

# The Commonwealth's proposal for the 1998–2003 Health Care Agreements

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## Abstract

*The new Health Care Agreements for 1998–2003 are currently being negotiated between the Commonwealth and State and Territory governments. The Commonwealth's offer aims to address the major problems associated with the current Agreements, including cost-shifting incentives and funding rigidities.*

*It has proposed a funding model whereby admitted and non-admitted patient services are funded on an output basis. Other aspects of the proposal include funding for quality enhancement and structural change, and specific funds for mental health and palliative care. The proposal also aims to achieve a more equal sharing of risks and benefits between the Commonwealth and the States and Territories.*

*The views expressed are those of the authors and should not be taken as an official view of the Department or the Minister. While the authors have had primary responsibility for the development of the Commonwealth model and the preparation of this paper, they wish to thank other members of the Health Care Agreements Branch (Heather Cocks, Ian Macdonald, Elaine Pringle and Shane Wright) for their assistance.*

## **Background to the Health Care Agreements**

The Commonwealth has been providing financial assistance to the States for health services and facilities since 1949–50. When Medibank was introduced in the 1970s, a cost-sharing system was implemented under which the Commonwealth met half the approved net operating costs of ‘recognised’ (public) hospitals in the States and the Northern Territory. Self-government had not yet been introduced in the Australian Capital Territory, which was covered by separate arrangements.

In 1981–82 this cost-sharing system was replaced with a series of ‘Identified Health Grants’ (IHGs). The IHGs were general purpose payments, so although they were nominally granted for hospital expenditure, the States had complete discretion to determine how the funds were spent. South Australia and Tasmania chose not to move to this new type of payment immediately, and continued to be funded through the cost-sharing arrangements until 1 February 1984 when Medicare was introduced.

The Medicare principle of universal access to treatment based upon clinical need was introduced to public hospital systems Australia-wide on 1 February 1984. In order to ensure that States and Territories were not financially disadvantaged by the loss of public hospital patient revenue arising from the introduction of Medicare, the Commonwealth introduced ‘Medicare Compensation Grants’ in addition to the IHGs already in place.

At the 1988 Premiers’ Conference, the Commonwealth, States and Territories agreed on a new funding system. The IHGs and the Medicare Compensation Grants were merged into a single specific-purpose payment, known as a Hospital Funding Grant (HFG). HFG funding levels, and the conditions attached to the funding, are contained in the so-called ‘Medicare Agreements’, which are re-negotiated every five years.

The current Medicare Agreements, which were signed by the previous Commonwealth Labor Government, are due to expire on 30 June 1998. At the time of writing, the Commonwealth and the States and Territories are negotiating the new Agreements (renamed Health Care Agreements) to cover the period 1998–2003. These negotiations are taking place within the context of the current Commonwealth Government’s stated commitment to retaining the principles of Medicare. This paper describes the Commonwealth proposal for the funding model under the new Agreements, which contains a number of features designed to overcome the problems which have plagued the current Agreements.

(In the rest of this paper, a reference to the States includes a reference to the Territories.)

## Problems of the 1993–1998 Agreements

The current Agreements have four main problems. First, Commonwealth funding for the public hospital system increased by approximately 10% in the first year of the Agreements. This did not, however, flow through to hospitals, as most States cut their own contributions. The State and Territory funding of the public hospital system did not return to pre-1993 levels until 1995–96.

Second, the States and Territories have shifted costs for services (which, under the Agreements, should have been provided free in public hospitals) onto the Medicare Benefits and Pharmaceutical Benefits programs funded by the Commonwealth.

Third, the Commonwealth has not compensated the States for the impact of falling private health insurance participation. While the Agreements require a review of funding levels if the private health insurance participation rate drops by 2 (or a multiple of 2) percentage points relative to June 1993, there is no requirement for the Commonwealth to provide additional funding. Two reviews have been conducted during the life of the current Agreements, but the Commonwealth has not increased its funding. This has been an ongoing source of friction between the Commonwealth and the States.

Finally, and most importantly, both the Commonwealth and the States see the current Agreements as reinforcing artificial boundaries within the health system. They not only encourage cost-shifting games, but also discourage health care providers from considering clinically appropriate and potentially more cost-effective treatments which could be delivered outside the traditional hospital setting, thus making integrated or coordinated care more difficult.

## Major objectives of the new Agreements

At the Health Ministers' Meeting in May 1997, Ministers agreed a vision

*...for a healthy Australia in which communities seek to improve their health over the whole of life. The focus will be on improving the health of the Australian community and in particular the health of specific population groups which have a lower standard of health.*

It is within the context of this vision that the Commonwealth's offer to the States and Territories on the new Agreements has been made.

The Ministers also agreed that in order to improve the flexibility of health financing and to achieve better integrated and coordinated care, several areas must be addressed.

These areas are:

- the introduction of an output and outcome focus, based on agreed targets for selected performance measures
- risk management arrangements based on the appropriate sharing of risk
- protocols to support ‘measure and share’ arrangements to ensure clinically appropriate services are provided cost-effectively in appropriate settings
- an integrated information system, including timely data exchange and the development of the capacity to identify services provided to the same (de-identified) patient in different settings.

From the Commonwealth’s perspective, an overriding goal of the new Agreements is greater flexibility in the provision of health care services. The funding basis should not present barriers to clinicians wishing to follow best practice in the delivery of health care services, even when those services are provided outside the hospital environment. If health care providers are able to develop a system of coordinated care, leading to improved patient outcomes, then the funding system should be flexible enough to allow resources to ‘follow the patient’ to the most appropriate care setting.

Another major objective for the Commonwealth is to reduce the level of cost-shifting, which has been an ongoing problem since the inception of Medicare. The issue of cost-shifting is discussed further below.

## **The proposed funding model**

The Commonwealth has proposed that its contribution to public hospital funding be calculated as the sum of several parts: an admitted patient component; a non-admitted patient component; and another component providing funding for mental health and palliative care, quality enhancement and system restructuring.

Funding for admitted and non-admitted patients would be calculated on the basis of system outputs, and would account for almost 95% of the funding available under the Agreements. However, while the grants would be calculated on the basis of system outputs in these areas, States would not have to account for this funding on the same outputs basis, and each State would be able to distribute the funds according to its own approach to hospital funding.

