The Senate

Finance and Public Administration References Committee

Implementation of the National Health Reform Agreement

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43rd Parliament

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Recommendation 1

4.19 The committee recommends that as a matter of urgency, the Commonwealth reinstate funding to states and territories cut retrospectively for the years 2011–12 and 2012–13 that were announced with the release of the MYEFO in October 2012.

Recommendation 2

4.20 The committee recommends that the Commonwealth immediately withdraw its threat to penalise Victorian taxpayers in order to refund the cuts to hospitals it instituted late last year.

Recommendation 3

4.21 The committee recommends at the Commonwealth immediately desist from attempts to bypass existing arrangements and the National Health Funding Pool to fund hospitals directly, as this will simply lead to additional compliance burdens for public hospitals, likely leading to a diversion of resources from patients.

Recommendation 4

4.22 The committee recommends that the Commonwealth commit to not undertaking retrospective funding cuts of this nature in the future. It is inevitable that any so-called funding adjustments for past years will have a substantial impact on patients as it is impossible to effectively reduce treatment levels when health services have already been performed.

Recommendation 5

4.23 The committee recommends that whenever an intercensal error is uncovered by the work of the Australian Bureau of Statistics, the Commonwealth should ensure:

a) that no rearrangement of payments or cuts are made until the final calculation and application of this error is completed (for example, when it is applied over multiple census periods as in the current instance); and

b) intercensal error recalculations should not be used to seek effective reimbursement for the Commonwealth where services have already been provided and there is no capacity for the state to seek refunds for their provision.

Recommendation 6

4.24 The committee recommends that consideration be given to a further inquiry into the Total Health Price Index formula, including its composition, calculation and application to funding of public hospitals.

Chapter 1

Terms of Reference

1.1 On 7 February 2013, the Senate referred the following matters to the Finance and Public Administration References Committee (the committee) for 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.[1]

Conduct of the inquiry

1.2 The inquiry was advertised through the Internet. The committee invited submissions from interested organisations and individuals, and government bodies.

1.3 The committee received 59 submissions. A list of individuals and organisations which made public submissions to the inquiry is at Appendix 1. The committee held one public hearing in Melbourne on 21 February 2013. A list of the witnesses who gave evidence at the public hearing is available at Appendix 2.

1.4 Submissions, additional information and the Hansard transcript of evidence may be accessed through the committee's website at www.aph.gov.au/senate_fpa.

Structure of the report

1.5 The committee's report for this inquiry is quite brief, given the limited time it had to consider the issues involved. Changes to the funding of public hospitals as a result of the 2012–13 Mid-Year Economic and Fiscal Outlook (MYEFO) are addressed in chapter 2, along with the reasons for the changes and how the changes were implemented.

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1 *Journals of the Senate*¸ No. 132, 7 February 2013, pp. 3594–3595.

1.6 Chapter 3 provides a summary of the evidence that the committee received on the impacts of the funding cuts and canvasses issues for sub-acute and palliative care services. The committee's conclusions and recommendations are presented in chapter 4.

Acknowledgment

1.7 The committee would like to particularly acknowledge and convey its appreciation to those organisations and individuals who, within a very short timeframe, provided submissions and gave evidence at the public hearing.

Chapter 2

Changes to the funding of public hospitals

Introduction

2.1 Public hospital funding has been an ongoing source of debate over the last decade. The Commonwealth and the states and territories have entered into various agreements to pursue reforms to increase the efficiency of the public hospital sector.

2.2 The Commonwealth plays a critical role as a significant funder of Australia's health system. In the hospital sector its funding role is significantly the result of the extreme levels of vertical fiscal imbalance that have been longstanding in our federation. For many years this has made the states dependent on Commonwealth funds to support the public hospitals which form a core part of the national Medicare scheme.

2.3 However, the funding cuts implemented by the Commonwealth during the 2012–13 financial year and announced along with the 2012–13 Mid-Year Economic and Fiscal Outlook (MYEFO) update call into question the commitment of the Commonwealth to the provision of a stable and viable public hospital sector.

2.4 The following outlines the current arrangements for public hospital funding and examines changes to the 2011–12 National Healthcare Special Purpose Payment (SPP) and the updating of funding estimates for 2012–13 to 2015–16 at the 2012–13 MYEFO.

Public hospital funding arrangements

2.5 The roles of the Commonwealth and state and territory governments in relation to health services are the subject of agreements of all governments. (A detailed explanation of the funding arrangements is provided in Appendix 3.) The states and territories are the managers of the public hospital system. The *Intergovernmental Agreement on Federal Financial Relations* (IGA) and the National Health Reform Agreement (NHRA) outline conditions for calculation of Commonwealth funding to the states.

2.6 The National Healthcare SPP arrangements were agreed to by COAG in March 2008. 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 SPP funding of $500 million per annum.[1]

2.7 In November 2008, COAG agreed to a range of reforms to the Commonwealth's financial arrangements with the States through the IGA including a major rationalisation of the number of payments to the states for specific purposes. Under the IGA, a new National Healthcare SPP was created and Commonwealth

1 Department of Health and Ageing and the Treasury, *Submission 55*, pp 3, 9.

funding of public hospital services was provided through the National Healthcare SPP from 1 July 2009.[2]

2.8 The IGA provided for the growth factor for the National Healthcare SPP. The growth factor is defined as the product of:

- a health-specific cost index (Australian Institute of Health and Welfare price index);
- the growth in population estimates weighted for hospital utilisation; and
- a technology factor fixed at 1.2 per cent (the Productivity Commission-derived index of technology growth).[3]

2.9 In August 2011, COAG signed the National Health Reform Agreement (NHRA). One of the major objectives of the NHRA is to improve transparency of public hospital funding through the establishment of the National Health Funding Pool. The Independent Hospital Pricing Authority (IHPA) has also been established. The IHPA provides the National Efficient Price Determination which is used as the basis of activity based funding from 1 July 2012.[4]

2.10 The Commonwealth noted that the first two years of the new NHRA funding arrangement (2012–13 and 2013–14) are transitional, in part to allow the newly established national health agencies to fully take up their statutory responsibilities. In the 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 Special Purpose Payment (SPP). The Commonwealth noted that the SPP indexation arrangements will continue to apply.[5]

2.11 In its submission, the NSW Government noted that in signing up to the NHRA the states understood that no state would be worse off in the short or long term, as the states would continue to 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 Agreement on Improving Hospital Services.[6]

2.12 Commonwealth growth funding to the states based on growth in activity and efficient cost commences from 2014–15. From 1 July 2014, the Commonwealth will fund 45 per cent of the efficient growth in 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.[7]

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2 Department of Health and Ageing and the Treasury, *Submission 55*, p. 9.

3 Commonwealth Government, *Budget Paper No 3, 2009–10*, p. 30; Department of Health and Ageing and the Treasury, *Submission 55*, p. 14.

4 Department of Health and Ageing and the Treasury, *Submission 55*, pp 5, 10, 21.

5 Department of Health and Ageing and the Treasury, *Submission 55*, pp 5–6.

6 New South Wales Government, *Submission 53*, p. 4.

7 Department of Health and Ageing and the Treasury, *Submission 55*, pp 5–6, 10–11.

Funding under the National Healthcare SPP for 2011–12

2.13 The Commonwealth makes advance payments through the relevant year to the states and territories for hospital services. The National SPP payments are finalised by the Commonwealth Treasury as at 30 June of the payment year, as required under the IGA. A determination is then signed by the Commonwealth Treasurer. The timing of this was designed so that Commonwealth involvement would not affect State hospital operating costs which are allocated in budgets for the start of financial years. The Commonwealth noted that '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'. Balancing adjustments are made when final indexation parameter values are known and the determination made.[8]

2.14 The Government's revision of the 2011–12 National Healthcare SPP was made in October 2012. This determined that the final 2011–12 National Healthcare SPP to be $12,548.12 million. The states and territories were informed that the outcome reflected an overpayment of $149.7 million of National Healthcare SPP payments in that financial year as a result of the indexation parameters used in the Treasurer's determination.[9]

2.15 As these amounts had already been transferred to the states and territories, and indeed the health services already provided, the Commonwealth sought to recoup the payments during the remainder of the 2012–13 financial year by implementing cuts which were to take immediate effect.

2.16 Across the states and territories, the amount of the cuts varied.

Table 2.1 National Health Reform funding – November 2012 Treasurer's determination cuts for 2011–12

$ million	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
2011–12	48.90	39.71	40.15	6.34	10.96	1.95	0.60	1.05	**149.67**

Source: Victorian Government, *Submission 54,* p. 4.

Changes to funding made at the 2012–13 MYEFO

2.17 As noted by the Victorian Government, the indexation of the National Healthcare SPP takes a year-on-year approach so that the change to the parameter values used in the Treasurer's determination of 2012 has on-going implications for funding over the forward estimates. The Commonwealth updated the NHRA funding estimates for 2012–13 to 2015–16 at the 2012–13 MYEFO published in October 2012.[10]

8 Department of Health and Ageing and the Treasury, *Submission 55*, p. 14.

9 Department of Health and Ageing and the Treasury, *Submission 55,* p. 15.

10 Victorian Government, *Submission 54,* p. 7.

2.18 In the Government's October MYEFO Overview, it was explained:

> To return the budget to surplus in 2012-13 and beyond, the Government has made substantial targeted savings, ensuring that Australia's public finances remain strong.[11]

2.19 The Government however, attempts to claim these cuts to the states for health were not savings measures. During his MYEFO announcement press conference Treasurer Wayne Swan explained the cuts as follows:

> There's been no cut at all and in fact states are continuing to receive very generous increases in terms of funding in health and education but the calculation of the latest indexation method done on an agreed formula, signed and sealed in the agreements, has produced in this year a lesser flow of money in some areas and nothing whatsoever to do with Government decision-making.[12]

2.20 Whatever you call it, the retrospective nature of these funding cuts meant the Government was taking back money it had not only allocated, but already transferred to the states and which had already been spent to deliver hospital services.

2.21 The extent of the Commonwealth funding cuts on a state by state basis can be seen by comparing the 2012–13 Budget and MYEFO figures. The full impact is shown in Table 2.2 below.

11 Mid-Year Economic and Fiscal Outlook, 2012–13, p. 1.

12 The Hon Wayne Swann, MP, Treasurer, Transcript, *MYEFO Press Conference*, 22 October 2012.

Table 2.2: Comparison of National Health Reform Funding – Budget 2012–13 and MYEFO Cuts 2012–13
(MYEFO 2012–13 figures highlighted)

$million	**NSW**	**VIC**	**QLD**	**WA**	**SA**	**TAS**	**ACT**	**NT**	**Total**	***Downwards revision***
2012–13	4,381	3,322	2,724	1,407	1,028	298	204	153	13,518	
2012–13	4,291	3,255	2,661	1,401	1,008	294	202	151	13,264	254
2013–14	4,608	3,584	2,929	1,522	1,041	319	234	146	14,383	
2013–14	4,464	3,484	2,840	1,530	1,010	312	233	142	14,014	369
2014–15	5,080	3,961	3,268	1,691	1,157	349	268	170	15,944	
2014–15	4,913	3,840	3,174	1,720	1,122	338	269	162	15,537	407
2015–16	5,590	4,373	3,635	1,876	1,282	382	306	195	17,639	
2015–16	5,399	4,226	3,539	1,928	1,242	367	309	183	17,192	447

The efficient growth funding component of National Health Reform funding in 2014–15 and 2015–16 is indicative only. The distribution of efficient growth funding will be determined by efficient growth in each State.

Source: Commonwealth Government, Budget Paper No. 3, 2012–13, p. 22, Table 2.1: Total payments for specific purposes by category, 2011–12 to 2015–16; MYEFO 2012–13, p. 74, Table 3.23: Payments for specific purposes by function, 2012–13 to 2015–16.

2.22 The total Commonwealth cuts at the 2012–13 MYEFO over the forward estimates to 2015–16 will increase from $254 million in 2012–13 to $447 million in 2015–16. In total, the Commonwealth will cut back payments to the states and territories by $1,477 million over the forward estimates.

Total Commonwealth cuts to funding for the states and territories for 2012–13

2.23 With the finalisation of the 2011–12 determination and the 2012–13 MYEFO, the Commonwealth commenced adjustments to the 2012–13 National Health Reform payments, that is, incorporating both the updated 2012–13 National Health Reform funding profile for the year, and recouping of the overpayments made under the National Healthcare SPP in 2011–12. These adjustments were made from December 2012.

2.24 The full impact from December 2012 to the end of the financial year in June 2013 can be seen in the following table.

Table 2.3 National Health Reform Funding – downwards revision of payments from December 2012 to June 2013

$million	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
	138.76	106.80	103.43	12.29	30.97	6.10	1.84	3.26	**403.48**

Source: Victorian Government, *Submission 54,* p. 4.

2.25 The reduction of Commonwealth payments into the National Funding Pool amounted to $57.57 million per month with Commonwealth payments into the Pool. For the Victorian Government, for example, the payments were reduced by $15.3 million per month.[13] This equates to 2 per cent of health services budgets in Victoria over the second half of the 2012–13 financial year.[14]

Changes to parameter values used in Treasurer's determination

2.26 As noted above, the growth factor for hospital funding is calculated using three factors. The technology factor is fixed at 1.2 per cent. However, the other two factors – the health-specific cost index and the growth in population estimates weighted for hospital utilisation – vary over time. It is the variation in these two factors for the Treasurer's 2012 determination which has resulted in the revision of payments to the states and territories.

Population growth estimates

2.27 The Victorian Government stated that 'at the heart of the matter is the calculation of Australia's population growth rate between 31 December 2010 and 31 December 2011'.[15] The committee concurs with this view.

13 Victorian Government, *Submission 54,* pp 4, 11.

14 Victorian Healthcare Association, *Submission 20,* p. 2.

15 Victorian Government, *Submission 54,* p. 8.

Calculation of population estimates

2.28 The Australian Bureau of Statistics (ABS) produces official population estimates for Australia known as Estimated Resident Population (ERP). Every five years the Census is conducted and the information collected is used to 'rebase' the ERP. To do this, adjustments are made for net undercount or overcount as determined by the Census Post Enumeration Survey. An adjustment is also made for Australians who are temporarily overseas on Census night. Between each Census, the ABS uses birth, death and the net migration outcome to calculate the ERP using the most recent Census as the 'base'. The difference between the original estimate and the rebased estimate is the 'intercensal error'.[16]

2.29 Following the 2011 Census, the ABS identified intercensal errors where the ERP of Australia was determined to be around 300,000 people less than estimates based on the 2006 Census trajectory. The intercensal error was more than three times greater, indeed the largest error ever seen, than the previous intercensal error.[17] The ABS indicated that the size of the error was primarily the result of changes to the ABS methodology used to calculate the undercount adjustment.[18] The results are shown in Table 2.4.

