SENATE FINANCE AND PUBLIC ADMINISTRATION REFERENCES COMMITTEE

INQUIRY INTO:
THE IMPLEMENTATION OF THE NATIONAL HEALTH REFORM AGREEMENT

JOINT SUBMISSION BY THE AUSTRALIAN GOVERNMENT DEPARTMENTS OF:

HEALTH AND AGEING; AND
THE TREASURY

FEBRUARY 2013

Terms of Reference

On 7 February 2013, the Senate referred the following matter to the Finance and Public Administration References Committee for inquiry and report by 7 March 2013:

Implementation of the National Health Reform Agreement with regard to recently announced reductions by the Commonwealth of National Health Reform funding for state hospital services, in particular:

a) the impact on patient care and services of the funding shortfalls;
b) the timing of the changes as they relate to hospital budgets and planning;
c) the fairness and appropriateness of the agreed funding model, including parameters set by the Treasury (including population estimates and health inflation); and
d) other matters pertaining to the reduction by the Commonwealth of National Health Reform funding and the National Health Reform Agreement.

Summary
Australian public hospitals and Local Hospital Networks (LHNs) are established and managed under State and Territory (State) legislation. States provide the majority of public hospital funding (approximately 52 per cent nationally). The Commonwealth funds approximately 37 per cent of public hospital expenditure through payments to LHNs and State governments, and a further approximately 2 per cent is provided through the Department of Veterans' Affairs (DVA).

Over the last five years, Commonwealth funding for public hospital services has grown significantly as a result of the Australian Government's 2008 decision to increase base funding by $500 million per annum and apply a more generous indexation formula. These arrangements have seen the Commonwealth contribute more than $4 billion additional funding than would have been provided under previous funding arrangements. This funding has been provided to States to improve the capacity of the public hospital system. It has become apparent that some States have used this additional funding to substitute for State investment. By way of illustration, prior to 2005-06, Commonwealth funding grew at an average of 2.7 per cent per year. In the period 2006-07 to 2010-11, when the Commonwealth increased its average annual funding growth by 2.9 percentage points, States chose to reduce their average funding growth by 3.6 percentage points.

In 2012-13, the Commonwealth is providing $13.3 billion to LHNs and the States under the National Health Reform Agreement (NHRA). This is an increase of 5.7 per cent over 2011-12 funding. Commonwealth public hospital funding is expected to grow by approximately 8.2 per cent per annum between 2012-13 and 2015-16, reflecting in part the commencement of the Commonwealth's $16.4 billion commitment to additional growth funding from 2014-15. The Commonwealth is also providing significant additional funding to improve the capacity of public hospitals through National Partnership Agreements ($4.1 billion has been paid since 2007-08, with a further $59 million scheduled to be paid in the remainder of 2012-13). In addition, under the Health and Hospitals Fund, the Commonwealth has committed $5 billion for health infrastructure across Australia.

The roles of Commonwealth and State governments in regards to health services are subject to the written agreements of all governments. The Intergovernmental Agreement on Federal Financial Relations (IGA) and the NHRA outline conditions for calculation of Commonwealth funding to the States and the subsequent roles of each government in the application of this funding.

The States' role as system managers of the public hospital system is explicitly recognised in both the *National Health Reform Act 2011 (Cth)* and the NHRA, and was a key requirement of the States in the negotiation of the Agreement. As system managers, the States have responsibility for determining the amount they pay for public hospital services, and the level and mix of those services. In line with these responsibilities, the States have undertaken to "meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution".

In contrast with the National Healthcare Specific Purpose Payment (SPP), Commonwealth public hospital funding under the NHRA will be subject to regular adjustments to reflect changes in activity – indeed from 2014-15 additional Commonwealth hospital funding will be determined on the basis of activity levels set by the States. States have a range of options available to them for managing variations in Commonwealth public hospital funding.

The NHRA provides for Commonwealth and States' maintenance of effort to be monitored and reported. For 2011-12 and 2012-13, States' maintenance of effort will be measured against previously budgeted forward estimates, and for 2013-14 State funding for public hospital services is benchmarked to grow by at least 5.25 per cent. Treasurers will provide advice to the Council of Australian Governments (COAG) about whether States are meeting the maintenance of effort benchmarks. The NHRA allows for an adjustment to the baseline for calculating future growth funding entitlements if the benchmarks are not met. Commonwealth maintenance of effort will be similarly assessed and reported.

The Treasurer's Determination of the 2011-12 Final Outcome of the National Healthcare SPP and the 2012-13 Mid-Year Economic and Fiscal Outlook (MYEFO) adjusted estimates of funding for public hospitals based on a formula agreed by the Commonwealth and all State Treasurers. The funding adjustment was calculated using parameters provided by independent agencies, *viz* the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS). Commonwealth funding is provided in advance on the basis of estimates; as parameters change, adjustments will continue to be made according to the agreed funding formula.

Funding calculations, made in accordance with the agreement between governments, include population growth as a factor used to index Commonwealth funding. Corrections to population estimates by the ABS following the 2012-13 Budget estimates have led to downwards revisions in funding. The Commonwealth Auditor-General has advised that the indexation process reflects the requirements of the *Federal Financial Relations Act 2009* and the IGA. In the event that upwards revisions to population estimates had occurred, the Commonwealth would have applied the same calculation, thereby increasing funding to the States.

It is noteworthy that the effect on funding of corrections to population have not affected funding per capita. Further, the Commonwealth's application of the adjustment across multiple months (rather than in a single month as would normally be the case) should assist States to manage the change.

Introduction

On 2 August 2011, the Council of Australian Governments (COAG) signed the NHRA under the framework for federal financial relations. Commonwealth payments for healthcare represent the largest proportion of payments for specific purposes to the States. In 2012-13 health funding accounts for nearly 40 per cent of the Commonwealth's $40.2 billion in total payments for specific purposes.

The NHRA is a shared commitment to national reform, covering both funding and governance issues, and sets out a range of objectives for health reform. Over the last 18 months significant work has been undertaken by all jurisdictions to realise the objectives of the NHRA. Table 1 sets out implementation activities and progress against each of the key objectives of the NHRA.

Table 1: National Health Reform Agreement implementation achievements

Objective	Implementation achievements (to date)
Improved transparency of public hospital funding through the establishment of the National Health Funding Pool	• Establishment of the National Health Funding Pool and appointment of Administrator (June 2012). • Development of national payment systems for hospital funding (June 2012). • Flow of funding (Commonwealth & State) through National Health Funding Pool (from 1 July 2012). • Publication of monthly Public Hospital Funding Hospital Reports identifying all Commonwealth and State contributions to Local Hospital Networks (from 7 November 2012).
Improved patient access and the efficiency of public hospitals through the introduction of activity based funding from 1 July 2012 based on a National Efficient Price	• Establishment of the Independent Hospital Pricing Authority (December 2011). • Publication of the Pricing Authority's 2012-13 National Efficient Price Determination (June 2012). • Commonwealth Activity Based Funding provided on the basis of the National Efficient Price (July 2012).
Improved performance reporting through the establishment of the National Health Performance Authority	• Establishment of the National Health Performance Authority (October 2011). • Publication of National Performance and Accountability Framework (May 2012). • Publication of the Performance Authority's First Public Hospital Report (December 2012).
Improved standards of clinical care through the permanent establishment of the Australian Commission on Safety and Quality in Health Care	• Establishment of the Australian Commission on Safety and Quality in Health Care as a permanent independent body (July 2011).
Improved local accountability and responsiveness through the implementation of Local Hospital Networks and Medicare Locals	• Establishment of 136 Local Hospital Networks in all States and Territories (July 2012). • Establishment of national network of 61 Medicare Locals (July 2012).
Improved sustainability of the Australian public hospital system, including through enhanced Commonwealth funding of growth in public hospital service levels	Commonwealth commitment to additional growth funding of at least $16.4 billion: • Commencement of Commonwealth efficient growth funding at 45 per cent (July 2014 as per the NHRA), and • Commencement of Commonwealth efficient growth funding at 50 per cent (July 2017 as per the NHRA).

