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**Commonwealth-State
Responsibilities for Health – ‘Big
Bang’ or Incremental Reform?**

by

Gareth Griffith

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EXECUTIVE SUMMARY

In the ongoing debate on the reform of Australia’s federal system of government no issue features more prominently than Commonwealth-State responsibilities for the funding and delivery of health care services. In October 2004, the then Premier of NSW, Bob Carr, flagged his willingness to renegotiate responsibilities between the Commonwealth and State governments and to even consider surrendering administration of health to the Commonwealth. In April 2005 the Prime Minister, while acknowledging that there ‘will always be room for improvement’, said he was not persuaded ‘by some of the options for radical reform that are often canvassed’. He continued, ‘In particular, I am not persuaded that the effectiveness or efficiency of health care in Australia would be improved by the Australian Government assuming responsibility for public hospitals’. In the communiqué from COAG of 3 June 2005, the Commonwealth, State and Territory ‘governments recognised that the health system can be improved by clarifying role and responsibilities, and by reducing duplication and gaps in services’ (pages 1-3).

Today’s health system is the product of past practice and decision-making. At the time of federation, the question of health was not at the forefront of public policy. By 1945 the situation had changed, with health firmly on the political agenda and health spending increasing. Before the Second World War the Commonwealth had only a limited stake in the health system. It had direct responsibility for quarantine, under s 51(ix) of the Australian Constitution and for ‘invalid and old age pensions’ under s 51(xxiii). In 1946, under new s 51(xxiiiA), the Commonwealth was granted power over social services, including ‘*pharmaceutical, sickness and hospital benefits, medical and dental services (but not do as to authorize any form of civil conscription)*’. Other sources of Commonwealth power include: s 96 (the power to make special purpose grants); ‘insurance’ (s 51(xiv)), the corporations power (s 51(xx)); the defence power (s 51(vi)); and, as amended by the referendum of 1967, s 51(xxvi) which empowers the Commonwealth to make laws for the benefit of Indigenous Australians (pages 4-11).

Politically, health has traditionally been a source of ideological difference between the Coalition parties and Labor, with the latter championing a national health insurance scheme, the current form of which is embodied in Medicare. The role played by private health insurance remains controversial (page 10 and page 39). Financially, in health as in all other areas, the Commonwealth is now the dominant force, as shown by the fact that the share of total tax revenues collected by the State (and local) governments has fallen from 87% in 1901-02 to 18% in 2004-05 (page 11).

From this mix of factors, the broader point to make is that constitutional responsibility for health care in Australia is divided between the Commonwealth and the States along lines that owe at least as much to the vagaries of history as to any principles of rational public administration. The result is a fragmented health system operating in the context of a form of co-operative federalism and maintained by complex bureaucratic and political mechanisms, some informal, other formal in nature (page 11-18).

Issues in health funding include health inflation. Between 1994-95 and 2004-05 the average rate of general inflation was 2.5% per year. Health inflation during that period averaged 2.9% per year, giving an excess health inflation rate of 0.4% per year. From 2003-04 to

2004-05, health inflation was 4.2%, the highest it has been over the decade. The Productivity Commission projects growth in public spending on health (excluding aged care) from 6% to over 10% over the next 40 years, with public spending on aged care increasing from under 1% to around 2.5% (pages 19-20).

Particularly contentious is public hospital funding. Between 1994-95 and 2004-05, the Commonwealth's funding dropped from 47.6% to 44.2% (a decrease of 3.4 percentage points), whereas the States and Territories lifted their share from 43.3% to 48% (an increase of 4.7 percentage points). Further, between 2002-03 and 2004-05, the Commonwealth share of public hospital funding declined 1.8 percentage points from 46% to 44.2%, whereas State and Territory government funding during this period increased 1.2 percentage points from 46.8% to 48% (page 22).

In 2004-05, the Commonwealth's funding of health expenditure was an estimated \$39.8 billion, up from \$35.7 billion the year before. This was 45.6% of total funding for health by all sources of funds. State, Territory and local government sources provided \$19.7 billion, or 22.6% of the total from all sources, with the remaining \$27.7 billion or 31.8% coming from non-government sources (page 24).

State and Territory governments are the main providers of publicly provided health goods and services in Australia, primarily through public hospitals. Those health goods and services are financed by a combination of Special Purpose Payments from the Commonwealth, funding by the States and Territories out of their own fiscal resources, and funding provided by non-government sources (usually in the form of user fees). State and Territory governments also provide or purchase ambulance, dental and community health services, for which they provide most of the funding. Further, they are a major source of public health activities, such as infectious disease control and health promotion campaigns (page 26).