Table 2.4: ABS preliminary intercensal error by number and percentage of total population for the 2006–2011 period for Australia, states and territories[19]

	Intercensal Error '000	**Intercensal Error** %
New South Wales	90.7	1.3
Victoria	87.0	1.6
Queensland	106.2	2.4
South Australia	18.1	1.1
Western Australia	-2.9	-0.1
Tasmania	-0.7	-0.1
Northern Territory	-1.0	-0.4
Australian Capital Territory	-2.1	-0.6
Australia(b)	**294.4**	**1.3**

(a) A positive number indicates that unrebased ERP as at 30 June 2011 was higher than rebased ERP. A negative number indicates it was lower than rebased ERP.
(b) Includes Other Territories

2.30 The ABS applied the conventional treatment for intercensal errors following the 2011 Census, that is spreading the error through the 2006–2011 period. The

16 Australian Bureau of Statistics, *Submission 25*, pp 1–2.

17 Ms Gemma Van Halderen, Australian Bureau of Statistics, *Committee Hansard*, 21 February 2013, p. 39.

18 Australian Bureau of Statistics, *Submission 25*, pp 3–4.

19 ABS Feature Article, *Preliminary rebasing of Australia's population estimates using the 2011 census of population and housing,* 3101.0 Australian Demographic Statistics, December 2011.

preliminary 2011 Census rebased ERP estimates were released on 20 June 2012. It resulted in a downward revision of population growth over the 2006–2011 period from 1.8 per cent (average annual growth) to 1.5 per cent.[20]

2.31 However, given the size of the intercensal error, and following extensive consultation, the ABS stated that it intends to revise historical population data over a 20 year period from 1991 to 2011, to ensure population growth in recent years reflects population components of births, deaths and migration. The ABS noted although a preliminary rebasing was released on 20 June 2012, the final rebasing would be released on 20 June 2013 which:

> …will therefore ensure that Australia's official population estimates not only reflect the best possible estimate of how many people we have in Australia today, but also our best estimate of how many people there were in our recent past.[21]

Use of the population estimate in the Treasurer's determination

2.32 The Commonwealth's release of the 2012–13 MYEFO claimed that as a result of the 2011 Census, population estimates have been revised down and that as a result there is a need to adjust the Commonwealth funding for the NHR:

> Following the results of the most recent 2011 Census, population estimates have been revised down for 2011 and in previous years dating back to the last Census in 2006. Therefore, an adjustment is necessary to correctly assess the appropriate health funding for Australia's population under the terms agreed to by all States and the Commonwealth, given overstated population growth in previous years.[22]

2.33 However, of critical importance to the growth in population used in the Treasurer's determination is which population estimate at December 2010 and December 2011 are used. When determining the population at December 2011, the results of the 2011 Census (adjusted for the large intercensal error) were used for the first time, while the December 2010 population estimate was based on the 2006 Census as adjusted by the ABS. As a consequence, the growth rate used in the Treasurer's determination was 0.03 per cent.

2.34 The Department of Health and Ageing described this as a 'correction' to the growth rate:

> …essentially, the growth in population has actually been too high over a number of years. What we now have is a correction by the ABS. Under the

20 Australian Bureau of Statistics, *Submission 25*, p. 3.

21 Australian Bureau of Statistics, *Submission 25*, p. 4; see also Ms Gemma Van Halderen, Australian Bureau of Statistics, *Committee Hansard*, 21 February 2013, p. 38.

22 Mid-Year Economic and Fiscal Outlook, 2012–13, p. 75.

> methodology contained in the agreement, this is reflected in the numbers as has been promulgated to the states.[23]

2.35 Submitters however suggested that the method used was 'erroneous' and 'extraordinary'.[24] The Queensland Government noted 'using a mix of 2006 and 2011 Census-based data produces population growth estimates that suggest that four states (NSW, Victoria, Queensland and South Australia) experienced a fall in population and that total Australian population growth between 2010–11 and 2011–12 was only 7,311 or 0.03%'.[25] The Queensland Government concluded:

> …the estimate of population growth applied by the Federal Government is based on two incompatible sources, is inconsistent with advice from the ABS, and is simply not credible.[26]

2.36 The Australian Medical Association (Victoria) also commented that the population data had been incorrectly applied resulting in a population growth in Victoria for this period being significantly underestimated.[27]

2.37 The NSW Government indicated that the actual growth rate for NSW was expected to be 1.5 per cent.[28] Victoria commented that the Commonwealth suggested that its population fell by 11,111 when it grew by 1.4 per cent or 75,000 people.[29]

2.38 The Commonwealth Treasury's use of population data needs to be further examined. There is evidence that the Commonwealth Treasurer used different population growth rates for the same period in two separate agreements with the Victorian Government pointing to a significant anomaly in growth rates for local government funding and the National Healthcare SPP. The national population at 31 December 2011 was provided by the ABS as being 22,482,217 persons. The Victorian Government commented that:

- in finalising Local Government funding, a population figure of 22,179,728 for December 2010, provided by the Australian Statistician, was used with population growth therefore being 1.4 per cent over the period December 2010 to December 2011; and

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23 Ms Jane Halton, Secretary, Department of Health and Ageing, *Committee Hansard*, 21 February 2013, p. 56; see also Department of Health and Ageing and the Treasury, *Submission 55*, p. 15.

24 Professor Stephen Duckett, *Submission 2*, Supplementary Submission, p. 1; Dr John Deeble, *Submission 26*, p.6; see also The Hon. David Davis MLC, Minister for Health, Victoria, *Committee Hansard*, 21 February 2012, pp 43, 45.

25 Queensland Government, *Submission 10*, p. 2.

26 Queensland Government, *Submission 10*, p. 2.

27 Australian Medical Association (Victoria), *Submission 11*, p. 1.

28 Dr Rohan Hammett, NSW Department of Health, *Committee Hansard*, 21 February 2012, p. 15.

29 The Hon. David Davis MLC, Minister for Health, Victoria, *Committee Hansard*, 21 February 2012, p. 43.

- in finalising the National Healthcare SPP, a population figure of 22,474,906 for December 2010 provided by the Australian Statistician was used with population growth therefore being 0.03 per cent over the period December 2010 to December 2011.[30]

2.36 When questioned, Treasury officials responded that the basis on which the population for both agreements was determined is consistent:

> For the latest year, it involves the numerator—utilising the latest available data from the statistician—being put over the denominator, the population number as determined for the previous year. In the case of the calculations that were made for the healthcare SPP and for the local government funding, the denominator was based on the 2006-based prior census data, not the 2011 data—they are consistent. The latest available population data based on the 2011 census was utilised for the estimate made for the 2012–13 year. Indeed, when we determine our forward estimates for health care, SPP and so on, we of course use the latest data. The estimates under both are calculated on a consistent basis. The final determinations are made on a similar basis.[31]

2.39 The Victorian Government also noted that in April 2011, the (then) Ministerial Council on Federal Financial Relations agreed that all National SPPs would be indexed using the 'latest available growth factor data'. The Treasurer's determination and any subsequent residual adjustment would be based on the most recent growth factor data 'available at 30 June of the payment year' and no further residual adjustments would be made to capture any revisions to data after that time.[32] The Victorian Government argued that the figures for the estimate of residential population grown between December 2010 and December 2011 did not incorporate the 'latest available' data supplied to the Commonwealth by the Australian Statistician.[33]

2.40 A further concern brought to the committee's attention was the lack of transparency in the basis for the weights of hospitals utilisation used to calculate the population estimates for growth purposes. The NSW Government noted:

> It would also be desirable to have information on the basis for the weights for hospital utilisation used to calculate the population estimates for growth purposes. Although the Commonwealth has not made available any information on its calculation of population weights, it is understood the weights are developed by the Department of Health and Ageing for the ABS based on the National Hospital Cost Data Collection, and it is understood that the specific contribution of hospital utilisation weights in

30 Victorian Government, *Submission 54*, pp 2, 8.

31 Mr Peter Robinson, Treasury, *Committee Hansard*, 21 February 2013, p. 56.

32 Victorian Government, *Submission 54*, pp 7–8; see also New South Wales Government, *Submission 53*, p. 5.

33 Victorian Government, *Submission 54*, p. 11.

> 2011-12 was about half that used in the prior two years. However, no information has been provided to States on the rationale for this reduction.[34]

Total Health Price Index

2.41 The Total Health Price Index (THPI) is produced by the Australian Institute of Health and Welfare (AIHW).[35] The THPI uses 14 areas of health expenditure and each is automatically weighted in accord with the expenditure composition of total health expenditure. In 2010–11, for example, public hospital services accounted for 29.9 per cent of total health expenditure.[36] The Treasury uses a five-year rolling average of the THPI in its calculations to smooth out any year-to-year volatility.

Table 2.5: Total Health Price Index

%	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
THPI	2.8	3.8	3.2	3.7	4	3.5	2.3	2.3	2.4	0.9
5 year average	–	–	–	–	3.5	3.64	3.34	3.16	2.9	2.28

Source: Australian Healthcare and Hospitals Association, Submission 15, p. 3.

2.42 The growth in the THPI in 2010–11 was 0.9 per cent. The AIHW noted that the lower Government Final Consumption Expenditure (GFCE) on hospitals and nursing homes deflator had a significant effect on the THPI growth in 2010–11. The lower inflation in this area was largely as a result of reductions in the price of medical and surgical equipment (up to 20 per cent) following increases in the value of the Australian dollar.[37] The Department of Health and Ageing and the Treasury added that the 'significantly lower growth in this independently-derived index for 2010–11 has driven down the five-year average of the index' to 2.27 per cent and which had previously been hovering around 3 per cent.

2.43 It was also stated that the lower THPI was a significant factor in the adjustments made to the NHR funding:

> 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

34 New South Wales Government, *Submission 53*, p. 5.

35 See Australian Institute of Health and Welfare, *Submission 52*, p. 1 for an explanation of how THPI growth is calculated.

36 Australian Institute of Health and Welfare, *Submission 52*, p. 1.

37 Australian Institute of Health and Welfare, *Submission 52*, p. 2.

> indexes become available in June, the estimates will be further adjusted – up or down based on movements in the indexes.[38]

2.44 While it was acknowledged by submitters that the health price index used by the Commonwealth is based on the formula set out in the IGA, it was argued that the index is no longer appropriate and does not reflect the true impact on public hospitals of cost changes.[39]

2.45 First, it was argued that the THPI is not hospital-specific. Dr John Deeble noted that the THPI is a combination of nine separate indexes weighted for their importance in nation health expenditure. He argued that the THPI was 'too influenced by conditions in other parts of the health care industry'. As the NHRA relates entirely to hospitals, the hospital-specific index would be a better measure for the agreement's purposes. He also noted that the THPI increases have been consistently lower from 2005–06 that the hospital-specific index. Dr Deeble concluded:

> The Commonwealth's inclusion of the lower-cost Total Health Cost Index in the 2011 agreement and its current reliance on that cannot be defended on other than short term grounds.[40]

2.46 The NSW and Victorian Governments also noted that the THPI is made up of different components such as Medicare medical services fees, capital expenditure, and household expenditure on chemist goods and dental services. These have little, if any, bearing on public hospital recurrent expenditure.[41] The lower THPI for 2010–11 has been due to the impact of Australian dollar appreciation, which has led to a 20 per cent reduction in expenditure on medical supplies and a 1.5 per cent reduction in pharmaceutical expenditure. On the other hand, wage costs which account for a significant portion of public hospital expenditure (up to 70 per cent of overall expenditure) have been growing by at least 2.5 per cent per year.[42]

2.47 There are also more hospital-specific data sets available which better reflect the costs of hospital services. The Victorian Government noted that one of those data sets is the National Health Cost Data Collection which indicates an escalation of costs of over five per cent. The Victorian Government concluded:

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38 Department of Health and Ageing and the Treasury, *Submission 55,* pp 15–16.

39 See for example, Mr Martin Laverty, Catholic Health Australia, *Committee Hansard*, 21 February 2013, p. 17.

40 Dr John Deeble, *Submission 26,* pp 7–9; see also Dr John Deeble, *Committee Hansard*, 21 February 2013, p. 53.

41 Mr Peter Fitzgerald, Department of Health, Victoria, *Committee Hansard*, 21 February 2013, p. 46.

42 New South Wales Government, *Submission 53*, p. 6; see also Victorian Healthcare Association, *Submission 20*, pp 3–4.

> The public hospital component of the AIHW total health costs indexation was about 1.4 per cent. So the difference is quite remarkable: one says 1.4 per cent, the other says five point something per cent.[43]

2.48 Submitters also noted that the outcome was not consistent with the Independent Hospital Pricing Authority's 5.1 per cent indexation of hospital costs in its 2012–13 National Efficient Price determination, and the health price inflation factor used for Private Health Insurance indexation has grown by over 5 per cent for each of the past three years.[44] Catholic Health Australia indicated that these two figures related more closely to its experience in the cost of delivering healthcare services.[45]

2.49 The NSW Department of Health put the view that previously the National Healthcare SPP allowed the states to use the funding across the entire health sector, including for capital purposes, and a broad based measure of inflation such as the AIHW index was appropriate. However, it was argued that this is no longer the case: the NHR funding is limited to the public hospital services as defined by the IHPA and excludes capital funding. NSW concluded that it is therefore no longer appropriate to index NHR payments by the THPI which applies more broadly to all forms of health expenditure, and does not provide sufficiently for the largest cost and cost pressures in hospitals, that is staff costs.[46]

Timing and implementation of the Commonwealth cuts

2.50 As noted above, the Commonwealth sought both to clawback payments for the 2011–12 financial year and to implement lower monthly payments to the states as a result of the MYEFO adjustments from December 2012 to June 2013.

