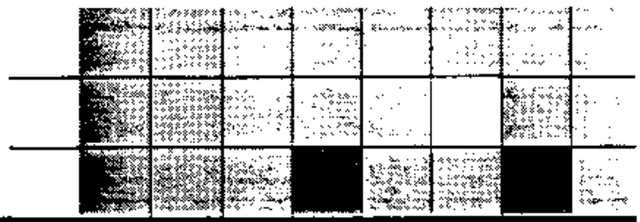
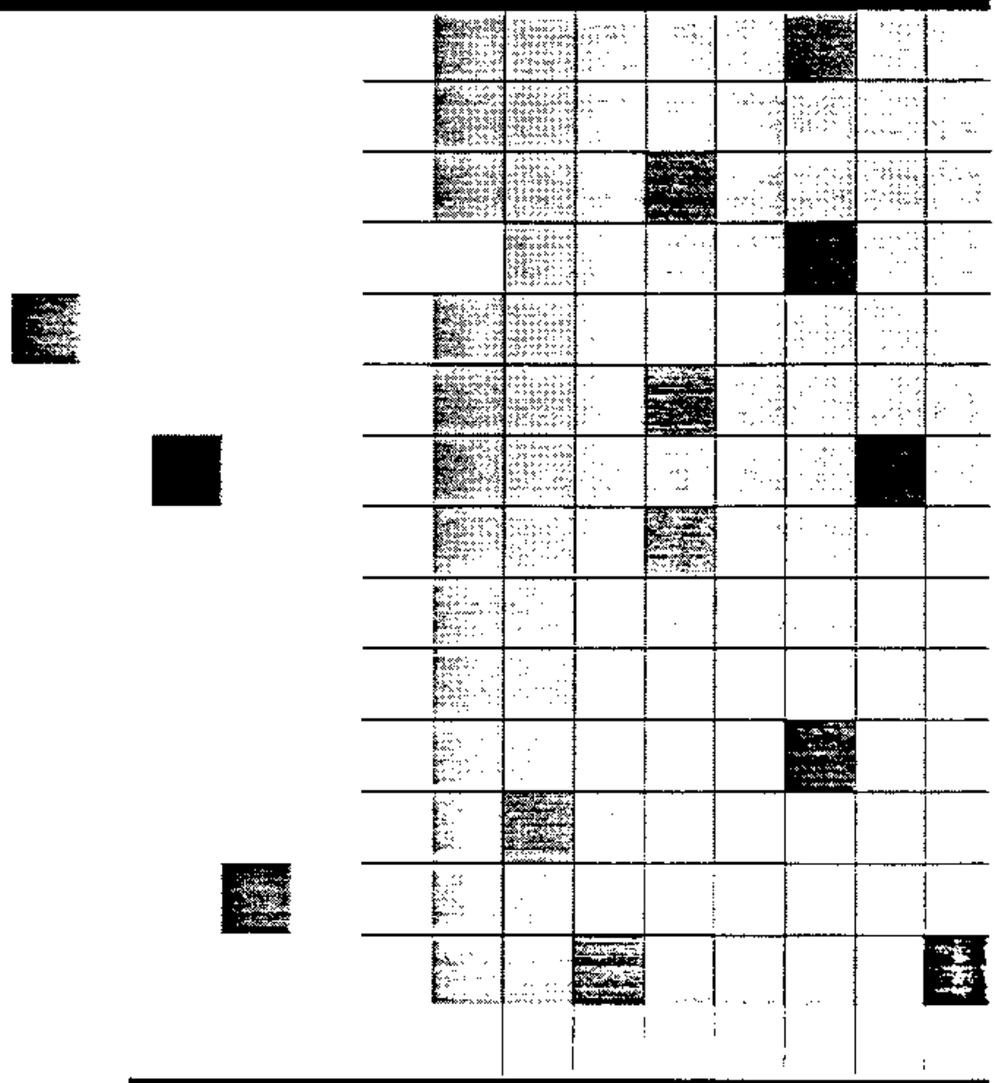


THE MEDICARE AGREEMENT

Some Implications for Queensland Health



Information Circular No. 22

QUEENSLAND HEALTH

EPIDEMIOLOGY AND HEALTH INFORMATION BRANCH
HEALTH FINANCING POLICY UNIT

BACKGROUND

In February 1993, the Queensland Premier signed a new Medicare Agreement with the Commonwealth ("Agreement between the Commonwealth of Australia and the State of Queensland in relation to the provision of public hospital and other health services from 1 July 1993 to 30 June 1998 under the Health Insurance Act 1973 (Cth)").

