Chapter 7

Conclusion

Labor's wasted opportunity for real health reform

7.1 During the lead-up to the April 2010 COAG meeting on health reform, the Prime Minister toured the length and breadth of the country, perched earnestly each day on the beds of the nation's patients commiserating with them over the multiple ills of the health system and most especially, the public hospital system. Mr Rudd was pictured in his white coat eagerly extending his hand of comfort and promising that he would take control of health care delivery, bringing 'an end to the blame game' between the Commonwealth and state governments and promising a 'federally funded, locally run' system.

7.2 Mr Rudd warned the Premiers to get out of the way of his health reform train. At the conclusion of April COAG meeting, the Prime Minister proclaimed the outcome as the greatest reform of the health system since Medicare, and the Premiers and Chief Ministers (except Mr Barnett from WA), newly enriched by Mr Rudd's various inducements to their coffers, were pleased to endorse that view.

7.3 However, as is clear from the many submissions and evidence at the hearing by health professionals who understand the system, there is a clear view that Mr Rudd has squandered a rare opportunity for true health reform. Indeed, the recent resignation of Professor Mendoza, Chair of the National Advisory Council on Mental Health, and the strident criticism of Professor Patrick McGorry regarding lack of focus on mental health in the package at the committee's hearing are only two of the examples of what has been described as a wasted opportunity for real reform.

7.4 In short, the outcome the Prime Minister negotiated is a policy and governance failure that will do nothing to 'end the blame game' between the Commonwealth and the states, while entrenching state control of the hospital system. This is a far cry from Mr Rudd’s 2007 election campaign promise of a 100 per cent takeover of the health system, when he promised that 'the buck will stop with me'.

7.5 After two and a half years of talk about reform, Mr Rudd announced the vastly less ambitious plan to simply reverse the current 40/60 per cent Commonwealth/State funding responsibility for hospital services to a 60/40 per cent split. Mr Rudd and Minister Roxon, insisted that the Commonwealth's 60 per cent 'dominant' share was the key and non-negotiable reform required to drive the reform plan, thus justifying the claw-back of 30 per cent of GST revenue.

7.6 The Australian public was invited by Mr Rudd to conclude that this would enable the Commonwealth to bypass incompetent and bloated state health bureaucracies to deliver the funding directly to the treating hospitals through the new Local Hospital Networks. However, the devil in this case is in the *lack of detail*. It was

very clear from the evidence to the inquiry that it is unclear precisely how the 60/40 split will 'end the blame game'.

No real reform and business as usual with the States and territories

7.7 It is clear that critical concessions were made to Victorian Premier Brumby in return for his agreement on the 30 per cent GST claw-back.

7.8 This focused on the establishment of separate health funding pools in each state and ensuring key governance elements remained with the states as well, including the selection of the Local Hospital Networks (LHNs). In short, in order to ensure a successful political outcome from his negotiations, at least with the Labor Premiers, Mr Rudd backed down on elements he had earlier described as critical to reform.

7.9 It is clear from the evidence and most particularly from the terms of the National Health and Hospitals Network Agreement (the 'Intergovernmental Agreement') that there has been no fundamental change in the roles and responsibilities of the Commonwealth and the states in health care delivery. It is unlikely that there will be any reduction in the size of the state and territory health care bureaucracies but there will be a new level of bureaucracy necessary to manage the new and complex funding arrangements between the Commonwealth and each of the individual states and territories.

7.10 One cannot but cynically think that perhaps the real intention was to leave the states in control of key aspects of the hospital system, so that the Federal Government can take the credit for any improvements in the system while continuing to attribute the blame for any failures to the states.

Specific concerns about the plan

7.11 Many concerns were raised about the plan. These included:

The involvement of local clinicians

7.12 Many submitters argued the need for local doctor representation on Local Hospital Networks and expressed concerns that the specific wording in the Intergovernmental agreement that clinical expertise will come from outside the local area, wherever practical which contradicts the promise of 'locally run'.

7.13 In short, there is a strong view that the doctors on the LHNs must come from the local communities served.

Governance and financing issues

7.14 Many submitters raised their concerns about the lack of detail regarding governance and accountability issues.

7.15 These concerns are compounded by the dumping of the central accountability and transparency mechanism of the National Funding Authority, which was inserted to ensure that the states and territories did not siphon off funds for other purposes or for added bureaucracy.

Activity-based funding and capping

7.16 Despite all the hype, it is clear in the Intergovernmental Agreement that the states and territories will decide not only the boundaries of each LHN but will also determine the budget for each LHN. States decide what services they will 'purchase' from each LHN under their agreement with the LHN.

7.17 This service agreement remains entirely a matter for the LHN (created by the state or territory) and the relevant state or territory government. Without any oversight it is not possible to guarantee that state governments may use these agreements to restrict rather than expand services in particular areas.

Recurrent and capital budget control: more opportunities for 'blame game'

7.18 Concerns about the 'blame game' continuing were succinctly summarised in this quote from the AMA submission:

> The AMA is concerned that the funding structure agreed to in the IGA will not end the blame game, but instead merely provide different opportunities to undermine and 'game' the system.[1]

7.19 Many of the details about recurrent and capital budget control are unclear. Specifically, while the Commonwealth will pay 60 per cent of the 'efficient cost' of hospital patient services, the states and territories will determine the level of services that each LHN will provide.

7.20 It remains unclear how the total budget available each year will be determined. Similarly, the Commonwealth will pay 60 per cent of capital expenditure but it appears the states will determine the total level of capital spending. On that basis, it remains unclear how the Commonwealth could prevent the states from setting the total recurrent and capital budget in any year to whatever level the states could afford at the 40 per cent contribution level with the Commonwealth consequently having to provide its 60 per cent share.

7.21 There are many references to the respective treasuries and treasurers providing advice on these issues, but concerns remain that the financial governance is wide open to disputed interpretations at each COAG meeting, so that the level of disputation may be worse than ever.

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1 Australian Medical Association, *Submission 10*, p. 3.

Bureaucracy

7.22 It is clear that there are several additional bureaucratic structures, both state and federal.

7.23 Whilst the stated intention is that the plan is that they be introduced with no increase in bureaucracy, concerns have been raised that this is not likely to be the case. Disappointment has been expressed about this given the original purpose was to reduce duplication and improve efficiency.

7.24 Other concerns have been raised. These include:

- how the new Independent Pricing Authority is meant to achieve the 'efficient price' of services given the absence of data that could be used for this purpose;
- doctors' opposition to any move away from fee-for-service funding; and
- the lack of involvement of private hospitals in the plan.

7.25 In conclusion, despite having over two and a half years of talk about health reform, the plan now being sought to be implemented was a massive political compromise from the Prime Minister cobbled together in the weeks preceding COAG.

7.26 Instead of achieving a 'federally funded, locally run' system, the Prime Minister has been comprehensively out-manoeuvred by the states which have ended up gaining substantial increases in funding without guarantees of improved patient access and outcomes. Australians had expectations that this plan would result in better run public hospitals. There is no confidence from the evidence in this inquiry that this will be delivered.

Senator Scott Ryan

Chair