2.51 The Commonwealth in its evidence argued that it sought to ease the impact of the changes by spreading the adjustments over the seven remaining months of the 2012–13 financial year when the IGA allowed it to seek full redress of the overpayments in the next payment, that is December 2012. It was stated that '[the Commonwealth] have gone as far…as we could in terms of the legislative basis that we have for making adjustments'.[47]

2.52 This is a nonsense proposition. This was the largest clawback of such payments, if the Commonwealth has implemented these cuts immediately, this would have led to even greater trauma for patients, staff and managers of public hospitals.

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43 Mr Peter Fitzgerald, Department of Health, Victoria, *Committee Hansard*, 21 February 2013, p. 46.

44 Victorian Government, *Submission 54*, p. 10; Australian Nursing Federation (Victorian Branch), *Submission 5*, p. 7; New South Wales Government, *Submission 53*, p. 6; Mr Martin Laverty, Catholic Health Australia, *Committee Hansard*, 21 February 2013, p. 17.

45 Mr Martin Laverty, Catholic Health Australia, *Committee Hansard*, 21 February 2013, p. 19.

46 New South Wales Government, *Submission 53*, p. 6; see also Dr Mary Foley, Department of Health, NSW, *Committee Hansard*, 21 February 2013, p. 14.

47 Mr Peter Robinson, Treasury, *Committee Hansard*, 21 February 2013, p. 57.

2.53 Submitters argued that the December 2012 Commonwealth cuts imposed an enormous burden on the delivery of health services from the middle of the financial year when budgets had already been planned and services already provided. In particular, there was widespread criticism of the retrospective aspect of the changes, with the Australian Medical Association, for example, stating:

> Added to the current under-funding, the adjustments for population estimates and the health cost index are being applied retrospectively, i.e. to services that have already been provided to patients and to money that has already been spent…Reductions applied retrospectively provide no scope for hospitals to systematically assess and plan how best to apply such reductions to the most sensible cost areas. Such reductions can take little account, if any, of the possible effects on the quality of outcomes.[48]

2.54 Catholic Health Australia also commented:

> The timing of the decision to reduce the Commonwealth's contribution to national public hospital spending by $254 million in 2012/13 has adversely impacted hospital service planning. Whilst no hospital group is likely to ever welcome reductions in funding as demand for services continues to grow, the way that the funding reductions have been imposed part way through a financial year has been particularly difficult to deal with and has magnified their impact. The requirement that this funding cut for a full year needs to be found over the remaining six months of this year multiplies the impact of the cuts.[49]

2.55 The problems caused by the implementation of the Commonwealth's cuts have been particularly felt in Victoria, where there is well established Local Hospital Network (LHN) management regime in place. The decentralisation of governance arrangements means that boards of health services set their budget for each upcoming financial year on the basis of the estimated flow of revenue and expenses. The impacts are explored in more detail in chapter 3.

2.56 The Victorian Healthcare Association commented that the short notice of the cuts placed health service boards and CEOs in Victoria under unique and significant pressure to manage the reductions at the local level. The Victorian Hospitals' Industrial Association suggested that the reductions would be difficult to achieve within the timeframe with the result that substantial budget deficits will be experienced across the system in the 2012–13 financial year.[50]

2.57 In Queensland, the impact of cuts of a similar scale have taken slightly longer to be felt at the local level. It was indicated that the reductions will be effective from February 2013. In the Queensland Minister for Health's submission he explained the impact of the February cuts:

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48 Australian Medical Association, *Submission 22*, p. 2; see also Australian Medical Association (Victoria), *Submission 11*, p. 2.

49 Catholic Health Australia, *Submission 21*, p. 3.

50 Victorian Hospitals' Industrial Association, *Submission 19*, p. 2.

> This gives Hospital and Health Services no more than five months to plan for, and implement, these significant budget reductions.[51]

2.58 Additionally, as the Queensland hospital sector already has in place significant efficiency targets, the Minister for Health stated that there is 'limited scope to meet cuts of this magnitude through further improvements in efficiency'. Rather, services and staffing levels will decrease.[52]

2.59 Of particular concern was that as the majority of hospital expenditure is in the form of labour costs, staffing levels will be the prime target when immediate and significant cost reductions are required.[53]

2.60 Due to the timing of the cuts imposed by the Commonwealth – almost halfway through the financial year, health services effectively had no time to adjust their budgets: by the time the cuts were announced, budgets had been prepared and health services were spending against them. Professor David Hayward concluded that:

> …by requiring the health services to manage cuts half way through the financial year, the Federal government effectively doubled the real impact of the funding reduction; for it is of course much easier to manage a given budget cut over 12 months than it is over 6.[54]

2.61 The Australian Nursing Federation (Victorian Branch) further explained the impact retrospective cuts had on the current day-to-day operational costs of hospitals:

> …the federal cut has been imposed mid-way through the financial year. By announcing them almost halfway through the financial year, the Federal Government effectively required the health services to manage cuts worth double the nominal amount.[55]

This is exacerbated by the fact that some of the cuts are for the previous financial year, compounding this impact.

2.62 Health Program Director at the Grattan Institute, Professor Stephen Duckett, argued that there were a number of options open to the Commonwealth, which would have improved the management and implementation of the cuts, and restricted the operational impact. This included:

- the Commonwealth phasing the cuts in over a period of time;
- a negotiation period could have been allowed for the States to discuss options for managing the cuts with the Commonwealth;
- the Commonwealth providing a greater lead time for the cuts to allow the states more time to manage their impact;

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51 Queensland Government, *Submission 10*, p. 1.

52 Queensland Government, *Submission 10*, p. 1.

53 Australian Healthcare and Hospitals Association, *Submission 15*, p. 3.

54 Australian Nursing Federation (Victorian Branch), *Submission 5*, Attachment, p. 6.

55 Australian Nursing Federation (Victorian Branch), *Submission 5*, p. 5.

- the Commonwealth consulting publicly on the preferred way to manage the funding cuts; and
- the Commonwealth offsetting the cuts against funding increases in the next year financial year.[56]

Commonwealth backflip on funding for Victorian hospitals

2.63 On 21 February, the day of the committee's public hearing in Melbourne, the Commonwealth Minister for Health, the Hon Tanya Plibersek MP, announced a so-called 'hospital rescue package' for Victoria.[57]

2.64 It was announced the Commonwealth funding will be paid directly to Local Hospital Networks in Victoria rather than through the Victorian Treasury. The Minister stated that the direct funding would bypass the Baillieu Government.

2.65 The Victorian Minister for Health commented on the arrangements for the repayments:

> It is quite clear that the Commonwealth has sought to undermine the pool that it advocated for, and it is a very strange decision—that is the only way you can describe it. The payment direct will set up another layer of administrative machinery to make payments.
>
> …The Commonwealth are now saying they are going to establish another layer of bureaucracy to send payments out in that way. I think this is a very unusual step. It undermines the Commonwealth's own intent. I think Victorian patients will appreciate the additional money. You have said to put aside the shuffling of sources. If we do that for the moment, the funding that comes through will assist Victorian patients. That is why the Victorian government had been so determined to publicly make clear that these cuts were going to have an impact on our patients.
>
> …The state is determined to put as much as it can into health. That is what we have done. We have put up health spending by $1.3 billion in the last two years. The idea that you would do these sorts of shuffles—I do not know really what the Commonwealth is actually thinking on this. I think they have not thought through the consequences of this fully. They have not thought through the fact that it undermines the administrator; it undermines the national pool approach. If you want that transparency, this seems to me to be the exact opposite of the way you would be heading.[58]

2.66 The Commonwealth at the eleventh hour has said they will reimburse the cuts they made but it was clear from witness testimony they have no clear plan for how it will be done. It was clear that an announcement had been made by the Government

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56 Professor Stephen Duckett, *Submission2,* p. 2; see also Australian Health Care Reform Alliance, *Submission 19,* p. 2.

57 The Hon. Tanya Plibersek MP, Minister for Health, 'Victorian hospital rescue package helps patients', *Media Release,* 21 February 2013.

58 The Hon. David Davis MLC, Minister for Health, Victoria, *Committee Hansard,* 21 February 2013, p. 51.

but no planning for implementation had been established. This was apparent by evidence provided by the Department of Health and Ageing to the committee:

> CHAIR (Senator Ryan): Are there discussions underway with hospital boards around memoranda of understanding or contracts that will be required? I assume you are not just going to turn up with a cheque, although I am sure the minister would turn up with a cheque and a camera. I assume there is going to be something more substantial to the relationship that has now been established between the Commonwealth and hospitals?
>
> Ms Flanagan: That is correct. We will start very soon to discuss with CEOs and LHNs how this is going to roll out.
>
> CHAIR: Do you plan to discuss with each CEO and each chairperson of the board as a collective? Is it going to be collective bargaining here or is it going to be individual?
>
> Ms Flanagan: We do not have that level of detail but I would just note here that, certainly, contact will be made. We have not yet decided on the form of that, but it will commence very soon.[59]

2.67 Furthermore, when questioned about payment conditions, and structures around reinstated Commonwealth payments, the Commonwealth seemed equally unsure about a method or timeframe:

> CHAIR (Senator Ryan):…Will the Commonwealth be using this payment to set conditions—apart from a general condition that this is to be used in health services or to reinstate services that hospital services announced they were cutting due to the Commonwealth cuts—around how it is spent, whether it is used for acute care, outpatients, treatment of particular conditions, elective surgery or ED? Will the Commonwealth be seeking to put conditions on the way hospital services spend the money?
>
> Ms Flanagan: The way we are going to do this is not yet fully formed.[60]

2.68 It is obvious that this announcement was a last-minute political fix without a thoroughly considered approach to payments, terms, negotiations, compliance or impact upon the national reforms including the Health Funding Pool, designed by the Commonwealth to ensure accountability and efficiency.

> CHAIR (Senator Ryan): And the point I made, Ms Halton, is that there is no detail around the implementation of that yet because the questions I have asked about the detailed implementation cannot be answered. But I accept that is not your issue, with an announcement that was made by the minister at seven o'clock last night.
>
> Ms Flanagan: One of the most important things, though, is that it is clear what amounts are going to be reinstated for each and every LHN. At least, they know that and they can start to do their planning around that now.[61]

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59 Ms Kerry Flanagan, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 21 February 2013, p. 66.

60 Ms Kerry Flanagan, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 21 February 2013, p. 66.

2.69 Furthermore, LHNs are now facing the additional burden of administering reinstated Commonwealth funding, outside of the agreed funding models and implementation methods. The high cost of restarting things after they had been shut down was noted by the Victorian Healthcare Association:

> Even with the money flowing back into Victoria, as announced overnight, that stop-start activity is something that still has a detriment and which generally leads to a higher cost to restart than when it is part of the normal business process.[62]

The impact of uncertainty

2.70 Problems with long-term planning in the hospital sector as a result of the Commonwealth cuts were also raised by the Victorian Hospitals' Industrial Association:

> The nature of hospital forward planning is such that, any change to these financial arrangements part way through a budget year, cannot be made without significant cost or other detrimental implications. For example, each year new Junior Medical staff appointments and clinical rotations commence in February however budget planning and a commitment to these positions must be made in the final quarter of the preceding year. Further, surgical rosters and surgical activity are planned in advance for the coming year based on performance volumes and targets.[63]

2.71 Witnesses said the unpredictable nature of the Commonwealth's behaviour made it difficult for them to plan hospital budgets in the future. The uncertainty created by the Commonwealth and the importance of funding certainty was highlighted by the Queensland Minister for Health:

> [A]ll we ask for is certainty in planning and if we cannot give our HHS certainties, they are going to have to make quite dramatic draconian decisions. What we are trying to do as a state funder of health is to tell them this year what they are likely to receive and next year what they are likely to receive, so they can set up for that. It becomes a real problem when one of the major funders—the Commonwealth—comes in and says, 'We are going to make a decision to reduce funding for previous years retrospectively, based on rebased figures,' that does not have any flattening and does not give them any time to adjust. We do not argue that everyone has financial challenges. We argue that we need far greater and better certainty around planning and that is the only way that we can deal with

61 Ms Kerry Flanagan, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 21 February 2013, p. 66.

62 Mr Trevor Carr, Chief Executive Officer, Victorian Healthcare Association, *Committee Hansard*, 21 February 2013, p. 30.

63 Victorian Hospitals' Industrial Association, *Submission 17*, p. 2.

> these sorts of things. Otherwise, we have a dramatic and brutal impact on our health system, which we have now.[64]

2.72 The Commonwealth is behaving entirely inconsistently and unfairly given that Victorian patients have allegedly been relieved of the impact of retrospective cuts, while patients in other states will be forced to bear them. The Commonwealth has refused to commit to reinstate funding to other states which have also suffered retrospective cuts. In a Press Conference at Casey Hospital on the day of this Committee's public hearing in Melbourne, Federal Minister for Health, the Hon Tanya Plibersek:

> Question: So are you saying that you will restore funding to other states as a result of this funding calculation for this financial year via a direct funding arrangement to hospitals?
>
> Tanya Plibersek: We've said that we are open to doing that. And I have to be very clear. This is money that is not coming from the Federal Government to the Government of Victoria. This is money that would have been paid to their Treasury. One example is a $55 million payment that the Victorian Government was eligible for if they got their occupational health and safety laws in line with other states. It is part of reward funding for a seamless national economy national partnership…And if we have to do that in other states we're open to it. But it's a redirection of their state funding to their hospital services. It is not endangering…
>
> Question: But when will you be making a decision about that? You say that you're open to it. Does that mean that you will do it?
>
> Tanya Plibersek: No. Open to it means that I might do it if the circumstances demand it.[65]

2.73 This uncertainty was particularly recognised by New South Wales Health Department officials. Dr Mary Foley, Director-General, New South Wales Department of Health, said:

> In New South Wales, the state Treasury has maintained our level of funding, in keeping with the service agreements and new funding model we implemented on 1 July last year. However, in terms of formulating next year's budget, the fact that there is less than we were originally expecting when planning these next years, as we move to 2014–15, has a significant impact in how we plan for our system. Perhaps even more importantly, we find—as we highlight in our submission—that the uncertainty around the ongoing funding arrangements for the national partnership agreements is also a critical factor.[66]

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64 The Hon. Lawrence Springborg MP, Minister for Health, Queensland, *Committee Hansard*, 21 February 2013, p. 27.

