred to previously, is a further area of concern to many of those making submissions to the Committee. Such anomalies and their causes include:

- **Funding of hospitals on global budgets**

  The existing mechanism for funding hospitals on a global budget basis, often on the basis of historical cost, results in the hospital manager bearing the risk of variations in throughput, changes in case mix, and the costs of services per case. The manager, however, has limited control over these factors, and is therefore often forced to resort to relatively crude strategies to contain costs, such as bed closures. At the same time, the funding mechanism provides an incentive for hospital managers to shift

costs to community services which are outside his/her budgetary responsibility.

As a novel twist to the latter feature, the Committee was made aware of the opposite reaction in the case of an early discharge program. Under a trial of such a program, the costs of inpatient services actually rose as a result of an early discharge program. This was due to the fact that the bed vacated by the early-discharged patient, who at the time of their discharge was at the low-cost recuperative stage of their treatment, was subsequently occupied by a patient who was at the higher-cost initial stage of their treatment. Thus the average bed-day cost rose under these circumstances, and the trial program was discontinued because of budgetary constraints. The fact that the discharged patient was also privately insured, and may not have been replaced by a similarly insured patient, exacerbated the net costs, since the hospital lost the private health insurance benefit for the treatment of the insured patient for those days foregone under the early discharge program.

Thus, the funding system can result in decisions which are contrary to both the individual needs of patients, and the development of more cost-effective methods of service delivery across the spectrum of hospital and community based services.

An alternative funding system based on hospital throughput rather than historical cost, is perceived by many to improve this situation. This approach typically uses Diagnosis Related Groups (DRG's) as the basis for classifying patients into clinically similar and resource homogeneous categories so that differences in hospitals' case mix are recognised and catered for. Under this system of funding, hospitals which can provide services to patients in a given DRG category at below the average cost for which they are funded receive a benefit, while those whose costs of service delivery exceed the average DRG cost are penalised. Thus a payment system based on DRG's provides considerable incentives for hospital managers to contain costs.

It is noted that DRG-based funding systems are at this stage limited to inpatient services only, and that separate mechanisms are required for the funding of outpatient, accident and emergency and outreach services.

Further, there are some types of inpatient services, such as those relating to psychiatric and rehabilitation services and some types of paediatric services which are not adequately catered for by DRG's.

DRG's are also considered to provide a valuable management tool for identifying areas of excessive costs both within and between hospitals, thereby enabling managers to focus on those areas of greatest concern. At the same time, however, concern has been expressed that the drive to contain costs under a DRG-based payment system may override concerns about patient care and the adequacy of the services provided.

DRG's have been developed in most countries, and are available for public hospitals in New South Wales. The Commonwealth Government is also giving consideration to their adoption in the funding of payments to the States, and they will be used in determining payment to New South Wales for the transfer of Concord Repatriation Hospital. Victoria has recently announced its intention to implement a DRG-based funding system for its hospitals from 1993-94.

Whilst a DRG-base funding system may improve the efficiency of funding hospital services, the issue of cost-shifting between hospital services and community-based services remains. In this regard it is essential that a more holistic approach to the funding of services is adopted, to facilitate the delivery and funding of the most appropriate form of care in a more cost-effective manner than is possible under existing funding mechanisms.

- **Separation of capital budgets from recurrent budgets**

The Health Department has identified that significant savings would accrue through an accelerated investment program through the efficiencies gained from more appropriately designed and located facilities. This feature highlights the important relationship between the investment in infrastructure and recurrent costs.

The Department has sought a rescheduling of capital funds to facilitate an accelerated investment program Should this not be possible, the Department has sought a growth in recurrent funding which it would seek

to apply to the capital infrastructure problem. Thus funds would be applied to the best long term strategic purpose.

- **The budgeting and planning time frame**

  The Health Services Association of NSW (HSA) identified a number of anomalies associated with the existing short time-frames adopted for budgeting purposes at the hospital level. These time-frames fail to take account of long-term planning, and inhibit the amortisation of capital investment which could lead to greater efficiencies and cost savings. They suggest that hospitals should be able to take a longer term view and raise funds through a variety of means (including retained savings due to efficiency gains) to achieve a medium to long term capital outlay, with a resulting saving to the health system at a later stage.

- **Centralised financial and asset control**

  The HSA also identified the anomalies arising from the existing centralised nature of financial and asset control, and the delays these cause between the inception of a plan and its implementation. Whilst providing control over system-wide costs, such an approach often leads to the lead time for new projects being extended to the point where the potential savings identified in the first instance are lost by the time the project is implemented. They advocate that the financial system should be "freed up", so that area and hospital managers are able to act on innovative ideas and opportunities with less constraint.

5.5 Anomalies at the local management level

At the hospital level, managers are faced with a range of disincentives and difficulties which act to inhibit efficiency and effectiveness. These were referred to in several submissions, and include:

- **Lack of management control and adequate information**

  Hospital managers have only limited control over both service provision and costs. This manifests itself in a variety of ways:

- inadequate information about costs of departments or procedures, resulting in an inability to make informed decisions based on relative costs

- the main drivers of costs are clinicians, not the managers, with clinical decisions often being made without knowledge of their budgetary effects

- the main performance measures tend to be bed usage and length of stay, neither of which provide incentives for cost-effective treatment or quality control

In commenting on the above features, Treasury states:

> "None of this is to say that hospital managers are seeking to act in perverse ways or contrary to the interest of the patient. To the contrary, hospital managers will try to reconcile these conflicts in objectives and seek to achieve the best outcomes for patients. However the existence of perverse incentives and lack of effective control over key decisions makes their task difficult"

- **Inadequate management structures in hospitals**

While some tertiary hospitals have departmental accounting structures and have facilitated accountability by clinicians, these practices are not the norm. Consequently there is a lack of accountability in both direct service areas and clinical support areas for financial performance.

5.6 Summary

The submissions to the Committee cited many examples of anomalies that exist within the system which serve to act as perverse incentives to both the funders and providers of health care, and as barriers to the efficient delivery of services.

The health care system itself, like many such systems internationally, fails to provide incentives for many participants. These include:

- clinicians who, despite being among the key drivers of costs, are not participants in the funding decision-making process;

- GPs who are discouraged by the method of remuneration from taking a more active role as advisors to patients on their health care needs, and from acting as gatekeepers to the health system; and

- the public sector which is both the funder and provider of services, which some argue creates a conflict between these roles, whereby the provider role gains dominance;

- consumers themselves whose preferences are unknown, and who are uninformed about the real costs of health care.

- lack of consumer power over the nature of treatment provided and the availability of alternatives.

The respective roles of the Commonwealth and State Governments in both the funding and delivery of health care services is a second source of anomaly. In particular, the following problems were identified:

- complex and confused lines of accountability result in the absence of any final level of accountability across the two levels of government;

- the different sources of funding for many components of the health system provide incentives for cost shifting both between the funding agencies and between the different providers of services;

- duplication of administration across the two jurisdictions;

- structural rigidity in program boundaries which inhibit the delivery of the most appropriate form of care; and

- a lack of integration of services limiting the potential for improved networking of service providers.

The nature of the funding system itself is a further cause for concern. Examples of the causes of the anomalies occurring within this aspect of the system include:

- global budgeting of hospitals on the basis of historical costs leads to managers having to resort to relatively crude measures to control costs, such as closing beds, and provides incentives for the manager to shift costs to community-based services which are outside of his/her budgetary responsibility;

- separation of capital budgets for major capital expenditure items from recurrent budgets inhibits the potential to make optimum use of recurrent savings for the purposes of infrastructure funding;

- the relatively short time frame for budgeting and planning restrict the time horizons of managers and limit the amortisation of capital investment which could lead to greater efficiencies and cost savings;

- centralised financial and asset control leads to delays between the inception of a plan and its implementation, often resulting in the loss of the potential savings originally foreseen.

Finally, at the local management level, several anomalies were identified:

- lack of management information and control;

- inadequate management structures in hospitals which inhibit the drivers of costs being accountable.

In summary, it is clear to the Committee that problems and anomalies in financial and organisational arrangements are impacting on the effectiveness and efficiency in provision of health care services in NSW. There are clear issues which need to be addressed. In particular, there is a need to simplify and clarify lines of accountability; to remove incentives for cost shifting; to eliminate duplications in administration; to provide for increased flexibility in defining program boundaries; to ensure that health services are better integrated; and to minimise or remove funding system anomalies. Each of these issues involves complex actions and in some cases, fundamental

changes. The Committee has made several recommendations in regard to some of these specific issues.

At a more global level, the Committee believes that many of the problems identified within the health sector could be addressed through a re-orientation of the health system focus towards achieving health outcomes. As previously stated, however, the Committee reinforces the need to ensure that the focus does not become only those programs for which outcomes are easily measurable, and that the effects of services on patients remain paramount. The Committee's attention was drawn to the discussion paper on accountability in health prepared by Professors Baume and Nutbeam in conjunction with the NSW Health Department. The Committee sees merit in a number of the suggestions made in this discussion paper, and has incorporated them in the strategies proposed in this report.

RECOMMENDATIONS

5.1 That the Health Department develop resource allocation processes which more closely link funds provided to services delivered, covering both hospital and community based services.

5.2 That early discharge programs be formally trialled and evaluated to determine their effectiveness on achieving health outcomes, their costs, and the nature and level of resources required.

5.3 That NSW Treasury and the Health Department further investigate strategies for the funding of physical infrastructure through more flexible arrangements between the recurrent and capital budgets.

6 ALTERNATIVES FOR THE PROVISION OF PHYSICAL INFRASTRUCTURE

This section reviews the range of alternatives available for the provision of physical infrastructure in the health industry, and their respective advantages and disadvantages from both an economic and social viewpoint. As in previous sections, these issues are considered under headings corresponding to the Terms of Reference.

Most of the alternatives and suggestions discussed below arise from submissions made to the Committee by a range of individuals and organisations. Many of the submissions focused on alternative ways by which the private sector might participate in infrastructure funding and delivery, and their relative merits. One possible option considered by the Committee however, did not emerge from the submitted materials. This potential area relates to ways in which the provision of physical infrastructure in health may arise from a wider assessment of State owned assets used for a range of broadly related human services, not merely within the health sector. The Committee considers that many of the traditional approaches to accessing resources within the public sector could benefit from a cross-portfolio perspective rather than from the more narrow confines and views of a single agency.

6.1 SOCIAL AND ECONOMIC COSTS AND BENEFITS OF ALTERNATIVE WAYS OF PROVIDING PHYSICAL INFRASTRUCTURE AND HEALTH SERVICES (TERM OF REFERENCE 1C)

6.1.1 Background

A number of submissions to the Committee argued that the dilemma facing the NSW hospital system in regard to its physical infrastructure is the large proportion which is in poor physical condition and inappropriately located to meet current and future needs. In its submission to the Committee, the Health Department stated that:

> "insufficient capital funds are available over the next ten years to satisfy the competing priorities of developing new facilities in growth areas and maintaining and modernising older facilities in established areas."

In examining this problem, the Department has investigated the prospect of accelerated investment in infrastructure, meaning the spending of the same amount of capital funds in the long term, but with a higher level of expenditure initially to "break the back" of the problem. Their analysis indicates that such a program would not only provide for the establishment of required facilities sooner, but that total costs would be lower than under a capital works program with a uniform cash flow. The reasons for the expected savings include a diversion of demand from dysfunctional facilities which may then be closed or allocated to other uses, together with asset sales and reductions in recurrent spending as the new facilities are more efficient.