The Commonwealth is seeking an output-based model because it believes that this will establish an identifiable and measurable basis for discussions between the Commonwealth and the States and Territories on possible changes in service

provision, not only between the sectors in acute care, but between acute care and other forms of care. When these changes are identified and measured, Commonwealth funding will be able to 'follow the patient' as appropriate. This ability will be particularly valuable in the development of 'measure and share' arrangements, under which funding streams may be redirected to support more appropriate care.

In the longer run, identification of funding related to level of output for particular services will assist in the development of notional regional health budgets in cooperation with the States, facilitating moves towards a population-based health funding system. The experience of the coordinated care trials will also be valuable in developments in this direction.

### **Admitted patient component**

The admitted patient component of the funding would be calculated on the basis of the number of casemix-adjusted separations per weighted uninsured capita, multiplied by a Commonwealth contribution.

For the purpose of this calculation, the uninsured population would be derived by subtracting from the estimated resident population the number of people covered by hospital insurance in each age/sex cohort (as reported by the Private Health Insurance Administration Council, PHIAC) and then weighting age/sex cohorts to reflect the cohort-specific rate of acute separations based on 1995–96 hospital morbidity data. Entitled veterans and their dependants would also be removed from the uninsured population because they are covered under separate Repatriation Commission arrangements.

The per capita rate of casemix-adjusted separations in the first year of the Agreements would be State-specific and based on an extrapolation from 1995–96 (this being the most recent year for which comprehensive data are available). The rate of the Commonwealth contribution per separation in the first year would be a derived figure, based on dividing the total funding available for admitted patient services by the number of services. The total funding available for admitted patient services (a little over \$4 billion) would in turn be derived as around 80% of ongoing funding (about the proportion of hospital expenditure related to admitted patients).

The rate of the Commonwealth contribution per separation would be indexed from year to year by reference to movements in a national Hospital Output Cost Index (see 'Risk Sharing' below). The uninsured weighted population would be adjusted each year on the basis of the latest ABS estimates of population, PHIAC data on insurance participation, and information from the Department of

Veterans' Affairs regarding the number of eligible veterans and their dependants. Finally, the rate of separations per capita would be increased from year to year by 1.6% to reflect underlying increases in demand not related to population growth and ageing – the so-called 'utilisation drift' factor.

Funding for the admitted patient component would then be calculated as the product of the rate of Commonwealth contribution per separation, the rate of separations per capita, and the uninsured weighted population.

This methodology addresses the issue of appropriate compensation for changing private health insurance participation rates which was one of the major areas of contention between the Commonwealth and the States during the current Agreements. Under the proposed model, changes in the level of insurance coverage would be automatically reflected in funding by removing the insured population from the weighted population. If the insurance rate should change, the uninsured population would change, with consequential effects on the level of funding.

The methodology also provides a firmer base for future growth pressures. For example, if there is no change in private health insurance participation, the age-weighted population index and the utilisation drift factor allow for growth in separations of around 4% per annum.

Once the admitted patient component had been calculated at the start of the year, it would not be reduced should actual activity be different from that assumed in the calculation. However, the reasons for any shortfall of more than 5% would be discussed between the Commonwealth and the State. In the (unlikely) event that there had been an ongoing reduction in services, Commonwealth funding in the following year would be adjusted to reflect this ongoing lower activity.

However, if the State was able to show that the reduction was temporary (for example, due to industrial action), or if the State was continuing to provide and fund the services but they had been moved outside the hospital environment, there would be no reduction in Commonwealth funding.

Any increase in actual activity above that assumed in the calculation for a year (once age-weighted population, private health insurance and utilisation drift were taken into account) would not attract additional funding.

## **Non-admitted patient component**

The Commonwealth's preference is to fund non-admitted patients on an output basis, similar to the system used for funding admitted patients. However, it appears unlikely that any State will have a sufficiently sophisticated classification system for non-admitted patient episodes to support an output-based model, at least for the first year of the Agreements.

The Commonwealth is thus proposing that the non-admitted patient component should initially consist of a population-based block grant, but that the Agreements commit the parties to working together to introduce output-based funding as soon as possible. This might be implemented in the first instance using output-based classifications being used in several States based upon clinic descriptors.

Under a population-based block grant, total funding in the first year would be set at around \$1 billion (derived as around 20% of ongoing funding, which is about the proportion of hospital expenditure related to non-admitted patients) and distributed between States on the basis of their total weighted population. As insurance status should not affect patient status in relation to accident and emergency or outpatient services, it would be inappropriate to adjust the population to reflect changes in the private health insurance participation rate.

In later years, the grant would be indexed by growth in the weighted population and a suitable costs adjustment factor. In initial discussions with the States, the Commonwealth has proposed use of the so-called Treasury WCI-1 index (75% safety net wage adjustment and 25% Treasury underlying measure of inflation), less an efficiency dividend. However, it is considering the possibility of using the Hospital Output Cost Index in the non-admitted patient component calculations.

## **Mental health and palliative care components**

The current Medicare Agreements provide specific Commonwealth funding to assist '... the State to meet the costs of reforming mental health services'. The Commonwealth is proposing to continue separate Commonwealth funding for this purpose, linked to States supporting the second National Mental Health Plan and meeting agreed mental health reform targets.

The funding would be available to orient mental health services to a more preventive and early intervention focus, to examine innovative approaches for improving service, and to improve quality and efficiency through pooling Commonwealth and State funding for specialised mental health services.

The mental health component of the Commonwealth funding (\$50 million in the first year) would be allocated between States and indexed for costs and for changes in the weighted population along similar lines to the non-admitted patient component, except that an efficiency dividend would not be applied. However, the weightings applied in calculating this weighted population may differ from the weightings used in the other components, given the differences in the age-weighted utilisation of mental health services compared with other health services. Additional funds (\$10 million per annum, indexed) would also be made available by the Commonwealth for national projects.

Funding for palliative care services is in some ways in a similar state to mental health. While the Commonwealth had made funding available under the 1993 Agreements, there is a case for continuing funding to support service development. Since 1997–98, Commonwealth funding for palliative care has been combined into one stream provided through the Medicare Agreements. It is proposed that this single stream of funding continue under the new Agreements, and that resources be directed to fund services in a range of settings.

Around \$30 million would be available for palliative care in the first year of the Agreements. This would be allocated between States and indexed for costs and for changes in the weighted population along similar lines to the non-admitted patient component, except that an efficiency dividend would not be applied.