65 *Transcript*, Casey Hospital – Health Funding, 21 February 2013, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/tr-yr13-tp-tpsp20130221.htm?OpenDocument&yr=2013&mth=02

66 Dr Mary Foley, Director-General, Department of Health, New South Wales, *Committee Hansard*, 21 February 2013, p. 12.

2.74 Furthermore, Commonwealth Department of Health and Ageing officials were not able to outline the Commonwealth's position in relation to future funding arrangements:

> Senator DI NATALE: You do not think it undermines the idea of a national funding pool if the Commonwealth government is essentially writing cheques to providers that are otherwise dealt with through the national funding pool?
>
> Ms Flanagan: This is a one-off deal for one state for part of one year to fix up an issue. It does not in any way or shape undermine national health reform. It is a one-off.
>
> Senator DI NATALE: So there is a guarantee that there will be no further payments made to other states who are in a similar position?
>
> Ms Halton: Senator, you are asking us something which is a matter of government policy, so we cannot comment. [67]

67 Ms Jane Halton, Secretary and Ms Kerry Flanagan, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 21 February 2013, p. 67.

Chapter 3

The impact of Commonwealth funding cuts on patient care and services

3.1 The cuts to Commonwealth Government funding for public hospitals in some states have had significant adverse effects on hospital services and patient care. The cuts have had an immediate impact in Victoria while in other states the funding cuts will take effect later this financial year.

3.2 In New South Wales, the Director General of the Department of Health, Dr Mary Foley, explained that the State Government was forced to reallocate funding from within State resources in order to cover the effect of the Commonwealth cuts:

> Senator McEWEN: Dr Foley, I want to go back to your earlier evidence. The New South Wales government was able to absorb the reduction in funding arising from the implementation of MYEFO?
>
> Dr Foley: Yes, it has done that.
>
> Senator McEWEN: From within the Health budget or across–
>
> Dr Foley: No, it is not from within the Health budget. It is from Treasury and out of the whole of government.[1]

3.3 In Queensland, as explained in chapter two, the Commonwealth cuts will be effective in the February 2013 budgets and provided Hospitals and Health Services no more than five months to plan for and implement the budget reductions.

3.4 In the case of Victoria, the decentralised Local Hospital Network (LHN) structure resulted in the Commonwealth's funding cuts impacting hospitals sooner and more directly than other states.[2]

3.5 The Victorian Health Minister, the Hon. David Davis MLC, informed the committee that each health service was asked to work through, with its board, its clinicians and its staff, how it would manage this Commonwealth cut in its funding.[3]

3.6 The committee also heard that the Victorian governance arrangements are being used as the model for future national governance arrangements under the NHR

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1 Dr Mary Foley, Director General, Department of Health, New South Wales, *Committee Hansard,* 21 February 2013, p. 14.

2 Mr Andrew McAuliffe, Australian Health and Hospitals Association, *Committee Hansard,* 21 February 2013, p. 34; see also Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard,* 21 February 2013, p. 32.

3 The Hon. David Davis MLC, Minister for Health, Victoria, *Committee Hansard,* 21 February 2013, p. 50.

and as a result, hospitals in other states will also feel the impact of funding cuts more directly and quickly in the future, as Victorian hospitals felt today.[4]

3.7 Thus, the immediate impact of the Commonwealth cuts on the Victorian public hospital sector provided the committee with direct evidence of the effects these cuts will have on other jurisdictions over the longer term.

Direct and immediate impacts on the availability of services

3.8 The Australian Health and Hospitals Association described the impacts of Commonwealth cuts on health services:

> These impacts are both direct, in the form of bed closures, cancelled surgery, service reductions and ongoing suffering for patients; and indirect in the form of the stress of the uncertainty of access for potential clients anticipating a need to access services in the future and the flow on effects of staffing reductions on workforce and community morale.[5]

3.9 The committee received specific examples from state governments and healthcare providers:

- *Bed closures*
  - up to 559 bed closures (both rural and metropolitan) announced in Victoria since the Commonwealth funding adjustment;[6]
  - 50 bed closures in Catholic Health Australia hospitals; [7]
- *Elective surgery*
  - reduction in elective surgery in Victoria (800 cases at Austin Health, 1800 cases at Southern Health, 1300 at Western Health, and a 25 per cent reduction at Southwest Healthcare Warrnambool);[8]
  - the Victorian Healthcare Association estimated that the worst case scenario for Victoria is that waiting lists to rise as high as 65,000, far higher than those prescribed by the Commonwealth under the National Elective Surgery Target;[9]

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4 Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard,* 21 February 2013, p. 34.

5 Australian Healthcare and Hospitals Association, *Submission 15,* p. 2.

6 Australian Nursing Federation (Victorian Branch), *Submission 5,* p. 4; see also Australian Medical Association (Victoria) Limited, *Submission 11,* p. 1; Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard,* 21 February 2013, p. 30.

7 Catholic Health Australia, *Submission 21,* p. 3.

8 Australian Nursing Federation (Victorian Branch), *Submission 5,* p. 5.

9 Victorian Healthcare Association, *Submission 20,* p. 2.

- reduction in elective surgery in Queensland;[10]

- *Reduction in services*
  - proposed closure of inpatient services in Moura, Central Queensland;[11]
  - closure of Colac Area Health Urgent Care between 10 pm and 7 am;[12]
  - since December substantial cuts to health services in Victoria include extensions of existing theatre closures, additional theatre closures, and impacts on community in-patient and outpatient mental health services.[13]

3.10 Reduction in staffing levels was a primary concern raised by witnesses with Catholic Health Australia reporting that the Commonwealth cuts would lead to staff level cuts in its hospitals.[14] Catholic Health Australia and other witnesses also pointed to uncertainty of employment for staff as a major factor following the funding cuts:

> Then there are the health professionals within our organisation—their employment arrangements becoming uncertain. That uncertainty exists today. There will be staff arriving in our hospitals today who yesterday thought cuts were coming; today they will be somewhat relieved that cuts are not coming, but then they will realise that in just a few months those cuts will need to be dealt with. This is an uncertain time for healthcare planning and administration. It is not the way in which, ideally, you would be managing your health services.[15]

3.11 Across all health services, the way in which the cuts were imposed midway through the financial year, and the consequent difficulties of incorporating those cuts in already established budgets and plans for services, was raised as a significant concern.[16]

3.12 The Queensland Minister for Health, The Hon. Lawrence Springborg, described the impact as 'brutal' and 'dramatic' because adjusting for something

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10 The Hon. Lawrence Springborg MP, Minster for Health, Queensland, *Committee Hansard,* 21 February 2013, p. 23.

11 Central Queensland Rural Division of General Practice Assn. Inc., *Submission 6,* p. 1.

12 Colac Area Health, *Submission 12,* p. 4.

13 Mr Paul Gilbert, Australian Nursing Federation (Victorian Branch), *Committee Hansard,* 21 February 2013, p. 6.

14 Catholic Health Australia, *Submission 21,* p. 2.

15 Mr Martin Laverty, Catholic Health Australia, *Committee Hansard,* 21 February 2013, p. 19.

16 Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard,* 21 February 2013, p. 31; Professor Stephen Duckett, *Committee Hansard,* 21 February 2013, p. 4; Services for Australian Rural and Remote Allied Health, *Submission 7,* p. 3.

midway through the financial year with such a retrospective impact is 'very difficult to do'.[17]

Impacts on rural hospitals

3.13 Evidence received by the committee suggested that funding cuts could have more severe impacts on smaller rural hospitals than on larger metropolitan hospitals as smaller rural and regional hospitals have less capacity to absorb these changes in funding.[18] The impact on rural communities will be severe with the Central Queensland Rural Division of General Practice Association commenting:

> The proposed changes will mean people living in rural and remote communities have no access to overnight hospital admissions, ante-natal or post natal care, palliative care, and aged care. Surgical and obstetrics services have previously been removed from these communities, although they have been available in the past. Communities are being told it is the Commonwealth Health reform and shortfalls in Commonwealth funding that are driving the changes in hospital services.[19]

3.14 The Rural Doctors Association of Queensland (RDAQ) stated that the Queensland Treasury has contacted hospital boards advising them of the reduced budgets ($16 million for Central Queensland) as a result of the Commonwealth funding cuts. The RDAQ provided the committee examples of the specific service closures and reductions:

- Service closures and reductions in rural Queensland include outreach clinics and programs which have been assessed as non-core business including women's health clinics, frequency of visiting specialist clinics, reduction in acute bed numbers and in some areas potential closure of whole hospitals. A full review of services with stated threats to overnight admission capacity is under way at a number of sites in Central Queensland and Wide Bay regions.
- There has been a workforce wide call for voluntary redundancies which has resulted in a reduction in the medical, nursing and allied health workforce in rural areas.
- Palliative care services have seen significant reductions in rural Central Queensland.

17 The Hon. Lawrence Springborg MP, Minster for Health, Queensland, *Committee Hansard*, 21 February 2013, p. 23.

18 Services for Australian Rural and Remote Allied Health, *Submission 7*, p. 3; Rural Doctors Association of NSW Inc., *Submission 9*, p. 1; Colac Area Health, *Submission 12*, p. 8; Rural Doctors Association of Australia, *Submission 18*, p. 1.

19 Central Queensland Rural Division of General Practice Assn Inc., *Submission 6*, p. 2.

- Chronic disease units have been significantly reduced in Mackay and Central Queensland.
- Children's health services have seen significant reduction with about 100 nursing positions abolished state wide. This includes services provided to rural and regional Queensland o Central Queensland has witnessed reduced specialised clinics including childhood immunisation and wound care.[20]

3.15 Witnesses also suggested to the committee that under the reformed funding environment, there are incentives for health and hospital boards to divert activity from smaller rural hospitals to larger metropolitan centres.[21]

Indirect effects in the health system

3.16 During the inquiry the committee received evidence that, in addition to the direct impacts on patients set out above, there were a range of indirect and flow-on impacts across the whole health system as a result of the Commonwealth funding cuts. These included the need for long-term service plans to be reviewed, staff leaving because they are fearful of losing their jobs, skill loss, increased costs of restarting programs, patient churn to alternative service such as emergency departments, and increased costs arising from untreated patients re-presenting with more serious conditions.

3.17 Witnesses commented that implementing the Commonwealth cuts has led to increased pressure on other parts of the hospital system, such as emergency departments:

> When you have people waiting longer for surgery, things go wrong and you get more emergency department presentations. Hospitals were operating substantially fewer beds last year than they were the year before. Consequently, it is difficult to have patients come in to an emergency departments who require admission and there is no bed for them. That obviously impacts on things. In order to create bed space, people are being discharged earlier than they would prefer and not necessarily with the support that they need.[22]

3.18 In addition, it was suggested to the committee that there may be incentives for public hospitals to treat more private patients to bolster their budgets. Catholic Health Australia commented that the 'targeting of additional private patients by public hospitals, particularly if it is at the expense of the treatment of public patients, will

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20 Rural Doctors Association of Queensland, *Submission 16,* p. 2.

21 Dr Ewen McPhee, *Submission 1,* p. 2; Central Queensland Rural Division of General Practice Assn. Inc., *Submission 6*, p. 1.

22 Mr Paul Gilbert, Australian Nursing Federation (Victorian Branch), *Committee Hansard,* 21 February 2013, p. 8.

further exacerbate public patient waiting times and further undermine the Medicare principle of universal access to treatment at the time of need, regardless of financial circumstance'.[23]

Palliative and sub-acute care

3.19 Evidence was received by the committee relating to palliative and sub-acute care and the impact on services arising from both the current funding cuts and transition arrangements for the NHRA.

Impact of funding cuts on palliative care

3.20 Submitters argued that palliative care would be hard hit by the Commonwealth's funding cuts. The Health Services Association of New South Wales for example, stated that one large regional hospital expects to have a shortfall of $790,000 in palliative care funding. This shortfall will mean patients and their families will be denied important and valuable medical services at an extremely critical time.

3.21 Flow-on effects of the Commonwealth's cuts and the impact on palliative care were also explored. Patients will either die in acute care beds, meaning other non-palliative care patients needing these acute care beds will be denied access to them, or, the palliative care patient will die at home where their family without any medical support will be forced to care for them.[24]

3.22 Palliative Care Australia stated that many service providers are ceasing services immediately, or ceasing to admit new persons into their service. They commented that this rationing of services will mean patients will not be able to access the palliative care services they need and assessed as requiring. It will also significantly compromise the palliative care workforce.[25]

Funding gap for palliative and other sub-acute services

3.23 As well as experiencing Commonwealth funding cuts arising from December 2012, submitters pointed to the impact of the withdrawal of funding when the National Partnership Agreement on the Health and Hospitals Workforce (NPA) ceases in 2013. Under the NPA the Commonwealth provided additional funding for the implementation of a national system of activity based funding, improving the efficiency of Emergency Departments and approximately $500 million in funding for sub-acute services. This NPA includes palliative care services.

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23 Catholic Health Australia, *Submission 21*, p. 2.