The first two years of the new NHRA funding arrangements (2012-13 and 2013-14) are transitional, in part to allow the newly established independent national health agencies to fully take up their statutory responsibilities. In this transition period the Commonwealth's funding contribution to public hospital services will be amounts equivalent to those that would otherwise have been payable through the former National Healthcare SPP, and the SPP

indexation arrangements will continue to apply. The current adjustment to funding reflects the application of those indexation arrangements.

Commonwealth growth funding to the States based on growth in activity and efficient cost commences from 2014-15. Through the NHRA, the Commonwealth has committed to provide additional funding of at least $16.4 billion for public hospital services over 5 years from 2014-15, resulting in an expected average annual growth rate over the forward estimates of 8.2 per cent. The NHRA guarantees that all States will receive additional Commonwealth funding for public hospitals compared with the former National Healthcare SPP. No State will be worse off in the short or long term as they will receive at least the amount of funding they would have received under the former National Healthcare SPP and their share of the $3.4 billion in funding available through the National Partnership on Improving Public Hospital Services (NHRA clause 15a).

For the first time, Commonwealth funding will be directly linked to the level of services delivered by public hospitals, with funding flowing from the National Health Funding Pool directly to LHNs. From 2014-15, Commonwealth public hospital funding will be uncapped – as service levels and costs rise, Commonwealth funding will rise to account for these increases.

Significant Commonwealth funding is also being provided for other health services, including preventive and primary health care health services which reduce demand for public hospital services. These initiatives include Medicare Locals and the National Partnership Agreement on Preventive Health. Further details are provided on pages 23 to 24.

The Commonwealth and the States are working in collaboration with the new national agencies to ensure the successful implementation of the NHRA.

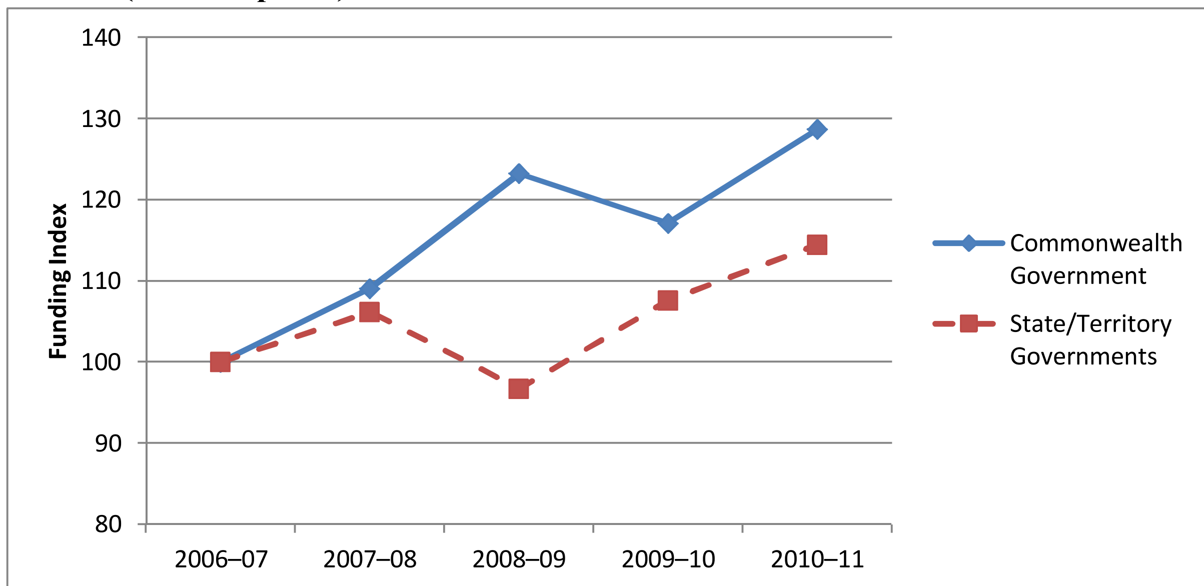
History of public hospital funding

Commonwealth and State funding of public hospital services

The operation of the Australian health system is strongly influenced by the federal system of government, with responsibility for the funding and provision of health care services shared largely between the Australian Government and the States.

In line with their role as system managers, States have traditionally provided the majority of government funding for public hospital services. The Commonwealth has been the majority public funder of public hospital services in only a few of the last fifty or so years since data have been routinely collected. Relative growth in Commonwealth and State funding for public hospitals over the period 2006-07 to 2010-11 is shown in Figure 1.

Figure 1: Index of Commonwealth and State funding for public hospitals, 2006-07 to 2010-11 (constant prices)

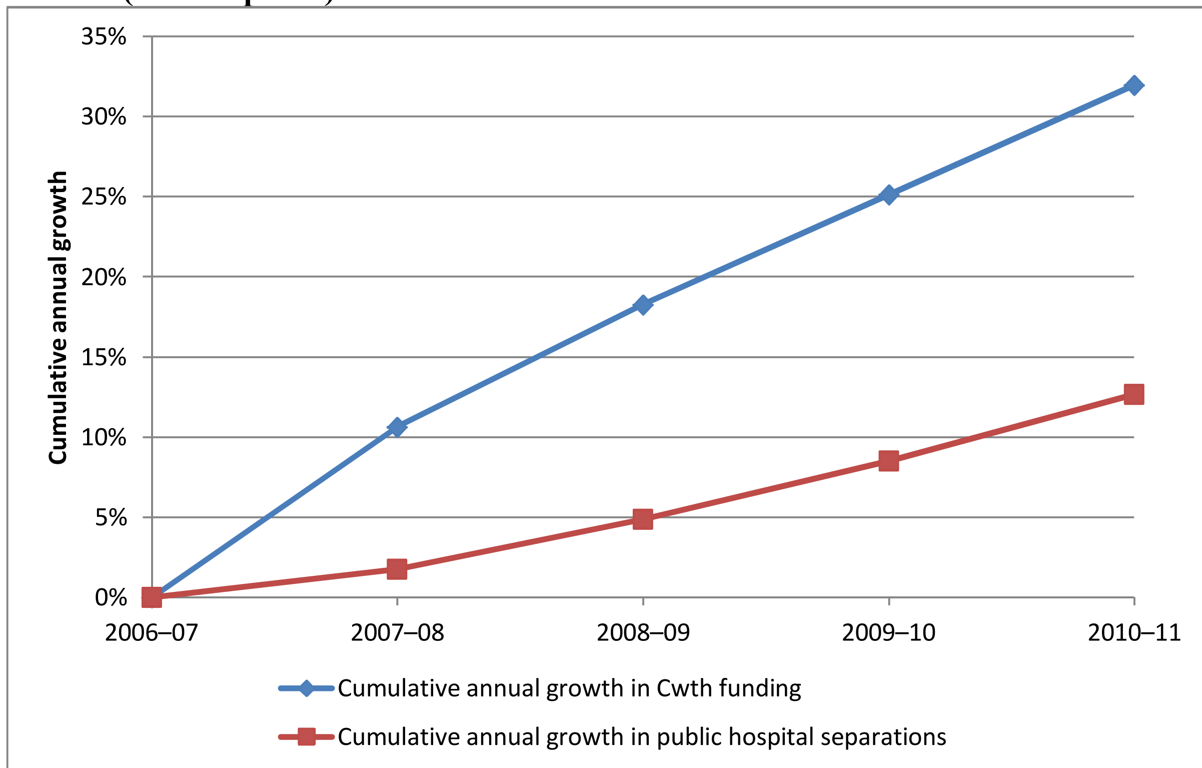


Note: Index set to 100 for base year 2006-07.
The above-trend increase in Commonwealth funding in 2008-09 is due to the provision of one-off additional funding of $1.25 billion to improve emergency department and sub-acute services capacity in public hospitals through the NPA on Hospital and Health Workforce Reform.
Source: AIHW 2012. *Health Expenditure* Australia. Page 57

Although the Commonwealth is not the majority funder of public hospital services, Commonwealth funding has grown as demand for services has grown. Figure 2 demonstrates that growth in Commonwealth funding has significantly exceeded growth in public hospital separations[1] over the last five years.