The Agreement details the arrangements under which the Commonwealth provides funding grants to Queensland to assist with the operation of public hospitals and other health services. Similar Agreements have been negotiated with other States and Territories. The Commonwealth passed the Medicare Agreements Bill in 1992 providing the basis for the Principles and Commitments of the Agreements, including :

- Eligible patients must be given the choice to receive public hospital services free of charge as public patients;

- Access to services is to be based on clinical need without regard to health insurance status or other factors;

- To the maximum extent possible, the State must ensure equity in access regardless of geographic location;

- The Commonwealth and States will make available all relevant information to eligible persons of their rights to services as public patients; and

- The Commonwealth and States are committed to improving the efficiency, effectiveness and quality of health services.

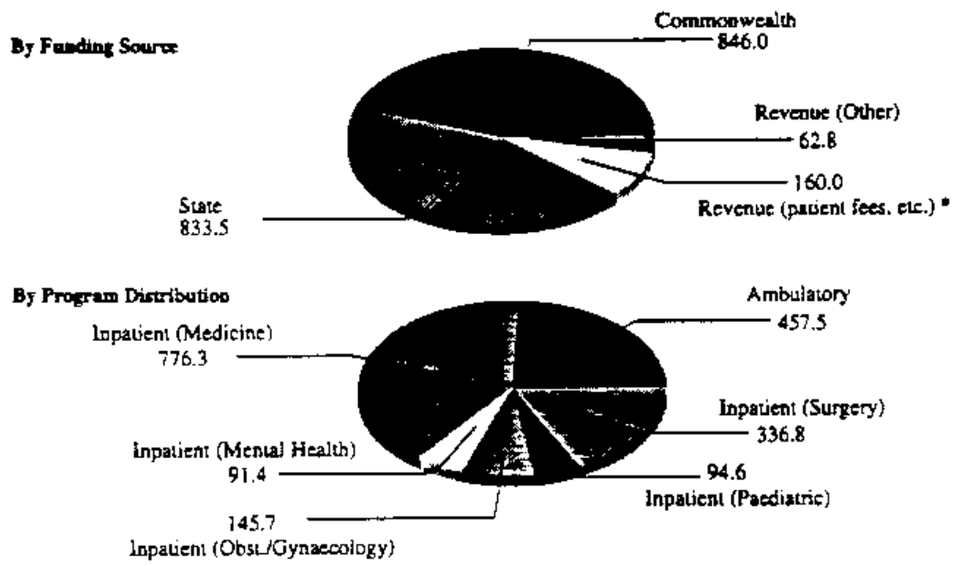
In signing the Agreement, Queensland has given an undertaking to give effect to the Medicare Principles and Commitments through legislation by 1 January 1994. Other reforms that have been initiated by the Government, such as the creation of the Health Rights Commission, will also fulfill the objectives of the Medicare Agreement.

STRUCTURE OF FUNDING GRANT

$1,902 million of the total health budget in 1993/94 ($2,275 m) has been allocated to hospital services, with $846 million coming from Commonwealth payments. These payments comprise the Hospital Funding Grant (HFG) provided under the Medicare Areement and a number of specific purpose payments.

Figure 1 shows the distribution of funding and the source of funding across the Ambulatory and Inpatient Programs, representing the public hospital system.

Figure 1. Distribution and Source of Funding for Queensland Public Hospitals 1993/94 ($m).



Source: Budget Paper No. 3, 1993/94

** Note : Other revenue receipts from Manufacturing Dispensary, Central Dental Roll Store and other trust funds. All external receipts (patient fees etc.) requiring approval, $160m/yr are transferred directly to Treasury and not retained by the Hospitals.*

In 1993/94, Commonwealth payments to Queensland under the Medicare Agreement will total over $800m, slightly less than half the annual operating cost of Queensland's public hospitals. Funding is provided through a number of grants, principally the Base grant ($612m) and Bonus grants ($163m). Other payments are for specific incentive programs such as Strategic Capital Planning and Area Health Management and other targeted health services, such as Mental Health, AIDs and Post Acute and Palliative Care services. Importantly, additional payments will be received from all other States and Territories for the provision of services to patients not resident in Queensland.

Most of the payments, including the Base Grant, are largely fixed for the life of the Agreement and will vary only according to an index based on CPI and labour cost increases and according to population increases. Queensland's share of these fixed payments is determined by its population share adjusted for age and sex weights. Queensland's share of the larger of the two bonus pools is also fixed for the life of the Agreement provided the level of public share remains above the base year less a tolerance of 2%.