The difficulty in implementing such a program lies in accessing the required funds for the initial cash flow. Traditionally, the NSW Treasury has been the provider of such funds. The Department has sought a rescheduling of anticipated capital and recurrent funding over the next ten years to meet the cash flows of an accelerated program.

In considering this prospect, Treasury, in its submission stated:

> "The difficulty is that there is little if any capacity for the State Budget to expand capital funding significantly in the health area and similarly no apparent prospects at this stage of the Commonwealth assisting.
>
> This raises the issue of what are the alternative avenues open involving private sector provision of health infrastructure."

The Committee considers that the matter of examining such alternatives inherently involves consideration of the respective roles of the public and private sectors in the health industry, as well as an examination of priorities in setting the State budget.

6.1.2 The role of government

The basis on which the choice between alternative means of funding health infrastructure is made relies as much on the perceived role of government in the funding and provision of health services as it does in the consideration of the economic and social outcomes of the alternatives. In its submission to the Committee, the NSW Health Department identified the aims of the State's involvement in the health system as;

"• improving health outcomes,

• ensuring access to appropriate services,

• continuity of care,

• maintenance of quality of care standards, and

• efficiency in service provision, distribution and delivery."

Both the Health Department and the NSW Treasury consider that the achievement of these aims does not necessarily require the public sector to be both the funder and the provider of such services. Treasury argues:

> "Government clearly has an important, indeed central role in establishing the health policy framework and in ensuring that adequate health services are available to all citizens. This is a purchaser and regulator role. ..... The achievement of these (the Health Department's) goals does not require that the public sector is the sole or even the predominant provider of such services. Indeed it can be argued quite strongly that the combination of these two roles in the one organisation means that the core role of purchaser and regulator is compromised in pursuit of the provider role."

Models involving funder/provider splits have recently, or are currently being, implemented in both the United Kingdom and New Zealand, and are being considered in several other countries. However, the limited time of the experience gained in their operation provides little empirical evidence on which to assess their long term economic or social consequences. Some

evidence exists of higher initial costs in the establishment of the necessary mechanisms to implement the systems and in the formulation of the necessary contracts, but their long-term effects are largely unknown at this time.

The Health Department identified two models of funder/provider splits as they might operate in NSW. The first is a "pure" model, whereby the Health Department would allocate funds to areas on an adjusted per capita basis, with Area Health Services then purchasing the required services from public and private hospitals and other service providers on a contractual basis. The second model, the "budget holder" model, would entail the appointment by the Department of a budget holder for a specified client group (such as aged care services, mental health services), who would then be responsible for determining the needs of their client group, and for purchasing the required services on their behalf.

It is claimed that this approach stimulates a more cost-effective service delivery through competition and substitution. This view was one which was advocated by Treasury, with the emphasis that the driving factor behind such models was the competition between health providers, regardless of whether they were in the public or private sectors. However, the difficulties in establishing internal markets in country areas are also acknowledged, where there is often only a sole provider of services in the region, and the capacity for increased competition is limited. The Health Department also felt that to be effective, this approach requires an improved management information system which provides for the high level needs assessment and quality assurance to be conducted.

A contrary view to that of Treasury was expressed by Professor Ian Webster who, in his submission to the Committee, cautions against "internal markets", emphasising that there is still no evidence that such an approach will yield greater efficiencies. He claims that for competition to achieve reduced costs, there must be excess capacity. In Australia, he asserts that there is no excess capacity in the public sector, since it "has already been trimmed through rationalisation and resource allocation formula". Under these circumstances, he considers that competition will lead to duplication, and that what is needed is "co-operation, not competition". His conclusion is that the current mix of private and public sector participation is reasonable, and that:

"the balance we have reached is between a strong public sector, 70% of the budget, moderated by the influence of private practice".

Within Australia, the case of the Port Macquarie Base Hospital contract represents the most well known example of the separation of the funder and provider roles in the delivery of hospital services. In this case, the private sector is to construct and operate a new private hospital at Port Macquarie, and, under the terms of a contract with the Health Department, will provide a defined range of services to public patients for a specified time period.

6.1.3 The role of the private sector

The private sector traditionally has provided hospital services in parallel to the public sector, with a heavy reliance on private health insurance as the primary source of funds via membership of patients. Whilst acknowledging the decline in the levels of private health insurance participation evident since the introduction of Medicare, the Committee was divided in its views as to the implications a continuation of this trend would have for the survival of the private hospital industry.

In recent times, there have been a number of initiatives whereby new private hospitals have been, or are seeking to be, established in close proximity to major public teaching hospitals. Such arrangements are perceived to yield mutual benefits to both hospitals, in the form of reducing the demand for acute beds in the public hospital while providing the private hospital access to specialist technologies and a broader patient base than they might otherwise gain. At the same time, such arrangements may reduce the revenue to public hospitals previously provided by private patients, and increase the costs to private health insurers.

In its submission to the Committee, the Private Hospitals Association of NSW stated its support for the development of private facilities on public campuses, but under clear criteria. In essence these related to ensuring that the private facility was in fact privately owned, that its management was separate from the public facility, and that any sharing arrangements were clearly defined and provided for on a contractual basis.

The possible development of contractual arrangements between the government and private hospitals for the provision of services to public patients of the type embodied in the Port Macquarie contract or other funder/provider arrangements, would signal a significant shift in the source of funds for private hospitals. Their dependence on private health insurance would be reduced, and replaced by a greater reliance on public funds. Should such arrangements become widespread, then the potential impact on private health insurance, and subsequently on private hospitals themselves, must be considered.

6.1.4 Alternatives for infrastructure and service provision

A number of the submissions to the Committee identified a range of alternative means by which physical infrastructure and health services may be provided, comprising various forms of participation by the public and private sectors. Some of these alternatives already exist within New South Wales and elsewhere in Australia, where the public and private sectors, individually and in some cases conjointly, fund and operate health care facilities. The Port Macquarie contractual arrangements are the most advanced of these initiatives, and were the subject of Stage 1 of this Inquiry.

In Victoria, contractual arrangements are nearing completion for a joint venture between the public and private sectors for a new hospital at Werribee. The existing public hospital is to close, and a new hospital is to be constructed and owned by a private consortium. A not-for-profit private operator is to provide services under a lease arrangement with the owners for approximately 18 years. At the end of the period, the operator will have the option to purchase the facility. Community services are not based at the hospital, but are to be provided through a separate public community health centre which is operated and funded independently. No formal arrangements are proposed for the co-ordination of hospital and community services, although it is hoped that such arrangements will occur at the operating level.

In Tasmania, negotiations are underway for the establishment of a new public hospital at Burnie in conjunction with the private sector. Under the proposed arrangements, the land is owned by the public sector, with a 50 year ground lease to be granted to a private consortium, who will construct and own a hospital at the site. A public operator will then lease the facility for an initial

term of 15 years, with the option of two 5 year extensions. The new hospital is adjacent to an existing private hospital, with a range of clinical support services to be provided to the two hospitals by a private sector operator under contract. These services are located between the two hospitals. In addition, obstetric services will not be provided at the public hospital, but will be provided under a service contract by the private hospital. Community services are to be provided from a separately operated and funded public community health centre.

These represent three examples of recent initiatives between the public and private sectors in the delivery of hospital services. In its submission to the Committee, the Health Services Association of New South Wales (HSA), provided one of the most comprehensive listings of existing and potential alternatives, including:

"• public provision of capital funds to construct infrastructure,

• private provision of funds to construct infrastructure,

• public provision of funds to run infrastructure,

• private provision of funds to run infrastructure,

• public contracting with the private sector to construct infrastructure with the public sector as the operator,

• the takeover by individual communities of existing public health services which are then run as not for profit community health services,

• public funds to provide the infrastructure with a contracted private operator,

• public health care facilities contracting with the community to take out bonds in the running of and financing of infrastructure of the health facility,

• public share floats of existing public health care facilities,

- the creation of limited internal markets through mechanisms such as purchaser/provider splits in which public and private operators would bid for the supply and provision of health care facilities to a community,

- the total deregulation of the health service where public and private facilities contract with the government to provide the health service needs to a particular community, with the best and most cost effective service winning each individual contract. The creation within such a system of a level playing field such that health care facilities which cannot financially survive, public or private, would eventually have to close, and

- the partial liberalisation of the public sector to enable the managers of health care facilities at either an Area or individual hospital level to develop health care facility sites at the most appropriate location which may require consolidation of various sites involving sales with the proceeds of such sales generating capital for development of green field sites. The extension of this type of deregulation to allow for public health facilities to do a lot more contracting out of services both clinical and domestic as well as providing mechanisms to radically change current infrastructure facilities."

Clearly, those alternatives which entail either the public or private sectors exclusively in the funding of infrastructure and the provision of services at a given site are the most common forms currently evident in Australia, and typify their traditional roles within the total health system. Other forms of co-operative venture between the public and private sectors, whether in the form of providing investment capital, the co-location of facilities or the contracting of services form the focus of the Committee's considerations. In the case of contracting for the provision of services, it is apparent to the Committee, as was illustrated in the case of Port Macquarie, that the nature of the contractual arrangements, and their capacity to adequately cater for the proposed range of services, are critical.

6.1.5 Economic considerations

In considering the economic implications of the various alternatives for the funding of health infrastructure and the delivery of services, the perspective taken is paramount. If the effects are simply viewed from the perspective of,

say, the State Government, then the perceived advantages may be considerably different than if a broader, all encompassing view is taken. This was demonstrated in the case of the Port Macquarie Base Hospital, where potential savings to the NSW Government were identified over a twenty year period under a private construction/private operator contract compared to a traditional public construction/public operator model. One of the major factors in achieving this result was a partial shift of the payment for service delivery to private health insurance funds, who would be obliged to meet the costs of all privately insured patients at private hospital rates, rather than at the lower fees charged by public hospitals.

At the same time, the contract provided the government with the opportunity to ensure the provision of the required health services at a new and modern facility without incurring the initial capital expenditure required for its construction. These capital savings were partly offset by higher recurrent costs in the payment for services and a facilities charge. Thus, in addition to a shift in costs between the sectors, there was also a change in the form of government payments from capital costs to recurrent costs, and a spreading of the expenditure over a longer time frame. This is expected to be typical of this form of contractual arrangement for the provision of services.

From a community perspective, the essential economic question to be asked is whether or not such arrangements are expected to result in the provision of services of equal or superior quality at a lower total cost. This view may differ from those of the individual parties funding the services, who are primarily concerned with the impact of the arrangements on their own operations. The optimum situation occurs where the total costs of service delivery are reduced, and where all parties involved in funding the services share in these savings.

Virtually all of the forms of co-operative venture between the private and public sectors outlined above entail some form of cost-shifting between funders of health care, or between types of expenditure. Whilst, for example, the overall economic impact may be (close to) neutral, the potential impact on the funders of health care affected by these arrangements must not be overlooked. To the extent that such arrangements add to the total costs of private health insurance funds, then without a commensurate increase in revenue through expanded membership, such arrangements must place the private health funds at greater financial risk. The potential impact of such a

risk on the private hospital industry, and the subsequent flow-on effects on the demand for public hospital services would be significant.

