Chapter 3

Commonwealth hospital funding

The 2014 budget did serious damage to Commonwealth-state relations and the confidence with which states could plan and manage health services. It did this by abrogating an agreement about public hospital funding which had been signed by governments of all political persuasions and unilaterally imposing a new funding model on the states.[1]

Dr Stephen Duckett, Director, Health Program, Grattan Institute

Introduction

3.1 The previous chapter provided the historical context of hospital funding in Australia, and the struggle to find an agreement between levels of government about funding responsibility. As noted in Chapter 2, a forum for cooperation between federal, state and territory governments was achieved in 2011 when all parties signed the National Health Reform Agreement (NHRA). As a result of this agreement, long term funding certainty, through until at least 2024-25 was achieved for hospital funding.

3.2 This chapter examines the impact of the Coalition Government's decision to cease the funding mapped out under the NHRA. The effects of this decision, made in the highly criticised 2014-15 Budget, have reached further than just the removal of funding. This chapter also looks at:

- the need for a mechanism that promotes cooperation between state and federal governments on hospital funding and planning;
- missed opportunities to promote reform in hospital funding;
- the need for long-term, sustainable funding which allows for workforce planning and infrastructure development; and
- issues that have emerged or been exacerbated by the removal of certainty in hospital funding.

2014 changes to Commonwealth hospital funding

Unsustainable health spending myth

3.3 A key element in the Coalition Government's justification of the cuts to hospital funding was the argument that government expenditure on health was unsustainable.[2] The same argument was used to justify the $7 co-payment policy, later scrapped, and the continuing freeze on MBS indexation.[3]

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1 Dr Stephen Duckett, Director Health Program, Grattan Institute, *Committee Hansard*, 4 November 2015, p. 1.

2 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

3 See the committee's first and second interim reports for further discussion of these policies.

3.4 This argument has been widely disputed. In its *Public Hospital Report Card 2015*, the Australian Medical Association (AMA) observed in relation to the Coalition Government's health and hospital funding cuts:

> The Government has justified its extreme health savings measures on the claim that Australia's health spending is unsustainable. But Australia's health financing arrangements are not in crisis.
>
> In 2012-13, Australia had the lowest growth (1.5 per cent) in total health expenditure since the Government began reporting it in the mid-1980s. Without any specific Government measures, there was negative growth (minus 2.2 per cent) in Commonwealth funding of public hospitals in 2012-13, and only 1.9 per cent growth in 2011-12. Our health sector is doing more than its share to ensure health expenditure is sustainable.
>
> Australia's expenditure on health has been stable as a share of GDP, growing only one per cent over the last 10 years. Health expenditure does not demand radical changes to existing services.[4]

3.5 Compared to other OECD countries, Australia spends just below the OECD average for health funding. In 2015, Australia spent 9.7 per cent of GDP[5] on health, while in comparison the US spent 16.4 per cent of GDP,[6] Canada spent 10.2 per cent,[7] and the UK spent 8.5 per cent.[8] The OECD *Health at a Glance 2015* notes that Australia's health expenditure 'achieves good outcomes relatively efficiently'.[9]

2014-15 Budget cuts to hospital funding

3.6 The *2014-15 Budget Overview* incorrectly categorised hospital funding as primarily a state responsibility:

> State Governments have primary responsibility for running and funding public hospitals and schools. The extent of existing Commonwealth funding to public hospitals and schools blurs these accountabilities and is unaffordable.[10]

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4 AMA, *Public Hospital Report Card 2015*, April 2015, p. 2.

5 AIHW, *25 years of health expenditure in Australia: 1989-90 to 2013-14*, 5 February 2015, www.aihw.gov.au/publication-detail/?id=60129554398

6 OECD, *Country Note: How does health spending in the United States compare?*, 7 July 2015, www.oecd.org/unitedstates/Country-Note-UNITED%20STATES-OECD-Health-Statistics-2015.pdf

7 OECD, *Country Note: How does health spending in Canada compare?*, 7 July 2015, www.oecd.org/els/health-systems/Country-Note-CANADA-OECD-Health-Statistics-2015.pdf

8 OECD, *Country Note: How does health spending in the United Kingdom compare?*, 7 July 2015, www.oecd.org/unitedkingdom/Country-Note-UNITED%20KINGDOM-OECD-Health-Statistics-2015.pdf

