Submission to the Senate Economics Committee Inquiry into the Federal Financial Relations Amendment (National Health and Hospitals Network) Bill 2010.

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Introduction and Scope

This submission provides a preliminary assessment of the proposed National Health and Hospital Network (NHHN) as articulated in the Federal Financial Relations Amendment (National Health and Hospitals Network) Bill 2010. Our analysis focuses on three important aspects of the proposed NHHN:

1) Its financial viability - Will the proposed network meet the likely short term cost of funding Australia's public hospital system? Will the proposed network alter the funding balance between the Commonwealth and States in relation to the public hospital system?;

2) Will the proposed network reduce demand for health service in Australia?;

3) Will the proposed network improve the efficiency of the supply of health services in Australia?

This focus reflects our expertise is in comparative health governance (Kay) and public finance and intergovernmental financial relations (Eccleston).

Context for Reform

The cost of health care provision is increasing in real terms across the all OECD economies and the impact of health inflation on public finances represents a major policy challenge in all advanced democracies (Productivity Commission 2008).

The financial challenge associated with funding public hospital services is especially acute in the context of Australian intergovernmental financial relations because State governments, with their small and declining revenue base, have primary responsibility for the funding and management of the Public Hospital System – the very area of government expenditure subject to the greatest cost pressures. The historical response to Australia's Vertical Fiscal Imbalance in the context of public hospital funding has been for the Commonwealth to provide Special Purpose Payments (SPPs) to the States under the auspices of Australian Health Care Agreements and, more recently, the National Healthcare SPP. Whilst SPPs have underpinned the financial viability of Australia's Public Hospital

System (contributing $14.3 billion 2010-11) the regime has been subject to a number of related criticisms.

First, in practice health SPPs negotiated under NHCA have not kept pace with the rate of health inflation. As a consequence (and given their constitutional responsibility for the management of public hospitals) the States have been forced to increase their direct contribution to public hospital funding from 48.4 % in 1998-99 to 52.8% in 2007-08 while the Commonwealth's contribution has decreased from 44.3% to 39.2% over the same period (AIHW 2009, 52), with the balance being provided from private sources. This trend has served as a catalyst for the current debate about the financial sustainability of Australia's public hospital system.

At a political level, the relative decline Commonwealth funding for public hospitals combined concerns about the quality and availability of public hospital care have served to increase intergovernmental conflict in relation to health policy and management in the Australian federation. The central objective of the National Health and Hospitals Reform Network has been to end this 'blame game' between the Commonwealth and States in the Health care arena.

Finally, the efficiency of health care provision in Australia has been exacerbated by the arbitrary division of responsibility between the Commonwealth and the States for different elements of the health system (eg. primary, hospital, aged and mental health). The proposed NHHN's ambition of improving the integration of health care delivery in Australia is laudable.

1. Macro Financial Analysis: The financial viability of the proposed NHHN

The intergovernmental accountability issues which have afflicted Australian health policy in recent years have both governance (who has effective control over and responsibility for the provision of health services?) and financial (who has the resources to fund provision of health services?) dimensions. This section focuses on the likely financial implications NHHN. The analysis which follows explores the macro financial implications of the NHHN by providing some indicative projections as to whether the proposed NHHN will be adequately funded in the short term. The second related issue is whether the proposed arrangements will influence the distribution of the funding burden

By way of caveats, this analysis is both preliminary and indicative. It is based on the extrapolation of recently published AIHW data (2009) on public hospital expenditure as well as Commonwealth Budget data (2010-11) on projected Commonwealth health funding and GST revenues. As a baseline, the analysis assumes expenditure growth on public hospitals will continue at a rate of 9.3% per annum (the trend rate 2003-08). While we recognise the proposed NHHN has the ambition of funding the provision of health services beyond those delivered to public patients in public hospitals, it is first important to establish whether the proposed regime is likely to meet 60% of the likely non-private costs of running Australia's public hospital system. Finally, the accuracy of any financial projections is also limited by uncertainty surrounding how the proposed funding model will work in practice (eg. determination of 'efficient price' for hospital treatments, training costs etc). Despite these qualifications, it is possible to make some tentative conclusions in relation to two threshold questions:

1) Will the Commonwealth's forecast contributions to the NHHN (As outlined in the forward estimates in the 2010-11 Budget) meet the likely cost of funding Australia's public hospital system? And;

2) Is the proposed model likely to reduce the State's financial commitment to funding Australia's public hospital system in relative terms?

