

# Chapter 2

## Background to hospital funding reform

### Introduction

2.1 This chapter traces the history of hospital funding arrangements in Australia. It commences with an examination of the pre-Medicare and Medicare eras and concludes with an overview of the historic National Health Reform Agreement.

### General

2.2 Australia's health system is funded and administered by several levels of government and supported in part by the non-government sector. Whilst the Commonwealth and the states and territories share many roles in policy, funding and regulation, service delivery is largely undertaken by the states and territories, local governments, and the non-government sector.<sup>1</sup>

2.3 The Commonwealth is the largest contributor of government funding to health services and its direct areas of responsibility include:

- Medicare;
- Pharmaceutical Benefits Scheme;
- Medical Research Grants; and
- Education of Health Professionals.<sup>2</sup>

2.4 States and territories are mainly responsible for areas including the:

- Management and administration of public hospitals (including emergency care);
- Delivery of preventative services; and
- Funding and management of community and mental health services.<sup>3</sup>

2.5 Shared Commonwealth-state responsibilities include:

- Funding of public hospitals;
- Preventative services;

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1 Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, pp 1–3 and 21–25.

2 Amanda Biggs, Parliamentary Library, *Health in Australia: a quick guide*, November 2013, pp 1–2; Council of Australian Governments, *National Healthcare Agreement 2012*; and Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, pp 1–3 and 21–25.

3 Amanda Biggs, Parliamentary Library, *Health in Australia: a quick guide*, November 2013, pp 1–2; Council of Australian Governments, *National Healthcare Agreement 2012*; and Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, pp 1–3 and 21–25.

- Registration and accreditation of health professionals;
- National mental health reform; and
- Aboriginal and Torres Strait Islander health services.<sup>4</sup>

2.6 Public hospitals are seen as the most significant area of shared funding between the Commonwealth and the states and territories.<sup>5</sup> Since the First World War, efforts to reach agreement in terms of funding arrangements and funding priorities for public hospitals have highlighted the considerable differences between the levels of government.<sup>6</sup> Past negotiations around new health funding models and the signing of new healthcare agreements between the Commonwealth and states and territories have often been marked by disputes and allegations of cost shifting. As a consequence, health and hospital funding has often been referred to as the "blame game".<sup>7</sup>

## **Hospital funding pre-Medicare**

### ***Federation – 1949***

2.7 Demand for public hospitals increased between the world wars but many hospitals struggled to raise enough revenue to cover their costs. While private health insurance was in operation, it was very limited. In 1928 and 1938 national health insurance schemes were proposed by the respective governments but were successfully opposed by businesses and the medical profession.<sup>8</sup>

2.8 Following the Second World War, the relationship between the Commonwealth and the states and territories was impacted by a succession of attempts by the Commonwealth to gain additional heads of power, including a power for 'national health' in 1945. Whilst the 1945 referendum was defeated, the Commonwealth was able to provide funding to the States and Territories through the

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4 Amanda Biggs, Parliamentary Library, *Health in Australia: a quick guide*, November 2013, pp 1–2; Council of Australian Governments, *National Healthcare Agreement 2012*; and Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, pp 1–3 and 21–25.

5 Department of Prime Minister and Cabinet, *Reform of the Federation White Paper 2014: Roles and Responsibilities in Health*, Issue Paper 3, December 2014, p. 21.

6 Greg Lewis, *Public Health and Commonwealth-State Relations*, Department of the Parliamentary Library Information and Research Services, 1998, p. 1.

7 House of Representatives Standing Committee on Health and Aging, *The Blame Game: Report on the inquiry into health funding*, November 2006.

8 Sidney Sax, *A Strife of Interests – politics and policies in Australian Health Services*, George Allen and Unwin, Sydney, 1984, pp 26, 36, 42 and 58; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp 15–22.

*Hospital Benefits Act 1945*.<sup>9</sup> This legislation specified that all people must have access to the public wards of hospitals free of charge; however, there was no intrusion by the Commonwealth into the organisation and management of hospitals.<sup>10</sup>

2.9 A year later, the 1946 referendum to give the Commonwealth new powers for a range of social services was successful. This gave the Commonwealth authority to provide pharmaceutical, sickness and hospital benefits as well as deliver and fund medical and dental services.<sup>11</sup> It led to a new Pharmaceutical Benefits Scheme (PBS) but the medical profession could not be convinced of the proposed national health insurance scheme.<sup>12</sup>

2.10 In 1948, the Chifley government passed the *National Health Service Act 1948* which allowed the Commonwealth to 'maintain and manage hospitals, laboratories, health centres and clinics, and to take over any of these services from the states',<sup>13</sup> but it was never fully implemented.<sup>14</sup>

### **1949–1984**

2.11 Under Medibank, the predecessor to Medicare, hospital funding was delivered via a cost-sharing arrangement, with the Commonwealth providing conditional grants to the states equivalent to 50 per cent of gross operating costs. The states would be required to fund the remainder from their own revenue.<sup>15</sup>

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9 This was through SPPs as the Commonwealth had no constitutional power over health services. Although the scheme stopped in 1949, Queensland continued to fund free hospital care; Sidney Sax, *A Strife of Interests – politics and policies in Australian Health Services*, George Allen and Unwin, Sydney, 1984, p. 52, 56, 58; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp ix–x and 22–35.