Notwithstanding these potential effects, the opportunities for economic gains through greater collaboration between the public and private sectors in the health industry warrant further investigation. To the extent that the private sector can provide services (either support or total health services) at a lower cost than their public sector counterparts, then economic benefits may accrue from such arrangements. Such savings may result from improved work practices, economies of scale, a stronger market focus, or from the competitive environment of the private sector. Similarly, co-location of public and private facilities may enable more efficient utilisation of joint services, facilities and equipment, thereby reducing total costs of services.

It is not appropriate, on an a priori basis, to classify forms of co-operation between the public and private sectors, into those which are inherently "good" or inherently "bad", or those which offer a greater economic advantage relative to others. Certainly, the high costs and unequal coverage of the predominantly private US health system are to be avoided. Conversely, it is too soon to fully assess the economic effects of the recently introduced funder/provider split systems in the UK and New Zealand. Within Australia, the Port Macquarie case is the most advanced form of contractual arrangement between the two sectors in the provision of hospital services. Whilst its potential implications have been examined, it will be some years before any empirical assessment of its effectiveness can be undertaken.

Clearly the nature and extent of economic costs and benefits of the alternatives for infrastructure funding and service delivery will vary on a case by case basis, and will be determined largely by the nature of the contractual arrangements, the costs of any alternative arrangements, and the respective benefits they offer to the participants. In assessing the value of such agreements, it is essential that a community perspective is adopted, and the costs and benefits to all affected parties are identified. Only by so doing can the real economic advantage be identified and assessed.

6.1.6 Social considerations

A second major consideration in assessing the relative merits of alternative forms of infrastructure funding is their potential impact on social and community issues. Within this context, the submission from the Health Services Association of NSW identified a number of basic social issues which should be taken into consideration.

The first is that of universality. A fundamental tenet of the health care system in Australia, and basic to Medicare, is the expectation that all persons are financially covered for basic hospital and medical care. In order to be acceptable, any proposals for the development of co-operative arrangements between the public and private sectors for the delivery of health services must be shown not to undermine this principle. Such agreements, whether they be in the form of contracts for services of the type at Port Macquarie, or for co-located hospital services, should be explicit in their arrangements concerning the financial coverage of recipients of those services. Protection must be provided within these arrangements to ensure that individuals are not exposed to a greater financial risk as a result of unpredicted illness than they would be under the existing public hospital system.

At the same time, it must be recognised that co-operative ventures between the two sectors carry a risk of creating a two tiered health system. Most of the arrangements between the sectors for the provision of hospital services encountered to date embody a continued distinction between the private component and the public component of the facility, at least in terms of its hotel functions if not its clinical functions. This distinction is generally predicated on the perceived need to provide a basis for people to receive "value for money" for their private health insurance. Whilst this distinction may be considered to exist already in the market, the closer proximity of the two sectors under contractual or co-location arrangements make the distinction more obvious. Under these circumstances, the social consequences of this distinction and its reflection on the social fibre of communities, particularly comparatively small or rural communities, must be taken into consideration when considering the overall merits of such proposals.

The second issue is that of equity. This relates to the provision of health services on the basis of need, rather than on the capacity to pay. Given the existing limitations on the public sector to provide the required infrastructure funding in its own right, co-operative ventures with the private sector may be regarded as facilitating the achievement of this objective. This is particularly evident given the existing maldistribution of resources between areas relative to need. Within this context, the conditions contained in any proposed arrangements should be seen to promote the concept of equity both in terms of the provision of services to whole communities and to individuals within communities.

A third issue of concern is that of the comprehensiveness of the services to be provided and the consistency of the means of providing the various elements of those services. Whilst it is recognised that some types of health services may lend themselves more readily to public/private sector co-operative arrangements, such as the provision of inpatient care, other types of health care may be less suited to such arrangements. This issue was of particular concern in the consideration given by the Committee to the provision of community health services during the inquiry into the Port Macquarie contract. Notwithstanding the arrangements made for the provision of those services in the Port Macquarie case, it serves an example of the need to ensure that not only are the services provided comprehensive in their totality, but that the arrangements made for individual service elements are consistent and appropriate to the nature of the service. In this regard, the potential for conflict between service elements should be recognised. For example, the development and delivery of a health promotion campaign, or the implementation of an early release program from hospital, may potentially conflict with a contract for inpatient services which remunerates the hospital operator on the basis of length of stay. Consideration of these issues may require these elements of health services to be undertaken by different providers. At the same time, the effects of such arrangements on the continuity of care and integration of service delivery is also of concern.

Finally, the issue of accessibility to services is of paramount concern. It is essential that any co-operative arrangements for service delivery guarantee equal access for all residents throughout the term of any agreement. Within this context, it is recognised that some form of rationing may be implemented as readily under a public hospital option (through limiting the recurrent funds

available) as it may under a contract with a private operator (by limiting the maximum number of services to be provided under the contract). Thus, the capacity for the funder of services (the public sector) to limit access to health services is not limited to co-operative ventures with the private sector. In fact, it is desirable for the funder of services to have the capacity to do so in order to control costs, and to limit the opportunity for potential over-servicing. On the other hand, any contractual arrangements for co-operative ventures must ensure that equal access to services are provided for under the terms of the contract.

6.1.7 Criteria for consideration of alternatives

The Committee considers it appropriate that, if private sector participation in the provision of services to public patients is to be considered, a framework should be developed for the evaluation of the alternatives for such participation. This is particularly important, given the considerations outlined above and the relative lack of experience in alternative forms of public and private sector joint participation in the funding and delivery of health services.

The HSA submission outlined such a framework which entails consideration of three main categories of issues:

The first category relates to the resource contribution of the proposal. The HSA suggested that the following questions be asked:

"Does it (the proposal):

- provide additional resources, or
- promote competition, or
- provide incentives for efficiency, or
- reduce regulatory restrictions which inhibit efficiency, or
- assist in developing a greater customer focus, or
- facilitate workplace reform?"

The second issue relates to the support provided by the proposal for the objectives of the health care system. In this regard, HSA suggested the following questions:

"Does it (the proposal)

- reduce financial risk to which individuals are exposed as a result of unpredicted illnesses;

- promote equity - that is, the provision of health care according to need where the burden of paying for services should be apportioned according to the ability to pay;

- increase quality;

- modify (increase or decrease) the levels and types of health care which people use in order to improve their health status; and

- encourage technical efficiency in the organisation and delivery of health services (i.e. not just incentives but actual evidence of efficiency)?"

The third category relates to the incorporation of the underlying program criteria in the proposal. These comprise:

"• universality - all residents should be financially covered for basic hospital and medical care;

- comprehensiveness - all needed health care services should be available; and

- accessibility - services should be accessible to all residents."

The ultimate assessment of the relative merits of the alternatives under consideration will depend on the relative weight applied to each of the above criteria used in the framework. The application of such a framework, however, will assist in ensuring that all aspects associated with such proposals are

considered in a comprehensive and structured manner. Equally important, it will help to bring a community perspective to the deliberations.

6.1.8 Making better use of existing publicly-owned human services physical infrastructure

Many submissions to the Committee have focused on problems of existing physical infrastructure in the health sector, and how future needs should be funded. Although no data were presented to the Committee, it is clear that there is already a substantial accumulated investment in physical health infrastructure in NSW. This investment is the result of decades of investment, the particular characteristics and circumstances of each area arising from a variety of factors.

It was also made clear to the Committee that a variety of health service resources are not as well distributed as needs may warrant. The Committee accepts that the Resource Allocation Formula (RAF) devised and used by the NSW Health Department is a rational basis for the redistribution of recurrent and capital resources on a regional or area basis. The Department stressed however, that the RAF can only be effective if it is fully integrated with the Capital Works Program (in respect of physical infrastructure).

A number of submissions to the Committee emphasised the continuing nature of change in the mix of health services needed within an area as its demography changes over time. In addition to these temporal changes, there are differences in demographic structure from region to region, and demographic processes may be occurring at different rates. In short, the precise mix of health services is complex and varies over time and in space.

It is also apparent that just as the requirements for health services change over time and differ from region to region, so does the demand for other human services such as education facilities, community centres, and various forms of public housing, including special forms of accommodation. The State has a significant, if not dominant position, in relation to investment in the physical infrastructure for these other forms of human services.

The Committee is concerned that the existing conceptual framework for examining public human services physical infrastructure needs is too narrow,

and poorly integrated across portfolios. Given the pressing financial and budgetary pressures within NSW, the Committee considers that it is appropriate to reconsider how the State should address the issue of re-allocating existing physical infrastructure across the range of human services provided.

The Committee is not in a position to recommend a detailed mechanism for how such a cross-portfolio approach to physical infrastructure re-use should be developed, but considers that the concept should be further examined. There is already a mechanism for the allocation of recurrent funding within the health portfolio. It is perhaps time to determine a mechanism for the re-allocation of existing physical infrastructure across the whole of the public sector, but especially in those portfolios concerned with the provision of human services.

It is clear that in an informal, or less structured manner, inter-agency transfers of buildings or other physical resources has and continues to occur. For example, a region which is characterised by a relatively narrow age range of young families will have different education, transport, community facilities, hospital and non-hospital health services, and housing requirements in 2003 than it needed in 1993. What happens to the building stocks of the various agencies as the demographic structure changes and demand for service profiles change? Is there a coordinated approach to the re-use of existing resources for new or changed purposes? No evidence has been presented to the Committee to suggest such an approach exists.

The Committee suggests that the concept of an "inter-departmental human services infrastructure needs, review, and re-allocation process" should be further examined as a matter of priority. The Committee believes that such activities would best operate on an area or regional basis, and that primary responsibility would not lie with Treasury or support services agencies (e.g., Departments responsible for capital works and administrative services).

While the concept may appear relatively straightforward, the Committee recognises that developing a suitable mechanism will require innovation, and will not be easy. The Committee believes that the issue of appropriate re-allocation or re-use of existing human services physical infrastructure cannot

be ignored and must proceed in line with exploring options for new health infrastructure.

6.1.9 Summary

Many of the submissions to the Committee considered that the dilemma facing the NSW hospital system in regard to physical infrastructure is the large proportion which is in poor physical condition and inappropriately located to meet current and future needs. The Health Department has identified that an accelerated capital investment program would not only alleviate this problem, but that it would prove cost-effective by reducing the level of recurrent funding due to inefficiencies associated with the existing infrastructure.

The difficulty in implementing this program, however, is in the formulation of the State budget to adequately cater for funds across all government program areas. Some members of the Committee considered that an increase in the total funds provided to health was appropriate, while others considered that an approach which focused on alternative methods of funding and service delivery from within existing capacity was appropriate.

The Health Department has explored a number of alternative avenues for funding, particularly from the private sector. A review of the alternatives necessarily requires consideration of the respective roles of the private and public sectors in the funding and provision of health services.

The view of Treasury and the Health Department is that the fulfillment of the public sector's role does not necessarily require the public sector to be both the funder and the provider of all services. Several models of the funder/provider split have been suggested, based on those recently introduced in the UK and New Zealand. The underlying concept behind these models is that increased competition results in improved efficiency and hence savings in the delivery of services. They also resolve the inherent conflict claimed by some to exist between the provider and regulatory roles of the public sector in the current system. This view was not ascribed to by some other parties making submissions to the Committee, who considered that such arrangements require excess capacity in the system to be effective, and that such excess capacity does not exist within NSW.

Examples of the funder/provider split already exist in NSW, the most well-known example being the contract for services at Port Macquarie Base Hospital. Other examples also exist in the contracting for support services at a number of public hospitals. In general, however, the private sector's participation in the health industry has traditionally centred upon the treatment of privately insured patients in private hospitals.