Year	(A) Projected GST Revenue	(B) 30% Contribution to National Healthcare SPP	(C) Non-GST Commonwealth Contribution	(D) Total Commonwealth Contribution	(E) Projected Public Cost of Public Hospitals (less private contributions)	(F) 60% Cost (C'wth)	(G) C'wealth Funding 'Surplus' (D-F)	(G) 40% Cost (States)	(H) Total cost to states (GST lost + 40%)
2010-11	47.9	NA	14.3	NA	36.9	22.1	NA	14.8	
2011-12	51.2	15.4	13.3	28.7	40.4	24.1	4.6	16.1	31.5
2012-13	54.5	16.3	14.5	30.8	44.1	26.4	4.4	17.6	33.9
2013-14	57.5	17.2	15.5	32.7	48.2	28.9	3.8	19.3	36.5
% Growth (nominal)	6.6%	5.8%	8.2% (2011-12 to 2013-14 only)	7.0%	9.3%	10.9%	-8.9%	10.9%	7.9%

Table 1. Short-run financial consequences of the proposed NHHN (AIHW 2009, 2010-10 Commonwealth Budget) Note: Assumes constant rate a health inflation. Excludes 'one-off' Commonwealth Transfers not included in forward estimates.

Analysis

1 – Regime Adequacy

The data (Column G) presented in table 1 suggest that short term Commonwealth contributions to the proposed NHHN would meet 60% of the forecast cost of funding Australia's Public Hospital System with a surplus of between $4.6 (2011-12) billion and $3.8 (2013-14) billion. However this 'Surplus' funding pool is modest given the Commonwealth's ambition to increasing funding for primary, aged and mental healthcare. To this extent we concur with John Deeble's recent comments that the proposed network will struggle to maintain the funding status quo (as quoted in Metherell 2010). Clearly the viability of the regime will be critically dependant on *ad hoc* funding (such as the $15.6 billion 'top up' funding from the Commonwealth, as well as the undertaking that no State will be made worse off). We believe that these funding pressures are likely to perpetuate intergovernmental conflict in the health arena.

Of greater significance is the fact that the Commonwealth funding surplus will decrease over the period of the Commonwealth forward estimates (Column G). This is a consequence of public hospital health inflation (9.3%) rising more quickly than GST revenue growth (6.6%). Under these circumstances the longer term financial viability of the regime is dependent on increasing Commonwealth SPPs to the funding network.

This raises the critical question of which level of government will ultimately manage the financial and political risks associated meeting the potential funding shortfall? Given that day-to-day management of Australia's Public Hospital remains the State's responsibility they will ultimately be held politically accountable for the quality and availability of health services delivered through the public hospital system. Moreover, as discussed below, ambiguity surrounding the 'efficient price' for hospital services, also poses significant financial risks for the States. In summary, inadequate funding combined with the fact that citizen's hold (and will continue to hold) State Governments accountable for the management of public hospitals is likely to perpetuate the current situation where the States are the funders of last resort for Australia's public hospital system.

2 – The Relative Burden of Public Hospital Funding

Notwithstanding the argument above that States will remain the 'funder of last resort' for the Public Hospital system, the NHHN model does provide some financial relief for the States in its basic form. This relief is represented in the total funding cost to the States (column H) which is the total of their 40% contribution to hospital costs less the 30% of GST revenue foregone. While this cost will increase at 7.9% per year over the course of the estimates, this is less than the forecast 9.3% rate of public hospital price inflation and is a consequence of the Commonwealth commitment to meet a greater (60%) proportion public hospital funding.

Despite limitations in relation to data and policy parameters the analysis above suggests that the proposed NHHN model will do little to address the structural financial problems and intergovernmental conflicts that have afflicted Australian health policy in recent years. In this context it is critically important to assess whether the NHHN is likely improve the efficiency of Australia's health system.

2a. The NHHN's Impact on the Demand for Health Services

Australia has a significantly higher rate of hospitalisation than the UK, USA, New Zealand and Canada (AIHW 2010). The achievement of a clear demarcation of roles and responsibilities in the health care system should help overall coherence of the system, reduce the political 'blame game' and mitigate unnecessary demands on public hospitals. When judged against a single funder ideal-model, the present reforms fall short; there is no neat separation of the Commonwealth as a purchaser of all health care and regulator of quality and states as providers of hospital services. Yet even if the single funder is politically infeasible at this time, nevertheless from a patient's point of view, there remains a pressing need to organise successful cross-jurisdictional pathways in the system; to not allow governance boundaries to inhibit the smooth and efficient delivery of health care to patients.

At the organisational level, the challenge of improving the connectedness of the system from the patient point of view relies on the relationship between the new Local Hospital Networks (LHNs) and Medicare Locals (MLs). However, these new boundaries in the system are currently underspecified

in the NHHN, as is their relationship to aged care. Although the three parts of new system – local hospitals, local medicare, aged care – are the building blocks of the health care system, how they are to be integrated and linked up is the critical success factor for the implementation of the reform package. The problems of organisational planning and partnership working are endemic in the public sector; and the NHHN lacks clarity on this implementation problem. For example, in terms of hospitals, it is still uncertain about territorial scale and governance arrangements for LHNs and whether these will be coterminous with MLs.