[1] The AIHW defines a separation as: the formal process where a hospital records the completion of an episode of treatment and/or care for an admitted patient.

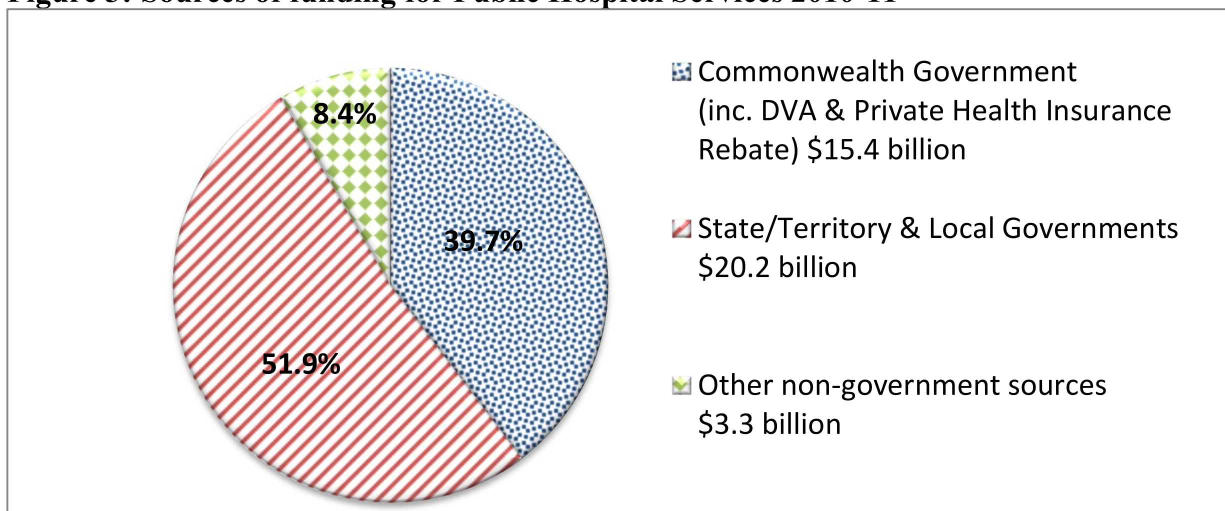
Figure 2: Cumulative annual growth in Commonwealth funding for public hospital services and cumulative annual growth in public hospital separations, 2006-07 to 2010-11 (current prices)



Source: Final Budget Outcome (2006-07 to 2010-11). Admitted Patient Care National Minimum Data Set (2006-07 to 2010-11). Funding amounts in current prices.

Public hospitals also receive significant funding from a range of non-government sources. These non-government sources include private health insurance (a proportion of which is subsidised through the Australian Government's Private Health Insurance Rebate), workers and motor vehicle accident compensation, bequests and donations, and other miscellaneous recoveries such as income from parking fees and leases for commercial business outlets on hospital land. Figure 3 shows the relative funding contributions of Commonwealth and State governments, and non-government sources.

Figure 3: Sources of funding for Public Hospital Services 2010-11



Source: AIHW 2012. *Health Expenditure Australia 2010–11*. Page 59

Commonwealth funding for public hospital services

The first Commonwealth and State public hospital cost-sharing arrangements were introduced in 1975-76. Nine years later, the commencement of Medicare (February 1984) saw the beginning of a nationally co-ordinated and federally funded approach to the provision of health care in Australia. One of the core policy objectives introduced by Medicare was provision of universal access to free hospital treatment. To achieve this objective, the Commonwealth entered into agreements with the States to compensate them for the loss of revenue from patient charges and increased demand for services.

From 1 July 1988, new five year agreements for the funding of public hospitals came into effect (1988, 1993, 1998, 2003). While there were some differences in the details of the agreements, they all shared the same core functions – to secure universal access to free public hospital services and to prescribe the level of Commonwealth financial support towards the cost of provision of public hospital services. Under these agreements, the Commonwealth did not purchase or deliver hospital services, but continued to rely on the States to fill this role.

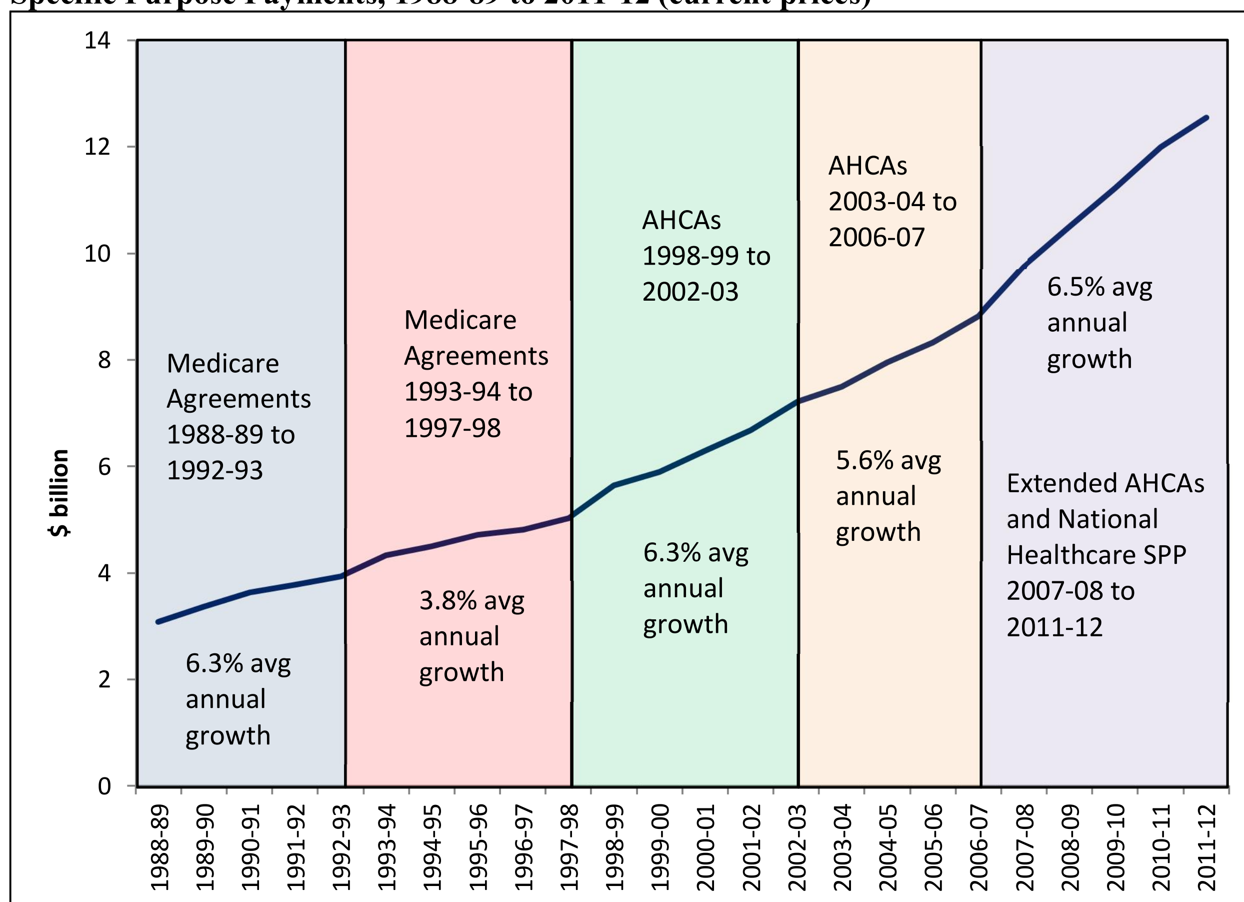
National Healthcare SPP

From 2008, the Commonwealth agreed to provide an additional $4.8 billion over five years for public hospital services, through the introduction of a more generous indexation formula and an increase to base Specific Purpose Payment funding of $500 million per annum.