### **Quality enhancement and system restructuring components**

The Commonwealth has taken the view that the best way a broad funding agreement can support improvements in the quality of service is through the provision of a relatively small financial incentive at the provider level. However, it is clearly inappropriate for the Commonwealth to be making judgements on the quality of service provision at this level. Accordingly, it is proposing to make available funding to the States on condition that they demonstrate a suitable process for rewarding quality service provision at the hospital provider level within their hospital systems.

The Commonwealth would provide \$75 million for this purpose in the first year of the Agreements, distributed between States on a weighted per capita basis. The amount available would increase by \$25 million a year, and the total would be adjusted for population growth and price movements on a similar basis to the palliative care funding.

In addition, the Commonwealth proposes to provide around \$500 million over the five years of the Agreements to support substantial projects designed to produce a more cost-effective health system, and one with stronger claims to



providing integrated care across the acute and other health sectors. This funding, to be known as National Health Development Special Assistance, is not intended to be used for the treatment of patients, but to achieve structural change within the health care system, leading to long-term efficiency gains. The Commonwealth does not envisage this fund continuing beyond the life of the new Agreements, and it is not intended to replace normal capital or recurrent spending by the States.

One particular area of system restructuring which the Commonwealth proposes to pursue is the supply of discharge and outpatient drugs through the introduction of PBS arrangements in hospitals. This would remove the current incentive for hospitals to dispense minimal 'starter packs', thus requiring patients to visit their general practitioner and receive a PBS script at a later date. It is proposed that the small transitional costs of this change be provided as National Health Development Special Assistance, and that the change be introduced without any 'clawback' from State funding.

The Commonwealth also envisages that funding could be used to implement reforms in areas such as the further integration of aged care services, or investment in information technology systems designed to improve the flow of information around the health care sector. However, States will be asked to present proposals for funding, and expenditure will therefore be directed towards areas which they consider are priorities.

## **Risk-sharing**

Under the current Agreements, the States accept the entire risk of increased demand for hospital services over and above that portion due to population growth and ageing, but in return they receive the entire benefit of any efficiency gains. The Commonwealth is proposing a more sophisticated model for risk-sharing, with a more equal distribution of risk and benefit between the parties.

The main area of risk is increased demand for admitted patient services due to changes in the private health insurance participation rate and utilisation drift. As noted above, funding for admitted patients will be calculated with reference to the weighted uninsured population, thus providing an automatic increase in funding if private health insurance coverage drops. The Commonwealth proposes also to share the risk of utilisation drift with the States by increasing the per capita rate of services which it funds by 1.6% each year.

Other areas to be considered in relation to risk-sharing include price movements and efficiency improvements. Under the current Agreements, funding has been

indexed for price movements by reference to a composite index combining average award rates of pay (75%) and the consumer price index (25%). This index has grown only marginally more slowly than the Australian Institute of Health and Welfare Hospital and Clinical Index. There has been no allowance for efficiency gains.

As noted above, the Commonwealth is proposing that the Commonwealth contribution to admitted patient separations (and possibly price movements in other areas) be indexed according to the Hospital Output Cost Index. This index will be influenced by two major factors: input costs and efficiency. Use of the Hospital Output Cost Index means the Commonwealth will share the risk of increases in the cost of hospital inputs, but it also means the Commonwealth will share the benefit of efficiency gains achieved within hospitals.

It has been argued in some quarters that calculating Commonwealth funding on the basis of increases in the cost of inputs (even if efficiency gains are also taken into account) removes the incentive for hospitals to minimise these increases. However, it must be remembered that the Commonwealth is not funding the entire hospital system, and the States have their own incentives to ensure that increases in hospital costs are minimised. In addition, the continuing pressure on hospitals to increase efficiency is expected to counteract any tendency towards unrestrained cost increases.

## **Performance indicators**

Experience under the current Agreements has shown that linking funding to performance targets does not provide appropriate incentives. Instead, it tends to encourage targets set at levels which will always be achieved. As such, the Commonwealth has proposed a series of ‘performance indicators’ which will not be tied to funding, and will not result in penalties for under-performers.

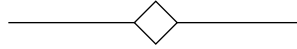
The Commonwealth and States would develop benchmark levels for the various indicators, and the results of the States could then be compared. These results would be available for public scrutiny, so the electorate would have access to information relating to how well their own State’s public hospital system is being managed.

## **Cost-shifting**

One of the major issues under the current Agreements has been cost-shifting. From the Commonwealth's perspective, States have adopted a wide range of practices clearly intended to shift costs onto the Commonwealth, private health insurance funds or patients.

In order to reduce cost-shifting and ensure that funding accurately reflects the level and types of services provided, the Commonwealth has proposed the establishment of an independent body to collect, analyse and disseminate de-identified patient level data from the Commonwealth and the States. This body will be able to identify the movement of services around the health system, and report on how these services are funded. The reports will be made available to all parties, and will be used for informed decision-making on the level of cost-shifting and appropriate adjustments to funding under the new Agreements.

## COMMENTARIES ON LEAD ARTICLE



*Australian Health Review* sought the following replies to the lead article, ‘The Commonwealth’s proposal for the 1998–2003 Health Care Agreements’, by Ian Bigg, Susan Azmi and Charles Maskell-Knight.

### **The Health Care Agreements and health: Is there any connection?**

PETER BAUME

Peter Baume is Professor of Community Medicine, University of New South Wales, and Chancellor, The Australian National University. He was formerly a Senator for New South Wales and a Federal Minister.

The new Health Care Agreements will have little or no effect on the health of Australians. An old political aphorism has it that ‘matters of principle are matters of money while matters of high principle are matters of a lot of money’. If that aphorism is only somewhat correct, then what is at stake is a matter of ‘high principle’. It is an argument between the Commonwealth (which has the money) and the States and one Territory (which have the responsibility). The Australian Capital Territory is excluded from my remarks, because it has taken up the Commonwealth offer and signed a new Agreement. (Subsequently, Queensland has announced its agreement to the new health care arrangements.)

The reason that the Premiers and the Chief Minister of the Northern Territory walked out of a recent meeting had to do with money and not with health. That it was ‘health money’ is more a matter of chance than anything else.

The Premiers and Chief Minister understand money more than they understand health. They asserted that the Commonwealth was not paying enough, and the Commonwealth said that it was. The Premiers might like to respond to the claim (see Bigg, Azmi & Maskell-Knight 1998, this issue) that not all the extra money that went to the States and Territories over the term of the current Agreement was in fact spent in the hospitals. Either that claim is true or untrue. It certainly weakens the case of the mendicants as it stands.