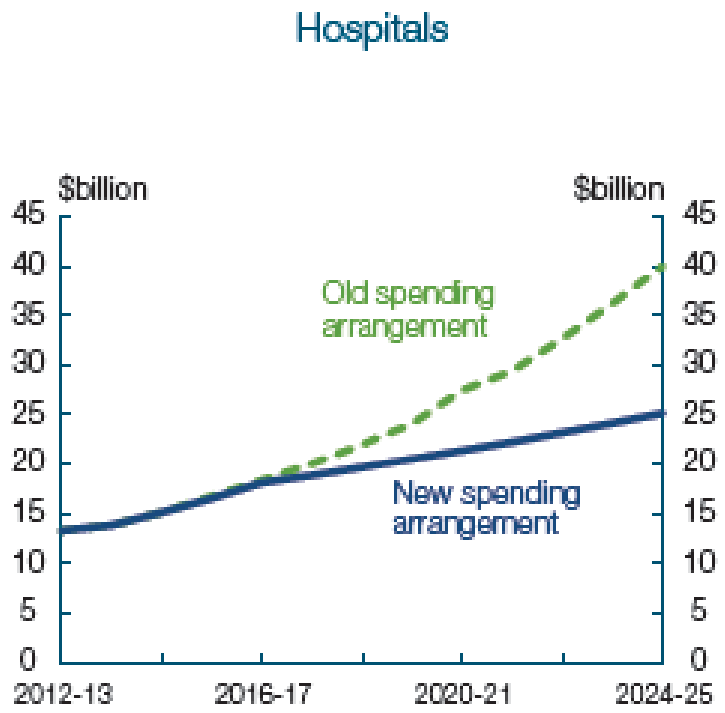
9 OECD, *Health at a Glance 2015: How does Australia Compare?*, p. 1. www.oecd.org/australia/Health-at-a-Glance-2015-Key-Findings-AUSTRALIA.pdf

10 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

3.7 On this argument, the government used the 2014-15 Budget to unilaterally cancel the NHRA, signed by the states and Commonwealth governments in 2011, and terminate various health-related National Partnership Agreements.[11] States were 'expected to continue contributing to these arrangements at their expense.'[12]

3.8 As part of the 2014-15 Budget, the Federal Government pledged that from 2017-18 Federal Government funding would revert to the former block funding model based on indexation at the Consumer Price Index (CPI) and population growth.[13] Despite promising "no cuts to health", the Federal Government projected that this new funding arrangement would save over $57 billion between 2017-18 and 2024-5.[14] Figure 1, reproduced from the *2014-15 Budget Overview*, shows the government's projected reductions to hospital funding.

Figure 1—projected hospital funding cuts from the 2014-15 Budget[15]



11 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

12 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

13 Australian Government, *'Part 2 Expense Measures', Budget measures: budget paper no.2: 2014-15*, www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm (accessed 5 April 2016); Administrator, National Health Funding Pool, *Basis of Commonwealth NHR Funding*, www.publichospitalfunding.gov.au/national-health-reform/reporting-basis-commonwealth (accessed 11 March 2016).

14 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7. The $57 billion figure was used at the Senate Economics Committee Estimates hearings in 2014, while the $56 billion figure was calculated by the PBO, based on information in the NHRA.

15 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7. In the graph, the green line of the 'old spending arrangement' represents the NHRA funding, while the blue line represents the indexed funding arrangements in the 2014-15 Budget.

3.9 The Coalition Government's 2014-15 Budget was widely criticised. For example Dr Stephen Duckett, Director of the Grattan Institute's Health Program, told the committee:

> The 2014 budget provided that future indexation to the states would be in line with:
>
> … a combination of the Consumer Price Index and population growth.
>
> If this is taken at face value, then the 2014 proposal is the most parsimonious indexation arrangement that has ever applied to public hospital funding grants.[16]

3.10 The Budget Overview went on to explain that the responsibilities of the different levels of government would be the subject of a White Paper on the Reform of Federation, to be completed at the end of 2015.[17] The recently abandoned White Paper process is discussed further below.