10 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, p. 27.

11 This was articulated as Section 51(xxiiiA) of the Constitution.

12 The Pharmaceutical Benefits Scheme was enacted under the Pharmaceutical Benefits Act 1948. Another scheme had been already in operation in early 1945 (the Pharmaceutical Benefits Act 1944), but it was declared unconstitutional in 1946. Parts of the 1948 Act would also prove to be unconstitutional in 1949; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp ix–x, 22–35; Scotton, Richard, B, *Medibank: from conception to delivery and beyond*, MJA Vol 173, 3 July 2000, pp 9–11.

13 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp ix–x and 22–35.

14 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp ix–x and 22–35.

15 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp 52–63; Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004 [www.aph.gov.au/About\\_Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/Publications\\_Archive/archive/medicare](http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/medicare) (accessed 1 March 2016).

2.12 To implement the hospital aspect of Medibank, the Whitlam government negotiated separate funding agreements with each of the states. These agreements sought to ensure:

- that all public patients in public hospitals received free treatments and access to medical services;
- hospital benefits were paid directly to hospitals not to patients;
- the end of the honorary system of hospital medical work; and
- grants were made to the states to compensate them for the loss of revenue that resulted from abolishing hospital fees and means-tests.<sup>16</sup>

2.13 It took until 1 October 1975 before all states had agreements in place with the Commonwealth and the hospital aspect of Medibank could be deemed as operating nationally.<sup>17</sup>

2.14 The Medibank program had only been operating for a few months when the Whitlam government was dismissed on 11 November 1975. Although the incoming Fraser government had indicated during the election that it would maintain Medibank, within months changes had been made. Medibank II was launched in 1976, Medibank III in 1978 and Medibank IV in 1979.<sup>18</sup>

2.15 In 1981, following the Jamison Committee of Inquiry into Efficiency and Administration of Hospitals,<sup>19</sup> the nature of the funding for hospitals from the Commonwealth changed from specific purpose funding to per capita block grants.<sup>20</sup>

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16 Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, p. 56; Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004.

17 The medical side of Medibank was effective nationally from 1 July 1975; Richard B. Scotton, *Medibank: from conception to delivery and beyond*, *Medical Journal of Australia*, Vol 173, July 2000, pp 9–11. Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004.

18 Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp 78–89.

19 This inquiry was established in 1979 to find ways of containing hospital costs and improving efficiencies. In doing so it looked at health insurance arrangements and the roles of the Commonwealth and states in the health sector. It reported in December 1980. Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pp 78–89.

20 Stephen Reynolds, *Australian Health Insurance Arrangements 1969-81: the roles of public and private health insurance*, Legislative Research Service, Department of Parliamentary Library, Basic Paper No.4, 1981; Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, p. 89.

## Medicare Agreements

### 1984–1988

2.16 Following the election of the Hawke government in 1983, legislation was introduced to return to the original Medibank model, albeit with grant based funding. The 'new' universal scheme was named Medicare<sup>21</sup> and began on 1 February 1984.<sup>22</sup>

2.17 Under Medicare the Commonwealth signed bilateral agreements with the states and territories in which the basic arrangement consisted of the Commonwealth providing funding in exchange for the states and territories providing free public hospital treatment as public patients. The first agreement extended until 1988 and thereafter each agreement was for five years.

2.18 The first round of Commonwealth payments to the states and territories consisted of Identified Health Grants and a Medicare Compensation Grant.<sup>23</sup> The grants not only provided for funding for hospitals but also for new community health services.<sup>24</sup>

2.19 By November 1986, the maximum gap<sup>25</sup> had increased from the initial \$10 to \$20; the in-hospital rebate was set at 75 per cent, with private health insurance to cover remaining 25 per cent.<sup>26</sup>

### 1988–1993

2.20 The second round of Medicare agreements saw a return to specific funding grants with the Identified Health Grants and a Medicare Compensation Grant being replaced with new Hospital Funding Grants. These grants were 'absorbed' into the pool of general revenue assistance.<sup>27</sup>

2.21 The base grant during this period of the agreements was adjusted for inflation and weighted population growth, as well as an adjustment for the treatment of

21 Relevant legislation introduced or amended included the *Health Legislation Amendment Act 1983*, *Health Insurance Act 1973*, *National Health Act 1953* and the *Health Insurance Commission Act 1973*; Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004.