Whilst members of the Committee agreed that an essential element of the private sector's role has been a strong reliance on private health insurance, there was a divergence of opinion on the importance of the recent trend of declining participation in such insurance since the introduction of Medicare on the private hospital industry. However, the possible development of co-operative arrangements with the public sector, in whatever form, would see a change in the source of funding for private hospitals, which may further exacerbate the decline in private health insurance. The potential effect of this on the private hospital industry was again a matter for difference of views between Committee members.

There are numerous alternatives for the private sector to participate in the development of health infrastructure and the delivery of health services in co-operation with the public sector. When assessing these alternatives, both their economic and social implications must be taken into account. In so doing, it is essential that the perspective taken is that of the community as a whole, and not that of an individual sector.

In considering the relative economic merits of the alternatives, the potential for cost-shifting between the public and private funders of health care, and between different levels of government must be taken into account. Typically, all suggested alternatives for co-operative ventures involve the shifting of some costs of service delivery from the public purse to private insurance funds. The financial effects of this shift on the private funds could potentially be unbearable.

In regard to the extent to which economic gains might be made through collaboration between the public and private sectors in the health industry, the Committee was divided in its opinion. Some members considered that these prospects warranted further investigation in order to determine their relative

merits. Others considered that the prospect of private participation was, of itself, inappropriate.

The social ramifications of each of the alternatives is also of paramount concern. The elements of universality, equity, the comprehensiveness of services, and access to services each require specific consideration. Any proposal for co-operative ventures must demonstrate its capacity and intent to address each of these issues, to the betterment of the affected population.

The Committee considers that, if co-operative ventures between the public and private sectors are to be considered, it is not feasible or appropriate to classify the range of alternatives into those which are inherently "bad" or inherently "good". There is too little experience in the alternatives on which to base any empirical judgement of their relative merits. Rather each case will need to be evaluated individually, based in its own merits. However, a framework for such evaluations is presented which considers the essential questions:

- Does the proposal lead to improved resource utilisation?
- Does the proposal support the underlying objectives of the health system?
- Does the proposal protect or enhance the rights of individuals and their access to health care services?

Whilst this framework has been proposed as a basis for consideration of alternatives by which the private sector might participate in the provision of services, it might be equally applied to consideration of any proposal, regardless of private sector involvement. The ultimate assessment of any alternative will depend upon the relative weights applied to the answers to these questions. However, the application of this framework will help to ensure that all aspects associated with the proposal are addressed in a comprehensive manner, and that a community perspective is applied.

Finally, the Committee considers that there may be potential to re-allocate or re-use some of the existing physical infrastructure currently owned by the State but managed and used by different agencies involved in providing

human services. The potential financial and service delivery benefits to NSW residents may be considerable.

RECOMMENDATIONS

6.1.1 That the relative merits of alternative methods of service delivery be evaluated on a case by case basis, based on the following criteria:

- **Does the proposal lead to improved resource allocation?**
- **Does the proposal support the underlying objectives of the health system?**
- **Does the proposal protect or enhance the rights of individuals and their access to health care services?**

6.1.2 That the Government establish an inter-agency working group involving the human services departments to review, and where appropriate to reallocate, public physical infrastructure.

6.2 COSTS OF ALTERNATIVE WAYS OF PROVIDING PHYSICAL INFRASTRUCTURE AND THE EXTENT TO WHICH COSTS ARE RECOVERABLE (TERM OF REFERENCE 1D)

6.2.1 Background

The provision of health infrastructure inherently involves the incurring of costs. Any examination of the alternative ways of providing infrastructure would be incomplete if it did not address the costs associated with each option. Equally important, the capacity for the NSW Government to recover at least some of those costs is important from a budgetary perspective.

This section reviews the traditional forms of public sector funding sources for health infrastructure, together with alternative forms of private sector involvement. In so doing, the effects of Loan Council guidelines and the taxation system both on the potential for such involvement and the capacity for cost recovery are examined.

6.2.2 Sources of infrastructure funding

The following sources were identified as being available for funding Budget sector infrastructure:

- **Budget support from State revenue sources.**

  Given the competing demands for State Government funds, the Treasury has indicated difficulty in further expanding funds from this source without a change in Government priorities, due to the fact that the Budget is in substantial deficit. Future prospects are for a continued restrained fiscal environment.

- **Transfer of savings on recurrent payments.**

  The public health sector may use savings from recurrent operations to fund capital payments, subject to the approval of the Ministerial Capital Works Committee. The Health Department is required to meet the recurrent costs associated with capital projects from its overall Budget allocation. However, given that Treasury considers that such capital works represent

a redistribution of the existing capital stock to improved quality and location rather than an expansion of the stock, there is an expectation that new infrastructure should generate savings.

Treasury also expressed the opinion that there exists considerable potential for further savings in recurrent funding through efficiency gains. In its submission it stated:

> "The health system has delivered significant savings to date and this can continue to be achieved. ..... It is clear that within the system there are significant variations in efficiency, and hence the capability for all hospitals to move to best practice within the New South Wales system.
>
> The Department of Health has estimated that additional savings of at least $300 million per annum from this source, and it is Treasury's view that this is conservative."

No information has been provided to the Committee as to the basis on which these potential savings have been determined, nor of the steps required to achieve them. Nor has information been provided on what impact such savings might have on the resources required for physical infrastructure development. However, the potential contribution any such savings could make to the funding of physical infrastructure warrants further investigation by the Department and Treasury.

- **Retention of own source funds.**

Hospitals may retain their own source non-tax revenue. These include such sources as private patient fees, prosthesis fees, facility charges for staff specialist use for private patient treatment, and donations and fund-raising. In some instances, this comprises a potential source for the recovery of some costs associated with the provision of services by the private sector. In those cases where a private operator is providing clinical support services at a public hospital (for example medical imaging or pathology services), charges by hospital for the use of its facilities (such as rental of space etc.) may be used to offset the costs of services provided under contract by the private operator.

- **Proceeds from asset sales.**

The existing surplus of assets in the health sector provides an important potential source of funding. However, the recent downturn in the commercial and dwelling property sector has resulted in a severe reduction in this source of revenue. Whilst the dwelling sector has shown signs of recovery, there appears little prospect for a similar recovery in the commercial sector for the foreseeable future.

- **Commonwealth capital payments.**

Capital payments to the health sector by the Commonwealth are relatively minor. Over the past six years (1987-88 to 1992-93), such payments to NSW have ranged from $8.7 million in 1991-92 to $27.8 million in 1987-88. The Health Department identified this as a potential source of financing, and one which would be consistent with a stimulus to the national economy and the unemployment problem. Obviously, such an initiative would require specific negotiation with the Commonwealth Government.

- **Borrowings**

Borrowings are regulated by the Australian Loan Council, with the global borrowing limit set by the Council declining significantly in real terms in recent years. Information contained in the submission from Treasury is reproduced in Table 5 below.

TABLE 5 - NSW GLOBAL BORROWING LIMITS

Year	Actual Limit	Real Limit ($ 1992-93)	Decline (%)
	$ millions		
1987-88	1,539.6	1,953.5	n.a.
1988-89	1,152.7	1,363.1	30.2
1989-90	1,134.0	1,241.7	8.9
1990-91	1,177.9	1,224.9	1.4
1991-92	1,204.2	1,228.9	(0.3)
1992-93	1,353.9	1,353.9	(10.2)

Source: NSW Treasury Submission to the Public Accounts Special Committee, pp 36

Treasury emphasises that global borrowings do not provide an additional source of funding above and beyond the Budget, since all payments (recurrent and capital) for Budget sector agencies are reflected in the Budget. Borrowings are not included as a revenue source, but are shown as a "below the line" method of funding the Budget deficit. Thus any increase in health capital payments funded by an increase in borrowings would increase the Budget deficit, to be funded by borrowings.

- **Private sector participation**

Treasury considers that the private sector provides the opportunity of meeting the needs for health infrastructure, subject to adherence to Loan Council and taxation policy. Options for private participation are discussed further below.

6.2.3 Australian Loan Council policy

Under conditions agreed in 1984, the Australian Loan Council determines the annual global borrowing limits for the States, which, according to Treasury:

> "includes all forms of external financing including borrowings, finance leases, trade credits and deferred payment arrangements. The exceptions to the limit are operating leases, borrowings by State financial institutions, ... borrowings by agriculture marketing authorities and temporary borrowings that do not extend beyond the confines of a financial year."

Operating leases will fall within the global limits from 1993-94.

Treasury advises that the administration of the global borrowing limits involves, among other things,

> "ongoing assessment of private sector infrastructure proposals to ensure that they conform to the spirit and technical requirements of the global borrowing limits. Treasury is required to assess all such proposals and does so on the basis of assessing whether or not the private sector absorbs the bulk of risk and benefits of the project. In

undertaking this role, Treasury liaises closely with the Loan Council Secretariat to ensure that our approach is consistent with the requirements of Loan Council."

The requirements of Loan Council centre upon whether the arrangement is a genuine service contract or an arrangement whereby the private sector is acting as an agent in what is effectively a financing transaction. The essential differentiating characteristic between these two arrangements is the transfer of risk from the public sector to the private operator. Three categories of risk are taken into account.

The first is that of construction risk, pertaining to the cost of construction and the timeliness of completion of the project. Such risks may be effectively transferred to the private sector even under public ownership by means of a fixed price contract with penalties for late completion. Thus the allocation of construction risk between the two sectors is not a sufficient condition to assess whether a project is a genuine private sector infrastructure project.

The second category of risk is that of market risk. This relates to the level of demand for and the price of the services generated by the infrastructure development. Where these factors are partially or totally guaranteed, this reduces or eliminates the risk. Such risk is considered to be maintained where the revenue stream is a function of the level of demand.

The third category of risk is that of operating risk, which relates to the exposure to variable performance or variations in costs. Under a genuine private sector project, it is a requirement that the private operator bear full responsibility for the quality of performance and that the price structure not be a cost plus approach.

In assessing proposals, an holistic approach is taken, rather than ensuring that no element of risk is retained by the public sector. This is based on the theory of efficient risk allocation, which requires that risk should be allocated between parties according to their respective capacities and capabilities to influence and control that risk. Under some circumstances, there are risks that are more able to be influenced by the public sector. However, this approach has not been regarded sympathetically by the Australian Taxation

Office, and there is a need to have the issues considered further by the Commonwealth.

In December 1992, Loan Council agreed to a revision of existing arrangements. These arrangements reflect the underlying macroeconomic and microeconomic objectives for borrowing controls for the public sector. Among the key elements of the new arrangements are the establishment by Loan Council of an agreed maximum public sector borrowing requirement for each year in advance for the Australian public sector, and its allocation between jurisdictions.

The borrowing requirement is measured as total revenue less total expenditure for the public sector, and hence, unlike the global borrowing limit, includes the use of cash balances to fund expenditure. As such it is a more comprehensive measure than the global borrowing limit, and is the equivalent of the change in net debt. Transitional arrangements provide for the continuation of the global borrowing limit for a further two to three years while the new arrangements are established. However, there is still considerable uncertainty about the policy procedures that will apply to private sector infrastructure.

6.2.4 Taxation policy

Commonwealth taxation policy may have a significant effect on private sector infrastructure funding decisions, joint ventures and contracting arrangements between the public and private sectors. Treasury states that:

> "An important taxation principle is that of neutrality, which recognises that taxes should not disturb the allocation of resources from what will occur in the absence of such taxes. The concern has been raised that the tax treatment of infrastructure projects could violate this principle."