Impact of hospital funding cuts on states and territories

3.11 The committee sought a submission from the Parliamentary Budget Office (PBO) in order to gain a clearer understanding of the impact the Coalition Government's funding cuts will have on each state and territory. The submission is reproduced at Appendix 4. Figure 2, which is based on the PBO's findings, shows the funding each state and territory will lose as a result of the 2014-15 Budget.

3.12 The funding cuts calculated in the PBO's submission relate to the 2014-15 Budget decision. These preceded the April 2016 COAG agreement to partly reinstate funding out to 2020. While this COAG decision, discussed below, has partially mitigated the 2014-15 Budget cuts, the $2.9 billion allocated across three years (2017-18 to 2019-20) is not adequate to address the $7.9 billion shortfall over this same period created by the 2014-15 Budget cuts.

3.13 During its inquiry, the committee has undertaken 52 hearings and held public hearings and site visits in every state and territory. The following eight chapters focus on each of the states and territories, detailing the extent of the loss of funding and the issues which have arisen for each state. While state governments have, to a large extent, provided short-term additional funding to cover the immediate Commonwealth shortfall, this situation is unsustainable long term. The loss of certainty over long term funding has also meant that state governments are unable to forward plan workforce and infrastructure and must subsist from budget to budget.

3.14 In addition to state-specific issues, there are also some issues caused by the cuts to hospital funding that are Australia-wide. These range from high-level policy questions, such as the need for a mechanism for cooperation between the states and federal governments, to grassroots impacts, such as increased waiting times. These national implications are discussed throughout this chapter.

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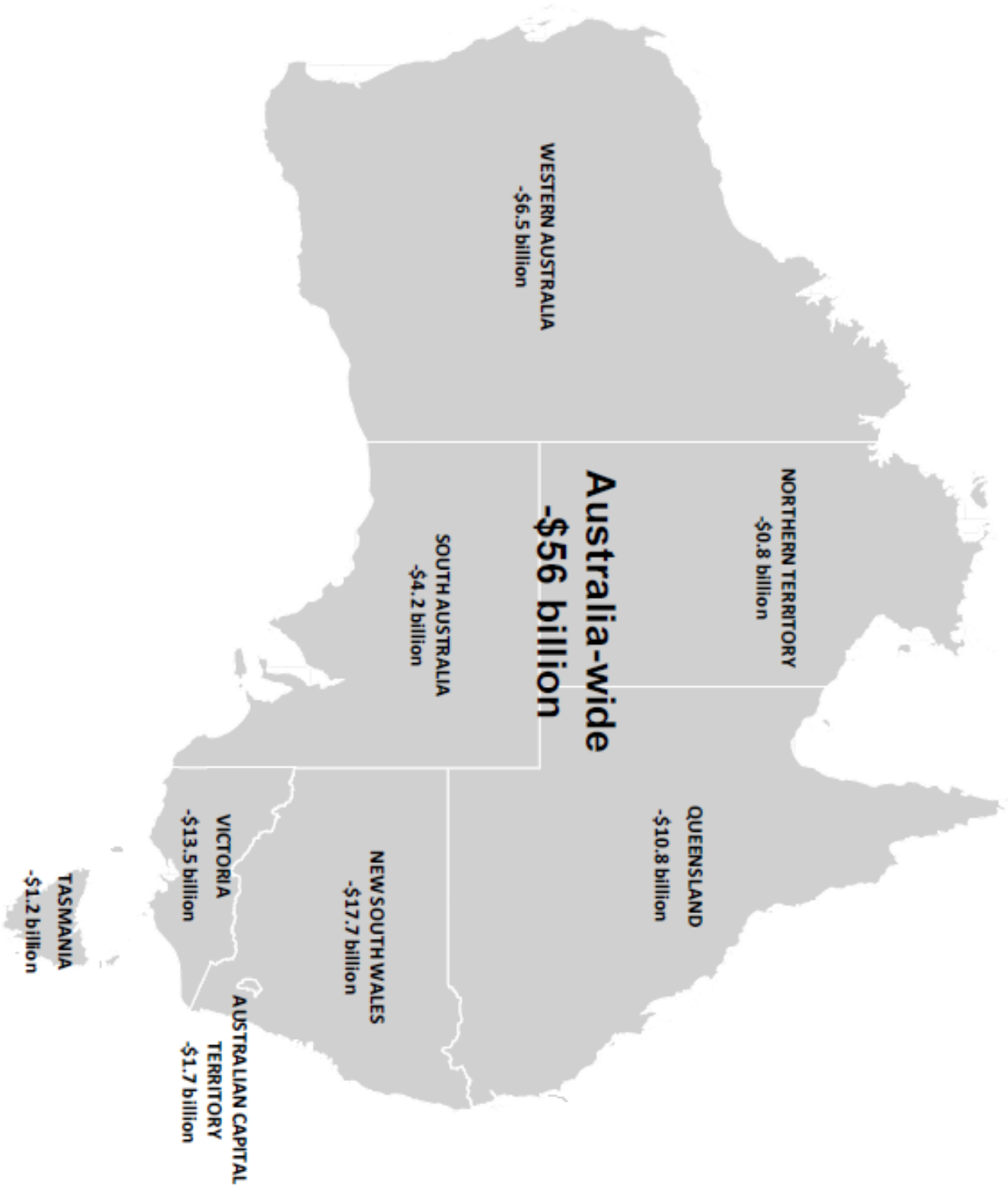
16 Dr Stephen Duckett, Director Health Program, Grattan Institute, *Committee Hansard*, 4 November 2015, p. 1.