24 Health Service Association of NSW, *Submission 4*, p. 1.

25 Palliative Care Australia, *Submission 24*, p. 3.

3.24 The NSW Government commented that the NPAs have provided critical funding for important health services which are core to national health service reforms.[26] Hammondcare Health and Hospitals pointed to the benefits of the additional funding:

> This NPA is highly significant because it was arguably the first real injection of new funds into the rehabilitation and palliative care sectors for decades, and allowed the opportunity to develop and implement many new and 'best practice' models of care delivery. The NPA rightly focussed on subacute care because of emerging evidence that an efficient subacute care sector was vital to the health of the acute healthcare sector, especially in terms of patient flow from acute care into subacute and community care, but also for best patient outcomes for people with life-limiting or complex illnesses, and ongoing disability.[27]

3.25 However, the NPA will cease on 30 June 2013 and submitters raised concerns about the transition from the NPA to the Activity Based Funding (ABF) model for funding for palliative care. Catholic Health Australia, which provides a large proportion – approximately half – of the nation's palliative care services, stated that there were questions about the transition to ABF and continuation of funding:

> At present the transitional arrangements to activity based funding commence in 2014–15 leave some questions about the transition from the existing national partnership agreement to the activity based funding arrangements when they commence. At risk in the coming financial year: in the state of New South Wales, 54 full-time equivalent positions in palliative care, employed state-wide, some of which are employed within Catholic facilities; in South Australia, some 30 full-time equivalent positions involved in palliative care, employed state-wide, some of which are employed in Catholic organisations. With the contracts about to end 30 June we are already starting to see within our services individual health professional choosing to leave employment because of the uncertainty about their ongoing contracts.[28]

3.26 Hammondcare Health and Hospitals stated that the transition is already causing problems for the effective delivery of rehabilitation services:

> Many of these new services will cease from July 1st 2013. Hospital administrations are already reducing the scope and caseload of these services, as staff members begin to leave seeking alternative employment.
>
> These rehabilitation services will cease not only because of a lack of ongoing funding, but also because many of the new models of care do not conform to "standard" hospital-based rehabilitation care, and so are not

26 NSW Health, *Submission 53*, p. 8.

27 Hammondcare Health and Hospitals, *Submission 23*, p. 1.

28 Mr Martin Laverty, Catholic Health Australia, *Committee Hansard*, 21 February 2013, p. 18.

> accommodated within the Activity-Based Funding models of rehabilitation care being applied across the country.[29]

3.27 Palliative Care Australia noted the impact of changes to funding on staffing retention with many staff in palliative care services looking at options to guarantee their future. This may result in a loss of many staff to overseas services or to staff leaving palliative care altogether. Palliative Care Australia provided further examples of the impact:

> The impact of such closures will be catastrophic nationally. For example:
>
> - In New South Wales, it is estimated that at least 53.95 full time equivalent (FTE) positions will cease on 30 June 2013.
> - In South Australia, indications are that in excess of 30 FTE positions will cease on 30 June 2013.[30]

3.28 Palliative Care Australia also pointed to flow-on impacts including cuts to clinics and education programs conducted with universities planned for 2013–14, compromising training of future palliative care professionals; cessation of rapid response to get patients home or to support them to stay at home, resulting in significant increases in hospitalisations; longer hospitalisations for palliative patients; reduction of social work services which support both patients and their families and carers; and unavailability of other services, such as pharmacists for example, to assist with education and support for nurses and doctors. In addition, palliative care research and trials will be at risk.[31]

3.29 The NSW Government stated that not only would community and hospital based palliative care be effected but also funding for rehabilitation services; funding to older people to leave hospital earlier – freeing up acute care beds; 69 short stay (<48 hour) Medical Assessment Unit beds treating around 17,000 patients per year; 8,300 Hospital in the Home packages and the contribution to salaries for Emergency Physicians.[32]

3.30 The NSW Government also commented that the states had unsuccessfully sought information from the Commonwealth, including through COAG, on how the services provided under the NPA would continue.[33]

3.31 In their joint submission the Treasury and Department of Health and Ageing described the NPA funding which started in 2008–09 as 'one off' funding.[34]

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29 Hammondcare Health and Hospitals, *Submission 23,* p. 1.

30 Palliative Care Australia, *Submission 24,* p. 4.

31 Palliative Care Australia, *Submission 24,* p. 6.

32 NSW Government, *Submission 53,* p. 11.

33 NSW Government, *Submission 53,* p. 11.

Committee comment

3.32 The evidence provided to the committee demonstrates the significant impacts of the Commonwealth funding cuts on public hospitals and the availability of hospital and health services. Any funding cuts of this scale would have a substantial impact, however the timing of the cuts, midway through a financial year, has exacerbated the outcome. Hospitals have had to make immediate and deep cuts in order to work within the reduced budgets over the last seven months of the current financial year.

3.33 The evidence also points to indirect effects of the cuts such as disrupted planning, problems with staff retention, loss of skills, patient churn to alternative services, such as emergency departments, and increased costs arising from untreated patients re-presenting with more serious conditions.

3.34 The committee flags some concern regarding the evidence that it has received about the potentially greater impact of the funding cuts on rural hospitals and the potential incentives to move services away from rural hospitals under the Activity Based Funding model. Due to the very short timeframe of this inquiry, the committee has not been able to investigate these matters in sufficient detail to draw any concrete conclusions. However, they do appear to be issues worthy of some attention and the committee invites the government to provide further information on those issues in its response to this inquiry.

3.35 The committee is also concerned about the uncertainty faced by the palliative and sub-acute care community working under the NPA. As witnesses have indicated to the committee a significant capacity to deliver services has been developed and is delivering services. It would be detrimental to patients if that capacity were to be lost completely or to substantially wither during a period of funding uncertainty.

3.36 While the Commonwealth Government may consider that it has made its position clear by stating that aspects of the NPA were 'one off', the evidence received by the committee demonstrates that both state governments and others in the sub-acute community do not appear to have sufficient information regarding the transitional arrangements.

3.37 The committee considers that the Commonwealth must make clear to providers the funding arrangements during the transition period to ensure that these critically needed services continue to be available to those who require them.

34 Department of Health and Ageing and Treasury; *Submission 55,* p. 22.

Chapter 4

Conclusions and recommendations

4.1 Public hospitals are a crucial part of the delivery of health services in Australia. The need to ensure an efficient and sustainable public hospital sector has been central to the reforms negotiated by the Council of Australian Governments. The Commonwealth plays a critical role, primarily through conditional funding arrangements.

4.2 However, the new outcomes under the NHRA are still 18 months away. What the committee has been examining is the cut to Commonwealth funding for public hospitals in the last seven months of the 2012–13 financial year. This funding cut has arisen because in 2011–12 funding to the states and territories was provided through National Healthcare Special Purpose Payments (SPP). The committee considers that the basis on which the calculation of the funding cuts has been made is flawed.

4.3 The growth in funding under the National Healthcare SPP is determined by the Commonwealth Treasurer based on three factors: population growth; a health-specific cost index; and a fixed technology factor. Changes to population growth and the health-specific cost index are the basis of the Commonwealth's cuts to public hospital funding.

4.4 The Australian Bureau of Statistics (ABS) provided the committee with evidence about changes to the methodology used to ensure the Census provides the most accurate estimate of the Australian population. The new methodology applied to the 2011 Census data resulted in the population at December 2011 being nearly 300,000 people less than had previously been estimated (the 'intercensal error'). The ABS also provided the committee with evidence that the intercensal error was large: in fact, three times larger than the previous largest error. Further, that around 84 per cent of the error can be directly attributed to the change in methodology. As a consequence, the ABS has decided to back-cast the population estimates from 1991 to 2011.

4.5 The committee agrees that the best possible estimate of Australia's population should be used in coming to a population growth figure. However, the committee does not consider that the Commonwealth's calculation of the population growth between December 2010 and December 2011 is defendable: it has compared Census figures derived where two different methodologies for ensuring the accuracy of the Census have been used and come up with a growth rate of only 0.03 per cent for the Treasurer's determination. It used the December 2010 population estimate based on the 2006 Census and the December 2011 derived from the 2011 Census taking into account the large intercensal error.

4.6 The Commonwealth has acknowledged that the majority of the cuts to the funding for 2012–13 are as a result of the population changes in 2011–12, some 60 per cent ($152.2 million) of the total cuts of $253.8 million. The Commonwealth has also acknowledged that 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.[1] However, the Commonwealth has not been comparing like with like and so these cuts are based on an erroneous method.

4.7 The other factor contributing the cuts is the very low (0.9 per cent) growth in the Total Health Price Index (THPI) for 2010–11. The Commonwealth has stated that revision of the THPI is the predominant driver (around 65 per cent) of the $1.5 billion cut to NHR funding over the forward estimates.[2] The committee considers that there are compelling arguments to reconsider the instrument used to measure changing hospital costs under the NHRA. First, the THPI was carried over from former agreements which incorporated other health services and therefore it was appropriate that indexation of costs include non-hospital factors. However, the NHRA is directly specifically at hospital funding. Hospital costs are only marginally influenced by fluctuations in the Australian dollar – the main element that has influenced the lower THPI – while the major component of cost pressures – wages – is not adequately taken into account. Secondly, other measures of hospital costs such as the indexation of the 2012–13 National Efficient Price determination and the indexation of private health insurance were both over 5 per cent. The committee considers that the 2010–11 THPI of 0.9 per cent appears to be a woefully inadequate measure of hospital costs and COAG should review its use to measure changes in hospital costs.

4.8 The committee considers the timing of the Commonwealth's cuts to be unrealistic. These cuts have imposed severe constraints on public hospital services. It makes no sense for the Commonwealth to seek reimbursement for services that were allegedly over-provided when the impact of seeking such a refund merely cuts services to patients today.

4.9 The Commonwealth's cuts were imposed on states and territories midway through the 2012–13 financial year following the Treasurer's determination of October 2012. The cuts have a significant retrospective element as hospitals had already received funding for services delivered in 2011–12 but the Commonwealth informed the states and territories that they had been overpaid and that it would recover overpayments of $403 million. At the same time, the Commonwealth cut funding for 2012–13 and over the forward estimates so that nearly $1.5 billion will be removed from the public hospital sector by the Commonwealth.

4.10 At a time when the Commonwealth has entered into agreements to improve the public hospital system for the benefit of all Australians and, as it has so widely proclaimed, increase the Commonwealth's contribution to the hospital funding, the committee finds the current cuts to funding extraordinary and indeed indefensible. Public hospital services for 2011–12 have already been delivered, the bills paid and the accounts finalised. To now ask public hospitals for the return of $403 million flies in the face of the Commonwealth's much vaunted position on its commitment to Australian's using the public hospital system. It is also recovering this overpayment in the same financial year that further cuts have been introduced – in total some

1 Department of Health and Ageing and Treasury, *Submission 55*, pp 15–16.

2 Department of Health and Ageing and Treasury, *Submission 55*, p. 15.

$657 million less will be provided to public hospitals between December last year and the end of this financial year.

4.11 The committee has heard evidence of the direct impact of the funding cuts on public hospitals: bed closures, loss of staff and curtailment of much needed services. The impact on rural communities will be severe, with one regional hospital closing its after-hours emergency services. This does not appear to be within the spirit of the agreement to reform public hospital services to improve access and service provision.

4.12 The impact of the cuts was severe and immediate in Victoria as its public hospital administration arrangements are different to those of the other states and territories. The Commonwealth made much of the decision of the other states to 'absorb' the cuts. Evidence from NSW and Queensland does not support this claim – the public hospital arrangements in those states are different to Victoria and though they have not had such an immediate impact, the cuts will be felt in the coming months, and cut backs to services and staffing will be just as severe. The NSW Government has commented that there will a significant gap between the policy intent of the NHRA and the actual growth funding public hospitals will receive. It will effectively jeopardise the benefits promised under this major national health reform program and affect the care of patients. Similarly, the Queensland Government has said the impact of the Commonwealth's cuts – though smaller in size for their state, will be felt from February 2013.

4.13 The committee notes the Commonwealth's commitment that no state will be worse off in the short or long-term because they will continue to receive at least the amount of funding they would have received under the National Healthcare NPP and their share of the $3.4 billion in funding available under the National Partnership Agreement on Improving Public Hospital Services.[3] However, at the same time that these funding cuts will be felt in the public hospital system, funding under some National Partnership Agreement programs will cease. The public hospital system will then be put under greater strain to fund essential services and to deliver much needed reforms.

4.14 The Commonwealth has made much of the argument that the states and territories signed up to the funding agreements. However, it is apparent that the agreements are silent on the methodology to be used for population growth estimates and there has been a lack of transparency regarding which estimates are used in the funding calculations for the Treasurer's determination. The committee also notes that at the time that governments entered into the agreements, it appears likely that the indexes were broadly expected to operate so as to increase funding, given their description as 'growth factors'. That the 'growth factors' would have resulted in reduced funding retrospectively to states and territories appears to have been unexpected. As the AMA submitted, this is consistent with the fact that the agreement

3 New South Wales Government, *Submission 53*, p. 2.

makes no explicit provision for how and when negative growth would be implemented.[4]

4.15 The Department of Health and Ageing also informed the committee that there was no discretion in the Federal Financial Relations Act for the adjustments to be made over a longer period to smooth their impact or to allow the Commonwealth and states to negotiate other courses of action. The committee considers that this is a significant issue which limits the ability of the states to adjust to the changes in funding levels in a planned way. The committee considers that COAG should reconsider this issue in relation to the Intergovernmental Agreement.

4.16 However, the committee also notes the inconsistency between the advice from officials that there was no discretion with respect to implementing these cuts, yet the night before the committee hearing the Health Minister announced a new hospital funding arrangement (albeit without any consideration or detail). In simple terms, the announcement made the night before the committee hearing could have been made at the same time the cuts were announced, thereby avoiding the drastic impact of the retrospective cuts, and the administrative and operational burden of reinstating the funding.

4.17 The states signed up in good faith to the funding agreements but it appears the Commonwealth pursued politically motivated funding cuts to improve its financial position at the expense of public hospital users. This was a short-sighted action which has now been recognised by the Commonwealth as such. The Commonwealth has announced additional funding for Victoria when it realised the severity and impact of the cuts. The Commonwealth announced a one-off funding of $107 million for Victorian hospitals, but there still remains a funding shortfall in the coming years. The Commonwealth has announced it will provide payments directly to hospitals in Victoria but not as part of the NHRA. Rather the funding will come from a source of funding which will not be utilised by Victoria. While the reinstatement of some funding is welcome, it appears to the committee that the Commonwealth is undermining the NRHA as the funding will not go through the Pool and there will be little transparency around the arrangement.

4.18 The evidence provided to the committee in relation to funding of public hospitals since December 2012 calls into question the Commonwealth Government's commitment to hospital reform. The cuts were implemented at short notice without consultation and appear to have been undertaken without consideration for the effect on hospital services and the users of those services. It is further evidence of the poor management of the Commonwealth Government.

Recommendation 1

4.19 The committee recommends that, as a matter of urgency, the Commonwealth reinstate funding to states and territories cut retrospectively for the years 2011–12 and 2012–13 that were announced with the release of the MYEFO in October 2012.

4 Australian Medical Association, *Submission 22, p. 3.*

Recommendation 2

4.20 The committee recommends that the Commonwealth immediately withdraw its threat to penalise Victorian taxpayers in order to refund the cuts to hospitals it instituted late last year.

Recommendation 3

4.21 The committee recommends at the Commonwealth immediately desist from attempts to bypass existing arrangements and the National Health Funding Pool to fund hospitals directly, as this will simply lead to additional compliance burdens for public hospitals, likely leading to a diversion of resources from patients.

