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