17 Commonwealth of Australia, *2014-15 Federal Budget Overview*, May 2014, p. 7.

Figure 2—Commonwealth hospital funding cuts from the 2014-15 Budget[18]



18 Source: Parliamentary Budget Office, *Submission 191*, Table 1, p. 5. Under the previous government, hospital funding was to be provided under the 2011 National Health Reform Agreement. The government policy introduced in the 2014-15 Federal Budget would have indexed funding by CPI and population growth from 2017-18 to 2024-25. Dollar amounts in the above diagram have been rounded.

'Skin in the game'

Removal of the mechanism for state and federal cooperation

3.15 As described in Chapter 2, the history of hospital funding in Australia has been marked by a struggle to find a means of settling the respective contributions of the state and federal governments. Of particular importance has been the need to avoid short-term funding agreements and instead establish sustainable long-term funding arrangements.

3.16 The Coalition Government's unilateral abandonment of the long-term NHRA did more than remove Commonwealth hospital funding. It caused the loss of goodwill in state-federal cooperation on health. Dr Stephen Duckett, Director of the Grattan Institute's Health Program, described the 2014-15 Budget as having done 'serious damage to Commonwealth-state relations and the confidence with which states could plan and manage health services.' It did this by:

> …abrogating an agreement about public hospital funding which had been signed by governments of all political persuasions and unilaterally imposing a new funding model on the states. The funding model promulgated in the 2014 budget was presented in the budget papers as saving more than a billion dollars over the forward estimates, with savings described as being in the tens of billions over the ensuing decade. The words 'saved' and 'savings' are an example of creative accounting. They are savings to the Commonwealth budget only, but are not real savings to the public purse at all. Instead, they are simply a massive and unsustainable transfer of costs from the Commonwealth budget to state budgets.[19]

3.17 Dr Duckett categorised the NHRA as having 'dealt with some of the dysfunctional aspects of federalism in health care'. The agreement had done this by:

> …creating an alignment of incentives. It made the Commonwealth share directly in the costs of activity growth in health care, which gave it an incentive to develop policies in its sphere that might mitigate that growth. For example, the Commonwealth traditionally funds primary care, while the states fund hospital care. Making the Commonwealth share responsible for hospital funding gave it a stronger incentive to improve primary care and reduce the number of avoidable and expensive hospital visits, generating actual savings to the public purse. The 2014 budget removed that alignment of incentives.[20]

3.18 Professor Mike Daube, Director of Public Health Advocacy Institute of Western Australia at Curtin University, agreed with Dr Duckett. Professor Daube described the situation after the 2014 cancellation of the NHRA funding agreement as:

> There is a whole lot in limbo now. I must say I think it created distrust of central government, because if you have agreements that are supposed to be

19 Dr Stephen Duckett, Director Health Program, Grattan Institute, *Committee Hansard*, 4 November 2015, p. 1.

20 Dr Stephen Duckett, Director Health Program, Grattan Institute, *Committee Hansard*, 4 November 2015, p. 1.

> lasting and suddenly they are cut then the state governments which had to implement them will have people on contracts and so on, because they would have assumed that the funding would continue. So it creates distrust for them. It creates uncertainty out in the community…[21]

3.19 In the two years since the 2014-15 Budget, there has been much debate about the role of the Federal Government in hospital funding. The Reform of the Federation White Paper process has been part of that debate, although not to the same extent as the ongoing criticisms of the 2014-15 Budget by groups like the AMA.