When I first went to Canberra as a Senator, an ex-premier told me that the aim of a lot of games was 'to take the socks off the Commonwealth'. It still is. At one time when the Commonwealth paid 50% of all hospital costs, one State decreed that all ambulance services were to be hospital services, thus transferring half of all costs for all ambulances to the Commonwealth.

Cost-shifting games are still practised assiduously. For example, the move to investigate patients by way of 'pre-anaesthetic clinics' is, whatever else it may be, often a cost-shifting game today: the Commonwealth picking up the costs of the investigations and the States and Territories avoiding those costs.

So the proposed Agreements are about money: how much, over what time and to whom. Moreover, they are about activity within the salvage sector of medicine. They are not about the health of Australians, which is probably not helped much (in the aggregate) by what occurs in most hospitals. They are about how we pay for activities which deliver more of the same, instead of being about a system which improves our health. They are an 'old game' in a situation crying out for new approaches and new thinking.

## **Hospitals and health**

It is clear that individuals do benefit from much of the activity covered by the Agreements. Individuals need hospitals, but it is less clear that society needs them to the same extent. It is the community that seems not to benefit as much from the whole exercise as do individuals.

Worse than that, the existence of 'hospitals' in some rural centres is often more about employment in rural towns, about the provision of long-care residential facilities, about the provision of an environment in which local medical practitioners can operate and about civic and political pride. It is seldom about health. The fact that a hospital with superior capacities to treat disease may exist 'up the road' seems not to matter, although common sense would then require that each town should have the equivalent of a casualty clearing station and an efficient evacuation system.

This view must be modified by any extra activity that will occur with palliative care and mental health. Both are woefully underprovided at present.

Actually, the new arrangement is also about efficiency, and this is welcome. But it is not about health and should not be presented as if it is. It is time that we had a policy directed to the health of society.

The new admitted patient component is based on casemix. This is simply a system of payment and, of itself, has nothing to do with the health outcomes that result. Health care is being defined by the exclusive use of iso-resource classifications, and DRGs in particular. Care is needed to avoid the assumption that production measured by DRGs says something useful about resource use and health gain.

The available evidence seems to be that health services are only proximately related to health outcomes. A closer relationship exists between measures of the 'equality' in societies and their health than between their hospital and medical services and the health of their societies.

It might give some proceduralists pause to realise that increased longevity in the past 50 years has been more than equalled by increases in the time people live with disability. If an important purpose of care is to increase valuable time for individuals, there is some question about whether this is what we have been doing in the past few years. A walk around the wards full of demented older Australians in most nursing homes makes this tragically clear.

That salvage care is vital to sick individuals is undoubted. What is less certain is that the same care contributes much to the health of the society in which it occurs.

## **Including health in the debate**

What is needed for the next round is some agreement that the health of Australians should be the primary focus. This would be a radical new approach. After all, is it too much to ask that housing programs should house somebody, or that education programs should relate to education? Why would it be radical to ask that health programs related to health?

They do not at present. Much of the activity helps mortal individuals to postpone dying, but does not help improve Australia's health.

We know today that provision of clean water, removal of human and community waste, the elimination of rats, the improvement of nutrition and the improvement of housing are the things that have improved Australia's health. If we add the provision of contraception and advice on family spacing, we have a suite of activities which improved our longevity and our health during the last century. Most of them today are provided outside the formal health care system, but that makes them no less valuable. And some Australians with demonstrably worse health (such as Aboriginal and Torres Strait Islander people) do not enjoy the benefits which that sanitary revolution gave to most people.

## **Rationing in the foreground?**

Having said all that, I accept that hospitals are politically sensitive and that funding arrangements are directed to their operation. That the Commonwealth has a role in directing how most hospitals are funded seems to me to be a confusion of funding and constitutional responsibility. Since rationing is inevitable, it is not surprising that the States and one Territory are 'blame-shifting' (to use the Prime Minister's words) as a preparatory action to cutting services.

Those of us in the game have known for years that there is not enough money to supply all services for everyone. There never has been and there never will be. But when did you last hear a politician admit that. The new Agreements merely set the rules for continuing this game. As such they are interesting, but they are incomplete.

## **Making a move on Medicare**

STEPHEN DUCKETT

Stephen Duckett is Dean of the Faculty of Health Sciences, La Trobe University.

The current Medicare Agreement expires on 30 June 1998 and we are currently seeing in the media the familiar elephant dance of Commonwealth/State relations as part of the renegotiation ritual. The States are trumpeting that they won't sign the next Agreement unless the Commonwealth hands over another \$5 billion. The Commonwealth, on the other hand, raises its trunk and howls that \$1.7 billion is enough. It is important to recognise, however, that there is a deal of smoke and mirrors about the amount of money available. The Commonwealth, for example, normally talks about additional funding available over the course of the Agreement: over a five-year Agreement the \$1.7 billion thus becomes about \$350 million a year, equal to an increase of perhaps 3% or less in public hospital funding.

One problem with previous Medicare Agreements was that there was little accountability to the Commonwealth, and increased Commonwealth funding was often not translated into improved services because States cut back on their own funding. This certainly happened over the early years of the current

Medicare Agreement. Over the period 1990–91 to 1995–96, total hospital expenditure in Australia increased by 18%. However, in most States these expenditure increases were principally met by the Commonwealth. Over this period, total Commonwealth hospital expenditure increased by 31% but, on average, State and Territory expenditure increased by only 11%. There were significant declines in State expenditure in Victoria (–14%), South Australia (–23%), Tasmania (–29%) and Northern Territory (–14%). New South Wales was the only State where total expenditure rose faster than Commonwealth expenditure. This represents the other side of the smoke and mirrors game engaged in by both sides.

Unlike other aspects of Commonwealth funding which are adjusted annually, the Medicare Agreement normally provides for a major renegotiation every five years. The quantum of increased funding provided under a new Agreement reflects both a catch-up for inadequate funding in the previous Agreement, and anticipated funding increases over the life of the forthcoming Agreement. Of course, ‘inadequate funding’ is in the eye of the beholder and, given the pattern of Commonwealth and State funding change shown above, State arguments of past underfunding are not credible.