Recommendation 4

4.22 The committee recommends that the Commonwealth commit to not undertaking retrospective funding cuts of this nature in the future. It is inevitable that any so-called funding adjustments for past years will have a substantial impact on patients as it is impossible to effectively reduce treatment levels when health services have already been performed.

Recommendation 5

4.23 The committee recommends that whenever an intercensal error is uncovered by the work of the Australian Bureau of Statistics, the Commonwealth should ensure:

a) that no rearrangement of payments or cuts are made until the final calculation and application of this error is completed (for example, when it is applied over multiple census periods as in the current instance); and

b) intercensal error recalculations should not be used to seek effective reimbursement for the Commonwealth where services have already been provided and there is no capacity for the state to seek refunds for their provision.

Recommendation 6

4.24 The committee recommends that consideration be given to a further inquiry into the Total Health Price Index formula, including its composition, calculation and application to funding of public hospitals.

Senator Scott Ryan
Chair

Labor Senators' Dissenting Report

1.1 The National Health Reform Agreement (NHRA) is a shared commitment to national reform of public hospital and health services which outlines conditions for calculating Commonwealth funding to the states as well as the role of governments in the application of this funding.[1] The adjustment in Commonwealth health funding to the states, announced as part of the 2011-12 Final Budget Outcome and the Mid-Year Economic and Fiscal Outlook (MYEFO) (published in September 2012 and October 2012 respectively), was undertaken in accordance with the agreement between governments.[2]

1.2 The NHRA aims to improve transparency of public hospital funding, patient access and the efficiency of public hospitals as well as performance reporting.[3] Funding from the Commonwealth under the NHRA is subject to regular adjustments to reflect, amongst other things, changes in activity and from 2014-15 will be determined on the basis of activity levels set by the states.[4]

1.3 In 2012-13, the Commonwealth is providing $13.3 billion to Local Hospital Networks and the states under the NHRA, which is an increase of 5.7 per cent over 2011- 12 funding.[5] Funding for public hospitals is expected to grow by approximately 8.2 per cent per annum from 2012-12 to 2015-16.[6] This increase reflects in part the commencement of the Commonwealth's commitment under the NHRA to increase funding by at least $16.4 billion between 2014-15 and 2019-20, compared to the former National Healthcare Special Purpose Payment (SPP).[7]

1.4 Additional funding to enhance public hospitals is also being provided through the Commonwealth via National Partnership Agreements, with $4.1 billion being paid since 2007-08 and another $59 million scheduled to be paid in the remainder of 2012-13.[8] Further, the Commonwealth has committed $5 billion for health infrastructure across Australia under the Health and Hospitals Fund.[9]

1.5 Taking Victoria as an example of state specific funding outcomes, the state is receiving a total of $3.6 billion in total health funding from the Commonwealth in

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1 Joint Submission – Australian Government Department of Health and Ageing and the Treasury, *Submission 55*, p. 5.

2 Health and Ageing and Treasury Submission, *Submission 55*, p. 18

3 Health and Ageing and Treasury Submission, *Submission 55*, p. 5.

4 Health and Ageing and Treasury Submission, *Submission 55*, p. 3.

5 Health and Ageing and Treasury Submission, *Submission 55*, p. 3.

6 Health and Ageing and Treasury Submission, *Submission 55*, p. 3.

7 Health and Ageing and Treasury Submission, *Submission 55*, p. 3 and p. 11.

8 Health and Ageing and Treasury Submission, *Submission 55*, 3.

9 Health and Ageing and Treasury Submission, *Submission 55*, 3.

2012-13.[10] This includes the Commonwealth providing an additional $196 million in NHRA funding (an element of the total funding the Commonwealth provides) to Victoria this year compared with 2011-12.[11] By 2015-16 total health funding from the Commonwealth to Victoria will equal $4.5 billion, an increase of $900 million over four years.[12] In terms of total National Healthcare SPP and National Health Reform figures, Commonwealth funding to Victoria will increase by 38.1% from 2011-12 to 2015-16.[13]

1.6 Total Commonwealth funding for other jurisdictions will also be markedly enhanced. For example, New South Wales, there will be an increase of 32% in Commonwealth funding during that same period and in Queensland total funding from the Commonwealth will increase 41.3%.[14]

(I) Adjustment

1.7 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.[15]

1.8 Professor Jane Halton, Department of Health and Ageing, told the committee:

> …I should make the point that, when it comes to appropriations in relation to health, there are a number of appropriation items which are standing appropriations. In other words, they reflect activity or other parameter adjustments. The fact that there is an estimate included in the Commonwealth Budget does not constitute a commitment to spend the amount of money nominated in the line item of the budget.[16]

1.9 The Treasurer's final determination of the 2011-12 National Healthcare SPP made a downward revision to the amount initially estimated in the 2012-13 Budget. This revision was a result of advance payments made in 2011-12 being higher than the outcomes specified in the Treasurer's determination.[17] The Federal Financial

10 Mid-Year Economic and Fiscal Outlook, Table 3.24: Payments for specific purposes by sector, 2012-13 to 2015-16, p. 77.

11 MYEFO, Table 3.23: Total payments for specific purposes by category, 2012-13 to 2015-16, p.74; Final Budget Outcome 2011-12, Payments for specific purposes to support state health services, 2011-12, p. 74.

12 MYEFO, Table 3.24: Payments for specific purposes by sector, 2012-13 to 2015-16, p. 77.

13 Health and Ageing and Treasury Submission, *Submission 55*, p. 17.

14 Health and Ageing and Treasury Submission, *Submission 55*, p. 17.

15 Health and Ageing and Treasury Submission, *Submission 55*, p. 15.

16 Professor Jane Halton, Secretary of the Department of Health and Ageing, *Committee Hansard*, 21 February 2013, p. 55.

17 Health and Ageing and Treasury Submission, *Submission 55*, p. 15.

Relations Act 2009 clearly states that any difference between the estimated and final outcome for the year is to be recouped by the Commonwealth.[18]

1.10 Following finalisation of the 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.[19]

1.11 Mr Paul Gilbert, Victorian Branch of the Australian Nursing Federation (ANF), explained to the committee that:

> …what occurred was consistent with the terms of the agreement. It might be prudent for people to look back and see what the terms said.[20]

(II) Calculating the Adjustment

1.12 In the first two transition years of the NHRA, Commonwealth funding variations may occur based on the application of the agreed funding formula set out in the Intergovernmental Agreement on Federal Financial Relations (IGA) that the Commonwealth and state Treasurers signed up to.[21] The formula is calculated with reference to growth in population estimates provided by the Australian Bureau of Statistics (ABS) 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 (which is fixed).[22]

1.13 The joint submission from the Department of Health and Ageing and Department of the Treasury (joint Health and Treasury submission) noted that:

> 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.[23]

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18 *Federal Financial Relations Act 2009* section 18; Health and Ageing and Treasury Submission, *Submission 55*, p. 15

19 Health and Ageing and Treasury Submission, *Submission 55*, p. 16.

20 Mr Paul Francis Gilbert, Assistant Secretary, Australian Nursing Federal (Victorian Branch), *Committee Hansard*, 21 February 2013, p. 7.

21 Health and Ageing and Treasury Submission, *Submission 55*, p. 20.

22 Health and Ageing and Treasury Submission, *Submission 55*, p. 14.

23 Health and Ageing and Treasury Submission, *Submission 55*, p. 14.

(i) Population Growth

1.14 In terms of population growth estimates, the ABS submission explained that the bureau introduced innovations that directly improved the quality of estimated resident population (ERP) figures when putting together the preliminary official population estimates based on the 2011 Census.[24] The innovation was the introduction of Automated Data Linking which meant an improved measure of net undercount than would have previously been possible under other Census estimates.[25] The submission noted that:

> This major improvement resulted in a lower estimate of how many people the ABS needed to add to the 2011 Census counts when deriving Australia's official population estimates for 30 June 2011. The ABS estimated that the previous method would have added in around 247,000 people who were not actually in the population.[26]

1.15 Ms Gemma Van Halderen, ABS, informed the committee that this recalculation occurred in a transparent and open fashion. Ms Halderen stated that the ABS:

> …put out advice prior to the population census in 2011 that it was going to be using a new method of measuring the quality of the census. We then put out advice in 2012, when the first census release came out and when first population estimates came out…Like the Australian Institute of Health and Welfare, we are very open and transparent in our methods and how we approach things.[27]

1.16 Professor Stephen Duckett, in responding to the question of whether the Commonwealth's application of population figures was fair, indicated that it was. He stated before the committee:

> In brief, yes…My view is that it was fair of the Commonwealth to say, "We are going to use the latest estimates that are available of population and we believe these are what should be applied." I think that is fair…[28]

(ii) Health Price Index

1.17 The AIHW advised that growth in the Health Price Index for the last available year of 2010-11 was the lowest for a decade and that this was a result of moderation in medical inflation rates and the price of the Australian dollar (which leads to a fall in the price of medical and surgical equipment sourced from outside Australia). This

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24 Australian Bureau of Statistics Submission, *Submission 25*, pp. 2-3.

25 Australian Bureau of Statistics Submission, *Submission 25*, p. 3

26 Australian Bureau of Statistics Submission, *Submission 25*, p. 3

27 Ms Gemma Van Halderen, First Assistant Statistician, Population, Education and Data Integration Divisions, Population, Labour and Social Statistics Group, Australian Bureau of Statistics, *Committee Hansard*, 21 February 2013, p. 37.

28 Professor Stephen Duckett, private capacity, *Committee Hansard*, 21 February 2013, p. 1.

lower growth has driven down the overall five-year average of the index calculated by the AIHW.[29]

1.18 David Kalisch, AIHW, stated in the submission to the committee that:

> On the issue of transparency, the AIHW fully explains the method of calculation for the THPI [Total Health Price Index] in our annual *Health expenditure Australia* report, which is released around September each year….I would suggest that the Committee does not confuse the issue of transparency which we have demonstrated with the perspective of those who believe the numbers should be higher in order to produce a higher funding level to state governments.[30]

(III) Timing

1.19 Much of the criticism directed at the Commonwealth relating to the adjustment in funding has focussed on the timing of the decision and the deadlines placed on states to adjust their budgets. However, the Commonwealth actually departed from normal practice by spreading the residual adjustment over the remainder of the 2012-13 financial year, commencing in December 2012.[31] This was done to assist states in managing cash flows even though normal practice is to make adjustments in full in the next available payment.[32]

1.20 The *Federal Financial Relations Act 2009* actually indicates that any adjustments should be made in the first practicable financial year following the change.[33] Further, the IGA requires that adjustments to account for the difference between estimated and actual outcomes are to be acquitted in the first available payment.[34]

1.21 Mr Peter Robinson, Treasury, informed the committee:

> In this case, we have spread the adjustment to the SPP over the course of 2012-13. So we have gone as far, I guess, as we could in terms of the legislative basis that we have for making adjustments.[35]

1.22 The NHRA was an agreement signed off by all governments after extensive negotiations. The nature of the agreement and how funding would be calculated were known to all jurisdictions for a substantial period of time and the Commonwealth made deliberate efforts to even out the adjustment whilst abiding by relevant legislative requirements.

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29 Health and Ageing and Treasury Submission, *Submission 55*, p. 15.

30 Australian Institute of Health and Welfare Submission, *Submission 2*, p. 1.

31 Health and Ageing and Treasury Submission, *Submission 55*, p. 16.

32 Health and Ageing and Treasury Submission, *Submission 55*, p. 16.

33 *Federal Financial Relations Act 2009* section 18.

34 Health and Ageing and Treasury Submission, *Submission 55*, p. 18; Clause D9 of the IGA.

35 Mr Peter Robinson, General Manager, Commonwealth-State Relations Division, Treasury, *Committee Hansard*, 21 February 2013, p. 57.

(IV) State Responsibility for Impact on Healthcare Services

1.23 Labor Senators note that the Commonwealth is actually providing an additional $716 million in public hospital funding to the states in 2012-13 compared to 2011-12.[36] Also, the states have numerous options at their disposal to adapt to the funding adjustment. For example, the joint Health and Treasury submission noted:

> 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.[37]

1.24 The NHRA recognises that the states are the system managers of the public hospital system. A core element of being the system manager of public hospitals is to ensure that services are appropriately funded. Clause A60 of the NHRA states:

> States will determine the amount they pay for public hospital services and functions and the mix of those services and functions, and will meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution.[38]

1.25 This means that where Commonwealth funding increases or decreases according to the agreed funding formula, the state has the critical role of assessing whether the state's funding contribution requires adjustments to enable the Local Hospital Network to meet the level of services set out in their Service Agreement. Some states have met their obligations; for example Dr Mary Foley, New South Wales Department of Health, told the committee:

> In New South Wales, the state Treasury has maintained our level of funding, in keeping with the service agreements and new funding model we implemented on 1 July last year.[39]

1.26 Other states have not met their obligations under the NHRA and have instead blamed the Commonwealth funding adjustments for service reductions driven by their own funding cuts. The submission from the ANF Victorian Branch states in the context of cuts to the Victorian health system that:

> …while these cuts [in the Victorian health system] have occurred subsequent to the Federal Government adjustments to state funding, it does not immediately follow that this is the sole cause or motivation for the cuts.[40]

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36 Health and Ageing and Treasury Submission, *Submission 55*, p. 18.

37 Health and Ageing and Treasury Submission, *Submission 55*, p. 18.

38 *National Health Reform Agreement*, clause A60.