Reform of the Federation White Paper

3.20 The White Paper process was begun in the first half of 2014. Its main objective was to 'clarify roles and responsibilities to ensure that, as far as possible, the states and territories are sovereign in their own sphere.'[22] Other objectives included reducing duplication between levels of government and improving the efficiency of the federation.[23]

3.21 As part of the White Paper process, issues papers regarding various aspects of the federation, including health and hospital funding, were produced in the second half of 2014. However the Green Paper, which was to be released in the first half of 2015, was not published until after it had been leaked in June 2015.[24]

3.22 The 'discussion paper', as the leaked Green Paper was titled, lists five options for reform of hospital funding. These range from a shared responsibility for funding between the state and Federal governments to sole funding responsibility resting on state and territory governments:

- establishment of a benefit scheme similar to the Medicare Benefits Schedule for all hospital treatments;
- Commonwealth and states jointly fund individualised care packages for chronic or complex conditions;
- establishment of regional purchasing agencies to source health services geographic areas;
- Commonwealth becomes solely responsible for funding; or

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21 Professor Mike Duabe, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, 10 October 2014, p. 27.

22 Department of Prime Minister and Cabinet, *Reform of Federation White Paper: Terms of Reference*, website, https://federation.dpmc.gov.au/terms-reference

23 Department of Prime Minister and Cabinet, *Reform of Federation White Paper: Terms of Reference*.

24 Phillip Coorey, Australian Financial Review, *Leaked proposal suggests states may lose $18b healthcare funding*, 22 June 2015, www.afr.com/news/politics/leaked-proposal-suggests-states-may-lose-18b-healthcare-funding-20150621-ghu001; Dan Conifer, ABC News Online, *Federal Government plays down discussion paper's 'secret plan' to strip billions in hospital funding from states and territories*, 23 June 2015, www.abc.net.au/news/2015-06-23/states-and-territories-could-lose-billions-in-health-funding-an/6565810

- states take full responsibility for public hospitals.[25]

3.23 It had been anticipated that federation reform would be part of the COAG leaders' retreat on 23 July 2015, but the topic was not covered in the communique for that meeting. Reform was discussed at the 11 December 2015 COAG meeting, but leaders only agreed to further consideration of health funding at the first COAG meeting of 2016.[26]

3.24 The White Paper on federation reform had been scheduled for publication at the end of 2015, but this did not happen. Instead, a variation of the options in the 'discussion paper' was put to the COAG meeting held on 1 April 2016, leading to an agreement to extend activity based funding to 2020 (discussed further below).

3.25 On 28 April 2016, the Prime Minister confirmed that the Reform of Federation White Paper process had been scrapped, with no White Paper to be released.[27] The cost of the process was reported to be in excess of $5 million.

3.26 The Reform of the Federation White Paper website explains that:

> …work to improve federal financial relations and the transparency of government spending will be progressed by the Council on Federal Financial Relations, and the Commonwealth, state and territory Treasuries. A progress report will be brought to the next COAG meeting.[28]

Committee view

3.27 The Reform of Federation White Paper could have been a valuable process for rebuilding state-federal relations after the disastrous 2014-15 Budget. Instead, it has been significant waste of public money, and has only resulted in returning state-federal relations back to the often combative forum of COAG.