In November 2008, COAG agreed a range of significant reforms to the Commonwealth's financial arrangements with the States through the IGA. The IGA included a major rationalisation of the number of payments to the States for specific purposes. Under the IGA, a new National Healthcare SPP was created, encapsulating a number of other SPPs relating to public health (including the former Public Health Outcome Funding Agreements), organ and tissue donation and youth health services. Commonwealth funding for public hospital services was provided through the National Healthcare SPP from 1 July 2009.

Figure 4 shows Commonwealth funding (in current prices) to the States over the period 1988-89 to 2011-12.

Figure 4: Commonwealth payments to States and Territories under the Medicare Agreements, Australian Health Care Agreements (AHCAs) and National Healthcare Specific Purpose Payments, 1988-89 to 2011-12 (current prices)



Note: From 2008-09, includes National public health, Essential vaccines - service delivery component and Youth health services
Source: 1988-89 to 2002-03 - DOHA records; 2003-04 to 2011-12, Final Budget Outcomes.

Initial analysis suggests that changes to Commonwealth funding arrangements since 2007-08 have increased payments by more than $4 billion over what would have been provided under the previous arrangements (over $1 billion more in 2012-13 alone).

National Health Reform Agreement 2011

Following the release of the National Health and Hospitals Reform Commission's final report in July 2009, COAG (with the exception of Western Australia) signed the National Health and Hospitals Network Agreement (NHHNA) in April 2010. The NHNNA was superseded by subsequent COAG agreements: the Heads of Agreement on National Health Reform in February 2011; and the NHRA in August 2011.

Under the NHRA, from 1 July 2012, the majority of the Commonwealth's funding for public hospital services is being provided under activity based funding (ABF) arrangements, based on the price determined by the Independent Hospital Pricing Authority (IHPA). For 2012-13 and 2013-14, this funding is "capped", based on the National Healthcare SPP (including its indexation formula).

From 1 July 2014, the Commonwealth will fund 45 per cent of the efficient growth of public hospital services, increasing to 50 per cent from 2017‑18. Commonwealth funding will be

directly linked to the level and cost of public hospital services. This uncapped funding will increase as service levels and efficient costs increase. It is this arrangement that sees annual growth in the Commonwealth's funding.

The new arrangements directly expose the Commonwealth for the first time to the demand and cost growth pressures of public hospitals, as Commonwealth funding will be uncapped from 1 July 2014.

The NHRA guarantees that total Commonwealth NHRA funding will increase by at least $16.4 billion between 2014-15 and 2019-20, compared to the former National Healthcare SPP. This guarantee is based on the projected growth in activity and efficient costs under the NHRA.

Of this increased funding, $9.5 billion is guaranteed on a State-specific basis commencing in 2014-15. This State-specific guarantee amount will be allocated on an equal per capita basis, to provide each State with certainty about their individual entitlement. Any top-up funding under the State-specific guarantee will be paid annually, as shown in Table 2. States are required to meet their maintenance of effort benchmarks for the state-specific guarantee to apply (clause A79).

Table 2: NHRA funding guarantees

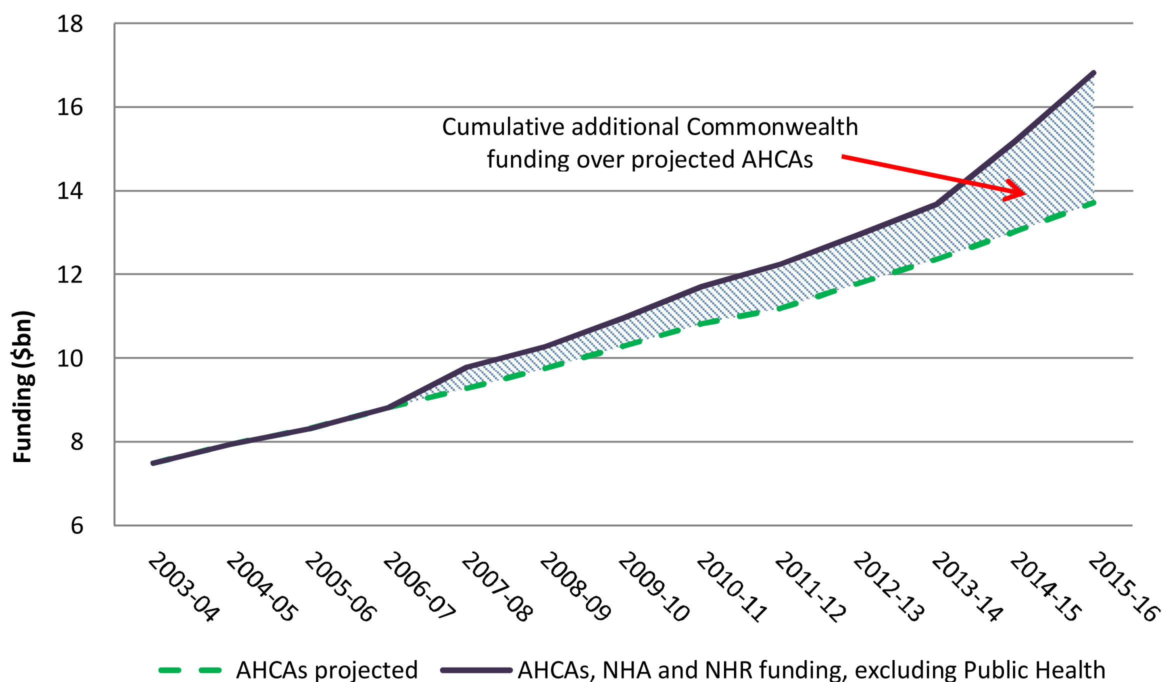
	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	Total
State specific guarantee amounts ($m)	575	1,225	1,500	2,000	2,000	2,200	9,500
Projected annual growth funding amounts – basis for $16.4B guarantee ($m)	574	1,231	1,983	3,012	4,161	5,433	16,394

Source: NHRA, clause A72

Prior to 2014-15 States will receive the same level of funding as would have been provided under the National Healthcare SPP (noting this includes more generous indexation arrangements than have previously applied).

Figure 5 shows growth in Commonwealth public hospital funding (Final Budget Outcomes and forward estimates) from 2007-08 compared to forecast funding under the previous Australian Healthcare Agreements. The increase in new funding compared to the previous forecast is due to the injection of $500 million in base funding from 2008 (as noted on page 9), plus higher indexation from 2008 and the introduction of growth funding under the NHRA from 2014-15.

Figure 5: Comparison of actual Commonwealth funding against projected Commonwealth funding under AHCAs (current prices)



Note: Public Health has been excluded from National Healthcare SPP and NHR funding so that it is comparable with AHCA funding.
Source: Final Budget Outcome (2003-04 to 2011-12), 2012-13 MYEFO. AHCAs projections based on unpublished Treasury calculations.

Public hospital service delivery

As already shown, since 2007-08 the Australian Government has made additional investments of billions of dollars in Australia's public hospital system. This extra funding has been provided to States to improve the capacity of the public hospital system. Figure 1 (on page 7) and Table 3 show that States have used this additional Commonwealth funding to substitute for State investment.

Table 3: Funding of public hospitals, average annual growth rates, 2000-01 to 2010-11 (constant prices)

	Australian Government (%)	State Governments (%)
2000-01 to 2005-06	2.7	7.9
2005-06 to 2010-11	5.6	4.3

Note: This table is presented in constant prices, so is not directly comparable to previous figures presented in current prices.
Source: AIHW 2012. *Health Expenditure Australia 2010–11*. Page 57

Table 3 shows that prior to 2005-06, Commonwealth funding grew at an average of 2.7 per cent per year. In the period 2006-07 to 2010-11, when the Commonwealth increased its average annual funding growth by 2.9 percentage points, States chose to reduce their average funding growth by 3.6 percentage points. This State decision to reduce growth has offset the Commonwealth's investments to enhance the capacity of our public hospitals, effectively undermining the intended benefits of the extra Commonwealth funding and diminishing its positive impact on service access.