Only the payments from other States and the Annual Adjustment Bonus Pool (Pool B) have the potential to vary greatly. Payments from other States will be determined by DRG weighted separations using AN-DRG weights and prices and are contingent on the timely provision of data. The Pool B payment is determined by the change in the level of public share (ie. percentage of public bed days to total bed days) relative to the base year (1990/91).

PUBLIC SHARE

Queensland's share of the available funding from Pool B in 1993/94 is notionally set at $27 million. The final payment will depend on the actual public share achieved in the year.

The public share will be measured in 1993/94 by the proportion of public bed days to total bed days, with non-acute bed days discounted. Public bed days are also discounted if Queensland does not match the national trend in reducing length of stay. Under the Agreement, the Commonwealth and States are committed to using DRG weighted separations to determine the public share from the second year of the Agreement (1994/95).

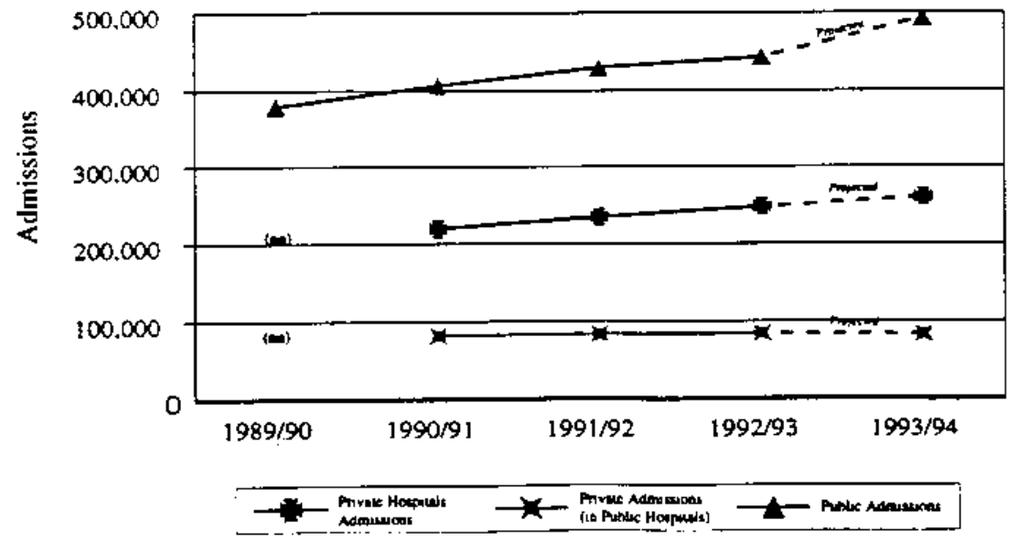
The public share has been calculated by the Commonwealth using a formula involving all aspects of the Australian hospital system. A number of complex adjustments are made to account for non-acute inpatients, and in classifying patient types in specialised institutions such as repatriation and psychiatric hospitals. However, the model is most sensitive to variations in the activity of acute patients in the public and private hospital system.

Figures 2 to 5 below illustrate the trends in acute hospital activity in recent years. For the purposes of this comparison, non-acute inpatients are not considered. Also excluded are repatriation hospitals and Compensible and Ineligible patients.

Figure 2 shows admissions for public and private acute inpatients in all Queensland hospitals (including private patients in public hospitals) from 1989/90 to 1993/94 (projected). The projected

Figure 2. Public and Private Hospital Admissions

Yearly Trends in Acute Admissions 1990/91 - 1993/94



Note: Private includes Compensible and Ineligible patients

data for 1993/94 include the estimated impact of new facilities, additional private sector contracts for public patients and growth targets determined for each Region. The figure shows that on an admission basis, the public sector has increased its share of total activity, and that this trend should accelerate in 1993/94.

Figure 3 shows occupied bed days for the same period. Here the trend is markedly different, since OBDs have remained static in the public sector and have increased only in the private sector. This trend is expected to be reversed in 1993/94 given the incentives contained in the Medicare Agreement for growth in service provision in Queensland public hospitals.