The essence of this concern lies in the fact that such projects typically involve substantial expenditure in the establishment phase, with long payback periods. Tax provisions require that the tax losses incurred in the establishment phase of a project must be carried forward as an offset against future assessable income. Treasury states that:

"the deferral of utilising tax credits is a present value loss to the tax payer which for a long term project can be very substantial."

Despite a number of recent changes announce by the Commonwealth Government, a number of issues remain. Treasury has identified these as including:

"• the timing of tax deductions on infrastructure is still deferred until assessable income is produced;

- Section 51AD and Division 16D of the Income tax Assessment Act can still create difficulties for well-based private sector infrastructure projects. These provisions were established to deny tax deductions for projects where the real end user is the public sector. In making an assessment of the real end user, the Australian Taxation Office has regard to similar conditions as are applied by the Loan Council, that is where the risk and reward of ownership rest, the public or private sector. However, the general approach followed by the ATO is to deny tax exemption except where all risks reside with the private sector. In certain projects such a 100 per cent assumption of risk can be quite inappropriate."

The different approach by Loan Council and the Australian Taxation Office in the allocation of risk thus creates "two hurdles", and it is clearly desirable for a single consistent policy to be applied on the issue of private infrastructure development proposals.

The second area of taxation policy of relevance to the issue of private infrastructure development is that of taxation compensation. Under a policy introduced by the Commonwealth in 1991, recognition is given to the fact that privatisation of Government owned agencies resulted in a loss of future revenue to the States and a corresponding gain to the Commonwealth. The policy provides for a compensation payment to the States equal to the present value of the projected next five years tax revenue of the privatised authority. Whilst this policy currently applies only to the sale of Government enterprises, the provision of infrastructure and the contracting for services to the public sector by the private sector confers a windfall gain to the Commonwealth. This comprises the income tax payable on any profits generated by the private

sector as well as sales tax on goods acquired in the course of their operations, neither of which are payable by the public sector operator.

It is Treasury's view that taxation compensation similar to that provided in the case of the sale of government agencies should also apply in such circumstances. It is questionable whether the Commonwealth Treasury will be agreeable to this argument, especially since it has already questioned the appropriateness of the existing taxation compensation arrangements.

The final area of taxation policy of relevance to the issue of public and private co-operative ventures is that of State based taxes. The major State taxes are payroll tax, contracts and conveyancing and other financial sector taxes, land tax, certain franchise license fees and gambling and betting taxes. Treasury described the State tax base as :

> "narrow, inefficient and regressive, meaning that there is little capacity to further increase the tax take. In response to the deteriorating Budget position the various States have increased taxes but the evidence is they have nearly reached their full capacity."

Payroll tax is the only tax base which broadly reflects the overall economy, with other taxes tending to grow more in line with the conditions in the property and financial markets. The latter have been the subject of severe downturns, and the outlook for the 1990's is for relatively poor growth prospects.

6.2.5 Options for private participation

There are numerous possibilities for ways in which the private sector may participate in the provision of infrastructure funding and the delivery of health services. Within this context, it should be realised that contracting for services by the private sector, whether it be in the area of clinical support or hotel services, or for the total health services at a given site, does not necessarily entail capital expenditure and an expansion of the health infrastructure. It may in fact improve the utilisation of a currently under-utilised existing facility. Equally important, such arrangements may avoid capital expenditure by the public sector, and the unnecessary duplication of infrastructure between the two sectors. This aspect of the issue highlights the

relationship between infrastructure funding and contracting for services. This dimension should be a prime consideration when considering the relative merits of any such proposals.

Many of the submissions to the Committee identified a range of options for the private sector to participate in the provision of services and funding of infrastructure and form the basis of the following discussion.

- **Limited participation through contracting for support services**

  This represents one of the most straight-forward options for private participation, and is one which has already been pursued by the Health Department in several areas such as laundries and cleaning services.

  The perceived benefits of this approach include:

  - the avoidance of capital costs associated with the provision of these services;

  - generally lower costs of services delivery;

  - assisting the public sector to focus on core services such as clinical care; and

  - greater innovation in service delivery.

  Notwithstanding these benefits, this form of participation is not expected to have a major impact on infrastructure needs.

- **Contracting of clinical services for public patients**

  The contracting of clinical services with the private sector has taken several forms in New South Wales in recent years. Such arrangements have occurred most notably in the Northern Sydney, Hunter and Illawarra health services and the North Coast region. The contracts related to day-only surgery, early transfer of maternity patients for post-natal care, and full acute medical and surgical services. During 1990/91 services worth

over $8 million were provided by private hospitals, with over half of this amount provided to patients injured in the Newcastle earthquake.

The most advanced example of this form of participation is represented by the Port Macquarie contract, which provides for the construction of a new private hospital and the subsequent provision of an extensive range of surgical and medical services to public patients under contract with the Health Administration Corporation. The question of whether or not community health services will provided under the contract has yet to be finalised.

As previously outlined, the criteria set by the Loan Council and the Australian Taxation Office have an important bearing on the nature of these contracts.

A number of benefits emanating from these arrangements have been identified. These include:

- the provision for incentives for improved design and execution of the hospital, by combining the role of design, construction, maintenance and management in one legal entity. This differs from the traditional public sector approach where the design is provided by the public sector and there is little incentive to economise on construction or operating costs of the facility. However, this raises the question as to why a similar approach might not equally be adopted by the public sector in the design and construction of public hospitals in order to achieve similar benefits;

- the achievement of lower operating costs, by virtue of the competitive pressure on the private operator to achieve an operating surplus. At the same time, such competition creates pressure on public hospitals to bear down on costs; and

- separation of the purchaser/regulatory role of the public sector from that of the provider, and the facilitation of a more formal and effective quality monitoring role.

The perceived disadvantages associated with this option include:

- additional costs incurred in contract management and building approval costs, as well as the payment of Commonwealth taxes which are passed on to the State through the contract fees without any compensation from the Commonwealth;

- the possibility of a local monopoly if there are no alternative service providers;

- the potential conflict between hospital services and community health services, and the appropriateness of having all such services provided by a private operator. The separation of these services may equally lead to a break in the continuity of care.

The implication of these disadvantages is to suggest that this form of private participation is best suited to urban areas, where alternative providers are available, thereby avoiding the concern about local monopolies, while at the same time maximising the competitive pressure to keep costs down.

- **Private sector joint ventures**

This model comprises an arrangement between the private and public sectors for the co-location of facilities, with the private component providing services to private patients together with the sharing of joint facilities. The Health Department advises that approval in principle has been given for private hospitals to be built on the campuses of Royal North Shore, Royal Prince Alfred, St George and Westmead Hospitals.

The benefits of this approach, as perceived by Treasury, include:

- relieving the pressure on public hospitals by providing for the diversion of private patients to the private hospital;

- demonstrates that private hospitals can provide an advanced level of service, thereby encouraging private health insurance coverage;

- provides additional funds to public hospitals through the sale or lease of land; and

- in the case of new public hospitals, provides the opportunity to reduce the scale of the hospital, thereby reducing capital costs.

The disadvantages of this approach include:

- assuming that the public hospital continues to operate at the same capacity, an increase in the net costs due to the loss of private patient revenue; and

- increased costs for health insurers and hence greater pressure on insurance premiums, thereby discouraging private health insurance participation;

- **The creation of competitive health services market**

This option adopts the broad framework of that recently implemented in New Zealand, and comprises the following essential features:

- creation of separate Health Purchaser Boards responsible for contracting for the provision of health services to the population of the area;

- establishment of public health providers as Government businesses, responsible for seeking contracts with the Health Purchaser. A derivative of this approach is the formulation of chains of service providers comprising hospitals and other service providers to reinforce an integrated approach to service delivery, which would then compete across areas.

- establishment of private sector hospitals on an equal footing with public hospitals by the adoption of an equal pricing policy, but with an offsetting payment to private health insurers to eliminate any windfall gain and avoiding any impact on private health insurance premiums.

The major difficulties in establishing such a system relate to the delineation of the Commonwealth and State roles. Under the existing global borrowing limits, this arrangement would qualify for exemption. However, under the new arrangements soon to come into force, the capital funding of all public entities would be included, regardless of the existence of a competitive market. This will require further discussion and negotiation with Loan Council to determine whether it is prepared to take a more flexible approach to the issue of infrastructure funding within the context of a competitive market.

6.2.6 Opportunities for cost recovery

The opportunities for the State Government to recover some of the costs associated with the various forms of infrastructure funding in co-operation with the private sector are largely limited to the payroll tax and land tax which may be paid by a private owner/operator which would not be paid by a public sector operator.

Land tax would be a one-off payment and its payment would depend on whether the site was already owned by the operator or needed to be acquired. Payroll tax would be a recurrent payment, and represents a recovery of part of the payments by the public sector for the provision of services. In the case of the Port Macquarie contract, for example, the estimated value of the payroll tax to be paid was of the order of $1.3 million in the first year, with a net present value over the 20 year contract period of $14.9 million. The Committee notes, however, that religious or not-for-profit hospital operators may be exempt from paying payroll tax, which would remove the capacity for the government to make this form of cost recovery in such cases.

The other area where cost recovery may be possible relates to the joint venture option, where a public and private hospital are co-located on an existing public hospital site. Under these circumstances, the sale or leasing of the land to the private operator has the potential to recover some of the costs.

It is clear that the actual costs which may be recovered from co-operative ventures with the private sector will vary according to the contractual arrangements and other circumstances unique to each case. These will therefore need to be examined on a case by case basis.

6.2.7 Summary

Sources of funding health infrastructure from traditional public sources are relatively limited, and are expected to remain so for the foreseeable future. Such sources include State revenue sources, savings on recurrent expenditure, retained own source funds, proceeds from the sale of assets, and Commonwealth capital contributions.

Of these sources, savings on recurrent expenditure appear to offer the greatest potential for additional funds, with the Health Department estimating that additional savings of the order of $300 million per annum could be achieved through continued efficiency gains. The Committee considers that the Department should give a high priority to the pursuit of these gains as a matter of urgency. At the same time, the effectiveness of alternative methods of service delivery should be monitored on an ongoing basis to ensure the most cost effective mix of services.

The borrowing of funds is regulated by the Australian Loan Council, with the global borrowing limit for NSW having reduced in real terms over the past two years. Treasury emphasises that any borrowings do not act independently of the Budget, as all repayments are reflected in the Budget. It has indicated that, under current government policy, there is little capacity within the Budget to expand current borrowings.

The constraints in existing public sector sources of financing infrastructure have led to the investigation of opportunities for the private sector to assist in this regard. Such opportunities are affected by the policies of the Australian Loan Council in regard to the nature of any contracts between the public and private sectors, and by taxation policy. To be excluded from the global borrowing limit, Loan Council requires any contracts to comprise genuine service contracts (whereby the majority of risk is transferred to the private sector), rather than an agency agreement (where the majority of risk remains with the public sector). Taxation policy also affects private sector participation through its ruling on tax-deductibility for projects where the end user is the public sector. Generally the Taxation Office requires 100% of risk to be transferred to the private sector, which is often both inappropriate and not feasible in many heath care projects. In addition, the different approaches of

Loan Council and the Taxation Office represent a "double hurdle" to be overcome in such ventures. The Committee considers that a uniform approach to this issue should be actively pursued by Treasury and the Health Department in negotiations with Loan Council and the Taxation Office.