22 Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004; Richard B, Scotton, Richard, B, *Milestones on the road to Medibank and Medicare*, *Medical Journal of Australia*, Vol 173, July 2000, pp 5–7; Richard B, Scotton, *Medibank: from conception to delivery and beyond*, *Medical Journal of Australia*, Vol 173, 3 July 2000.

23 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, July 2000, pp 33–34.

24 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, July 2000, pp 33–34.

25 The gap is the amount paid for medical or hospital charges, over and above the rebate from Medicare or private health insurance.

26 Amanda Biggs, *Medicare Background Brief – E-Brief*, October 2004.

27 This is a practice that continued with all subsequent Medicare and AHCA agreements; Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, July 2000, pp 34–35.

HIV/AIDS patients and the development of incentives programs including 'casemix' systems,<sup>28</sup> day surgery and early discharge programs.

2.22 The *Medicare Agreements Act 1992* contained the key principles underpinning the agreements. These Medicare Principles specified that:

- Principle 1 (Choices of Services): Eligible persons must be given the choice to receive public hospital services free of charge as public patients;<sup>29</sup>
- Principle 2 (Universality of Services): Access to public hospital services is to be on the basis of clinical need;<sup>30</sup> and
- Principle 3 (Equity in Service Provision): To the maximum practicable extent, a state will ensure the provision of public hospital services equitably to all eligible persons, regardless of their geographical location.<sup>31</sup>

### **1993–1998**

2.23 The third round of Medicare Agreements commenced from 1 July 1993. The new agreements were still based upon the three principles in the *Medicare Agreements Act 1992*, however there were some changes to the funding arrangements between the Commonwealth and the states and territories. The base grant continued to be calculated in the same way—adjusted for inflation and for weighted population growth, but two bonus payment pools were introduced to encourage improved public access.<sup>32</sup> There were also additional payments including incentives packages for reforms relating to improvements in quality and management of services.<sup>33</sup>

2.24 These 'performance-based funding' measures were countered by penalty provisions which were enforced when levels of public patient access fell below the specified base threshold.<sup>34</sup>

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28 'Casemix' is a method of classifying the number and types of patients using hospital systems. Casemix funding is when hospitals are funded on the basis of their output, rather than on the level of funding provided from the previous year. This means that such funding is on the basis of how much each jurisdiction is prepared to pay for the care and treatment the casemix not actually how much it costs to care for and treat a particular mix of patients; Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, 2000, p. 39.

29 Subsection 26(2), *Medicare Agreements Act 1992*.

30 Subsection 26(2), *Medicare Agreements Act 1992*.

31 Subsection 26(2), *Medicare Agreements Act 1992*.

32 Bonus Pool A was to be distributed to States and Territories for additional public bed-days above a benchmark proportion of 51.5 per cent of total bed-days. Bonus Pool B was to be distributed to States and Territories that increased their share of public bed-days over the public share in 1990-91; Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, 2000.

33 Senate Community Affairs References Committee, *First Report: Public Hospital Funding and Options for Reform*, 11 July 2000, pp 35–37.

34 Senate Community Affairs References Committee, *First Report: Public Hospital Funding and Options for Reform*, 11 July 2000, pp 35–37.

## Australian Health Care Agreements

### 1998–2003

2.25 The development of Australian Health Care Agreements (AHCAs) in 1998 were characterised by acrimonious disputes between the Commonwealth and the states and territories over the scope of the agreements.

2.26 Despite the fact that the AHCAs largely re-stated the Medicare Principles, the AHCAs were seen as a significant departure from the Medicare Agreements in that they encompassed greater scope for altering future funding levels and enabled flexibility in service provision. They also included a stronger focus on the provision of equitable access to public hospital services regardless of geographic location.<sup>35</sup>

2.27 In contrast to the Medicare Agreements, variations to AHCAs base grant were made on the basis of a weighted population index, changes in hospital output costs, changes in the veteran population and private health insurance coverage.<sup>36</sup>

2.28 Controversially, the agreements included a new provision which enabled grants of financial assistance to be made by the Commonwealth, to entities other than a State, such as a hospital or 'other person'.<sup>37</sup> The extension of the Minister's power to make grants to 'other persons' was seen at the time as a 'considerable departure from traditional and current arrangements'.<sup>38</sup>

### 2003–2008

2.29 The negotiations for the AHCAs for 2003–2008 were characterised by fraught negotiations between the Commonwealth and the States and Territories that included a walk-out by the states over funding arrangements.<sup>39</sup>

2.30 Preliminary negotiations at COAG in April 2002 Health Ministers established nine expert reference groups, to provide advice and recommendations on specific areas, such as the interaction between hospital funding and private health insurance, which would inform the process of negotiation for the new AHCAs. Notably, these reference groups were co-chaired by a non-government clinical expert and a senior

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35 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, July 2000, p. 37; P. Mackey, *Health Care (Appropriation) Bill 1998, Bills Digest*, 1998 <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;orderBy=customrank;page=0;query=health%20care%20appropriation%20Bill%201998%20mackey;rec=1;resCount=Default> (accessed 5 April 2016).