39 Dr Mary Foley, Director-General, New South Wales Department of Health, *Committee Hansard*, 21 February 2013, p. 12.

40 Australian Nursing Federal (Victorian Division) Submission, *Submission 5*, p. 3.

1.27 Furthermore, Labor Senators note allegations put before the committee that the Victorian Government may have acted to ensure that the Commonwealth funding adjustment was implemented in such a manner as to maximise service cuts to Victorians. Mr Gilbert stated:

> It has been put to me that there was one example where a health service proposed to deal with the cuts by way of not closing any beds or reducing theatre sessions and that that proposal was rejected in favour of one that closed beds and reduced theatre sessions. I think [Victorian Health] Minister Davis, as is his role, for the good of Victoria, in his view, ensured that the impact was as severe as it could be in order to generate the positive outcome.[41]

1.28 When questioned on whether he thought that the Baillieu Government intentionally sought to make the adjustment in Commonwealth funding appear more severe as part of a public relations effort, Mr Gilbert responded:

> I am saying that a hospital changed its proposal to deal with the cuts [following submission to the Victorian Department] to one that had a greater media impact. I am saying this was consistent with the minister's message. Whether the minister ever had communication with that health service, it [sic] will never know.[42]

1.29 Despite the protestations of the Baillieu Government, data recently released by the AIHW demonstrates that Victorian hospitals were tracking well below their performance targets prior to concerns being raised about the Commonwealth funding adjustment. In fact, Victorian hospitals were only seeing 62.8% of emergency patients within four hours in the September quarter, and only seeing 65% on time over the 2012 calendar year, figures were well below the target of 70% for the year.[43]

1.30 **It is because of the Victorian Government's inability to** manage their own health system that the Commonwealth is paying $107 million directly to Local Hospital Networks and not to the Baillieu Government.[44] This payment was necessary because of the decision of the Baillieu Government to make substantial cuts of some $616 million from the Victorian health system.[45]

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41 Mr Paul Francis Gilbert, Assistant Secretary, Australian Nursing Federal (Victorian Branch), *Committee Hansard*, 21 February 2013, p. 11.

42 Mr Paul Francis Gilbert, Assistant Secretary, Australian Nursing Federal (Victorian Branch), *Committee Hansard*, 21 February 2013, p. 11.

43 Minister for Health and Ageing, the Hon Tanya Plibersek, "Baillieu government failing on hospitals long before funding dispute", *Media Release*, 28 February 2013.

44 Minister for Health and Ageing, the Hon Tanya Plibersek, "Victorian hospital rescue package helps patients", *Media* Release, Thursday 21 February 2013.

45 Victorian Budget Paper No 3 2011-12, Chapter 2, Service Delivery 2011-12, p 112, (a figure of $481.9 million is derived by adding election commitment savings and measures to offset the GST reductions); Victorian Budget Paper No 3 2012-13, Chapter 1, 2012-13 Service Delivery, p. 23 (a figure of $134.1 million is derived by adding total savings).

1.31 The ANF Victorian Branch submission also observed that Victoria has previously issued, through its Department of Health, quarterly reports of elective surgery waiting lists and emergency department waiting times. As the submission suggests, these are reasonable measures against which to assess the impact of any cuts on patient care and services. However, since June 2012, the Victorian Government has failed to update these reports.[46]

1.32 The inquiry also heard that ordinarily Victorian health services enter into Statements of Priorities with the Victorian Department of Health which indicate what services they intend to provide. Unlike in previous years, these statements have not been published, although according to the ANF Victorian Branch an initial set was negotiated and signed but not published once the Commonwealth funding adjustment was announced.[47] The committee heard that:

> They would have been a good benchmark on which to judge the impact of the federal cut because you could have said, "Looking at what was going to happen before anyone knew about the federal cut, we could say this is what happened as a consequence of the federal cut".[48]

1.33 Another key concern raised at the inquiry was the fact that the Victorian Government has refused to provide the independent Administrator of the National Health Funding Pool with details on how it is allocating the Commonwealth funding.[49] When questioned on why the Victorian Government would not want this data published Professor Duckett responded to the committee:

> I do not know. I think it is very regrettable, as I said in my opening statements. I think part of these reforms are about transparency, and I think that the Victorians should supply that data to the independent administrator; it is part of the reforms they agreed to.[50]

1.34 The ANF Victorian Branch submission speculates as to the reasons for these various omissions on the part of the Victorian Government:

> It may be inferred from this that cuts to services were already intended…the timing of the Gillard Government funding adjustment has enabled the entire woes of the Victorian health system to be blamed on the actions of the Commonwealth. The absence of usually available State statistics has made this an easier task.[51]

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46 Australian Nursing Federal (Victorian Division) Submission, *Submission 5*, p. 3-4.

47 Australian Nursing Federal (Victorian Division) Submission, *Submission 5*, p. 4.

48 Mr Paul Francis Gilbert, Assistant Secretary, Australian Nursing Federal (Victorian Branch), *Committee Hansard*, 21 February 2013, p. 6.

49 Professor Stephen Duckett, Private capacity, *Committee Hansard*, 21 February 2013, p. 3.

50 Professor Stephen Duckett, Private capacity, *Committee Hansard*, 21 February 2013, p. 4.

51 Australian Nursing Federal (Victorian Division) Submission, *Submission 5*, p. 4.

1.35 This misleading attribution of blame to the Commonwealth may apply even where health services have specifically linked changes in their services to the Commonwealth's funding adjustment. Mr Gilbert stated before the committee that:

> …there were substantial cuts going on in, for example, elective surgery procedures that were indeed publicly announced at Christmas before last and they were already impacting on health services. Simply because a statement says that it is because of something [adjustment in Commonwealth funding] is not itself evidence to me that that is the case.[52]

1.36 Labor Senators encourage all states to transparently reveal how Federal Government funding to their health systems is being spent and take responsibility for cuts in funding that occurred independently from the adjustment in Commonwealth funding announced last year.

(V) Response to Recommendations

1.37 In relation to recommendation 1, Labor Senators do not consider it necessary to reinstate funds to the states and territories for the years 2011-12 and 2012-13 that were affected by the release of MYEFO. The decision to alter Commonwealth funding was done in accordance with a formula designed so that the Commonwealth does not over-fund if costs or services are lower than expected.[53] A decision on whether other jurisdictions will receive a funding rescue package similar to the one provided to Victoria will be made by on a case by case basis. However, Labor Senators point out that other states have succeeded in meeting the costs of health services from their own budgets.[54] As noted, the New South Wales Government absorbed the Commonwealth funding adjustment from across the entire state's budget and there was no reduction of funds dedicated to health services.[55]

1.38 Labor Senators reject the premise of recommendation 2. In order to secure the emergency funding package to Victoria the Commonwealth has had to redirect funding from the Seamless National Economy National Partnership, with the balance of the $107 million to come from decisions on future funding projects for the state.[56] This, however, is not a threat to the state's taxpayers but rather a necessary commitment on the part of the Commonwealth to ensure that essential health services meet the needs of all Victorians. Such a step would not have been necessary if the

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52 Mr Paul Francis Gilbert, Assistant Secretary, Australian Nursing Federal (Victorian Branch), *Committee Hansard*, 21 February 2013, p. 6.

53 Health and Ageing and Treasury Submission, *Submission 55*, p. 14.

54 Dr Mary Foley, Director-General, New South Wales Department of Health, *Committee Hansard*, 21 February 2013, p. 12.

55 [55] Dr Mary Foley, Director-General, New South Wales Department of Health, *Committee Hansard*, 21 February 2013, p. 14.

56 Minister for Health and Ageing, the Hon Tanya Plibersek, "Victorian hospital rescue package helps patients", Media Release, Thursday 21 February 2013.

Baillieu Government had not cut hospital budgets and then engaged in a cynical scare campaign aimed at falsely attributing blame to the Commonwealth.[57]

1.39 In terms of recommendation 3, Labor Senators think that the Commonwealth should retain discretion to bypass existing arrangements and fund state hospitals or hospital administrators directly in order to swiftly secure vital health services. Although this approach does depart from regular funding processes, it may be necessary in particular circumstances such as in Victoria where the Baillieu Government cut $616 million from the state's health system.[58] The Commonwealth would of course prefer to avoid future emergency rescue payments and encourages all jurisdictions, including Victoria, to support the NHRA and fulfil their obligations as system managers of the public hospital system.

1.40 In response to recommendation 4 the Commonwealth will, depending on the circumstances, consider how to apply funding adjustments if and when they arise. In the present scenario, the Commonwealth spread the funding adjustment over the course of the financial year even though it would have been permissible to make the adjustment earlier (i.e. first available payment).[59] Under the NHRA, there will continue to be regular variations in Commonwealth funding for public hospital services. Commonwealth funding is calculated according to a designated formula agreed to by all jurisdictions and the formula will change depending on the inputs into that formula.[60] As part of the NRHA, all states have agreed to a future process of six-monthly reconciliations of Commonwealth funding against public activity levels and funding from the Commonwealth will vary if actual activity differs from what was originally forecast.[61] Also, it is important to remember that the states will be able to amend the service levels outlined in Service Agreements at any time. The Commonwealth's activity based funding will be based on the forecast activity in these agreements, meaning that it will be varied if amendments are made by the states.[62]

1.41 Labor Senators do not support recommendation 5 and believe that the Commonwealth should be afforded the flexibility to rearrange health payments as considered suitable depending on a variety of factors. The adjustment in funding was not undertaken to reimburse the Commonwealth for an ancillary purposes; it was done completely in accordance with the NHRA.

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57 Minister for Health and Ageing, the Hon Tanya Plibersek, "Victorian hospital rescue package helps patients", Media Release, Thursday 21 February 2013.

58 Victorian Budget Paper No 3 2011-12, Chapter 2, Service Delivery 2011-12, p 112, (a figure of $481.9 million is derived by adding election commitment savings and measures to offset the GST reductions); Victorian Budget Paper No 3 2012-13, Chapter 1, 2012-13 Service Delivery, p. 23 (a figure of $134.1 million is derived by adding total savings).

59 *Federal Financial Relations Act 2009* section 18; Health and Ageing and Treasury Submission, *Submission 55*, p. 18; Clause D9 of the IGA.

60 Health and Ageing and Treasury Submission, *Submission 55*, p. 19.

61 Health and Ageing and Treasury Submission, *Submission 55*, pp. 19-20.

62 Health and Ageing and Treasury Submission, *Submission 55*, p. 20.

1.42 In terms of recommendation 6, Labor Senators note that the nature of the Health Price Index and how it was calculated was one of the conditions for Commonwealth funding set out in the IGA which all jurisdictions were aware of prior to the recent Commonwealth funding adjustment. The Commonwealth has no present plans to alter the formula.

(VI) Conclusion

1.43 The NHRA ensures that all states will receive additional Commonwealth funding for public hospitals compared with the National Healthcare SPP.[63] Adjustments to Commonwealth funding were not arbitrarily decided but rather were consistent with the regular budget processes that Treasury undertakes throughout each year after due consideration of the estimated population growth and the Health Price Index.[64] Some states have refused to meet the requirements of the NHRA and perform their role as system managers. This has impacted on service delivery in those states.

1.44 It is also important to consider that the NHRA contains a dispute resolution clause which is available to all jurisdictions and could have been utilised to handle this matter currently before the committee.[65] However, as the Department of Health and Ageing mentioned during the inquiry, the dispute resolution arrangements have not been triggered by Victoria or any other state.[66] If the Victorian Government or any other government was confident that the funding adjustment was unreasonable it could have opted to employ this clause at any time after the Commonwealth Treasury informed state Treasuries on 3 November 2012 that adjustments would occur across the remainder of the 2012-13 financial year.[67]

1.45 The timing of the adjustment has provided an opportunity for the Victorian Government to attempt to lay blame on the Commonwealth for its own health funding cuts. This is a false ascription of culpability that ignores the fact that the NHRA contains mechanisms to adjust Commonwealth funding in accordance with the application of a known formula. The states have an important role to play as system managers and this is explicitly recognised in the agreement.[68]

63 Health and Ageing and Treasury Submission, *Submission 55*, p. 6.

64 Health and Ageing and Treasury Submission, *Submission 55*, p. 14.

65 *National Health Reform Agreement*, clauses 21-23.

66 Professor Jane Halton, Secretary of the Department of Health and Ageing, *Committee Hansard*, 21 February 2013, p. 56.

67 Health and Ageing and Treasury Submission, *Submission 55*, p. 18.

68 *National Health Reform* Agreement, clause 8a; Health and Ageing and Treasury Submission, *Submission 55*, p. 3.

1.46 The Commonwealth and the states signed up to the NRHA to secure the future health of Australia with less waste and increased transparency and accountability. Labor Senators urge all states and other stakeholders to closely scrutinise the terms of the NHRA and recognise that the adjustment was in keeping with the agreement.

Senator Helen Polley
Deputy Chair

Senator Anne McEwen
Senator for South Australia

Australian Greens

Additional Comments

1.1 The Australian Greens agree with the Committee's main findings as detailed in this report. While we may not agree with some of the specific commentary, evidence presented to this inquiry raises real questions regarding the Commonwealth Government's actions with respect to fulfilling its obligations under the National Health Reform Agreement. This is particularly true with respect to the use of population growth data. The Committee received evidence from many witnesses on this point including Professor Stephen Duckett who noted:

> It is therefore not estimating population growth at all. It is not comparing like with like and its estimates of so-called growth are erroneous.[1]

1.2 The use of data points from two differently-based series to determine the growth number was not justified to our satisfaction. The suggestion was made by non-government witnesses that this amounted to an abuse of good statistical practice done in pursuit of other budgetary aims. The timing of the cuts, combined with their retrospective nature, further undermines the Government's claim to have acted in good faith and in partnership with the states.

1.3 The Australian Greens deplore the resulting cuts to services that have impacted patients and broken faith with the community. It is clear that, especially in the case of Victoria, these cuts are a direct result of the reduction in funding by the Commonwealth. However, it is important to note that the Commonwealth does not bear sole responsibility for problems with state hospitals. Under-investment by State governments, particularly in Victoria and Queensland, has left public hospital systems reeling and ill-equipped to absorb any fluctuation in funding without severe and immediate impacts, including further rationing of services. The MYEFO cuts to NHRA funding were significant, but have also provided an opportunity for state governments to sheet home all the blame for underperforming hospitals to the Commonwealth. In fact, many of these problems are longstanding and chronic.

1.4 The 11th-hour decision by the Government to restore funding to Victoria, using an ad hoc system of direct payments to local hospital boards, undermines the National Health Reform Agreement. It does little to address the underlying issues, due to its timing and lack of detail, and would appear to be a hasty and piecemeal response to a larger problem. The Australian Greens welcome the return of funding to Victoria but do not agree that this is an appropriate mechanism to restore that funding. Instead of searching for a way to cooperate with the states on the issue of hospital funding, it merely continues the "blame game" between the two levels of government.

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[1] Professor Stephen Duckett, *Supplementary Submission 2*, p. 1.

Recommendation 1

1.5 That the Commonwealth restore to the National Health Funding Pool the funding cut made retrospectively at the MYEFO for the 2011-2012 financial year.