A number of alternatives for private participation in the provision of health infrastructure have been considered. In so doing, the Committee recognises that such arrangements do not necessarily require additional infrastructure development, but may avoid such expenditure through improved utilisation of existing resources across the two sectors.

Alternatives considered for co-operative ventures with the private sector included

- contracting for support services,
- contracting for clinical services,
- joint ventures involving co-location of public and private hospital facilities, and
- the development of competitive health services markets.

In regard to their respective capacity to assist in the funding of infrastructure, the Committee considers that, whilst useful in some circumstances, the contracting of support services and co-location of facilities offer limited opportunities for a significant contribution. Nevertheless, such opportunities warrant investigation where they are considered to be appropriate. Contracting for clinical services, either on a case by case basis or through the creation of a wider competitive market system, provides a greater opportunity either for a significant injection of funds, or the avoidance of capital expenditure by the public sector.

The State's narrow tax base provides limited opportunity for cost recovery via the tax system in the various forms of co-operative venture with the private sector. The most likely form of recurrent funds recovery is payroll tax paid by a private operator, although this may not apply to not-for-profit private operators. In the case of co-location, some opportunity for cost recovery may

exit under a lease arrangement with the private operator. Other options for cost recovery are largely in the form of one-off payments. The potential for the State to recover costs will therefore need to be evaluated on a case by case basis, having regard to the particular circumstances of each case.

RECOMMENDATIONS

6.2.1 That the Health Department clarify the basis on which the additional savings it has identified in recurrent health funding may be achieved, specify the procedures by which it plans to realise those savings, and implement a program for their realisation.

7 HEALTH EDUCATION, PREVENTATIVE HEALTH AND COMMUNITY INVOLVEMENT IN/AND RESPONSIBILITY FOR HEALTH OF THE COMMUNITY (TERMS OF REFERENCE 2A AND 2B)

Term of Reference 2 of the Special Committee was to report to Parliament:

> "concerning the effect of the alternative ways of providing infrastructure on:
>
> (a) health education and preventative health;
>
> (b) community involvement in/and responsibility for the health of the community."

Most submissions dealing with these issues considered them together, reflecting the degree to which they overlap. The Committee considers that this is a reasonable approach, and enables the various dimensions of these issues to be considered simultaneously. Accordingly, the report addresses both issues under common headings in the following sections.

7.1 Background

When addressing this topic, most submissions to the Committee focused on what might happen to the overall health system under conditions of greater private sector participation in infrastructure provision. A number of submissions argued that non-hospital health services, preventive health, and community involvement in health care would be substantially affected by such an approach. Whilst the Committee acknowledges the importance of these issues, and addresses them in section 7.5 of this report, the Committee also considers that a wider perspective should be brought to these Terms.

Section 3 of this report outlined the Committee's general approach to the Terms of Reference, and the perspective taken in the conduct of this Inquiry. This perspective is of particular relevance to the Terms covered in this section of the report. The Committee believes that proper consideration of the principles of community participation and the role of health education and health promotion within the spectrum of health services is fundamental to the future planning for and delivery of health services in NSW.

It is increasingly recognised that an effective health system should contain an appropriate mix of prevention oriented services in addition to primary, secondary and tertiary health care services. In Australia, each of these dimensions within the health system has differing organisational structures, ownership and funding strategies, a wide variety of professionals involved in service provision, different ideologies and perspectives, a variety of service delivery approaches or models, and diverse historical origins. All of these factors contribute to the complexity of the health system.

Many of these issues have been recognised in the National Health Strategy Review (the Review), with Background Papers and Issues Papers published which address them in considerable detail. The Terms of Reference for the current Inquiry specifically call for the Committee to minimise duplication with the Review. Indeed, many of the submissions to this Inquiry have replicated information provided to the Review. Rather than reiterate the arguments and findings of the Review, the Committee has sought to refer to those Papers published by the Review of particular relevance to this Inquiry, together with additional information provided directly to the Committee, as the basis for this section of the report.

7.2 National and international trends

Background Paper No 12, "Healthy Participation - Achieving greater public participation and accountability in the Australian health care system", published by the Review in March 1993, develops a framework for greater community participation in the health care system. In so doing, it identifies the international and national trends in this area, which are summarised below.

The World Health Organisation (WHO), together with an emerging movement in public health, has been instrumental in a growing emphasis on greater community participation, control and ownership of health services and the decision-making processes. In particular, the adoption of primary health care, health promotion and community development strategies have emerged as increasingly important models for the improvement of the community's health status. The WHO has stressed the importance of informed opinion and the active co-operation of the public in the improvement of the population's health status. These aspects have been central to the statements made in the Alma-

Ata Declaration from the 1978 Conference on Primary Health Care, and the Ottawa Charter for Health Promotion (1986).

Perhaps the most well known example for community participation in the setting of health care spending priorities occurred in the American State of Oregon during 1989, where the community was consulted in determining a list of priorities to apply to medical and hospital services funded through the public sector. The approach involved an extensive and wide ranging debate, whereby lists of interventions were prepared and people ranked them in order of priority. At the same time, the cost-effectiveness of services was also examined. The concept behind their approach was that those services which gained sufficient public support and for which adequate funds were available would be provided, while those which did not receive adequate support would not be provided. Its aim was to provide adequate access for those on low incomes to health care services within existing funding constraints by restricting the range of treatments provided.

There has been much debate over the approach taken by Oregon in conducting this assessment, which others seeking to replicate the model would be advised to take into account. In an article titled "The rationing of health care: Should Oregon be transported to Australia?" (Australian Journal of Public Health, 1992, Vol 16, No 4), Hall and Haas identify a number of advantages of the process, including:

- priorities were based on cost-effectiveness analysis, using data on clinical effectiveness and costs.

- community consultation and values were used to guide resource allocation.

- the process of developing priorities was explicit and accountable.

Hall and Haas also identify a number of criticisms of the process, including:

- final priorities were made by the Health Commission, and were not in accordance with the published criteria.

- the community survey was neither large nor representative of the total population.

- the community meetings were small, not well represented by the target population and dominated by health care workers.

- the revision of the list of services upon which the final list was based was obscure, and the basis for its compilation was not made public.

Notwithstanding these criticisms, the Oregon approach was a landmark in raising the community's awareness of, and participation in, the planning and delivery of health services.

A different approach was adopted in Wales, where the Health Policy Board of the National Health Service (NHS), established the Welsh Planning Forum in 1988 as an expert planning group for the planning of health services. The Forum developed a strategic plan which focused on the improvement of health outcomes as the underlying mission of health services. The plan comprised three main elements which, in a paper provided to the Committee, Professors Peter Baume and Don Nutbeam described as follows:

> "The first (element) was that the health system's "success" would be judged by its ability to reduce premature death from a specified group of diseases and improve the well-being of individual patients and the population as a whole. Achieving the appropriate balance in service provision between prevention and promotion, diagnosis and assessment, treatment and care, and rehabilitation and maintenance, was central to this.
>
> The second (element) was that services provided should be planned and delivered in consultation with the community, and that there should be increased emphasis on the quality of service delivery. There is an explicit and defined commitment to "people-centred" services as part of this element.
>
> The third (element) was that resources should be "invested" in those services most likely to bring about the most significant health gain for the population. Both existing activity and proposed new services would

be judged by criteria designed to assess their ability to achieve health gain."

In Australia, a number of reports and projects initiated by the Commonwealth Government have been produced which address these issues. These include "Health for All Australians" (Health Targets and Implementation Committee, 1988), "National Better Health Program" (National Centre for Epidemiology and Population Health, 1992,1993), and "Improving Australia's Health: the Role of Primary Health Care" (National Centre for Epidemiology and Population Health, 1992)

The State Governments of Victoria, Tasmania, Western Australia and Queensland have recently reviewed their health systems with a view to improving their equity, access, efficiency and accountability. Reports from these reviews have recommended a decentralised decision-making process and a population approach which responds to health needs at a local level. Each report proposes changes which

- acknowledge the need to link health interventions with health outcomes to ensure efficiency and effectiveness, and

- recognise that finite resources available to the health system require priorities to be set in health spending in which the public should be involved.

The National Consumers' Advisory Council's (NCAC) report titled "Developing a Consumer Perspective on Health Services" (1992) suggests that involving people at the local level can strengthen health service responsiveness and priorities. This view was echoed in the review in Western Australia, the report from which ("Western Australian Metropolitan Health Services Review, 1991:139) stated:

"Any health services organisation focusing on the needs of a specific population is enhanced by input from representatives of that community."

The Committee considers that such an approach to the planning and delivery of health services is one which should be further pursued in New South Wales.

7.3 Developments in New South Wales

Over the last several years, the NSW Health Department has undertaken a number of initiatives aimed at improving decision-making at the local level and facilitating community involvement in the planning for and delivery of health services. Examples of such initiatives include:

- The creation of Area Health Services in metropolitan NSW.

- The devolution of authority and the introduction of global budgets and performance agreements to the Area Health level.

- As from 1 July 1993, the creation of 22 Rural Health Districts aimed at improving networking of services in rural areas and encouraging a greater focus on the health needs of the community.

- The introduction of a "Health Outcomes Program", including a series of demonstration projects aimed at improving health outcomes in identified priority areas.

The Department acknowledges that its primary focus in recent years has been on improving the efficiency of its health services. In information provided to the Committee, the Department stated:

> "Initiatives which increase the efficiency of health service delivery are important because they free up resources which can be put to more effective use in improving the health of the population".

The development of a greater focus on health outcomes is the major concern facing the Department today. The Committee understands that the Department is in the process of developing a document which outlines its strategies in this area, and which details the means by which the community will be involved in the process of reform. A program has also been prepared for the preparation and distribution of a series of discussion papers over the next eighteen months covering a wide range of issues in the NSW health system, aimed at informing the community of current developments and seeking comments on the proposals for reform.

The Department has also identified a number of barriers to reform, many of which are discussed in section 5 of this report. Within the area of community based services, anomalies caused by the respective roles of various sectors in the provision of health education and other forms of community-based health, are considered to comprise one of the major hurdles to be overcome. The responsibilities of the different sectors are illustrated in Table 6 below:

TABLE 6 - ROLES OF THE GOVERNMENT AND PRIVATE SECTORS IN HEALTH EDUCATION AND COMMUNITY-BASED HEALTH

	Preventive Programs	**Health Education/ Promotion**	**Community Nursing**	**Other Community Health Services**	**Primary Medical Care**
Local Government	*Provide Fund*		*Provide*	*Fund*	
State Government	*Provide Fund*	*Provide Fund*	*Provide Fund*	*Provide Fund*	*Provide Fund*
Commonwealth	*Fund*	*Fund*	*Fund*	*Fund*	*Fund*
Private Sector	*Provide Fund*	*Provide Fund*	*Provide Fund*	*Provide Fund*	*Provide Fund*
Voluntary Sector	*Provide*	*Provide*	*Provide Fund*	*Provide Fund*	*Provide Fund*

Notes:

"Provide" Takes responsibility for services provision.
"Fund" Provides funding for services provided by own staff or allocated to others to provide specified types and/or volumes of services.

Source: NSW Health Dept. Submission to the Public Accounts Special Committee, pp 10.1

Given this structure, it is clear that extensive consultations with health service providers, other levels of government, the private sector and the wider community will be essential to the reform process. Whilst the Department has acknowledged this fact in its various representations to the Committee, its

strategies for enlisting the support of representatives from each of these areas in the consultation process do not appear to be well defined at this time. In addition, the impression gained by the Committee from the evidence provided, is that the Department's strategies appear to be focused primarily at a State-wide level, with limited reference to the local level. It is in these areas that the Committee considers further advances can be made.