36 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform*, 11 July 2000.

37 This meant that the funding was no longer composed of only 'direct' funding to the states and territories but also indirect funding; P. Mackey, *Health Care (Appropriation) Bill 1998, Bills Digest*, 1998.

38 P. Mackey, *Health Care (Appropriation) Bill 1998, Bills Digest*, 1998.

39 PM, *COAG Walkout* – Transcript [www.abc.net.au/pm/content/2003/s935154.htm](http://www.abc.net.au/pm/content/2003/s935154.htm) (accessed 6 April 2016); House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007: Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007.

government official. Unfortunately input from the reference groups ultimately had little substantive impact on the new agreements which were signed in August 2003.<sup>40</sup>

2.31 An important condition of the new AHCA was that each State and Territory had to increase funding so that the growth in the States' and Territories' own funding for hospitals would match the cumulative rate of growth in Commonwealth funding over the five year life of the agreements.<sup>41</sup>

2.32 The Commonwealth contributed an estimated \$42 billion during the life of the 2003–08 agreements whilst the states collectively contributed about \$58 billion.<sup>42</sup> However, in contrast to previous agreements, about 4 per cent of AHCA payments to the states and territories were conditional on the states complying with various accountability requirements.<sup>43</sup>

2.33 The increased emphasis on accountability went further with the new AHCA requiring the Commonwealth to publish an annual report, *The state of our public hospitals*, which 'considers how the states...are performing in the delivery of public hospital services and records their expenditure on public hospitals.'<sup>44</sup>

## **Development of the Intergovernmental Agreement**

### ***National Health and Hospitals Reform Commission***

2.34 The National Health and Hospitals Reform Commission (NHHRC) was established in early 2008 to provide advice on progressing health reform.

2.35 Its reports consistently gave strong support for the use of activity-based funding:

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40 Stephen J Duckett, *The Australian Health Care Agreements 2003-2008*, Australia and New Zealand Health Policy, 2004, p. 2; House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007): Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007.

41 House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007): Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007, p. 3; House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding*, November 2006, p. 20.

42 House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007): Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007, p. 2.

43 House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007): Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007, p. 20.

44 House of Representatives Standing Committee on Health and Ageing, *Review of Auditor-General's Report No. 19 (2006-2007) : Administration of State and Territory Compliance with the Australian Health Care Agreements*, August 2007, p. 3; see also Minister's foreword, Department of Health and Ageing, *The state of our public hospitals, June 2006 report*, Commonwealth of Australia, 2006, p. iii.

...as the principal mode of funding for both public and private hospitals, where the level of funding is linked to the volume of services hospitals provide using casemix classifications.<sup>45</sup>

2.36 The NHHRC also argued that activity based funding would provide a 'powerful incentive' for hospitals to perform as efficiently as possible.<sup>46</sup>

2.37 In its first report, *Beyond the Blame Game* (April 2008), the NHHRC provided advice to inform the negotiations around the Australian Health Care Agreements. The report took a long-term view of the health system, identifying key health challenges, developing performance indicators and benchmarks and a set of design and governance principles to underpin the health system of the future.<sup>47</sup>

2.38 The Final Report: *A Healthier Future For All Australians* (June 2009), built on the previous reports, making 123 recommendations and identifying three reform goals:

1. Tackling major access and equity issues that affect health outcomes for people now;
2. Redesigning our health system so that it is better positioned to respond to emerging challenges; and
3. Creating an agile and self-improving health system for long-term sustainability.<sup>48</sup>

### ***Intergovernmental Agreement on Federal Financial Relations***

2.39 In 2007 the Rudd Government announced its intention to progress through COAG a range of reforms affecting intergovernmental financial arrangements. When COAG met in December 2007, it:

Recognised that there was a unique opportunity for Commonwealth-State cooperation, to end the blame game and buck passing, and to take major steps forward for the Australian community.<sup>49</sup>

2.40 Following much negotiation, the *Intergovernmental Agreement on Federal Financial Relations* (IGA) was signed in November 2008. The IGA aimed to:

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45 National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Interim Report*, December 2008, [www.health.gov.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/\\$File/NHHRC.pdf](http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/NHHRC.pdf), p. 23, (accessed 6 April 2016).

46 National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Interim Report*, December 2008, p. 23.

47 National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Final Report*, Introduction, June 2009, [www.health.gov.au/internet/nhhrc/publishing.nsf/content/1AFDEAF1FB76A1D8CA257600000B5BE2/\\$File/INTRODUCTION.pdf](http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/1AFDEAF1FB76A1D8CA257600000B5BE2/$File/INTRODUCTION.pdf) (accessed 6 April 2016).