Although conventionally hospitals are seen as a State responsibility, the Commonwealth wears a lot of the political blame for inadequacies of the hospital system, including waiting times for treatment. The key problem with the current Agreements from the perspective of consumers is probably waiting times. Health policy *aficionados* identify another set of problems including ‘cost-shifting’ (the most obvious being closure of State-funded hospital outpatient services and subsequent increased billing on Commonwealth-funded Medicare), inefficiencies in the system, and inappropriate incentives. It is alleged that much of the time of bureaucrats is spent policing the boundaries between their respective jurisdictions in terms of who pays for what and whose policies can be held responsible for what problems. This focus on cost-shifting and blame attribution in a system divided between governments diverts attention from the real problems faced by consumers: improving timely access to appropriate, high quality treatment.

## **Risk-sharing**

The current Commonwealth offer is an incremental improvement on the previous Medicare Agreement: it strengthens accountability, deals in part with some of the more obvious bones of contention, and provides for more Commonwealth cash to be passed into the coffers of the States.



The critical issue in any Agreement is how the Commonwealth and States share the financial risks inherent in the health care system, including how the costs of the following factors will be shared: population growth and ageing; decline in health insurance (which, at the least, leads to a loss of revenue for State public hospitals and might also lead to increased demand as the previously insured forsake private hospitals for public hospitals); and the costs of increased admissions and increased cost per case because of technological change. Consideration also needs to be given to how the benefits of any efficiency improvements are distributed between the Commonwealth and the States, and to whether States are to be held accountable for differences in utilisation rates at the commencement of the Agreements. Table 1 summarises the apportionment of risk in the Commonwealth's current offer.

**Table1: Risk apportionment for admitted patients in Commonwealth offer (March 1998)**

Admission growth from population growth and ageing	Population-weighted separation rate used Utilisation drift of up to 1.6% assumed Commonwealth financial contribution about 50% Commonwealth bears about half risk
Admission growth from health insurance decline	Population-weighted separation weights adjust for health insurance decline Commonwealth financial contribution about 50% Commonwealth bears about half risk
Technological charge	Utilisation drift of up to 1.6% assumed (see above) No provision for change in cost per case due to technological change State bears excess risk
Efficiency savings	Hospital-specific price index to be used, hence Commonwealth will share (on a lagged basis) system-wide efficiency dividend
State-specific historical patterns of utilisation	State-specific separation rate used as basis Commonwealth financial contribution about 50% Commonwealth bears about half risk

Whether this is a fair distribution of risk is still a matter of debate. On the one hand, the Commonwealth has most access to tax-raising and so can most easily meet increased expenditure demands; has constitutional responsibility for 'hospital benefits'; and has electoral responsibility for Medicare. On this basis it should bear all the risk. On the other hand, hospitals have traditionally be seen to be a State responsibility and the States determine funding and management

policies for hospital care. A split down the middle (50:50 sharing of risk) thus doesn't seem unreasonable, with the exception of the risk associated with the decline in health insurance.

Health insurance policy is clearly a Commonwealth responsibility and it would seem fair for the Commonwealth to bear the full risk of the effects of its policies. The current Medicare Agreement simply commits the Commonwealth to think about providing additional funding; which no doubt it did but no money changed hands. Under the proposed funding formula the Commonwealth contribution would increase in line with increases in the uninsured population, but as the Commonwealth's contribution is only about half the costs of hospital care, the States will bear some cost risk of health insurance decline. The exact proportionate risk borne by the States is difficult to estimate as the population dropping out of health insurance is healthier than the average population.

### **Reducing the perverse incentives**

The new Agreements should provide a platform for addressing some of the problems of cost-shifting and perverse incentives. In particular, hospitals should be able to bulk bill the Commonwealth for medical outpatients at 75% of the scheduled fee and should be able to prescribe drugs on the Pharmaceutical Benefits Scheme at a discounted rate. These initiatives would provide increased revenue for the States and would also reduce the States' interest in cost-shifting to the Commonwealth. The Commonwealth's offer addresses the Pharmaceutical Benefits Scheme side of this proposal in an unclear and indirect way. A more forthright commitment is warranted.

The introduction of these reforms might also provide some offsetting savings to the Commonwealth through reduced cost-shifting. Producing a 'plain English' version of the Agreement, to ensure clinicians are aware of the provisions of the Agreement, should also act to deter dubious cost-shifting behaviour.

### **Eschewing small programs**

Previous Medicare Agreements have had a number of small programs tacked on to the main Agreement. The amount of money involved in these has been relatively small and States have objected to these programs because of their intrusiveness and reporting burden. In the last Agreement, in particular, the programs looked like every Canberra bureaucrat's latest bright ideas were wheeled into the Agreement. In the interest of facilitating clear accountability, the Commonwealth should avoid proposing multiple sub-buckets within the new Agreements.

## Defining the big picture

The recent walk-out by the Premiers provides an opportunity for a fundamental rethink of how hospital services are funded in Australia. In my view, the time is now ripe for the Commonwealth to assume direct responsibility for access to hospital care.

Since Federation, the Commonwealth has moved from not being involved in health to being the government that has determined the key features of our national health system. Over the same time it has become the major funder of health services, providing two-thirds of the direct government funding of health services in Australia, not counting the unidentified contribution it makes through general purpose payments to States. Moreover, this has happened with the clear, explicit support of the Australian people, through the referendum of 1946 where they voted to change the Constitution to enable greater Commonwealth involvement despite concerted opposition from many quarters, including the medical profession, and through the very clear continuing popular support of Medibank/Medicare.

Australians do not appreciate the endless bickering and histrionics between the Commonwealth and the States over public hospitals. They would rather a hospital system that worked well, and where it was clear who was responsible for making it work. The Commonwealth will continue to pick up the States' slack in funding the hospital system, because only it has the revenue base to do so, and because the Australian health system, through Medicare, is a product of Commonwealth policy.

Resolving the historical Commonwealth–State impasse over hospital funding by funding the public hospital system directly would be both popular and a decisive demonstration of the government's capacity to implement needed reform. With developments in casemix funding, it is now technically possible to have a unified funding system throughout Australia.

The Commonwealth's current Medicare offer already provides for an 'admitted patient component' with a standard Commonwealth contribution towards the cost of each person admitted for treatment, weighted according to how much they cost to treat. A new scheme should introduce a Hospital Benefits Schedule (to parallel the Medical Benefits Schedule), which would provide for a uniform casemix-related payment for the full cost of hospital admissions to any approved ('public') hospital in Australia, subject to expenditure caps through declining marginal payment.