7.4 Perspectives on reform

The Committee acknowledges the initiatives undertaken to date by the Health Department outlined above, and encourages the Department in its proposals for further reform. In this context, the Committee has also sought the views of a range of experts on ways in which this process may be further developed. In presenting these views, it is the Committee's intention to provide a series of alternatives for consideration and further investigation as part of the program of reform.

A discussion paper prepared by Professors Baume and Nutbeam in conjunction with the NSW Health Department titled "Achieving Accountability for Health Outcomes", describes a process for ensuring community and other forms of consultation and its proposed use in NSW. The authors state:

> "One clear lesson from overseas is that the successful introduction of a health outcomes approach is related to the investment in consultation and consensus building. Developing a sense of 'ownership' among clinicians, health service managers and key community groups is essential for long-term success. This can only come through dialogue with these interested parties".

The mechanism for consultation and consensus building is based on the "Panels of Review" concept developed in Wales. In the Wales model, membership of the Panels included service providers from primary, secondary, and tertiary services, externally appointed experts and community members. This has meant that the roles of each are clarified and the relative contribution of each to the specified health outcomes is measurable.

Within NSW, the authors consider that Panels of Review would probably operate best at a State level, working within a broad framework of priority

goals and targets which have been established nationally. The process of assessment and consultation would lead to the development of a plan in which each of the elements of the health system (prevention and promotion, diagnosis and assessment, treatment and care, rehabilitation and monitoring) are defined, based on their respective capacity to maximise health outcomes.

At the same time, the need for an extensive consultation process among the broader community is identified as an essential element in managing community expectations of the health system. This should include a communication strategy aimed at informing and engaging the media's understanding and support to the new approach. The purpose of this approach is provide the community with more information and to build consensus on health care priorities. This process also assists the empowerment of the community over the decisions which will affect its members.

In a paper titled "Primary Health Care in the 1990's and Beyond: A Prescription for Practice", Dr William Corlis identified six main strategies for the primary medical and health care system in the short, medium and long term:

- Restructuring medical school curricula with the introduction of a core teaching program of general medical practice. This should be introduced at the commencement of clinical studies; and be an ongoing program at all stages of the curricula.

- Vocational training, comprising a three year mandatory training program divided between community oriented hospitals and approved general practice teaching units. Vocational registration would be conditional upon completion of the program.

- Greater integration of primary medical and health care practice units, consisting of general practitioners and community nurses working closely with other health personnel in the community.

- Consumer group participation and representation at regional and local levels, together with consumer educational programs to evolve self help, preventative and promotional health initiatives.

- Decentralisation of health and community support services to regional authorities and local communities.

- Learning and evaluation to be an ongoing process, and one which needs to be developed as an integral part of service delivery and development.

Professor Ian Webster, in a paper titled "Consulting the Community" considers that currently only token interest is shown by health authorities and universities in consulting the community. He suggests that:

> "most professional organisations, bureaucracies and political parties function at the lower end of Arnstein's ladder of community participation, as shown below;
>
> Citizen Control
> Delegated Power
> Partnership
> Placation
> ----------Area Health Services
> Consultation
> ----------Universities
> Information
> Therapy
> Manipulation"

Professor Webster identifies a series of ways in which the community can be more involved in both the provision and planning of services, and in the expansion of teaching services for medical professionals in the community. He suggests a number of options for consideration:

- The establishment of a pilot Area with 50% of the Area Health Board being elected by the local community.

- The establishment of Health Service Development Groups at the area level in defined areas of community need with clearly specified requirements for community representation, involvement and legal responsibility.

- The provision of funds for the establishment of Health Consumer Agencies or similar bodies at the Area level, with local health authorities and community groups invited to make joint submissions for the establishment of these agencies.

- The establishment of national pilot projects using seed funds for a management structure at an Area or Regional level which incorporates a model for community participation, including consideration of elected representatives from the local community to the board(s) of health services.

- A formal review of community-based teaching in undergraduate medical curricula, and in the first two years of graduate training.

The Consumers' Health Forum (CHF) verbal submission to the Committee also emphasised the difficulty in achieving appropriate and effective community participation in health policy and programs. As a general rule, the CHF believes that consumer representatives should be tied to membership of groups, thus overcoming the problem of 'untied' individuals on boards being perceived as not representing the needs of the community within the area. The CHF views the introduction of a Charter of Patient Rights as one means of ensuring that consumers' interests are adequately recognised in relation to community and other health services.

The importance of educational programs in the area of general practice was also emphasised in a number of submissions to the Committee. The Committee considers that the undergraduate curricula should incorporate elements of community-based medicine, and that this should also extend to post-graduate studies. In regard to the latter, the Family Medicine Program (FMP), administered by the Royal Australian College of General Practitioners (RACGP), is one such program and provides for three years post-graduate training in general practice. The Committee considers that such a program provides the opportunity for further enhancing the integration of services between hospitals and the community, and endorses its wider adoption.

The views and suggestions presented above are representative of a range of opinions expressed to the Committee from a wide cross-section of parties.

The recurrent theme through many of the submissions to the Committee is the need for greater community participation at a State, regional and local level in the planning for and delivery of health services. This theme is reflective of similar initiatives in other States and at the national level. Within New South Wales, the position of Director of Community Health is one which has the potential to provide a focal point for greater community involvement, and to facilitate the integration of services at a local level. The Committee understands that these positions are not provided in all Areas and Districts, and that this leads to inconsistencies in approaches to these issues. In order to provide for a more consistent approach, and to assist in the development of a suitable structure to facilitate the integration of health services, the Committee considers that these positions should be provided at all Areas and Districts, with representation at the Area and District Executive level.

Clearly, there is a considerable body of expertise within the community, in academia and in the Health Department itself which, collectively, has the capacity to develop and implement a program for reform which will maximise health outcomes. The challenge is to establish a forum by which that expertise may be accessed. The Committee has included a number of specific recommendations which provide examples of ways in which this approach night be initiated. At the same time, the Committee considers that an ongoing program of pilot projects should be maintained which explore and evaluate alternative methods by which the objectives of community participation and program evaluation may be furthered.

7.5 The effects of private sector participation on community health services

Submissions to the Committee from a number of organisations on the issue of expanded private sector participation and its effects on community health services offered the Committee a range of views. These varied from the need for caution under increasing levels of private sector participation, to the belief that such infrastructure changes would clearly be harmful to the interests of public health. The following discussion considers two of these views. Firstly, the view expressed by some individuals or organisations that privatisation of health services (particularly in the more intangible health prevention, education, and community-based areas), is generally negative and should be avoided. The second view perceives some negative consequences through

changing infrastructure and in particular, increasing privatisation, yet can see structural reforms as solutions to some emergent problems.

- **Opposition to privatisation**

The NSW Community Health Association Co-Operative Ltd. (CHA) presented a series of arguments based on economic grounds, expressing concern about the role of private operators in community and other health activities. The CHA's arguments are summarised as follows:

- Community health services are often most directed to the disadvantaged within the community, and accordingly, do not lend themselves to profit-making activities;

- Community health services have essentially arisen to fill a niche left void by the private sector (the private sector does not really have the necessary expertise in this area);

- Where private ownership of a facility such as a hospital exists, it would not be in the best interests of community-based services to be part of the same management arrangements because there would be pressure to integrate the services with other acute medical services;

- There is an inherent conflict of interest within one-ownership conditions between hospital and community-based services. Both would be competing for the same clients (one to 'capture' admissions; the other to prevent hospitalisation);

- Community health services are already efficient with most potential for profit coming from the main cost area - salary and wages of professionals. In these circumstances, the temptations are to cut services or to fundamentally re-orientate them towards post-acute care;

- Opportunity costs may be larger in the long term under a privately operated community health system. The costs would be borne by local government, welfare and voluntary agencies.

Elsewhere in their submission, the CHA pointed out that many of the newer community-based public health initiatives sought to operate across jurisdictions - for example, drug and alcohol diversionary programs, road safety initiatives, farm safety and others. In these circumstances, the CHA questions the ability of a private operator to effectively deliver services in a multi-jurisdictional setting.

Professor Ian Webster submitted to the Committee that the privatisation of health services should be of concern for a number of reasons, some of which are outlined as follows:

- Superior private sector efficiency over the public sector is not yet proven;

- Very low private health insurance levels will mean that the government is going to have to subsidise whatever agreement is made with whatever organisation;

- The profit motive will distort the provision of medical services.

A number of submissions argued that under greater private sector control, there will be a distortion in terms of what types of services will be offered - tangible, high priced services will be favored (e.g., surgery), and less tangible services (mental health, rehabilitation) de-emphasised. Overall, the market will distort services away from preventive health, community health and home care programs.

- Under private control, there should be concern about the community's ability to relate to developments in the system.

- There should be concern over the notion of charity (e.g., as in some of the larger Church-run hospitals) as the primary basis for providing services to a large part of the population.

The Evatt Foundation was explicit in its view of private sector involvement in community health with the following comment.

> "Private operators are not experienced in the provision of community health services and the basic philosophy of private operation is in conflict with the philosophy of community health".

The view was also expressed that community health services have tended to develop where there have been gaps in service not provided by private providers. It is argued that the risk with a private provider is that services will be reduced to a minimum, and that the operating philosophy might change (i.e., be less focused on prevention).

The Evatt Foundation submission, like that of Professor Webster, argued that under conditions of private operation, many of the intangible benefits arising from health education and prevention programs would be at risk and may not continue. Similarly, it would be difficult for private operators to integrate their programs with the predominantly government co-ordinated national and international strategies in community health and prevention.

Other concerns of the Evatt Foundation include the risk that the privatisation of community health services will force a focus on supporting patients discharged from hospitals, thus reducing their opportunity to concentrate on prevention issues. A further concern is that private providers may use community services as a source of increasing the use of more profitable inpatient services (although admitting that this would be difficult to monitor).

- **A cautionary approach to privatisation**

In its first submission to the Committee, the Health Services Association (HSA) of NSW was clear in its view that

> "...there are some aspects of the health care delivery, which prove extremely difficult to administer in any setting other than the public sphere...It is suggested that such activities (health education; preventative health) where there is a much longer and less obvious financial gain to be achieved should always remain in the public sector".

The HSA also saw the potential for contractual abuse where preventive health is concerned, and suggests avoidance of these circumstances wherever

possible. Similarly, the role of the community in shaping the nature of community-based health service delivery programs was seen as being more difficult under conditions of private ownership than if the services are community-owned.

In a supplementary submission to the Committee (a copy of the HSA's submission to the Committee of Review regarding 'Community Health Services and Port Macquarie Base Hospital'), the HSA proposed a mechanism which it believes could ensure the viability of community health services under conditions where a major private health service provider (as in the Port Macquarie Hospital case) exists in virtual monopoly circumstances. Under a District Health Board structure (which the HSA believes will emerge as a result of the imminent restructuring of rural health services), the HSA proposes that a position of Director of Public Health and Community Health be created. This position would report to the Chief Executive Officer of the Board.

The HSA recommends that the new Director be responsible for all community health services in the District, and that some community health staff be allocated, as appropriate, to specific hospitals for the operation of specialist and outreach services. Given the overall responsibilities of the new position, the incumbent would advise the Board on the most appropriate allocation of resources between inpatient and community health services.