Elective surgery data provides an indication of management performance. The Commonwealth is providing significant additional funding to States to improve timely access to elective surgery in public hospitals – from 2007-08 through the Elective Surgery Waiting List Reduction Plan (over $590 million) and $800 million nationally from 2010-11 to

2015-16 for elective surgery facilitation, reward and capital funding. When combined with the 2008 increase to base funding provided through the National Healthcare SPP, it could have been expected that performance would improve – but there has been only marginal improvement overall. Table 4 shows that overall national performance in elective surgery does not reflect increased Commonwealth funding.

Table 4: Admissions from waiting lists for elective surgery, public hospitals, states and territories, 2007–08 to 2011–12

						Change (per cent)	
	2007–08	2008–09	2009–10	2010–11	2011–12	Average since 2007–08	Since 2010–11
Total							
Number of hospitals	***189***	***190***	***190***	***190***	***190***		
Number of admissions	***561,254***	***590,923***	***602,370***	***617,414***	***627,400***	***2.8***	***1.6***
Admissions per 1,000 population	***26.5***	***27.4***	***27.5***	***27.8***	***27.9***	***1.3***	***0.3***
New South Wales							
Number of hospitals	97	97	96	96	96		
Number of admissions	200,949	200,775	199,912	206,266	211,452	1.3	2.5
Admissions per 1,000 population	29.0	28.6	28.1	28.7	29.2	0.1	1.5
Victoria							
Number of hospitals	31	31	32	32	32		
Number of admissions	131,211	148,516	156,598	157,572	154,079	4.1	-2.2
Admissions per 1,000 population	25.0	27.8	28.8	28.7	27.6	2.5	-3.5
Queensland(a)							
Number of hospitals	*28*	*29*	*29*	*29*	29		
Number of admissions	*100,566*	*102,762*	*106,794*	*107,507*	114,328	*3.3*	*6.3*
Admissions per 1,000 population	23.8	23.8	24.3	24.2	25.3	*1.5*	*4.8*
Western Australia(a)							
Number of hospitals	14	14	14	14	*14*		
Number of admissions	57,389	60,701	61,634	65,142	*65,330*	*3.3*	*0.3*
Admissions per 1,000 population	26.8	27.4	27.2	28.1	*27.4*	*0.5*	*-2.5*
South Australia(a)							
Number of hospitals	8	8	8	8	*8*		
Number of admissions	41,328	44,454	44,557	46,433	*47,797*	*3.7*	*2.9*
Admissions per 1,000 population	26.0	27.7	27.5	28.4	*29.1*	*2.8*	*2.2*
Tasmania							
Number of hospitals	4	4	4	4	4		
Number of admissions	14,067	17,090	16,756	16,624	15,802	3.0	-4.9
Admissions per 1,000 population	28.4	34.1	33.1	32.6	30.9	2.2	-5.3
Australian Capital Territory							
Number of hospitals	2	2	2	2	2		
Number of admissions	9,618	10,160	9,830	11,389	11,362	4.3	-0.2
Admissions per 1,000 population	28.0	29.0	27.5	31.3	30.6	2.3	-2.0
Northern Territory(b)							
Number of hospitals	5	5	5	5	5		
Number of admissions	6,126	6,465	6,289	6,481	7,250	4.3	11.9
Admissions per 1,000 population(c)	28.1	28.9	27.5	28.1	31.2	2.6	11.0

(a) For 2011–12, Western Australia reported data for an additional 22 rural hospitals and South Australia reported data for an additional 32 hospitals. Queensland was not able to provide data for 3 hospitals in 2011–12 that reported almost 10,000 admissions from elective surgery waiting lists in 2010–11. In this table the additional hospitals for Western Australia and South Australia, that reported during 2011-12 only, have been excluded. For Queensland, figures for 2007-08 to 2010-11 have been revised to exclude the three hospitals not reporting in 2011-12.

(b) Between 2010–11 and 2011–12, the increase in numbers of admissions for the Northern Territory was, in part, due to the inclusion of certain surgical procedures that had previously been incorrectly excluded from the NESWTDC by the Northern Territory.

Source: AIHW *Australian hospital statistics 2011-12 Elective Surgery waiting times*, table 2.2, and Elective Surgery Waiting Times collection 2007-08 to 2011-12.

Process for SPP adjustments
Commonwealth Treasury finalises the National SPP payments for a given financial year using the most up-to-date parameters as at 30 June of the payment year, as required under the IGA and the agreement of the Former Ministerial Council for Federal Financial Relations (MINCO, now the Standing Council for Federal Financial Relations). Given that parameters as at 30 June need to be finalised after the end of the financial year, the final determination is not made until several months into the following financial year.

Such timing is applied to determinations made under National SPPs, GST and Financial Assistance Grants to local governments (see page 20 for further information about 2011-12 final GST entitlements). In some cases, further updates to parameters may be available after 30 June, but before the final determination is made. However, as outlined above, all Treasurers have agreed the determination will be made using the parameters available on 30 June.

Commonwealth National Healthcare SPP funding formula
The growth factor used to index the National Healthcare SPP was agreed by the Commonwealth and all States in 2008-09 under the IGA. This growth factor is calculated from the product of:

- growth in population estimates weighted for hospital utilisation;
- the rolling five-year average of growth in the Australian Institute of Health and Welfare (AIHW) Health Price Index; and
- a technology factor, fixed at 1.2 per cent (Productivity Commission-derived index of technology growth).

All nine jurisdictions have agreed that this formula reflects the costs of delivering public hospital services. The funding formula ensures the Commonwealth provides funding which reflects increasing demand for health services – as costs or population levels change, Commonwealth funding changes. The components of the formula ensure that the Commonwealth does not under-fund services if costs and/or population growth are higher than expected, and conversely does not over-fund if costs and/or services are lower than expected.

The Commonwealth makes advance payments through the relevant year (based on the latest available estimates of these parameters) with a final determination and balancing adjustments (positive or negative) made after the end of the year when final parameter values are known. This balancing adjustment process occurs with all the National Specific Purpose Payments, the Goods and Services Tax, and payments to local government.

Adjustment to the 2010-11 National Healthcare SPP
The Final Budget Outcome adjustment to the 2010-11 National Healthcare SPP was made in October 2011, at which time the Commonwealth reimbursed the States with calculated underpayments made in 2010. The underpayment for that year was included in the first available payment following signing of the Treasurer's determination, consistent with clause D9 of the IGA which states that:

> *An adjustment amount (which may be positive or negative) to account for any difference between the estimated and actual outcome for the items listed in Clause D5 for the previous financial year will be acquitted in the first available payment following advice of the final outcome.*

Final determination of the 2011-12 National Healthcare SPP

Revisions to weighted population growth included in the Treasurer's determination of the 2011-12 National Healthcare SPP saw a $149.7 million downwards revision to the amount estimated in the 2012-13 Budget. That is, advance payments made throughout the 2011-12 financial year proved to be higher than the final outcome specified in the Treasurer's determination. Any difference between the estimated and final outcome for the year is recouped (if negative) by the Commonwealth in accordance with Section 18 of the *Federal Financial Relations Act 2009* (which specifies that any adjustment should be made in the next practicable income year) and the IGA provision outlined above which provides for even more timely adjustment.

Population estimates used in the Treasurer's determination of the 2011-12 National Healthcare SPP were provided to Treasury by the ABS and incorporated, for the first time, data from the most recent Census in 2011. Such data revealed an 'intercensal error', where the estimated resident population of Australia was determined to be around 300,000 people less than estimates based on the 2006 Census trajectory. For this reason, calculation of the population growth rate using the new population for 2011 as compared to the population determined in 2010 (based on the 2006 Census), in accordance with the IGA, has led to a correction to the growth rate. The significance of the intercensal error has resulted in the ABS deciding to back-cast population levels over a 20 year period, with this work to be completed around mid-2013.