Recommendation 2

1.6 That the Commonwealth recalculate the 2012-13 National Health Reform Agreement funding to the states using a revised 2010-11 population growth estimate based on the 2011 census figures, and apply this funding through the National Health Funding Pool.

Senator Richard Di Natale
Senator for Victoria

APPENDIX 1

Submissions and Additional Information received by the Committee

Submissions

1 Dr Ewen McPhee
2 Prof Stephen Duckett
3 Consumers Health Forum of Australia
4 Health Services Association of NSW
5 Australian Nursing Federation (Victorian Branch)
6 Central Queensland Rural Division of General Practice
7 Services for Australian Rural and Remote Allied Health
8 Victorian Emergency Physicians Association Inc
9 Rural Doctors Association of NSW Inc
10 Queensland Government
11 Australian Medical Association (Victoria) Limited
12 Colac Area Health
13 Health Workforce Queensland
14 Moura District Health Care Association Inc
15 Australian Healthcare and Hospitals Association
16 Rural Doctors Association of Queensland
17 Victorian Hospitals' Industrial Association
18 Rural Doctors Association of Australia
19 Australian Health Care Reform Alliance
20 Victorian Healthcare Association
21 Catholic Health Australia
22 Australian Medical Association
23 HammondCare Health and Hospitals
24 Palliative Care Australia
25 Australian Bureau of Statistics
26 Dr John Deeble
27 Dr Yvonne McMaster

28 Confidential
29 Dr Jennifer Mann
30 Prof Steven Faux
31 Confidential
32 Mr Michael Mardel
33 Mr Phil Browne
34 Ms Leanne Callahan
35 Ms Tam Kruger
36 Ms Hailey Weedon
37 Mr Chad Kelly
38 Ms Ali Beer
39 Ms Colleen Reynolds
40 Ms Marie Formisano
41 Confidential
42 Dr Karen Chia
43 Ms Claire Jackson
44 Ms Denise Hadley
45 Ms Laura Cook
46 Ms Sarah King
47 Ms Debra Howlett
48 Ms Ella Tesselaar
49 Ms Sarah Oborne
50 Ms Naomi Colvile
51 Ms Belinda Rogers
52 Australian Institute of Health and Welfare
53 NSW Government
54 Victorian Government
55 Commonwealth Department of Health and Ageing and the Treasury
56 Queensland Nurses' Union
57 Dr Kathryn Antioch
58 Northern Territory Government
59 Mr Paul Cross

Tabled Documents

1 The Hon David Davis MP, Minister for Health, Victoria, Additional Information, tabled at public hearing, 21 February 2013.

2 The Hon David Davis MP, Minister for Health, Victoria, Health Services Amendment (Health Purchasing Victoria) Bill 2012, tabled at public hearing, 21 February 2013.

Additional Information

1 Dr Tony Sherbon, Chief Executive Officer, Independent Hospital Pricing Authority, Supplementation of evidence following public hearing, 21 February 2013, received 4 March 2013.

APPENDIX 2
Public Hearing

Thursday, 21 February 2013

Mantra Hotel, 222 Russell Street, Melbourne

Witnesses

Professor Stephen Duckett

Australian Nurses Federation (Victorian Branch)

Mr Paul Gilbert, Assistant Secretary

NSW Department of Health

Dr Mary Foley, Director-General

Dr Rohan Hammett, Deputy Director-General, Strategy and Resources

Catholic Health Australia

Mr Martin Laverty, Chief Executive Officer

Queensland Government *(via teleconference)*

The Hon. Lawrence Springborg, MP, Minister for Health

Australian Healthcare and Hospitals Association

Mr Andrew McAuliffe, Senior Director, Policy and Networks

Victorian Healthcare Association

Mr Trevor Carr, Chief Executive Officer

Mr Tom Symondson, Research and Policy Manager

Australian Bureau of Statistics

Ms Gemma Van Halderen, First Assistant Statistician, Population, Education and Data Integration Division, Population, Labour and Statistics Group

Mr Bjorn Jarvis, Director, Demography

Australian Institute of Health and Welfare

Mr David Kalisch, Director and Chief Executive Officer

Victorian Government

The Hon. David Davis, MLC, Minister for Health

Dr Philip Pradeep, Secretary, Department of Health

Mr Peter Fitzgerald, Executive Director, Strategy and Policy, Department of Health

Dr John Deeble

Department of Health and Ageing

Ms Jane Halton, Secretary

Ms Kerry Flanagan, Deputy Secretary

Treasury

Mr Peter Robinson, General Manager, Commonwealth-State Relations Division

Independent Hospitals Pricing Authority

Dr Tony Sherbon, Chief Executive Officer

Mr James Downie, Executive Director, Activity Based Funding

Appendix 3

National Health Reform Agreement

Background

The Commonwealth and state and territory governments jointly fund public hospital services. Since the introduction of Medicare in 1984, the transfer of funds from the Commonwealth to the states and territories has been made pursuant to agreements entered into by the respective governments.[1] The Medicare Agreements were followed by the Australian Health Care Agreements (AHCAs). The AHCAs were five year bilateral agreements. The indexation under the AHCAs was calculated according to (weighted) population figures which took into account demographic characteristics such as ageing and the Commonwealth Wage Cost Index 1.[2] Following the election of the Rudd Labor Government, the final AHCA was extended into the 2008–09 financial year.

In December 2007, COAG agreed to commence a program of substantive reform in order to increase productivity, address emerging inflationary pressures and improve the quality of services delivered to the Australian community in seven areas including health and ageing.[3] As part of this process, the National Health and Hospitals Reform Commission (NHHRC) was established in February 2008. The NHHRC provided advice on a framework for the next AHCAs and development of a long-term health reform plan to provide sustainable improvements in the performance of the health.[4]

At the March 2008 COAG meeting, it was agreed that in developing the new health care agreement there would be a review of the indexation formulas for the years ahead. COAG also agreed that the new Australian Health Agreement should move to a proper long-term share of Commonwealth funding for the public hospital system. COAG also agreed that the new health care agreement would be signed in December 2008 with a commencement date for the new funding arrangements of 1 July 2009.

COAG also agreed for jurisdictions, as appropriate, to move to a more nationally-consistent approach to activity-based funding for services provided in public hospitals but one which also reflects the Community Service Obligations required for the maintenance of small and regional hospital services.[5]

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1 For a description of funding arrangements from 1975 to 2000, see Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform,* July 2000, pp 31–37; and Department of Health and Ageing and the Treasury, *Submission 55,* p. 9.

2 Senate Community Affairs Committee, *First Report: Public Hospital Funding and Options for Reform,* July 2000, p. 39.

3 Council of Australian Governments, *Communique,* 20 December 2007.

4 Council of Australian Governments, *Communique,* 20 December 2007, Attachment 1.

5 Council of Australian Governments, *Communique,* 26 March 2008.

At the March 2008 COAG meeting, a new model for federal financial relations and modernisation of payments for special purposes was agreed. The Commonwealth also announced an immediate allocation of one billion dollars to the public hospital system, half of which was to be provided in 2007–08. Funding of $9.7 billion for public hospitals was announced for 2008–09.[6]

At the 29 November 2008 COAG meeting, the new National Healthcare Agreement (NHA) was announced. Under the measures agreed, the Commonwealth provided $60.5 billion over five years with $4.8 billion in additional base Specific Purpose Pyament funding.[7] In addition, the Commonwealth committed to a more generous indexation formula which delivered 7.3 per cent per year compared to 5.3 per cent under the previous agreement.

The *Intergovernmental Agreement on Federal Financial Relations* (IGA) provided for the growth factor for the National Healthcare SPP. The growth factor is defined as the product of:

- a health-specific cost index (AIHW price index);
- the growth in population estimates weighted for hospital utilisation; and
- a technology factor (the Productivity Commission-derived index of technology growth).[8]

The National Health and Hospital Network Agreement was announced in April 2010. COAG, with the exception of Western Australia, reached agreement on significant reforms to the health and hospitals system – the establishment of a National Health and Hospitals Network. The National Health and Hospitals Network Agreement combined reforms to the financing of the Australian health and hospital system with major changes to the governance arrangements between the Commonwealth and the States to deliver better health and hospital services.

The National Health Reform Agreement

In February 2011, heads of agreement on National Health Reform were negotiated by COAG and in August 2011 the National Health Reform Agreement (NHRA) was signed by all states, territories and the Commonwealth under the framework for federal financial relations.[9] This agreement supersedes the NHHNA.[10] A range of other agreements have also been revised:

> The Council of Australian Governments (COAG) has also agreed to a revised National Partnership Agreement on Improving Public Hospital

6 Parliamentary Library, *Bills Digest: Federal Financial Relations Bill 2009*, p. 18.

7 Council of Australian Governments, *Communique,* 26 March 2008; Department of Health and Ageing and the Treasury, *Submission 55,* p. 9.

8 Australian Government, *Budget Paper No 3,* 2009–10, p. 30.

9 Department of Health and Ageing and the Treasury, *Submission 55,* p. 5.

10 *National Health Reform Agreement,* August 2011, p. 4; Department of Health and Ageing and the Treasury, *Submission 55,* p. 10.

Services (following the National Partnership Agreement on Improving Public Hospital Services Expert Panel Report) as well as amendments to the National Healthcare Agreement and the Intergovernmental Agreement of Federal Financial Relations.[11]

The NHRA is part of the broader National Health Reforms (NHR) which are also supported by the following agreements between the Commonwealth and state and territory:

- National Partnership Agreement on eHealth;
- National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes;
- National Partnership Agreement on Hospital and Health Workforce Reform;
- National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan;
- National Partnership Agreement on Preventive Health (NPAPH); and
- National Partnership Agreement on Health Infrastructure.[12]

The NHRA aims to deliver a national unified and locally controlled heath system through:

- Introducing new financial arrangements for the Commonwealth and states and territories in partnership
- 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 increasing the Commonwealth's share of public hospital funding through an increased contribution to the costs of growth
- 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.[13]

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11 National Health Reform Agreement, http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nat-health-reform-agreements, (accessed 20 February 2013).

12 National Health Reform Agreement, http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nat-health-reform-agreements, (accessed 20 February 2013).

States, territories and the Commonwealth are jointly responsible for funding public hospital services under the NHRA. An activity based funding model is used where practicable and block funding is used in other cases. Activity based funding replaced the previous arrangements whereby the states and territories received block grants, negotiated through health care agreements. The NHRA also explains how states will go about budgeting for public hospitals under an activity based funding system and how activity based funding will affect other Commonwealth funding streams to the states for health care.

The funded services are provided for under the NHRA:

> Under the Agreement, the scope of public hospital services that are funded on an activity or block grant basis and are eligible for a Commonwealth funding contribution currently includes:
>
> - All admitted and non-admitted services
> - All emergency department services provided by a recognised emergency department
> - Other outpatient, mental health, sub-acute services and other services that could reasonably be considered a public hospital service.[14]

For services outside the scope of the agreement, such as dental services, primary care, home and community care, residential aged care and pharmaceuticals, public hospitals continue to receive funding from other sources, including the Commonwealth, states and territories.[15]

To implement and administer the agreement, a National Health Funding Pool (NHFP) has been established under Commonwealth, state and territory legislation. The NHFP is administered by an Administrator who is a statutory office holder distinct from Commonwealth and state and territory government departments.

> The Administrator and Acting Administrator are appointed by the Standing Council on Health (SCoH). An Acting Administrator is responsible for acting in the role of the Administrator during any period when the office is vacant.
>
> The National Health Funding Pool is the collective term for the state pool accounts of all states and territories. A state pool accounts is a Reserve Bank account established by a state or territory for the purpose of receiving

13 National Health Reform Agreement, http://www.publichospitalfunding.gov.au/national-health-reform/agreement, (accessed 8 February 2013).

14 National Health Reform Public Hospital Funding, http://www.publichospitalfunding.gov.au/national-health-reform/funding-who, (accessed 8 February 2013).

15 National Health Reform Public Hospital Funding, http://www.publichospitalfunding.gov.au/national-health-reform/funding-who, (accessed 8 February 2013).

> all Commonwealth and activity based state and territory NHR funding, and for making payments under the Agreement.[16]

The National Health Funding Body (NHFB) has also been established as an independent statutory authority to assist the Administrator in performing his or her functions:

> The Administrator is responsible for ensuring that state and territory deposits into the pool accounts, and payments from the pool accounts to local hospital networks are made in accordance with directions from the responsible State or Territory Minister, and in line with the Agreement. The Administrator is also responsible for calculating the Commonwealth public health funding contribution to states and territories and ensuring funds are deposited into pool accounts accordingly and in line with the Agreement. In addition, the Administrator is responsible for reconciling estimated and actual service volumes, authorising payment instructions, and reporting on all activities for the National Health Funding Pool.[17]

Several other bodies have also been established to support the implementation of the NHRA, including:

- the Independent Hospital Pricing Authority;
- the National Health Performance Authority; and
- the Australian Commission on Safety and Quality in Healthcare.[18]

The Administrator of the National Health Funding Pool provides a range of reports, including monthly reports of NHR funding at a national, state or territory level, and local hospital network level for each state and territory. The monthly national reports also include information on the NHR payments to states and territories.

Sources of NHR funding are divided into four categories:

- **Commonwealth ABF funding** represents acute admitted public, acute admitted private, non-admitted, and emergency department service categories, which are funded through the state pool account and subsequently paid to local hospital networks.
- **Commonwealth Block funding** represents mental health, small rural and metropolitan hospitals, sub-acute, teaching, training and research, and other categories, which are paid to state managed funds.

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16 National Health Reform Public Hospital Funding, http://www.publichospitalfunding.gov.au/national-health-reform/funding-who, (accessed 8 February 2013).

17 National Health Reform Public Hospital Funding – Role of the Administrator, http://www.publichospitalfunding.gov.au/national-health-reform/funding-who, (accessed 8 February 2013).

18 National Health Reform Public Hospital Funding, http://www.publichospitalfunding.gov.au/national-health-reform/funding-who, (accessed 8 February 2013).

- **Commonwealth Other funding** represents other amounts transacted through the state pool account and subsequently paid to state or territory health departments. This currently represents the Commonwealth contribution to public health.
- **State/territory funding** represents funding contributions paid in by states and territories into their own state pool account, and subsequently paid to local hospital networks within the state or territory and/or to state or territory health departments.[19]

19 National Health Reform Public Hospital Funding, NSW Report, September 2012, p. 7.