In the context of the Port Macquarie Review, the HSA believes that their recommended approach would provide a range of checks and balances, thus ensuring that the community has access to a full range of community and other health services, and at the same time avoiding concerns about a conflict of interest associated with private hospital ownership.

Some of the benefits of the above approach perceived by the HSA are as follows:

- provides for a unified strategic basis for development of public, community, and hospital-based health services;

- provides a basis for the introduction of purchaser/provider split arrangements for public and community health services;

- provides greater flexibility in resource allocation (including transfers or adjustments between acute and community health services);

- gives hospitals the ability to participate in the allocation of resources for community and public health purposes;

- ensures that the hospitals receive a fair allocation of community health resources;

- ensures that should a major private operator (e.g., hospital) appear to be using community health resources to increase the profitability of its business, the situation can be objectively considered, appropriate action instituted and the community reassured through the District Board;

- provides continuity of care through the allocation of community health staff to hospitals;

- the proposal would be acceptable to both the Commonwealth and State agencies in relation to HACC and Geriatric Assessment Teams;

- avoids fragmentation of services;

- improved staff development; and

- improved quality of outcomes.

Representatives of the College of Health Services Executives (CHSE) strongly supported the concept of the Area Health Board as a means of overcoming the potential for conflicting interests and objectives in a system with private and public health care providers. Indeed, Mr Watson, a spokesman for CHSE at the Committee hearings, commented that

> "...the best way of ensuring proper networking of services and proper performance by a private operator is to have an Area Health Board type arrangement where an Area Health Board takes responsibility for the whole of the services in that community and then as one of its activities

it has a contract with the private operator to operate some of the services".

The CHSE for example, sees some of the host hospital's reluctance to embrace Dr Wilson's Hospital Extension Services (HES) Pty. Ltd. post-acute program, in terms of a lack of coordination, or the absence of the ability at say Area Board level, to examine the full impacts of early discharge schemes on the total area health budget. In effect, HES's activities were solely dependent upon the goodwill of the host hospital. In such circumstances, there are conflicts of interest within the hospital which operate to the disadvantage of community-based services such as HES (either private or public).

Both the HSA and CHSE views seem to reflect two basic issues. Firstly, changes in the nature of funding NSW health infrastructure will bring about a number of changes, some of which (particularly where privatisation occurs) will not necessarily be in the general public interest. Secondly, these changes to the health infrastructure require a new form of structure to ensure quality, consistency, an integrated approach to resource allocation, and accountability to the community. The HSA has proposed a detailed structure and lines of responsibility for a District Board structure (that it sees as a likely outcome of restructuring of NSW rural health) which is seen as providing the necessary safeguards for community health services operating under a mixed public-private ownership environment.

The CHSE sees the key to the effective management of a mixed health services economy in the activities of the Area Health Board, which would act as the central conduit and coordinator of health services of all types in a defined geographic area.

7.6 Summary

There is an increasing trend internationally and nationally towards a greater focus on the achievement of health outcomes, and for greater community participation in determining the priorities for health care services. A number of examples of this trend have been identified, particularly in the UK and USA, which provide valuable lessons in pursuing this direction in Australia.

Within Australia, there have been a number of reports at the national and State levels which have acknowledged the need for reform on these areas, and which have proposed strategies for the implementation of reform. The National Health Strategy Review has published a series of Issues and Background Papers which deal specifically with the problems to be addressed and which call for new initiatives to be undertaken.

In NSW, the Health Department has implemented a number of organisational changes aimed at greater devolution of decision-making in the planning and delivery of health services to the local level. It has also indicated that a greater focus on the achievement of health outcomes is a major priority for its future activities, and that it is developing a program for greater community participation in the planning process. The Committee acknowledges these developments, and has identified a number of strategies which could serve to facilitate this process.

A range of views are presented on ways by which health services might be planned with greater participation by local communities. Clearly, there is a considerable body of expertise within the community, in academia and in the Health Department itself which, collectively, has the capacity to develop and implement a program for reform which will maximise health outcomes. The challenge is to establish a forum by which that expertise may be accessed. The importance of health education in promoting greater community participation in the planning for, and delivery of, health services among local communities, and in facilitating the integration of services is also recognised.

The Committee has included a number of specific recommendations which provide examples of ways in which approaches to these issues might be initiated. In addition, the Committee considers that an ongoing program of pilot projects should be maintained which explore and evaluate alternative methods by which the objectives of community participation and program evaluation may be furthered.

In regard to the participation of the private sector in the area of community health services, virtually all parties making submissions to the Committee recognised these services as traditionally falling largely in the province of the public sector. The private sector is involved to a lesser extent through the activities of some charitable, community and religious organisations and the

work of volunteers. Many of the submissions argued strongly that such services would be adversely affected by the for-profit private sector becoming involved in service delivery. There were differing views, however, as to the appropriate approach for involving the private sector.

The Department of Health considered that a shift in the provision of infrastructure might alter the balance in the way such services might be delivered, but not the fundamental way in which the State and Commonwealth Governments fulfilled their respective responsibilities in fostering the development of appropriate services.

Some submissions to the Committee were strongly opposed to the for-profit private sector being involved in these services. They referred to an inherent conflict of interest between the provision of acute hospital services and those of community health services, which manifests itself in a variety of ways. For example, community services and hospital services often compete for the same clients - one to prevent hospitalisation and the other to "capture admissions". Similarly, the argument was put that there would be a tendency to divert resources under a private operator to the more tangible services (such as surgery) rather than the more intangible services (such as mental health, rehabilitation etc.). Equally important, the capability of the private sector to provide community services across the range of jurisdictions often involved in these services was also challenged.

Other views expressed to the Committee were less opposed to private sector involvement in this sphere, but advocated a cautionary approach. The Health Services Association (HSA) proposed a mechanism for private sector involvement in community health services which would help to protect these services and their consumers from potential abuse. Their approach revolves about the appointment of a Director of Public Health and Community Health who would be responsible for all community health services in the area, and would advise the Area and District Health Board on the most appropriate allocation of resources between inpatient and community health services.

There is little doubt that any changes to the nature of funding health infrastructure will bring about a number of changes, not all of which will necessarily be in the general public interest. These changes will require a new form of structure to ensure the quality, consistency, integration of

services and accountability to the community. It is essential, therefore, that this structure provides appropriate mechanisms for the active participation of the community in the planning for, delivery of and monitoring of services.

RECOMMENDATIONS

7.1 That a public education program be developed and implemented into the nature and costs of health services, as a precursor to greater public participation in the planning for health services. This may include the publication of particular State-wide and regional issues such as waiting times, surgery rates, admission rates etc.

7.2 That a program be developed for greater ongoing public participation in the strategic planning process and determination of priorities for health services. Issues papers covering specific topics should be developed and circulated widely, with comments sought from expert bodies and the general public.

7.3 That a program be developed for greater decentralisation of community health services planning and delivery to facilitate community participation in these processes.

7.4 That Area Health Boards and District Health Boards be required to develop a dynamic working relationship with the community in developing policies and programs to service their communities, and that they report on their activities in their Annual reports, including their structure and effectiveness.

7.5 That the position of Director of Community Health at the Area and District level be adopted universally, with representation at the level of the Area and District Executive.

7.6 That area and District Chief Executive Officers develop programs to facilitate the integration of general practice, community health and inpatient services.

7.7 That the Health Department, through its Area and District structure, support and encourage the development of the family medicine program by expanding its role in the integration of health services.

APPENDIX A

LIST OF PERSONS AND ORGANISATIONS MAKING SUBMISSIONS TO THE INQUIRY

LIST OF SUBMISSIONS

Accounts Receivable Management Group Pty Ltd

Albury and District Private Nursing Home

Australian College of Health Service Executives

Australian Geriatrics Society, NSW Division

Baird, G

Brooks, Dr E

Chiropractors Association of Australia, NSW Branch

Combined Pensioners and Superannuants Association of New South Wales, South Coast Area Council

Combined Pensioners and Superannuants Association of NSW

Corlis, Dr W L

Council of Social Services, New South Wales

D'Souza, J

DiSalvo, T L & B I

Doctors Reform Society

Dwyer, Professor J

Eastern Suburbs Action Group

Egan, M MLC

Federated Iron Workers Association, Port Kembla Branch, Retired Members Association

General Practitioners Group of South Illawara and Kiama

Grant-Curtis, B

Hastings Hospital Action Group

Health Care of Australia

Health Services Association of NSW

Hospital Extension Services Pty Ltd

Kiama Municipal Council

Liverpool City Council

Mackay, T

Metals and Engineering Workers' Union

NSW Community Health Association Co-operative Ltd

NSW Department of Health

Oldfield, Dr G S

People's Action for Preservation of Public Services

Private Hospitals Association of NSW

Public Sector Union, NSW Branch

Public Service Association, Hastings District Hospital,

Puris, Dr G A

Richards, W

Royal Far West Children's Health Scheme

The Labor Council of NSW, the Nurses Association of NSW, the Health and Research Employees Association of NSW, the Australian Salaried Medical Officers Association (NSW), the Public Service Association, the Hospital Officers Association and the Evatt Foundation

The Public Health Association of Australia

The University Teaching Hospitals' Association (Industrial) NSW

Trevan, B

United Mineworkers Federation of Australia, Northern District Branch

Wagga Wagga Base Hospital

Webster, Professor I

APPENDIX B

LIST OF WITNESSES

LIST OF WITNESSES

Thursday 11 December 1992

Ms E M Hall, Hastings Hospital Action Group
Mr R A McClelland, Hastings Hospital Action Group
Mr S T Williams, Hastings Hospital Action Group

Tuesday 16 march 1993

Ms J M Fisher, University Teaching Hospitals Association
Mr B W Johnston, University Teaching Hospitals Association

Ms K Moore, Consumer's Health Forum of Australia

Mr M G Lambert, New South Wales Treasury
Mr L J Powrie, New South Wales Treasury

Ms P J Staunton, New South Wales Nurses Association
Dr P C Botsman, Evatt Foundation

Mr L L Wilson, Hospital Extension Services Pty Ltd

Wednesday 17 march 1993

Professor I W Webster, University of New South Wales

Mr R G Wraight, NSW Department of Health
Mr A R Keith, NSW Department of Health
Mr D A Gates, NSW Department of Health
Mr W B Jurd, NSW Department of Health

Dr S R Spring, Northern Sydney Area Health Service

Professor P E Baume, School of Community Medicine, University of NSW

Wednesday 17 march 1993 (Continued)

Mr J P Rasa, Australian College of Health Service Executives, NSW Branch
Mr R B Watson, Aust. College of Health Service Executives, NSW Branch
Ms K M Chant, Australian College of Health Service Executives, NSW Branch
Mr W L Westcott, Aust. College of Health Service Executives, NSW Branch

Thursday 18 march 1993

Mr B E Semmler, Private Hospitals Association of New South Wales

Mr A G Owen, New South Wales Community Health Association
Mr M A Allerton, New South Wales Community Health Association

Mr R J Schneider, Australian Health Insurance Association

Mr R P Young, Health Services Association of New South Wales
Dr S W Spring, Health Services Association of New South Wales

Professor R J Lusby, Australian Medical Association, NSW Branch
Dr M J B Nicholson, Australian Medical Association, NSW Branch
Dr J Lee, Australian Medical Association, NSW Branch
Dr P C Arnold, Australian Medical Association, NSW Branch