Figure 3. Public and Private Hospital Occupied Beddays (OBDs)

Yearly Trends in Acute OBDs, 1990/91 - 1993/94

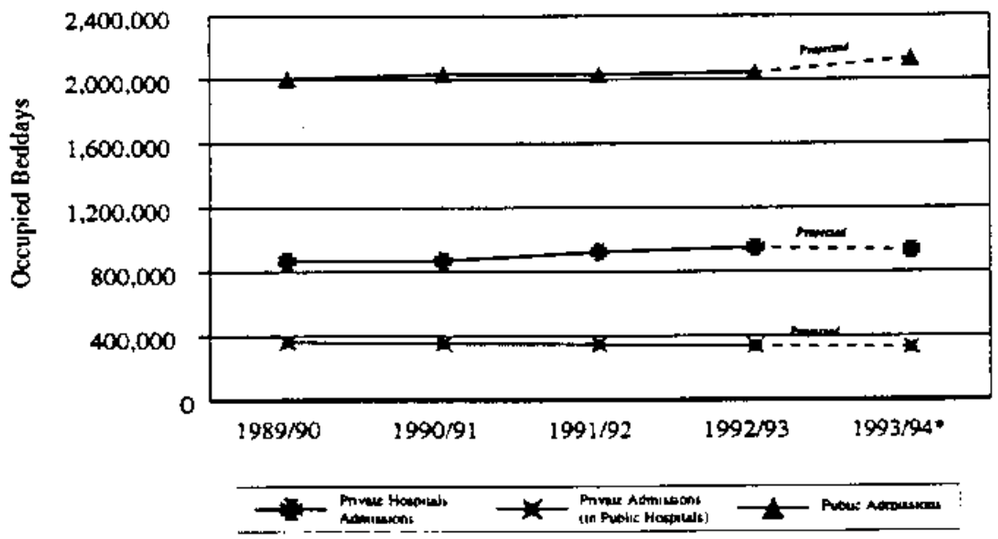
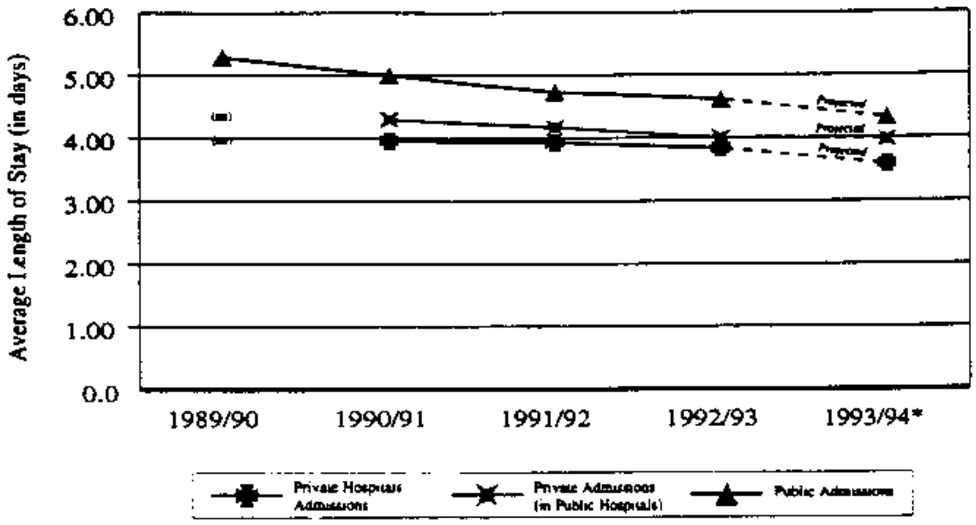


Figure 4 shows the decline in length of stay in both the public and private sector. While a marked decline is seen overall, the decrease in the public sector has been greater and is expected to continue with additional day procedure facilities.

Figure 5 shows the calculation of the public share according to the formula used by the Commonwealth. The base year share (59.02 %) in 1990/91 was followed by a drop to less than 58.50 % in 1991/92 and a further marginal decline in 1992/93. It is anticipated that the public share can be returned to a level above the base year given the strategies being implemented to increase throughput.

Figure 4. Public and Private Hospital Average Length of Stay (ALOS)