An important side benefit of this reform is that it provides a significant rebalancing of Commonwealth and State responsibilities, thus helping to redress the problem of vertical fiscal imbalance – one of the Premiers’ criticisms. Admittedly, it does so by expanding the Commonwealth’s role (rather than increasing State taxation), but that direction of reform is probably more politically popular.

With one level of government responsible for all of Medicare for the first time, reforms could be focused on looking more carefully at trade-offs between the interrelated parts of the health system to achieve better, more integrated, care, rather than being distracted by arguments about who pays, as is most often the case at the moment.

Unfortunately, the scheme proposed will not eliminate all ‘boundary disputes’ and opportunities for cost-shifting. There will always be boundaries between what is covered by Medicare and what is not (such as care for the disabled), and hence there will always be potential for gaming at these boundaries. The problem with the current boundaries is that there is such a high level of substitution between services on one side of the current boundary and the other, that almost no other dividing line would cause such anomalies.

In 1946 one of Australia’s few successful constitutional amendments gave the Commonwealth power and pre-eminence in the field of hospital benefits. However, the Commonwealth has not exercised this and hospitals are still seen as a State responsibility. Unfortunately, I think a radical restructure of the kind outlined above is probably too bold for implementation in this round of Agreements and the current set of confused accountabilities is likely to be left unchanged. Although the Commonwealth’s current offer is a definite improvement on the existing Agreement both in terms of structure and funding, more could be done either incrementally or, preferably, by pursuing bolder reforms.

# **We have come to raise Medicare, not to bury it**

**STEPHEN R LEEDER**

Stephen Leeder is National President of the Public Health Association of Australia and Dean of the Faculty of Medicine at the University of Sydney.

## **How the morality play is unfolding**

The negotiations among the States, Territories and the Commonwealth with regard to the funding of public hospitals and related services are now in full production, with histrionics, shouting, walk-outs and name-calling all occurring according to careful choreography. The States and Territories accuse the Commonwealth Government of heartlessness, and the Commonwealth responds with accusations of profligate inefficiency and cost-shifting. Not the stuff of good health.

## **The complexities of the Health Care Agreements**

It is evident from the paper by Bigg, Azmi and Maskell-Knight (see this issue, page 8) that the Agreements between the States, Territories and the Commonwealth are a complex arrangement, requiring reciprocal legislation in all Australian parliaments. They are complex technically as well as legally. The current formula allocates resources according to the age and size of the population of each State and Territory, and the prevalence of private health insurance. The proposed version for the next five years adds indices of inpatient and ambulatory care, quality, outcomes and outputs, and ways of assessing cost-shifting activity (which has developed into a growth industry). In the current Agreements, several appendices required participating States and Territories to work together to define better measures of health gain or outcome to better judge the effects of investment (Appendix H) and also required their participation in the definition of goals and targets for health gain (Appendix I).

## **Formula that challenges the mind**

Bigg, Azmi and Maskell-Knight describe the complex weightings and calculations that are to be applied to the determination of the federal contributions to each State and Territory. Therein lies one of the current difficulties. When the Medicare Agreements come to be negotiated directly by Premiers without health ministerial or health bureaucratic support, the complexities cannot possibly be understood and will probably be interpreted as provocative and confusing. That appears to be one of the variables accounting for the extraordinary walk-out by Premiers from the Medicare negotiations in March.

## **Why the Premiers cannot cope with the Health Care Agreements**

These complexities aside, there are several reasons why the current round of negotiations are especially tense. For example, although the contributions of each State and Territory have been reviewed in the current Agreement as it requires when private health insurance prevalence has fallen, no change in funding from the Commonwealth to the States and Territories has followed.

Why this has occurred is not clear. There have been skirmishes over cost-shifting in the life of the current Agreement as well which have done nothing but inflame State and Territory passions. State and Territory governments, under pressure from treasuries who see health as a black hole with little return for squillions invested, have generally cut their contributions to public hospital funding, spectacularly so in Victoria but not in New South Wales. The Commonwealth is thus afforded easy access to the moral high ground from which it can accuse the States and Territories of hypocrisy in their quest for increased Commonwealth support simply so they can cut their own health budgets to better spend money on other services and capital works, many of which have much higher visibility and political yield than further investment in the expensive health care system. Does this opera have a moral point to it? Indeed it does.

## **Where the Agreements fit in the Australian non-health non-system**

To understand the significance of the Agreements, one needs a simple map to the health care system in general. The Australian health care system accounts for about 8.5% of gross domestic product; is said to be our third largest employer; costs somewhere between \$35 and \$40 billion depending on what is included; is administered by both the States and Territories and the Commonwealth Government; and is paid for in the ratio of 2 to 1 from the public and the private purse (Australian Institute of Health and Welfare 1996). In short, Australia has

one of the more mixed, disintegrated and confusing systems on earth. It constantly astonishes patients, doctors and visitors that it works at all, let alone so seemingly well. It is probably fortunate, then, that the public health system, excellent food supply and general levels of prosperity create, by international standards, a very good place to live if you wish to be healthy. The health of Aboriginal and Torres Strait Islander people is an appalling exception, their health status being dramatically below that of the majority of the community.

The introduction of universal health insurance, Medicare, was the biggest change to the Australian health care system. It has proved to be popular, durable and now has bipartisan Commonwealth support. Visits to general practitioners can be charged to Medicare on a fee-for-service basis. Some general practitioners charge the full fee and patients then seek reimbursement, say about 80%, from Medicare, or the general practitioner may bill Medicare directly without co-payment. Waiting lists exist for elective surgery in public hospitals, but emergency care is excellent.

Public hospital care is managed by the six States and two Territories. They receive money from the Commonwealth specifically for this purpose and also make a substantial contribution from their general revenue, much of which comes from the Commonwealth as part of general grants, but also from State sales and gambling taxes. Many elements, such as public hospital expenditure, are capped, and although prices are controlled for general and specialist services, there is less limitation on volume and hence a perverse incentive to overservice. The generally uncoordinated nature of the system allows for major inefficiencies at this level, with patients moving from one professional to another. The Pharmaceutical Benefits Scheme, which covers drugs prescribed outside the public hospitals, is also uncapped with regard to volume. In an attempt to control volume, co-payments have been progressively introduced here, while not tolerated for general practitioner consultations. Thus having the script filled can be far more expensive than seeing the general practitioner. This inconsistency does not seem to bother anyone. Allied health professional services are generally not covered by Medicare, thus limiting the use that could be made of them as an alternative to drug therapy. Coordinated care trials currently under way with Commonwealth sponsorship, using general practitioners as notional fundholders, are thus of great interest for their potential to overcome some of these difficulties.