48 National Health and Hospitals Reform Commission, *A Healthier Future For All Australians – Final Report*, Recommendations, June 2009.

49 Council of Australian Governments, *Communique*, Melbourne, 20 December 2007.

...improve the quality and effectiveness of government services by reducing Commonwealth prescription, aligning payments with the achievement of outcomes and/or outputs and giving States the flexibility to determine how to achieve those outcomes efficiently and effectively.<sup>50</sup>

2.41 As part of this new COAG reform agenda, a program of major health reform was agreed, including targeting elective surgery waiting times, aged care, public dental programs and preventative health.<sup>51</sup> Additionally, from 1 July 2012 the National Healthcare SPP was to be replaced by National Health Reform (NHR) funding, which would be subject to the terms and conditions agreed in the NHRA.

### ***National Healthcare Agreement***

2.42 Within the IGA the health sector was covered by the *National Healthcare Agreement* (NHA)<sup>52</sup> which detailed the objectives, outcomes, outputs and performance indicators, and clarified the roles and responsibilities of the Commonwealth and the states and territories in the delivery of health services.<sup>53</sup>

2.43 The respective roles and responsibilities of the different tiers of government were classified into three distinct categories:

...those shared by the Commonwealth with the states and territories; those for which the states and territories were solely responsible; and those for which the Commonwealth alone would be responsible.<sup>54</sup>

2.44 The NHA also set out the key principles for the provision of a range of jointly funded health services. National objectives in prevention, primary and community care, hospitals, aged care, social inclusion and indigenous health, sustainability and the patient experience were agreed.

2.45 The IGA committed the Commonwealth to provide funding of \$60.5 billion over five years to the States and Territories to deliver health services. This included:

- the introduction of a more generous indexation formula of 7.3 per cent per annum;
- an additional \$750 million to relieve pressure on public hospital emergency departments;
- an increase to the SPP base of \$4.8 billion over the forward estimates; and
- a package of reforms under the new hospitals and health workforce reform National Partnerships of \$1.7 billion, including a \$1.1 billion health workforce package.<sup>55</sup>

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50 Council of Australian Governments, *The Federal Financial Relations Framework*, [www.coag.gov.au/the\\_federal\\_financial\\_relations\\_framework](http://www.coag.gov.au/the_federal_financial_relations_framework) (accessed 6 April 2016).

51 Council of Australian Governments, *Communique*, Melbourne, 20 December 2007.

52 Council of Australian Governments, *The Federal Financial Relations Framework*.

53 Council of Australian Governments, *The Federal Financial Relations Framework*; Council of Australian Governments, *National Healthcare Agreement 2012*.

54 Council of Australian Governments, *National Healthcare Agreement 2012*.

2.46 The NHAs also put into effect activity based funding (ABF) which had been agreed to by COAG in November 2005:

The Commonwealth and the States have also agreed to provide a basis for more efficient use of taxpayer funding of hospitals, and for increased transparency in the use of those funds through the introduction of Activity Based Funding. It will also allow comparisons of efficiency across public hospitals.<sup>56</sup>

2.47 While the states and territories were not be able to redistribute Commonwealth health funding from one sector to another, neither the IGA or NHA specified any conditions in respect of how States or Territories allocated their own funding within sectors.<sup>57</sup> This was in contrast to the previous series of AHCA's.<sup>58</sup>

### ***National Partnerships***

2.48 The IGA also established National Partnership Payments (NPPs) which were underpinned by National Partnership Agreements (NPAs). The NPPs encompassed defined payments for defined periods that could only be used for specific projects/priority areas as detailed in the agreements.<sup>59</sup>

2.49 While the NHA set the broad policy and funding framework, NPPs were structured to drive more specific health outcomes such as those relating to Hospitals and Health Workforce Reform, Preventative Health, Public Hospitals and Indigenous Health. In later years they also expanded to cover health infrastructure, mental health, public dental services, vaccines and other health services such as bowel cancer screening, kids' health checks and antimicrobial surveillance.<sup>60</sup>

55 Council of Australian Governments, *Communique*, Canberra, 29 November 2008.

56 Council of Australian Governments, *Communique*, Canberra, 29 November 2008.

57 Council of Australian Governments, *Intergovernmental Agreement on Federal Financial Relations*, 2008, [www.federalfinancialrelations.gov.au/content/intergovernmental\\_agreements.aspx](http://www.federalfinancialrelations.gov.au/content/intergovernmental_agreements.aspx) (accessed 6 April 2016).