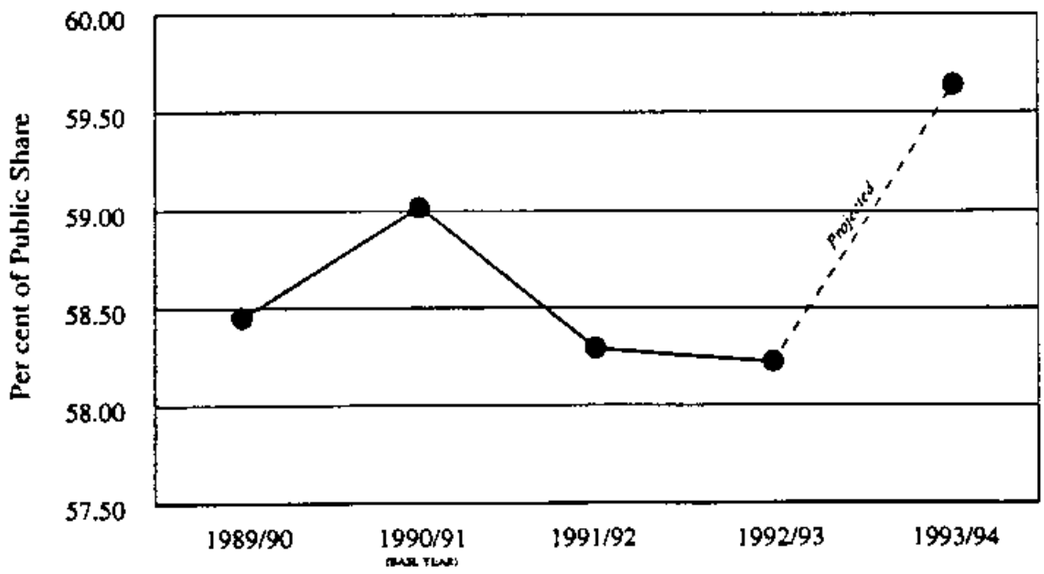
Yearly Trends in Acute ALOS, 1990/91 - 1993/94



Note: Private includes Compensable and Ineligible patients

Figure 5. Public Share

Financial Year Trends in Public Share 1990/91 - 1993/94



INTERSTATE FLOWS

Table 1 below indicates the relative levels of patients flowing into, and out of, Queensland for hospital treatment in 1991/92 :

Table 1 : Interstate Flows, Number of Separations (not adjusted to casemix) In and Out of Queensland 1991/92

	NSW	TAS	VIC	SA	WA	ACT	NT	AUST
QLD INFLOW	8,132	81	1,088	279	162	109	252	10,103
QLD OUTFLOW	4,697	54	502	166	157	83	8	5,667

Queensland experiences a net inflow of patients from all States and Territories. Under the Agreements being negotiated with each State and Territory, Queensland will receive quarterly payments based on DRG weighted separations, adjusted for actual data for the relevant year, as such data becomes available. Importantly, morbidity data relating to interstate patients must be grouped to AN-DRGs and provided to the State of residence within 180 days. Timely capture of these data from hospitals is critical to Queensland Health finances under the Medicare Agreement.

REGIONAL ACTIVITY TARGETS

It is estimated that, in addition to one-off strategies such as the reclassification of acute patients in psychiatric facilities and a contract with the Mt. Olivet Private Hospital, some 2.1 million public bed days will be required from acute public hospitals in Queensland to achieve sufficient growth and ensure that the Pool B allocation can be retained. If the projected growth is not achieved, the notional Pool B allocation will have to be repaid, together with any resultant penalties. The allocation of funds to Regions to increase bed days is therefore contingent on achieving the Statewide target. Activity targets have now been negotiated with all Regions, consistent with the Statewide target.

ADMISSION POLICY

A key issue related to activity targets will be the data collection systems and admission procedures in the hospitals. Regions have been notified of changes to the reporting of monthly activity and have received a draft admission policy for Queensland Hospitals. Essentially, the major issue is the interpretation of the minimum criteria for admission as specified in the Medicare Agreement. Further consideration of issues regarding admission policy and procedures will occur throughout this year in the context of a National audit of hospital data collection systems being coordinated by the Commonwealth.

An admission will be recorded if the attending medical officer, or referring clinician, is satisfied the patient's treatment requires at least one overnight stay, or where the patient falls into one of the specified day procedure bands. "Banding" for private patients has been in place for a number of years, however many hospitals may not admit public patients for similar treatment. A general rule is to ask whether or not the patient (public) could have been assigned to one of the day procedure bands if they had been a private patient.

CONCLUSION

The Medicare Agreement reflects the Commonwealth's policy towards health and hospital services in a number of key aspects. Despite retaining a population based formula, the new Agreement provides increased funding for increased public share; linking funding directly to activity. In later years of the Agreement, the public share will be determined through casemix measures, a reform that the Commonwealth has been actively pursuing. Casemix is an essential part of the Agreement, with States and Territories using casemix measured data to successfully negotiate cross-border funding arrangements. These developments clearly place increasing importance on hospital statistical collections. Close monitoring of patient activity and hospital expenditure will be required.

Contact:

David Renfrey	(07) 234 0837
Peter Morero	(07) 234 1784
Martin Therkelsen	(07) 234 0949