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Ms Christine McDonald
Secretary
Standing Committee on Finance and Public Administration

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Dear Ms McDonald

Re Inquiry into the implementation of the National Health Reform Agreement

The unedifying spectacle of Commonwealth and State health ministers blaming each other for cuts to patient care in Victoria demonstrates that the 'blame game' in health care is not yet at an end. I have outlined my interpretation of how the current imbroglio arose in a recent piece in *The Conversation*: https://theconversation.edu.au/blame-game-cutting-through-the-spin-on-victorias-hospital-funding-cuts-11881.

The public 'debate' has not involved any engagement between the parties. It is a fact that Victoria has implemented cuts against the forward estimates for hospitals; it is a fact that the Commonwealth is increasing its funding of public hospitals. But neither of these points is germane. The salient fact is that the Commonwealth has reduced its (increase) in funding compared to what was announced before the start of the financial year and that the state has passed that change in expected funding on to hospitals.

Australia is at the start of a very long transition period in terms of allocating Commonwealth funding to the states. For 2012/13 and 2013/14 the quantum of funding is determined by the historical base amounts adjusted for population growth, health inflation and a technological change effect. As far as possible these have a formulaic basis to avoid judgements by either side outside the negotiated settlement. The Commonwealth has applied the relevant formulae in accordance with the (current) Agreement.

In my view the National Health Reform Agreement is clear and Commonwealth funding to the states should be based on the revised population estimates. But mechanistic application of the formulae has clearly led to problems in Victoria. My concern is with how the funding adjustments have been made, the issue covered in the section (b) of the Committee's Terms of Reference.

Prior to 1994, the annual Commonwealth Budget was announced some months after the start of the relevant financial year. Coupled with the traditional summer slowdown in Australian decision making processes, this meant that Budget measures would often only have a few months operation in the financial year. The 1994 budget-timing change, also adopted for state and territory budgets, means that budget impacts can be transmitted to funded agencies before the start of the financial year. This allows good management practice. In the health sector, for example, hospitals can prioritise their work and plan to respond to any budget changes in a measured and consistent way.

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The converse situation, where budget changes were announced after the start of the financial year, is what happened to Victorian public hospitals this year. Effectively, hospitals were advised of the full year impact of budget reductions in the second quarter of the financial year in the immediate lead-up to the summer slowdown, effectively allowing less than five months to implement twelve months' worth of changes. This exacerbated the impact the changes had on patient care.

What should have happened? As I have indicated, the Agreement provides for funding allocations to be adjusted for population changes, and in this instance that applies to application of a change in the way the population is estimated. But the Agreement is silent about what period of notice should be given for the application of the formula, especially where there was a change between the amount forecast in the Budget issued in May and the funding that is to be allocated in the current financial year.

Good governance normally avoids retrospective changes and the problems facing Victorians would have been mitigated or eliminated if better notice had been given.

If we assume that the Agreement provisions should apply, and this is my view, then a phasing of the impact should have been offered to the states which lost money as a result of the change in the estimated resident population. This would be relatively easy to implement. The extent of phasing should have been subject to negotiation.

Commonwealth funding to the states is expected to increase significantly post 1 July 2014 and the reductions could have been offset against the increases in that year. The Commonwealth should have offered states the choice about phasing on the condition that the phasing would be cost-neutral to the Commonwealth. Given the Agreement is a signed document, phasing may have required new bilateral Agreements. Under such an arrangement, the base allocations would be as specified in the National Health Reform Agreement, hospitals would have had longer to prepare for the budget reductions and the significant adverse impacts on patients would have been avoided.

Although post-2014 funding for states and territories is not based on population estimates, it may be prudent to include provision for a funding phasing option if key parameters change unexpectedly.

Yours Sincerely

Stephen Duckett

13/2/13