April 2016 COAG agreement

3.28 On 1 April 2016 the Prime Minister, the Hon Malcolm Turnbull MP, faced a hostile COAG meeting with states and territories concerned that the 2014-15 Budget cuts to hospital funding would leave them unable to provide adequate hospital services.[29] The Prime Minister's proposal to the states was for an additional $3 billion

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25 Department of Prime Minister and Cabinet, *Reform of Federation White Paper: Discussion Paper*, website, https://federation.dpmc.gov.au/publications/discussion-paper

26 COAG, 11 December 2015, *Communique*, www.coag.gov.au/node/529

27 Eliza Borrello, ABC News Online, *Malcolm Turnbull scraps federation white paper after $5 million work*, 28 April 2016, www.abc.net.au/news/2016-04-28/malcolm-turnbulls-$5-million-tax-white-paper-scrapped/7367204

28 Department of Prime Minister and Cabinet, *Reform of Federation White Paper*, website, https://federation.dpmc.gov.au/

29 Liz Jackson, ABC Radio PM Program, *Thousands will go untreated in SA public hospitals under current funding: report*, 29 March 2016, www.abc.net.au/pm/content/2016/s4433224.htm

over three years for hospital funding, and the possibility that the states could raise their own income taxes as funding for the longer term.[30]

3.29 While the income tax proposal was rejected by the states, COAG did agree to a Heads of Agreement for hospital funding to run from 1 July 2017 to 30 June 2020 'ahead of longer-term arrangements'.[31] Additional Commonwealth funding under the agreement was to be $2.9 billion between 2017-18 to 2019-20, with growth capped at 6.5 per cent per year.[32] The funding was to be provided primarily on the basis of activity based funding and block funding under certain circumstances as set out under the NHRA.[33]

3.30 For their part in the agreement, states undertook to:

- reduce demand for hospital services through better coordinated care, particularly for people with complex and chronic diseases;
- improve hospital pricing mechanisms; and
- reduce the number of avoidable hospital readmissions.[34]

3.31 Although the April 2016 agreement provides partial and short-term respite from the full force of the 2014-15 Budget funding cuts, the additional funds in the agreement fall well short of the funding states would have accessed under the NHRA. Instead of the NHRA's funding increase of 9 per cent per annum, the states will see funding growth capped at 6.5 per cent, only 2 per cent improvement on the 4.5 per cent rate unilaterally imposed by the 2014-15 Budget.[35]

3.32 As discussed earlier, the additional $2.9 billion figure compares poorly with the funding increase of $7.9 billion which would have flowed to the states had the government not abandoned the NHRA.[36]

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30 Lenore Taylor, The Guardian Australia, *Turnbull looks to income tax-raising powers for states to fix school and hospital funding*, 30 March 2016, www.theguardian.com/australia-news/2016/mar/29/states-offered-5bn-hospitals-funding-income-tax-raising-powers

31 COAG, 1 April 2016, *Communique*, www.coag.gov.au/sites/default/files/COAG_Communique.pdf

32 COAG, 1 April 2016, *Communique.*

33 Heads of Agreement 1 April 2016, www.coag.gov.au/sites/default/files/Heads%20of%20Agreement%20between%20the%20Commonwealth%20and%20the%20States%20on%20Public%20Hospital%20Funding%20-%201%20April%202016_0.pdf

34 COAG, 1 April 2016, *Communique*.

35 Lenore Taylor, The Guardian Australia, *Malcolm Turnbull promises states hospital funding in budget after Abbott cuts*, 24 February 2016, www.theguardian.com/australia-news/2016/feb/24/malcolm-turnbull-promises-states-hospital-funding-in-budget-after-abbott-cuts

36 Parliamentary Budget Office, *Submission 191*, p. 5.

Need for long-term, sustainable funding

3.33 The April 2016 COAG agreement is welcome in that it is an improvement on the hospital funding cuts contained in the 2014-15 Budget. However, it does not go towards solving the larger problem: that a long-term funding agreement is urgently needed to replace the NHRA which was abandoned in the 2014-15 Budget.

3.34 Since May 2014, state and territory governments have been forced to operate in an atmosphere of uncertainty. States have faced the fact that Commonwealth funding will decrease from the expected NHRA levels, and have been planning how to mitigate the worst impacts of the loss. In South Australia, representatives of the Department of Health and Ageing told the committee that their ability to plan for future hospital services is compromised by the uncertainty around funding:

> It is clear that where the Commonwealth provides funding it is welcome by the state. However, South Australia and SA Health is keen to ensure that any benefits of reform measures…are durable in the long term. SA Health's ability to undertake budgetary and service planning is compromised by uncertainty created by the Commonwealth. Uncertainty remains about public hospital funding. National Health Reform Agreement arrangements are unlikely to be clarified until the release of the Commonwealth's white paper on the reform of the federation in 2016.
>
> SA Health looks forward to the ideas to be presented by the Commonwealth about future roles and responsibilities for the health system as part of this process. The present situation leaves the state bearing the risks associated with growing demands on hospital costs and without the resources to meet the expected growth. The state has had limited ability to influence the full range of policy levers across the health system as a whole that drive demand and public hospital services. This is not a sustainable process for the health system in the future.[37]