## **The need for a strong Medicare (and Agreements) for our future**

Medicare is now 15 years old. It has served as the central instrument of a national commitment to equity in health care in Australia – equal access to equal care for equal need. Only the allocation of health dollars to geographical areas according to the age and illness experience of the population, as done in New South Wales, comes near it. As far as fairness in access to health care resources goes, Medicare is it. This is not to say that Medicare is perfect, or that complete equity is achieved as a result. Waiting lists indicate otherwise. It is to say, though, that without Medicare we can forget about equity in health care in Australia. But if Medicare goes, put the United States on standby for a ginormous takeover and contemplate the possibility of a significant minority of our population missing out on essential health care.

Medicare has served general practice and public hospitals well. Those interested in effective universal health care schemes, such as Hillary Clinton, have come to see how it works. It forms the basis of remuneration for general practitioners and for the hospital Medicare Agreement. There is, by any reckoning, underfunding of our public hospitals, but there is also ingrained inefficiency, although the latter is unlikely to be remedied while the hospitals are fighting for survival.

There are three things needed for Medicare's future. First, Medicare must be seen in future as the tax that pays for health and for that reason located centrally within the current debate about tax reform. Its base could be broadened. It should be hypothecated for health care. The Medicare levy covers only one-ninth of our current \$40 billion per annum health expenditure, and hence about one-sixth of public expenditure on health, and this should be remedied. It should be greatly increased, to cover at least all Commonwealth Government expenditure on health. A compensatory decrease in personal taxation could follow. A corrected Medicare levy would then send a price signal to all who use it. The taxpayer would know more clearly what health care costs and be better able to assess value for money.

Second, Medicare needs to be increased absolutely as well as cosmetically, as suggested above. An increase of 1% would raise another \$2 billion per annum, enough to refit the public hospital system and increase the general practitioner reimbursement rate a little. This tax increase, if it were hypothecated to health, may well be widely accepted. The public wore the small increase for the gun buy-back scheme: a more substantial increase, contained within a 'price-signal' version of Medicare which reflected real government investment in health care, might also be well tolerated.



Third, more investment in health care in Australia as would occur with an increase in Medicare funding must take account of the proven capacity of health care systems internationally to reorganise toward greater efficiency. This will require megavolts of managerial commitment, far greater development of ambulatory hospital-based care, stronger integration of hospital and community care for patients, and a relentlessness in funding only those things for which there is evidence that doing them achieves enough good to justify the cost. This does not mean eliminating all expensive or extreme treatment: some of it, which achieves great things for desperately ill patients, may well be justified as defined above. Nor does it mean reducing health expenditure to a common denominator or vouchers: some people have great health needs and the resources devoted to them, on the basis of equity, should be great. But mindless, evidence-free treatment can no longer be condoned in any form, especially when the consumption of the medical commons occurring as a result denies others effective and sometimes essential care. What is occurring in research and education needs to have a greater impact on clinical practice.

This constructive path for Medicare continues the tradition of Australian commitment to fairness, blending it with a growing desire for evidence-based accountability about the way in which we spend these vast amounts in health care.

The centre of Medicare has always been the provision of effective care for those who need it irrespective of their capacity to pay. If we lose that plot, contemplating instead how we might sell sickness to profit-makers or list it on the stock exchange, we can bid goodbye to equity in health care. This, in turn, would be a serious threat to Australia's standing as a civil society.

Thus if Australia is to preserve and embellish the values of social justice which give social and moral meaning to the lives of millions of Australians, we must find the will to raise Medicare as the single most specific mechanism we have for achieving equity. We must come to raise it, and not to bury it.

## References

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## Reform? Rhetoric does not match reality

TIM SMYTH

Tim Smyth is Deputy Director-General, Policy, New South Wales Department of Health.

*'It is not what you say, it is what you do that counts.'*

In May 1997, as the authors correctly point out, all Australian Health Ministers met and agreed on a set of principles that had as their goal the development of an integrated health system focused on health outcomes. In May 1998, the States are being presented, on a take-it-or-leave-it basis, with an Australian Health Care Agreement that has lost sight of this goal. What is of more concern is that the draft Agreement will actually set Australia back and move us further from the goal post. It is a sad situation to find that 12 months later, the Commonwealth rhetoric is not matched by the draft Agreement reality.

It is important to note that the dispute between the States and the Commonwealth is not just a difference about dollars. The huge gap between the funding needed and the funding offered remains. However, the States see with growing dismay the Commonwealth walking away from an opportunity for real reform and squandering an historic opportunity in May 1997 to work towards the shared goal of an integrated health system.

The draft Agreement that the Commonwealth has only recently, and with great reluctance, actually provided to the States governs what will actually happen over the next five years. And what is the reality compared to the rhetoric?

Far from providing a flexible system to encourage a move away from a focus on acute inpatient care, the draft Agreement introduces a rigid separation into three funding modules. The concept of a flexible block grant for health by the Commonwealth has been abandoned. The rhetoric is that States will be free to move dollars between modules. What is the reality? If a dollar moves from the inpatient to the ambulatory care module the funds are automatically cut by over 3%. First of all there is a Commonwealth-imposed cut of 1%, secondly, the States lose access to the 1.6% real growth factor in the admitted patient module, thirdly, the indexation factor is lower. This is a funding model that has, as an explicit incentive, a continued focus and dependence on acute inpatient care.

The rhetoric about private health insurance and encouraging the private sector also fails the reality test. Firstly, the much touted automatic indexation for

changes in private health insurance is linked to coverage and not actual utilisation in our public hospitals. Were the Commonwealth able to increase the coverage under any insurance plan, the funding to Australia's public hospitals is automatically cut even though the people covered do not use their insurance when admitted. Every hospital knows that health funds are actively promoting to their members to be a public patient if admitted. But there is more!

The draft Agreement makes it harder to elect to be a private patient. It also prohibits States for the first time from changing hospital charges for private patients without Commonwealth agreement. In another move on private patients in public hospitals, the Commonwealth has expressly tied its funding contribution to public patients only. For the first time since 1983, the Commonwealth will no longer provide a contribution towards the cost of public hospital treatment of private patients.