Population growth has been a factor used to index the National Healthcare SPP under the IGA; under the AHCAs prior to the IGA; and in the transition from the AHCAs to the IGA. Any downward adjustment to population growth rates in prior years following adjustment for the intercensal error would mean that States have been paid on inflated population growth rates since the early 1990s and have been the beneficiaries of higher funding over this period.

Revisions to National Health Reform funding in the 2012-13 MYEFO

The process used to finalise the 2011-12 National Healthcare SPP and update National Health Reform funding estimates for 2012-13 to 2015-16 at MYEFO was consistent with the regular budget processes that Treasury undertakes throughout each year.

Estimates for National Health Reform funding in respect of 2012-13 (which commenced from July 2012) were updated in the MYEFO having regard to changes in estimates of the growth factor parameters. The residual adjustments to the National Healthcare SPP in 2011-12 had a flow-on effect for National Health Reform funding in 2012-13, with further effects on the growth factor caused by a fall in growth of the AIHW Health Price Index.

Growth in the Health Price Index for the latest available year, 2010-11 was the lowest for a decade (around 0.9 per cent). This parameter was revised and provided to Treasury by the independent AIHW. The fall in this index in 2010-11 reflects moderation in medical inflation rates across the sector, with a significant contributor to this being falls in the price of medical and surgical equipment. This is likely to have arisen from a high Australian dollar exerting downward pressure on the prices of imported foreign-manufactured medical goods. The significantly lower growth in this independently-derived index for 2010-11 has driven down the five-year average of the index.

The downwards revision to the AIHW Health Price Index is the predominant driver of the estimated $1.5 billion downwards adjustment in National Health Reform funding over the

forward estimates period (accounting for around 65 per cent of the total downward revision). However, it should be noted these are estimates going forward. As revised indexes become available in June, the estimates will be further adjusted – up or down based on movements in the indexes.

Effects of population changes in 2011-12 account for around 60 per cent (or $152.2 million) of the total $253.8 million downwards revision to National Health Reform funding in 2012-13. However, as indicated above, across the forward estimates, the impact of the population growth rate adjustment becomes less pronounced, accounting for around 35 per cent of the total downwards revision.

On a state-specific level, there is also an impact on funding due to changes in States' equal per-capita (EPC) shares. For example, changes in EPC shares in 2012-13 resulted in a reduction in funding to Queensland of $12.2 million and an increase in funding to Western Australia of $20.6 million.

Consistent with past practice, changes to National Health Reform funding across the forward estimates were released with publication of the 2012-13 MYEFO. The Treasury does not release details of MYEFO until it has been formally published.

Following finalisation of MYEFO, the Treasury was able to commence adjustments to 2012-13 National Health Reform payments, incorporating both the updated 2012-13 National Health Reform funding profile for the year, and the recoupment of overpayments made under the National Healthcare SPP in 2011-12.

In contrast with the 2010-11 adjustment and normal practice, the Commonwealth has spread the 2011-12 residual adjustment over the remainder of the financial year, commencing in December 2012, to assist States in managing cash-flows as a result of the changed entitlement. Normal practice is to make adjustments in full in the next available payment, consistent with the prescription of the IGA. In the case of the end-of-year adjustment to GST payments, a $440.1 million adjustment in the States' favour, this amount was paid in full in November 2012. The reality is that end-of-year adjustments are an inherent feature of a system where the Commonwealth chooses to make payments in advance of final outcomes being known; some up and some down.

<u>Quantum of 2012-13 MYEFO adjustment</u>
Table 5 shows the forecasts and growth rates for public hospital funding over the forward estimates. It is clear from this table that the adjustments to the 2011-12 National Healthcare SPP and revisions to National Health Reform funding across the forward estimates in the 2012-13 MYEFO do not lead to a net reduction in Commonwealth funding. Over the period 2011-12 to 2015-16 average annual growth in funding is 8.2 per cent, which is 1.7 percentage points higher than the average annual growth rate from 2007-08 to 2011-12. Growth in Commonwealth funding reaches 10 per cent per annum in the last two years of the forward estimates.

Table 5 –National Healthcare SPP and National Health Reform funding ($ million), all States, and Australia

$ million		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2010-11	Final Budget Outcome	3,935.7	2,910.7	2,382.3	1,224.6	958.4	263.6	166.0	149.4	11,990.5
2011-12	Final Budget Outcome	4,088.9	3,059.7	2,505.3	1,305.4	978.1	277.6	183.0	150.2	12,548.1
	% growth on previous year	3.9%	5.1%	5.2%	6.6%	2.1%	5.3%	10.3%	0.5%	4.7%
2012-13	2012-13 MYEFO	4,291.3	3,255.4	2,660.7	1,401.2	1,008.4	294.2	202.3	150.8	13,264.4
	% growth on previous year	5.0%	6.4%	6.2%	7.3%	3.1%	6.0%	10.5%	0.4%	5.7%
2013-14	2012-13 MYEFO	4,463.6	3,484.5	2,839.9	1,529.6	1,010.1	311.7	232.5	142.3	14,014.3
	% growth on previous year	4.0%	7.0%	6.7%	9.2%	0.2%	6.0%	15.0%	-5.6%	5.7%
2014-15	2012-13 MYEFO	4,912.8	3,839.6	3,174.4	1,719.6	1,121.7	338.2	269.1	161.9	15,537.3
	% growth on previous year	10.1%	10.2%	11.8%	12.4%	11.0%	8.5%	15.7%	13.7%	10.9%
2015-16	2012-13 MYEFO	5,398.5	4,226.0	3,539.1	1,928.0	1,242.2	366.7	308.9	182.9	17,192.2
	% growth on previous year	9.9%	10.1%	11.5%	12.1%	10.7%	8.4%	14.8%	13.0%	10.7%
% growth 2011-12 to 2015-16		**32.0%**	**38.1%**	**41.3%**	**47.7%**	**27.0%**	**32.1%**	**68.8%**	**21.7%**	**37.0%**

Fairness and appropriateness of the agreed funding model

Under previous funding agreements, growth in Commonwealth public hospital funding was provided according to agreed formulas incorporating the cost of services and weighted population (indicative of demand for services), along with other minor components. The National Healthcare SPP growth formula reflects this approach.

The previous arrangements indexed healthcare grants by Wage Cost Index 1 (WCI-1), a parameter averaging less than 2 per cent per year over the last decade. With the introduction of the IGA, WCI-1 was replaced by the five-year average of growth in the AIHW Health Price Index (a parameter higher than WCI-1), which increased the rate of indexation. All States agreed to the use of the new parameter, to provide a fairer representation of the increasing demand for healthcare services within Australia.

The Treasury does not set parameters used in the formulas to determine the National Healthcare SPP and National Health Reform Funding. Such parameters are calculated by independent agencies (ABS, AIHW and the Productivity Commission) and are provided to the Treasury in time for its required estimates updates.

Commonwealth funding is provided to LHNs and State governments based on the agreed formula, in accordance with the IGA (including the move to EPC shares as agreed by all states). If the intercensal error had shown the Australian population had grown more than previously forecast, the Commonwealth would have been required to increase funding to the States under the indexation arrangement to reflect the higher number of residents with the potential to impact on healthcare services in Australia. Regardless of which way the population estimates change, Commonwealth funding will be adjusted to accurately reflect the number of Australian residents.

Treasury has calculated the growth factor for National SPPs consistent with its interpretation of the IGA and consistent with the outcomes of agreed recommendations with Heads of Treasuries and MINCO.