3.35 In Victoria, representatives from the Department of Health and Human Services told the committee that the Commonwealth is a 'critical partner' for states in providing high quality hospital services:

> The adoption of activity based funding as the basis for Commonwealth funding contributions in 2011 signalled a commitment to carry a share of hospital demand growth. To give that some perspective, Commonwealth funding for public hospitals grew by an average of 6.6 per cent per annum for the decade to 2010-11, growing to 7.1 per cent per annum to 2013-14. And growth was estimated at 9.4 per cent beyond the 2013-14 forward estimates, based on projected growth for Victorian public hospitals published in the 2013-14 MYEFO.[38]

37 Ms Skye Jacobi, Director, Intergovernment Relations and Ageing, Department for Health and Ageing, South Australia, *Committee Hansard*, 11 June 2015, p. 21.

38 Ms Kym Peake, Acting Secretary, Victorian Department of Health and Human Services, *Committee Hansard*, 4 November 2015, p. 39.

3.36 The experience was similar in Queensland. Ms Kathleen Forrester, Deputy Director-General Department of Health, told the committee that the NHRA had provided a 'new and very different Commonwealth funding methodology' which:

> …created the financial incentives for all levels of government to work together to ensure the health system functions efficiently and holistically to improve overall health outcomes. Furthermore, the methodology accounted for all the main drivers of public hospital service cost growth, because it is based on the actual increase in the volume of public hospital services provided to patients.[39]

3.37 In comparison, the 2014-15 Budget decision to base funding on indexation of CPI and population growth would 'break the link established…between Commonwealth funding and efficient [growth] in public hospital services, reducing the financial incentives for all aspects of the health system to work together to improve outcomes.'[40] The result would be:

> …the major costs associated with other drivers of healthcare demand would be borne by the states and territories, leading to an ever-increasing share of state funding and a declining Commonwealth share. The proposed funding model assumes that all population groups have the same need for public hospital services. For example, it does not take account of the greater health needs of Indigenous people and people from rural and remote locations. This is particularly important for Queensland, which has the most decentralised population in Australia. Nor does it take account of the ageing population or the changing cost of service provision due to technological advances.[41]

State issues

3.38 Chapters 4 to 10 of this report provide details of the impact of the Federal Government's hospital funding cuts on each state and territory. While the cuts had not been due to begin until 2017-18, the announcement of the decision in the 2014-15 Budget included the removal of many of the National Partnership Agreements which had provided funds to states and territories as part of the NHRA. The effect of the funding cuts was therefore immediate, and states had to begin planning for how to make up the shortfall in funds.

3.39 National Partnership Agreements, such as that relating to improving hospital services, provided significant benefit, particularly to smaller states and territories. In these cases, the funding cuts were felt most acutely. The Northern Territory Chief Minister, the Hon Adam Giles MLA, described the loss of the National Partnership Agreement funding:

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39 Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

40 Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 15.

41 Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division, Department of Health, Queensland, *Committee Hansard*, 16 November 2015, p. 14.

> Contrary to comments made by the Prime Minister today, the pain from these front line service cuts will start being felt by the States and Territories from July 1, 2014.
>
> Let's look at two examples. In 43 days time, the Territory stands to lose $1.4 million in Federal funding for pensioner concessions and health funding will be cut by $33.8 million or the equivalent of a minimum of ten hospital beds.
>
> These funding decisions will have a real and immediate impact on the front line services offered to Territorians.[42]

3.40 Many states pledged to cover the immediate funding gap themselves; however, that situation is not sustainable beyond the very short term. Issues have already begun to emerge which demonstrate that without a state-federal funding partnership, the states cannot adequately support Australia's hospitals.

Committee view

3.41 Since its establishment in June 2014, the Senate Select Committee on Health has seen other disastrous health policies from the 2014-15 Budget scrapped or put on hold. But while the government has reversed ill-conceived policies like the $7 co-payment, the cuts to hospital funding have lasted until 2016, when backlash from the states forced the government to make a temporary and partial extension of funding.