58 Council of Australian Governments, *Intergovernmental Agreement on Federal Financial Relations*, 2008.

59 Under the Intergovernmental Agreement on Federal Financial Relations, National Partnership payments to the States are facilitated by the following types of agreements:

- National Partnerships, which support the delivery of specified projects, facilitate reforms or reward those jurisdictions that deliver on nationally significant reforms;
- Implementation Plans, which are not required for all National Partnerships, but may be required where there are jurisdictional differences in context or approach to implementation, or where information additional to the National Partnership is required to increase accountability and transparency; and
- Project Agreements, which are a simpler form of National Partnership, used for low value and/or low risk projects.

Council of Federal Financial Relations, *Agreements*, [www.federalfinancialrelations.gov.au/content/npa/default.aspx](http://www.federalfinancialrelations.gov.au/content/npa/default.aspx) (accessed 6 April 2016).

60 Council of Australian Governments, *Communique*, Canberra, 29 November 2008.

### ***The National Health and Hospitals Network Agreement***

2.50 The National Health and Hospitals Network Agreement (NHHNA) was signed on 20 April 2010 by all states and territories apart from Western Australia.<sup>61</sup>

2.51 The NHHNA was structured so as to establish:

- the Commonwealth as:
  - the majority funder of public hospital services...
- Local Hospital Networks (LHNs) with responsibility for the management of hospitals within their networks...
- the states as:
  - responsible for system-wide public hospital service planning, policy and performance (in conjunction with LHNs) and capital planning...<sup>62</sup>

2.52 As the majority funder of public hospital services under the NHHNA, the Commonwealth agreed to fund 60 per cent of the national 'efficient price' for hospital services, as well as guaranteeing \$15.6 billion in top up funding over 5 years.<sup>63</sup>

2.53 However, in 2010 the NHHNA arrangements were superseded and under the Gillard Government negotiations began for a National Health Reform Agreement. Although the funding arrangement has changed it was expected that various components of the NHHNA, such as the establishment of Local Hospital Networks would be retained under any new agreement.

### **National Health Reform Agreement**

2.54 The *National Health Reform Agreement* (NHRA) was signed in August 2011. It implemented the National Health Reforms as agreed by COAG in February 2011 under a *Heads of Agreement on National Health Reform*. It also complemented the NHA and included the parties':

...commitments in relation to public hospital funding, public and private hospital performance reporting...<sup>64</sup>

2.55 The provisions of the NHRA were enacted by the *National Health Reform Act 2011*. The NHRA was created with the aim of delivering a nationally unified and locally controlled health system through:

- Introducing a number of financial arrangements for the Commonwealth and states and territories in partnership

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61 R de Boer & J Tomaras, *Bills Digest- National Health and Hospitals Network Bill 2010*, 2011, p. 4; R deBoer & R.Webb, *Bills Digest – Federal Financial Arrangements Amendment (National Health and Hospitals Network) Bill*, 2010, p. 3.

62 R deBoer & R.Webb, *Bills Digest – Federal Financial Arrangements Amendment (National Health and Hospitals Network) Bill*, 2010.

63 R deBoer & R.Webb, *Bills Digest – Federal Financial Arrangements Amendment (National Health and Hospitals Network) Bill*, 2010.

64 Council of Australian Governments, *National Healthcare Agreement 2012*.

- Confirming state and territories' lead role in public health and as system managers for public hospital services
- Improving patient access to services and public hospital efficiency through the use of activity based funding (ABF) based on a national efficient price
- Ensuring the sustainability of funding for public hospitals by the Commonwealth providing a share of the efficient growth in public hospital services
- Improving the transparency of public hospital funding through a National Health Funding Pool
- Improving local accountability and responsiveness to the needs of communities through the establishment of local hospital networks (LHNs) and Medicare locals
- New national performance standards and better outcomes for hospital patients.<sup>65</sup>

2.56 As part of the NHRA several initiatives forecasted as part of the NHHNA were implemented. This included the establishment of Local Hospital Networks to deliver decentralised and specialised hospital services across jurisdictions and work with Medicare Locals to deliver integrated care.<sup>66</sup>

2.57 Under the NHRA Commonwealth funding would be delivered via the following arrangements:

- on the basis of activity based payments where practicable, however block funding<sup>67</sup> and public health funding<sup>68</sup> will continue where applicable;<sup>69</sup>
- 45 per cent of efficient growth<sup>70</sup> of activity based services would be funded by the Commonwealth from July 2014 whilst 50 per cent would be funded from 1 July 2017;<sup>71</sup>

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65 Administrator, National Health Funding Pool, *National Health Reform Agreement summary*, [www.publichospitalfunding.gov.au/national-health-reform/agreement](http://www.publichospitalfunding.gov.au/national-health-reform/agreement), (accessed 11 March 2016).