The 2010 Intergenerational Report (Treasury 2010), as well as an 2009 IMF report, preview the extent of the fiscal costs of health and long term care of population over 65 confronting Australia: these will increase from 6.5% GDP up to 12.6% GDP on relatively modest assumptions by 2050 and in Commonwealth budget terms, on current policy settings, there will be a substantial redistribution as health increases its share of total expenditure from 15% to 26%. Importantly, it is older Australians that face the biggest boundaries in the system: those between health, aged and community care. This is the sharp end of the cross-jurisdictional, joined-up ambitions in reform package. There is a pressing requirement for universal case management with its corollary of an effective e-records system as well as sustained assistance for the aged care industry. Low-level, non-clinical health and social care needs more private and voluntary sector involvement, for example to increase the number of places in homes and care facilities. The link between hospitals and nursing homes remains poorly understood and planned; as is the connection, particularly for older Australians, between community care services and primary health care services such as chronic disease management strategies. The reform package at this design stage lacks detail and clarity about how these sorts of governance arrangements will be implemented.

There is always a difference between the 'ideal' system and 'real' system. Improving connections between different parts of the Australian health care system will require, at the clinical 'coalface', cross-boundary case management teams and clear, established pathways through the system. In turn, this requires genuine devolution of power to the level at which health care is actually supplied. In such terms, there was a consensus that greater clinician involvement in making decisions about these clinical pathways through the system was highly desirable (e.g. outpatient centres and GP links). However, will the implementation of the devolution of power to LHNs foreseen in the reform design actually succeed in releasing dynamism and innovation in the system to mitigate the adverse influence of boundaries? The role of the Commonwealth health minister and State health ministers in the 'blame game' is critical in realising the beneficial consequences of decentralisation. From the perspective of the contemporary politics of health and experience in other OECD countries, in particular where individual cases of mistakes or poor performance gain attention and come to stand as representative of the whole, there are grounds for some scepticism about devolution in practice.

A proposal to mitigate this problem of health politics would be a formal separation of policy and operations at the Commonwealth level. The capacity of LHNs to realise the potential for autonomy envisaged in the reform package demands both early leadership from the new organisations as well as a Commonwealth commitment to insulate the operational management of LHNs from ministerial interference; this commitment is more credible when it is in solid organisational form, for example a separate executive, perhaps with regional offices, that manages the Commonwealth's transactions with LHNs. In addition, the Commonwealth will need to provide some regional support for primary

carers, aged care and community care, as well as supporting information linkages throughout the system through e-health initiatives.

2b. The NHHN's Impact on the Supply of Health Services

In principle, activity based funding should be good for the public hospital system by improving the transparency of the relationship between what is done and what is funded. But international experience is that the incentives created by activity-based funding are complex and potentially perverse. Implementation difficulties have been a feature of all countries that have introduced national pricing schemes, with schedules having to be constantly rebalanced and methods for setting prices regularly revisited. Hospitals do not face a single price but rather an extensive menu of prices for different Diagnosis-related group (DRG) codes, and it is relative prices that will provide incentives for behaviour of the system and patients. In such terms, the incentives in performance terms in the NHHN are not clear. If the national price is greater than cost of provision then hospitals will supply that service, but what if the national 'efficient price' is lower than the hospital's cost? Will there be transition arrangements until price equals cost or will hospitals be permitted to withdraw services that they are unable to provide at the efficient? The micro-level mirrors the macro set out in section 1:the States still bear the demand risk in the system.

Furthermore, activity-based funding is a means of allocating a health budget and does not reveal cost information; therefore it may provide inaccurate signals for supply capacity, and both the renewal and maintenance of health care capital. How the prices will be set by the new national HPA will be critical to the supply incentives in the system. For example, if average cost pricing rather than marginal cost pricing is adopted, then at the margin, the Commonwealth could potentially be funding well over 60% of MC providing incentives to states to oversupply certain hospital services.

In addition, there are two other common problems about case-based funding that have occurred internationally. First, there is the selection problem of incentives to take the easy cases, and reduce the harder, more expensive clinical services, and second, national prices by DRG code provide low-powered incentives for clinical service quality.

While activity based funding presents some governance advantages in the system by increasing transparency and facilitating accountability, it is moot whether it will drive efficiencies in hospital service provision to overcome the macro-level financial pressures outlined in section 1.

Conclusions

Understood as macro reform, the NHHN does not hold the prospect of resolving the medium term financial resource pressures in the Australian health care system and associated intergovernmental fiscal tensions. Similarly, if we see the NHHN as a micro reform then there are reasons to doubt whether demand growth will be mitigated or supply capacity increased to mitigate those macro-level financial tensions.

Our recommendation is that the Committee examines closely the implementation of the NHHN, paying particular attention to three key factors:

(i) The interrelationships of LHNs, MLs and aged care provision in terms of the coherence of the patient experience of the Australian health care system;

(ii) The role of the Commonwealth in promoting decentralised health care decision-making;

(iii) The role of State governments in the design and implementation of the new LHNs.