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.