Timing of funding adjustment
As allowed for by section 17 of the *Federal Financial Relations Act 2009*, the majority of intergovernmental financial payments in any year (including National Health Reform payments) are made in advance. The amount of the monthly advance payments is based on the latest published estimate of the annual payment from either the MYEFO or the Budget and is adjusted along the way such that total monthly payments through the year equal the relevant proportion of the current estimate (consistent with clause D7 of the IGA). Thus, the monthly advance payment can be expected to change on the release of revised Budget documentation.

The 2011-12 Final Budget Outcome and MYEFO were published in September 2012 and October 2012 respectively. On 3 November 2012, the Commonwealth Treasury informed State Treasuries that adjustments arising from the Treasurer's 2011-12 determination and the 2012-13 MYEFO update, would be spread evenly across the remainder of the 2012-13 financial year commencing through the National Health Funding Pool in December 2012, easing the impact of the adjustment.

As noted previously, Clause D9 of the IGA provides that adjustments to account for differences between estimated and actual outcomes for intergovernmental financial transfers (including National Health Reform funding) are to be acquitted in the first available payment following advice of the final outcome. This is the approach normally taken by the Commonwealth, and which was taken for the adjustment to the 2010-11 National Healthcare SPP (see page 14).

However, to assist States to manage the impact of the 2011-12 change, these adjustments will be spread over payment periods for the rest of the 2012-13 financial year.

The 2012-13 NHRA payments are similar to GST payments, in that payments are advanced to the States on a monthly basis, based on the most recent estimates (for GST, estimates of population distribution[2] and GST pool size influence the overall payment). Estimates change at each estimates round (Budget and MYEFO) and a final determination of the GST distribution (based on finalised parameters) is made by the Commonwealth Treasurer after year end. As noted above, the overall positive balancing adjustment of $440 million for the 2011-12 GST distribution was included in the November 2012 monthly payment (i.e. made in full in a single payment).

Impact on patient care and services
The Commonwealth is providing an additional $716 million in public hospital funding to the States in 2012-13 compared to 2011-12 (representing 5.7 per cent growth over 2011-12). This additional funding is intended to provide extra public hospital services, including elective surgery, emergency department services and outpatient consultations in Australia's public hospitals. The Commonwealth will also provide States with $48.2 billion in "untied" GST payments in 2012-13, which States could apply to public hospital services if they choose to do so.

The 2012-13 MYEFO adjustment varied the Commonwealth payment in 2012-13. It does not automatically flow that this should have a negative impact on patient care or services.

[2] Population growth is not a factor used in determining the total GST pool. Population is used to distribute the GST pool. As such, the intercensal error has no effect on the 2011-12 determination of GST entitlement.

States' role

States are recognised as system managers of the public hospital system in both the *National Health Reform Act 2011 (Cth)* (Section 58A) and the NHRA (Clauses 1f.i. and 8a). It has been agreed that the States are, and will be, responsible for "system wide public hospital service planning and performance" (NHRA clause 8a.ii), "purchasing of public hospital services and monitoring of delivery of services purchased" (clause 8a.iii). The system manager role was one that the States strongly protected in the negotiation of the NHRA.

As system managers, the States have responsibility for determining the amount they pay for public hospital services, and the level and mix of those services. In line with these responsibilities, the States have undertaken to "meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution" (clause A60).

Public hospitals have a range of funding sources which they can direct towards the delivery of services (as discussed on page 8). States, as system managers, have overall responsibility for agreeing service levels and establishing annual budgets for LHNs. In this role, States have responsibility for ensuring that each LHN has sufficient funding from all sources to ensure its agreed service levels can be achieved. This responsibility matches the States' role in previous hospital funding agreements; it is not a new requirement. Given this responsibility, any change in the level of public hospital services provided is a state decision, taken in a particular resourcing context.

Funding flows

Under previous public hospital funding agreements, Commonwealth funding was paid directly to State Treasuries by the Commonwealth Treasury. State Treasuries made annual appropriations to cover overall public hospitals funding requirements and changes or adjustments in Commonwealth payments were managed by State Treasuries. Under these arrangements, States could decide to maintain their original appropriations, in line with the State responsibility, as system managers, to ensure public hospitals are appropriately funded to meet the number of services agreed. However, this process was not transparent, and States were not accountable for the allocation of Commonwealth public hospital funding.

Under the NHRA, Commonwealth funding does not flow to State Treasuries, but the States continue to be responsible for ensuring public hospitals are appropriately funded. While the process itself has changed, the principle of the system manager taking responsibility for funding public hospitals appropriately has not changed.

Regular variations in Commonwealth funding

Regular variations in Commonwealth funding for public hospital services are a feature of the NHRA agreed by all States. Commonwealth funding is calculated through the application of an agreed formula, and the level of funding will change as the inputs to that formula change. These changes could happen at least two times throughout the year. The components that may vary are:

1. *Activity reconciliation*: under the NHRA, all States have explicitly agreed to a process of six-monthly reconciliations of Commonwealth funding against actual public hospital activity levels, to be undertaken by the Administrator of the National Health Funding Pool. When actual activity varies from forecast activity, Commonwealth funding will change accordingly, in line with the Commonwealth's commitment under the NHRA to

contribute to the funding of all public hospital services. This will occur twice each year, according to the agreed timeframes.

2. *Service volumes*: States, as system managers, are able to amend the service levels determined in Service Agreements at any time. Commonwealth activity based funding will be provided based on the forecast activity levels in the current Service Agreements, and will vary according to any amendment of Service Agreements.
3. *National Healthcare SPP parameter adjustments (2012-13 and 2013-14 only)*: in the first two transition years of the NHRA, Commonwealth funding variations may occur at Budget, MYEFO or the Final Budget Outcome, based on the application of the agreed funding formula set out in the IGA.

In each of these cases, the States are responsible for managing the variations as part of their role as system managers.

Options available to states

As system managers, it is the States' role to decide how to respond to changes in revenue for public hospitals, including changes in Commonwealth funding. Some States have decided to respond to the 2012-13 MYEFO adjustments by negotiating service level reductions with their LHNs. However, States have several other options open to them to accommodate the 2012-13 MYEFO funding adjustments without requiring LHNs to change existing levels of patient care or the numbers and mix of services delivered.

Almost all States received significant increases ($440.1 million nationally) in their GST payments as a result of the Treasurer's determination of the final GST entitlement for 2011-12. The States received the full amount of this balancing adjustment upfront in November 2012, and these windfall gains could be directed towards public hospital services, as they more than offset the 2011-12 National Healthcare SPP residual adjustment. Table 6 shows the impacts of the 2011-12 GST and National Healthcare SPP adjustments.

Table 6: Changes resulting from the 2011-12 National Healthcare SPP and GST determinations

$million	2011-12 National Healthcare SPP	2011-12 GST Entitlements	Net Impact
New South Wales	-48.9	127.0	**78.1**
Victoria	-39.7	66.9	**27.2**
Queensland	-40.2	-8.4	**-48.6**
Western Australia	-6.3	91.1	**84.8**
South Australia	-11.0	46.6	**35.6**
Tasmania	-2.0	34.7	**32.7**
Australian Capital Territory	-0.6	23.5	**22.9**
Northern Territory	-1.1	58.6	**57.5**
Total	-149.7	440.1	**290.4**

Further information on key components of National Health Reform

In addition to increased Commonwealth funding flowing through the National Health Funding Pool, the National Health Reform arrangements introduce a range of additional governance arrangements aimed at improving the transparency of public hospital financing and performance:

- The IHPA to set an efficient price for public hospital services;
- The Administrator of the National Health Funding Pool to report on Commonwealth and State expenditure on public hospitals;
- The National Health Performance Agency (NHPA) to advise on the performance of individual public hospitals; and
- An independent dispute resolution process to end the 'blame game'.

In addition, since 2007-08 the Australian Government has made a series of targeted investments in Australia's public hospitals to improve their capacity.

<u>Health Reform National Bodies</u>

The Independent Hospital Pricing Authority

The IHPA was established under legislation on 15 December 2011. The IHPA is responsible for determining the National Efficient Price (NEP) for public hospital services through the analysis of data on the actual activities and costs of public hospitals. The development of the NEP, combined with block funding, will ensure public hospitals receive an appropriate level of funding and will encourage all public hospitals to become more efficient.