66 Council of Australian Governments, *National Health Reform Agreement 2011, Schedule D*.

67 Block funding is for teaching and research and to fund small and regional hospitals.

68 Public health funding is paid by the Commonwealth to the states and territories for population health activities.

69 Clause A2, *National Health Reform Agreement 2011*.

70 Efficient growth consists of : a) the national efficient price for any changes in the volume of service provided; and b) the growth in the national efficient price of providing the existing volume of services; Council of Australian Governments, *National Health Reform Agreement 2011*.

71 Clause A3, *National Health Reform Agreement 2011*.

- 45 per cent of growth in the efficient cost<sup>72</sup> of block grants would be funded by the Commonwealth from July 2014 whilst 50 per cent would be funded from 1 July 2017;<sup>73</sup>
- an additional \$16.4 billion in Commonwealth funding would be provided through the revised funding arrangements between 2014-15 and 2019-20. This is in addition to what would have been provided through the National Healthcare SPP;<sup>74</sup> and
- Commonwealth funding would be dependent upon the provision of data by the state and territories to the National Bodies including data on the provision of services to patients; public or private status of the patient, the nature of the service provided and where the service was provided.<sup>75</sup>

2.58 The following National Bodies were established under the NHRA to administer key financial arrangements:

- The Administrator of the National Health Funding Pool—its role is to administer the National Health Funding Pool, to oversee payments into and out of the state pool account for each state and territory, and to report on various funding and service delivery matters.<sup>76</sup>
- National Health Funding Body (NHFB)—its primary function is to assist the Administrator of the National Health Funding Pool (the Administrator) in enabling and supporting more transparent and efficient public hospital funding and reporting.<sup>77</sup>
- Independent Hospital Pricing Authority (IHPA)—its role is to implement Activity Based Funding for Australian public hospital services by delivering an annual National Efficient Price (NEP).<sup>78</sup>

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72 'Efficient cost will be determined annually by the Independent Hospital Pricing Authority, taking account of changes in utilisation, the scope of service provided and the cost of those services to ensure the LHN has the appropriate capacity to deliver the relevant block funded services and functions', Clause A4, *National Health Reform Agreement 2011*.

73 Clause A4, *National Health Reform Agreement 2011*.

74 Clause A5, *National Health Reform Agreement 2011*.

75 The requirements are articulated in Schedule B of the *National Health Reform Agreement 2011*; also see Clause A8, *National Health Reform Agreement 2011*.

76 Administrator of the National Health Funding Pool, *The Role of the Administrator*, [www.publichospitalfunding.gov.au/administrator](http://www.publichospitalfunding.gov.au/administrator) (accessed 8 April 2016).

77 National Health Funding Body, *Welcome from the CEO*, [www.nhfb.gov.au/](http://www.nhfb.gov.au/) (accessed 8 April 2016).

78 The NEP is a major determinant of the level of Australian Commonwealth Government funding for public hospital services and provides a price signal or benchmark for the efficient cost of providing public hospital services. Independent Hospital Pricing Authority, *What we Do*, [www.ihoa.gov.au/what-we-do](http://www.ihoa.gov.au/what-we-do) (accessed 8 April 2016).

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- National Health Performance Authority (NHPA)—its role is to monitor and report on the performance of public and private hospitals, primary health care organisations and other bodies that provide health care services to the community.<sup>79</sup>
  - Australian Commission on Safety and Quality in Health Care (ACSQHC)—its primary function is to lead and coordinate national improvements in safety and quality in health care.<sup>80</sup>

2.59 The funding from Commonwealth and state and territory governments under the NHRA is paid into a NHFP (administered by the NHFPA). Each state and territory also has a separate fund (known as its state managed fund) for receiving Commonwealth NHR block funding via the NHFP, receiving block funding directly from the state or territory itself, and for making payments of block funding by the state or territory to LHNs.<sup>81</sup> Figure 1 below illustrates how the funding between the Commonwealth and the states and territories flows.<sup>82</sup>