Other principles agreed to by the Ministers in May 1997 were the principles of 'measure and share', a sharing of risks and the principle of certainty of funding. What is the reality?

The draft Agreement and the enabling legislation introduced to the Parliament without any consultation with the States contains a raft of surprises that abandon any pretence at a commitment by the Commonwealth to sharing. Firstly, the Office of the Health Information Commissioner is established. This so-called 'independent person' is subject to the direction of the Commonwealth Minister. On the unchallengeable say-so of this person, the Commonwealth may, at its absolute discretion, unilaterally cut the funding to any State during the life of the Agreement. To add insult to injury, the Commonwealth will levy the States to recoup the cost of the Commissioner!

The draft Agreement, without any discussion with the States, unilaterally introduces cross-border charging for outpatient and emergency department services. The Commonwealth will be the sole arbiter of disputed charges. What is more, the Commonwealth explicitly prohibits the States from controlling the flow of these patients, thereby creating a new, uncapped funding liability for the States. But there is more! Again, without any discussion with the States, the draft Agreement requires the States to provide at no charge any drug available under the Pharmaceutical Benefits Scheme to every admitted patient. This will apply no matter what drugs the Commonwealth decides to put on the Pharmaceutical Benefits Scheme and no matter what restrictions it may put on the availability of the very same drug through community pharmacies. It will significantly increase the number of drugs that a hospital will have to stock. The draft Agreement proposes that the Commonwealth pick up the cost of drugs for

outpatients. Sounds good? What is the reality? The Commonwealth will only pay hospitals the manufacturer's price, not the wholesaler or distributor's price. Mark-ups on these drugs are often over 100%. The Commonwealth also saves on not having to pay the dispensing fee to community pharmacists. A cost-shift to the hospitals perhaps?

The draft Agreement requires States to 'maintain their funding' and imposes a Commonwealth-determined formula to calculate this. This formula will unilaterally cut the Medicare grant if the Commonwealth deems it expedient to do so. There is no such requirement on the Commonwealth and readers will note that the Commonwealth automatically cuts its contribution to ambulatory care, mental health and palliative care each year without penalty.

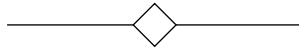
Bit by bit the States are finding out other pieces of policy that the Commonwealth wishes to impose without debate or discussion. Commonwealth funding for mental health and palliative care will now have a 1% efficiency cut imposed each year, despite the Prime Minister's public commitment that 'every dollar' will flow. The Department of Veterans' Affairs has advised that there has been a major overestimate in the potential additional funding that might flow from their new purchasing arrangements. For one State alone the error is an overestimate of 60%, or \$175 million!

Far from creating a climate of 'measuring and sharing', a climate of trust and cooperation and a climate of a joint commitment to true structural reform, the legislation and the draft Agreement reinforces the divide between Commonwealth and State, between public and private patient, between public hospitals and general practice and between the Health Insurance Commission and the States.

In the face of this widening chasm between Commonwealth rhetoric and reality, it should not be a surprise that no State has signed up. It is what is in the fine print and in what is not set out in the media releases from Canberra that really matters. The rhetoric does not match the reality and it is time that the Commonwealth recognised that they are going the wrong way and that they withdrew their Agreement and its enabling legislation so that, as a nation, we can start again and build on the principles agreed in May 1997.

This is what the health care professions, the providers and the Australian people want – a sustainable health system. We need leadership and a shared commitment, not modules and spreadsheets.

## RESPONSE TO COMMENTARIES



### CHARLES MASKELL-KNIGHT

Charles Maskell-Knight is Assistant Secretary, Health Care Agreements Branch,  
Commonwealth Department of Health and Family Services.

Professor Duckett claims that the Commonwealth will bear only about half the risk of admission growth from any decline in private health insurance coverage – presumably on the basis that the Commonwealth contributes only half the cost of the hospital system. While this is true, under its funding model the Commonwealth assumes that those leaving insurance are as sick – or as healthy – as the general population, and calculates an \$83 million increase in grants to the States for every percentage point reduction in private health insurance coverage.

This exceeds the highest estimated cost of \$78 million per percentage point decline in coverage derived in the joint Commonwealth–State reviews of the effects of declining private health insurance levels (the ‘2% Reviews’). These estimates are based on an assumption that significant adverse selection is taking place, and that those leaving insurance are healthier than the general population.

As Professor Duckett points out, the inclusion of ‘multiple sub-buckets’ of funds in the current Agreement has been a point of contention. Accordingly, the new Australian Health Care Agreement funding proposal has fewer components, and it is not envisaged that any of the components would be used to fund small projects.

Professor Leeder suggests that an overhaul of the Medicare levy is necessary. Given the broader taxation implications of such a change, this is beyond the scope of the Agreements, and could only be considered in the context of system-wide tax reform.

Professor Leeder’s suggestion that the health system requires an extra \$2 billion per annum is unrealistic – the demand for public health services simply does not justify a 39% funding increase in the Commonwealth contribution to hospital funding. Even the State governments have not claimed that this level of increase is necessary.

Finally, Professor Leeder suggests that investment in Australia's health care system is needed to increase efficiency. The Commonwealth has proposed a \$500 million National Development Fund specifically to address questions of efficiency within the health sector.

Dr Smyth's comments have an underlying theme that the Commonwealth is imposing policy on the States without consultation, and that the Agreements were presented 'on a take it or leave it basis' and 'contain a raft of surprises'.

The fact is that the Commonwealth convened three meetings of officials between October 1997 and March 1998 to discuss the whole range of issues to be covered under the Agreements. In convening the meetings, the Commonwealth made it clear that officials could not resolve the money question, but that there were many other issues that needed to be discussed by officials in order to draft sensible Agreements.

Every meeting was cancelled by the States, on the basis that State Ministers were not prepared to have substantive discussions of any other issue until the quantum of funding was resolved.

As a senior State official, Dr Smyth ought to be well aware of the fact that the lack of consultation is entirely of the States' making. The Commonwealth remains ready to discuss any aspect of the Agreements with a State.

While space does not permit a detailed treatment of his many misunderstandings, it should be noted that the Commonwealth is basing its funding model on growth in the uninsured population simply as a means of adjusting funding in line with changes in the participation rate. It does not imply – as Dr Smyth claims – that the Commonwealth is explicitly ending its contribution to the cost of private patients. Were it seeking to do so, it would be reducing base funding by 32% in recognition of the proportion of the population that are presently insured.