The IHPA successfully delivered its critical milestone for 2012-13, publishing a robust *Pricing Framework* and *National Efficient Price Determination 2012-13* on 8 June 2012. This work enabled the commencement of the national system of ABF for public hospital services on 1 July 2012.

The IHPA is well advanced in its development of the 2013-14 NEP and an updated pricing framework, both of which are expected to be published in early 2013.

The Administrator and the National Health Funding Body

The NHRA ensures that all hospitals are funded under the same arrangements, through the National Health Funding Pool, allowing all Australians to see where and how their tax dollars are being spent. National Health Funding Pool Accounts will be audited, have complete transparency in reporting and accounting, and will meet all other transparency requirements established by COAG and relevant legislation.

The Administrator of the National Health Funding Pool oversees payments into and out of the state pool account for each State, and ensures funds are deposited into pool accounts in line with the NHRA. The National Health Funding Body assists in the performance of the Administrator's functions.

Commonwealth legislation to establish the Administrator of the National Health Funding Pool and the National Health Funding Body received Royal Assent on 25 June 2012. Payments have been made through the National Health Funding Pool since July 2012.

The National Health Performance Authority

The NHPA monitors performance of every hospital (public and private), every LHN, and every Medicare Local. This will identify high performance to facilitate the sharing of

innovative and effective practices, and poor performance to allow remediation. The NHPA was established under legislation on 21 October 2011.

The NHPA released its first report *Hospital Performance: Time Patients Spent in Emergency Departments in 2011-12* on 14 December 2012.

Dispute resolution provisions

The NHRA contains provisions for the handling of disputes and cost shifting (clauses 21-23 and A99-101). No jurisdiction has sought to trigger the dispute resolution processes or cost shifting mechanisms provided for under the NHRA.

Additional funding provided to States through National Partnership Agreements and the Health and Hospitals Fund

National Partnership Agreements

Since 2007-08 the Australian Government has provided States with the following additional funding to improve the capacity of their public hospital system:

- National Partnership Agreement (NPA) on the Elective Surgery Waiting List Reduction Plan which provided $600 million to reduce the number of Australians waiting longer than clinically recommended times for elective surgery by improving the efficiency and capacity of public hospitals;
- NPA on Hospital and Health Workforce Reform which included:
    - $133.4 million to assist with the implementation of a national system of ABF;
    - one off funding of $500 million to improve the volume and quality of sub-acute services;
    - one-off funding of $750 million to improve the efficiency of Emergency Departments;
- NPA IPHS which provides up to $3.4 billion in project and reward funding to assist States to build capacity and increase efficiency. This funding will help States meet the National Emergency Access Target and the National Elective Surgery Target, as well as provide an additional 1,316 sub-acute beds or equivalent services.

The Commonwealth recognises that States would prefer certainty about the future of funding related to the NPA IPHS. Clause 44 of the NPA IPHS requires a review to be completed and a decision made about this by COAG by December 2013. This timing reflects the need for certainty of arrangements for the States, given the current expiry of funding by the end of 2013-14. This review will be undertaken within the framework of the COAG-agreed process for the consideration of National Partnerships. It has been agreed that the review will consider the projected impact on the health system and patient care of any discontinuation of NPA IPHS funding. The NHRA explicitly allows for State Treasurers to advise the Commonwealth Treasurer of their views about whether NPA IPHS funding should continue.

Health and Hospitals Fund

The Health and Hospitals Fund (HHF) was established on 1 January 2009 by the Australian Government as part of its broader nation-building infrastructure program. The objectives of the HHF, while not replacing State and Territory effort, are to invest in major health infrastructure programs that will make significant progress towards achieving the Commonwealth's health reform targets; and make strategic investments in the health system that will underpin major improvements in efficiency, access or outcomes of health care.

Under HHF, funding of $5 billion has been committed for 224 projects across Australia. Funding announced in May 2009 (Round 1) is being used for 64 projects to:

- develop a world class cancer care system;
- build a hospital system for the future; and
- improve medical research and workforce infrastructure to support the transfer of research outcomes into better patient care.

A second round of HHF funding announced in April 2010 (Round 2) is for 21 projects that will help establish a network of best practice regional cancer centres and associated accommodation facilities to:

- improve access and support for cancer patients in rural, regional and remote Australia; and
- help close the gap in cancer outcomes between people living in metropolitan and regional areas.

Funding announced in May 2011 for 63 projects (Round 3) and in May 2012 for 76 projects (Round 4) supports projects that will improve access to essential health services for Australians living in rural, regional and remote areas by:

- providing upgrades to regional health infrastructure;
- expanding regional hospitals; and
- providing support for clinical training capacity in regional hospitals.

Projects receiving funding under HHF include:

- *Victorian Comprehensive Cancer Centre, Parkville:* Under Round 1 of the HHF, the Department of Human Services was funded $426.1 million (with a total project cost of $1.1 billion) for the construction of the Victorian Comprehensive Cancer Centre. A component of the project includes the provision of 160 multi-day beds; 40-bed Critical Care Unit (providing 32 Intensive Care Unit and 8 High Dependency Unit beds); and 110 same day beds.
- *Bega Valley Health Service Development, NSW:* Under the HHF 2010 Regional Priority Round (Round 3), the Commonwealth is providing $160.1 million to the NSW Government for the Bega Valley Health Service Development. The project will deliver a new integrated health care facility to replace the existing hospitals at Bega and Pambula on a single site. The NSW Government is providing $10 million towards the development.
- *Townsville Base Hospital - Planned Procedure Centre:* Under the HHF 2010 Regional Priority Round (Round 3), the Commonwealth is providing $12.1 million to the Queensland Government for the construction of a planned procedure centre at Townsville Hospital to enhance patient access to elective surgery services. The project will include procedure rooms, recovery areas, clinical rooms, administration, clinical services, and procedural support areas.

<u>Other Commonwealth funding</u>
Commonwealth public hospital funding also needs to be considered within the context of Commonwealth funding for the broader health system. In addition to providing over $13 billion under the NHRA in 2012-13, the Australian Government is also providing over $50 billion in funding for a range of other health and aged care programs and activities, including:

- payments that cover costs which would otherwise be borne by public hospitals;

- primary care and public health services which improve the general health of the population; and
- initiatives targeting at-risk populations to better manage their care and reduce the incidence of hospital attendance.

Some examples of Commonwealth funding are provided below.

The Australian Government is providing funding of $681.8 million (63 per cent of total funding) in 2012-13 for blood and blood related products under the National Blood Agreement, with the states also providing their own share of funding (37 per cent of total funding).

The Australian Government is providing the States with $642.9 million over eight years through the NPA on Preventive Health to address rising levels of chronic disease and educate Australians about healthy behaviour, amongst other things. This is in addition to the Commonwealth's own investments in programs such as early detection cancer screening programs, reducing tobacco use and drug and alcohol education programs.

In addition, the Australian Government is providing more than $900 million in 2012-13 for primary health care activity, excluding Medicare Benefits Schedule (MBS) payments. This includes funding for Medicare Locals to improve primary healthcare delivery at the local level, Practice Incentives for General Practice and workforce incentives to improve primary healthcare access in rural and remote Australia.

The Australian Government is also providing over $760 million for programs aimed at improving the health of Aboriginal and Torres Strait Islander Australians (excluding MBS payments).

The Australian Government provides significant levels of additional funding through a range of demand driven programs which assist in reducing the burden on the public hospital system or offer additional sources of revenue to public hospitals. This includes providing over $18 billion in 2012-13 through the MBS which funds primary and specialist care services provided by General Practitioners, Nurses, Specialists and Allied Health providers, and private patient services in both public and private hospitals. Furthermore the Private Health Insurance Rebate (over $5.7 billion in 2011-12) assists over 12.4 million Australians take out private health insurance cover annually.