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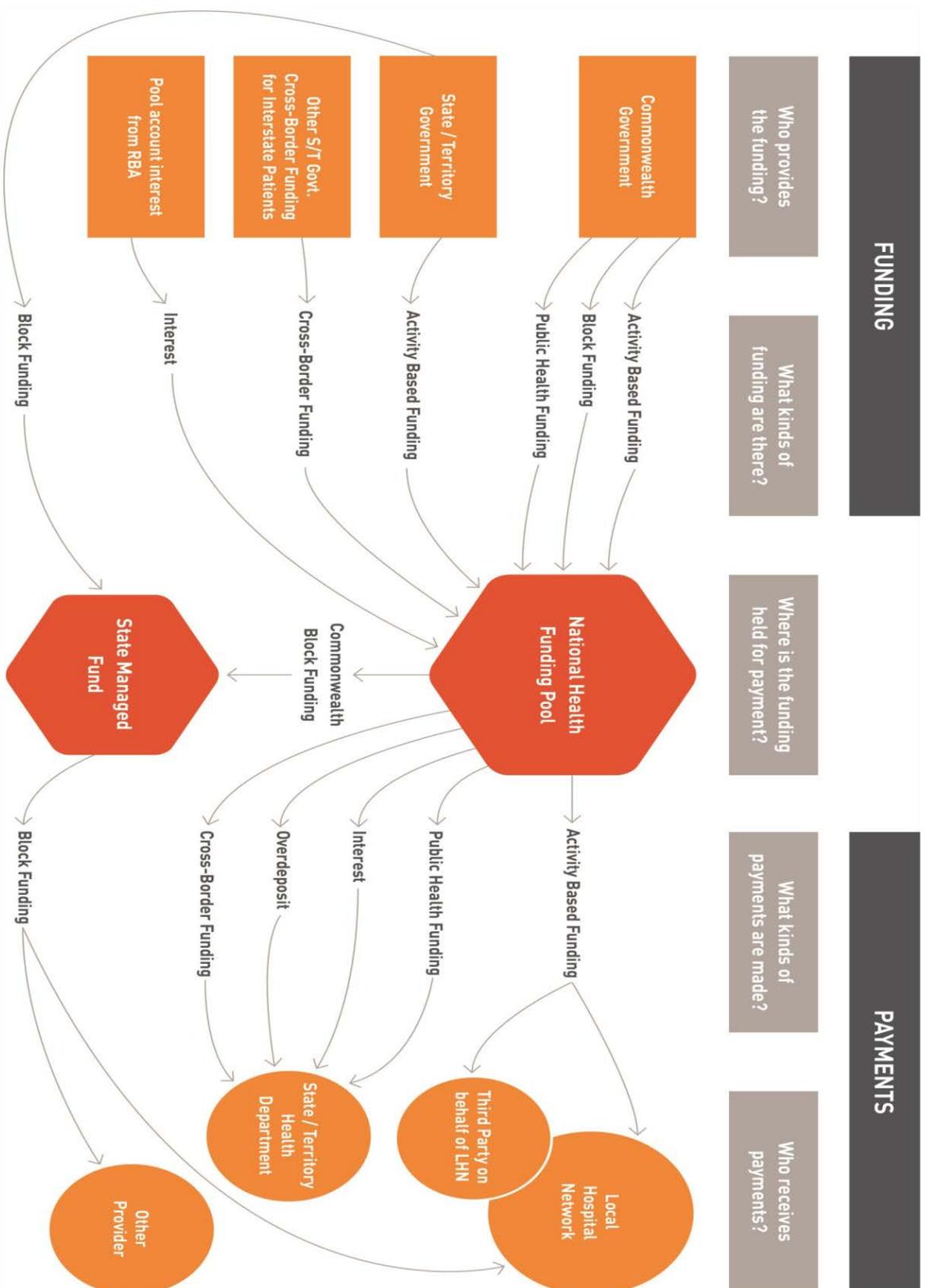
79 National Health Performance Authority, *About Us*, [www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/About-us](http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/About-us) (accessed 8 April 2016).

80 Australian Commission on Safety and Quality in Health Care, *Governance*, [www.safetyandquality.gov.au/about-us/governance/](http://www.safetyandquality.gov.au/about-us/governance/) (accessed 8 April 2016).

81 Administrator, National Health Funding Pool, *National Health Reform funding flows*, [www.publichospitalfunding.gov.au/national-health-reform/funding-flows](http://www.publichospitalfunding.gov.au/national-health-reform/funding-flows) (accessed 11 March 2016).

82 Administrator, National Health Funding Pool, *National Health Reform funding flows*.

**Figure 1—National Health Reform funding flows**



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## **Committee view**

2.60 The signing of the NHRA by the states and federal governments in 2011 was an historic point for hospital funding in Australia. This was the first time that hospital funding arrangements were mutually agreed and set out for the longer-term. It was also the first time that a mechanism had been created that encouraged cooperation, through aligned incentives, between the states and federal government to ensure that funding was used efficiently.

2.61 Long-term certainty of funding for Australia's hospitals was a significant casualty of the disastrous 2014-15 Budget. Chapter 3 examines the impact that the 2014-15 Budget decision has had on hospital funding, while the remaining chapters of this report detail the effect on individual states and territories.

2.62 The Senate Select Committee on Health's examination of the issues around hospital funding, through its extensive hearings and the submissions received, has been relatively brief in comparison to the work which went into the National Health and Hospitals Reform Commission in 2008. The NHHRC's work was comprehensive, and laid the foundation for the NHRA; it mapped a way forward to end the 'blame game' between the states and federal governments on hospital funding.

2.63 However, the committee notes that the same issues that were identified by the NHHRC are coming to the fore since the 2014-15 Budget decision. The following chapters demonstrate that with one decision in the 2014-15 Budget, the Coalition Government has put hospital funding back ten years, to face the same issues all over again.