3.42 Before the NHRA was agreed in 2011, respective hospital funding contributions had been a struggle between the state and federal governments. The reforms to hospital funding implemented by the previous government allocated virtually equal responsibility for funding to the state and federal governments, and created a mechanism for all parties to work together to ensure that funds were used efficiently.

3.43 When the Federal Government unilaterally tore up the NHRA in the 2014-15 Budget, the action set hospital funding arrangements back ten years. The decision obliterated states' confidence in any federal-state funding negotiation process. State hospital infrastructure and workforce planning, which was appropriately based on the long-term funding agreement in the NHRA, was thrown into uncertainty. State governments struggled to figure out how to make up the shortfall in funding; many admitting that it would not be possible unless funding was taken from other areas.

3.44 The defining achievements of the NHRA were to:

- provide long-term funding and continuity of funding to enable workforce and infrastructure planning;
- create a forum for states and federal governments to work together on hospital funding; and

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42 Chief Minister, the Hon Adam Giles MLA, 'Territory Health and Education Funding Under Threat', media release, May 2014, www.chiefminister.nt.gov.au/media-releases/territory-health-and-education-funding-under-threat

- establish an activity based funding model and the associated national efficient price for hospital services.

3.45 The Government's 2014-15 Budget decision to allocate federal hospital funding based on indexation of CPI and population growth, and unilaterally scrap the NHRA, has:

- destroyed state and territory government confidence in negotiation with the federal government;
- removed the best forum for state-federal partnership and cooperation over hospital funding; and
- created a shortfall in hospital funding that the state governments are struggling to cover.

3.46 The Federal Government claimed in 2014 that the Budget measures were put in place because health funding was unsustainable. In actual fact, the 2014-15 Budget has created the situation where hospital funding, with the burden shifted significantly to the states, is unsustainable.

3.47 Although the COAG agreement of April 2016 has partially mitigated the damage done by the 2014-15 Budget, the future of hospital funding is bleak. At best the three year agreement has created space for the federal government to work to rebuild the confidence of the states and establish a long-term agreement on hospital funding, backed by fair, equitable and sustainable federal funding.

3.48 As the following chapters of this report show, the NHRA had been working effectively to distribute funding in a responsible and equitable way to public hospitals. The Coalition Government unilaterally scrapped the NHRA and replaced it with what can only be described as an omnishambles or 'a situation that has been comprehensively mismanaged, characterised by a string of blunders and miscalculations'.[43]

3.49 The committee believes that there is only one way Commonwealth-state hospital funding arrangements can be repaired, and that is to work through the NHRA. The committee's recommendations go towards this goal.

3.50 In building on the NHRA, rather than the omnishambles created by the 2014-15 Budget and the Government's misguided actions since, the committee believes that the Federal Government needs be a partner with the states in terms of hospital funding. Without 'skin in the game', there is no incentive to work with state governments to ensure that funding is used efficiently. The Federal Government needs to urgently build goodwill with the state and territory governments, in order to create a solid foundation for any future finding agreement.

43 Oxford English Dictionary

Recommendation 2

3.51 The committee recommends that the Government reconstitute the National Health and Hospitals Reform Commission or a similar body to review hospital funding arrangements and build on the National Health Reform Agreement. This process should be guided by the principles of equity, fairness, adequate funding and long-term certainty to ensure the continuity of public hospital services.

3.35 While the committee is pleased that the Federal Government has made a temporary agreement with the states until 2020, which partially restores the withdrawn NHRA funding, the committee believes that this is not sufficient. Until recently, the Federal Government was actively working to remove the mechanisms by which activity based funding was set up. The committee urges the government to halt the closure of the Independent Hospital Pricing Authority, and the other structures put in place by the former government to implement activity based funding.

3.52 The committee supports activity based funding as the best means of delivering limited funds in a manner that drives greater efficiencies and provides a strong incentive for the Commonwealth to improve primary care and reduce the number of avoidable and expensive hospital visits.

Recommendation 3

3.53 The committee recommends that the Government urgently give an undertaking that the mechanisms for activity based funding, such as the Independent Hospital Pricing Authority, and the other structures put in place by the former government to implement activity based funding, will not be dismantled.