Major issues in the health debate include: cost shifting between the different levels of government; Indigenous health; access and equity in remote and rural Australia; and health workforce shortages. Some of these are more closely aligned to the Commonwealth-State division of responsibilities than others (pages 33-46).

The various proposals for a more integrated health system begin by setting out the major options for reform, usually in terms of: (a) the Commonwealth assuming responsibility for health care; (b) the States assuming responsibility for health care; and (c) some kind of combined administrative structure, based on the pooling of funds for allocation at the regional level. Option (a) is of course very appealing to many, as are different versions of option (c). Option (b), however, seems to have no champions and is so politically unviable that it can be discounted for all practical purposes (page 64).

The main case of the Productivity Commission and others for major reform is founded on the contention that the big challenges to the health system lie in the near future, as funding pressures increase. In which case, the distinction between those problems that are caused in whole or part by the federal division of responsibilities, as against those caused by other factors needs to be clearly drawn (page 67).

1. INTRODUCTION

In the ongoing debate on the reform of Australia’s federal system of government no issue features more prominently than Commonwealth-State responsibilities for the funding and delivery of health care services. Writing in 1997, Swerissen and Duckett echoed the concerns of many when they said that ‘the current arrangements lead to cost shifting, duplication, inefficiency and game playing, which distract from the objective of producing a better health system’.¹ More recently Duckett, a former Secretary of the Commonwealth Department of Human Sciences and Health, has argued:

Government responsibility for health and community services in Australia is shared between the Commonwealth and the states. This split responsibility means that it is difficult to develop comprehensive national policies. States have responsibility for hospital services, the Commonwealth assumes responsibility for medical services, and both take some responsibility for home and community care projects, and for disability services. These divisions render coherent policy making, even at the state level, almost impossible.²

In March 2004, the Commonwealth Health Minister Tony Abbott said the idea of a federal takeover of health was ‘the debate we had to have’, arguing that ‘Removing one level of government will certainly reduce the scope for buck passing and blame shifting which bedevils every health policy discussion’.³ In October 2004, the then Premier of NSW, Bob Carr, flagged his willingness to renegotiate responsibilities between the Commonwealth and State governments and to even consider surrendering administration of health to the Commonwealth.⁴ He said:

it would make sense to have the national level of government responsible for delivering the whole range of health care services. A trade off would be [for the Commonwealth government] to cede autonomy over schools and TAFE policy to the States.⁵

This coincided with the release of a draft report by the Productivity Commission pointing to widespread claims of ‘considerable inefficiency and waste’ in health care, with the Commission’s chairman Gary Banks saying the health system was ‘beset by structural problems that require nationally co-ordinated action’.⁶ Similar views were expressed in a

¹ H Swerissen and S Duckett, ‘Health policy and financing’ in H Gardner ed, *Health Policy in Australia* (1997), p 37.

² SJ Duckett, *The Australian Health Care System*, 2nd ed (2004), p 112.

³ T Abbott, ‘Health reform – its possibilities and limitations’, *Speech to Queensland Press Club, Brisbane, 26 August 2005*.

⁴ A Davies and M Wade, ‘Health-care reform is next on agenda’, *SMH*, 28 October 2004, p 6.

⁵ A Davies, ‘Carr offers to trade powers with Canberra’, *SMH*, 20 October 2004, p 1.

⁶ ‘Productivity Commission calls for urgent look at way health system is run’, *SMH*, 27 October 2004, p 5.

policy statement, *Practical Federalism*, announced in June 2005 by the former Leader of the Opposition, John Brogden. Speaking of the ‘many examples of failure of the Australian federal system’ he commented

the problems are most stark in the area of health. The Federal Government funds Medicare, nursing homes, private health insurance and the Pharmaceutical Benefits Scheme, while the States part-fund and manage public hospitals, and run public health programs, public dental programs and mental health programs. These shared and often overlapping responsibilities inevitably see the Commonwealth and the States working at cross-purposes.⁷

Not all the commentary is negative. For example, the Prime Minister said recently that there is no crisis in the health system.⁸ At the same time the fact that problems exist in this area is recognised more or less across the board. Identifying problems can be difficult enough. Deciding what to do about them is more difficult again. As the Productivity Commission chairman went on to observe, ‘there is less agreement on the best way forward’.⁹ In April 2005 the Prime Minister, while acknowledging that there ‘will always be room for improvement’, said he was not persuaded ‘by some of the options for radical reform that are often canvassed’. He continued, ‘In particular, I am not persuaded that the effectiveness or efficiency of health care in Australia would be improved by the Australian Government assuming responsibility for public hospitals’.¹⁰ A ‘single-funder’ model was proposed in a paper commissioned by the Prime Minister in 2005 and written by Andrew Podger, another former secretary of the Commonwealth Health Department.¹¹ For the Federal Opposition, health spokeswoman Julia Gillard has said that ‘Reform is never easy, but no reform is not an option. Our health system will break’.¹² Indeed, Gillard has suggested that a future Labor government would not only tackle issues of cost-shifting, but would also undertake a ‘serious discussion’ about a Commonwealth takeover of the State’s public hospitals.¹³ Big questions are about to be asked, it seems. On that theme, Roger Wilkins, until recently the Director General of the NSW Cabinet Office, states:

⁷ J Brogden, ‘Practical Federalism’, *Address to the Federal Council of the Liberal Party of Australia*, June 2005, p 3.

⁸ Department of Premier and Cabinet, Victoria, *Governments Working Together: A third Wave of National Reform – A New National Reform Initiative for COAG*, August 2005, p 32.

⁹ Productivity Commission, ‘Review of National Competition Policy Reforms’, *Media Release*, 27 October 2004.

¹⁰ J Howard, ‘Reflections on Australian Federalism’, *Address given to the Menzies Research Centre, Melbourne*, 11 April 2005, pp 11-13.

¹¹ The paper was never released – J Breusch, ‘Labor labours health policy initiatives’, *The Australian Financial Review*, 22 September 2006, p 20. See A Podger, ‘Directions for health reform in Australia’ in Productivity Commission, *Productive Reform in a Federal System, Roundtable Proceedings*, Canberra 27-28 October 2005.

¹² J Gillard, ‘The health system is in dire trouble’, *The Age*, 23 August 2006, p 19.

¹³ J Breusch, n 11, p 20.

The biggest single problem about federalism has been and is the failure of successive Commonwealth and State governments to engage in looking at the big question: what are the roles of the States and the Commonwealth in delivering the core public services of health, education, aged care, disability services, housing, child care?¹⁴

In relation to health, these issues are now under serious consideration, including in the communiqué from COAG of 3 June 2005, stating that the Commonwealth, State and Territory ‘governments recognised that the health system can be improved by clarifying role and responsibilities, and by reducing duplication and gaps in services’.¹⁵ On 16 March 2005 the House of Representatives Standing Committee on Health and Ageing resolved to conduct an inquiry into health funding. Its terms of reference include:

- examining the roles and responsibilities of the different levels of government (including local government) for health and related services; and
- simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with particular emphasis on hospitals.

This paper does not attempt to pre-empt that inquiry. Rather, it is largely descriptive in nature. It seeks to set out the respective responsibilities of the Commonwealth and State governments for health care in as clear a way as possible, identifying those areas where cost-shifting and duplication exist. Some of the major issues in the health debate are also discussed, with a view to identifying the extent to which they are connected to the federal division of responsibilities. In this context, the major research findings and recommendations for reform of the health system are considered, specifically with a view to deciding whether the evidence presented points more towards a ‘big bang’ solution as preferred by many commentators, or does it suggest a need for ongoing incremental change, the position preferred by the Prime Minister? This briefing paper represents the state of play as at 17 November 2006.

¹⁴ R Wilkins, ‘A new era in Commonwealth-State relations?’ (April 2006) *Public Administration Today* 8 at 11.

¹⁵ <http://www.coag.gov.au/meetings/030605/index.htm - health>

2. HISTORICAL AND CONSTITUTIONAL BACKGROUND

2.1 The health system in NSW before 1945

Today's health system is the product of past practice and decision-making. As Crichton comments:

The Australian system of financing and managing health care services is complex and difficult to understand unless one takes an historical perspective, for it is a system which has been evolving gradually from a private entrepreneurial-philanthropic way of providing care towards a government funded and controlled service organisation. Because the system has evolved and is still evolving, it reflects compromise rather than rational planning.¹⁶

At the time of federation, the question of health was not at the forefront of public policy. The Federation Convention Debates themselves are silent on the subject. Before 1914, 'health' appeared not at all and 'hospitals' only intermittently as a heading in the index to NSW parliamentary debates.

Of course health related issues were debated in the nineteenth century, among them arrangements for quarantine and the construction of public works for the provision of clean water and an efficient sewerage system. A major spur to legislative reform was the smallpox epidemic of 1881 which saw the establishment of a Board of Health. The control of infectious diseases was a major concern of the NSW *Public Health Act 1896*. Five years later the bubonic plague arrived in Sydney. The registration of legally qualified medical practitioners was dealt with under the *Medical Practitioners' Act 1898*. That same year major mental health legislation was passed in the form of the *Lunacy Act*, although in that case statutory arrangements had been in place for many years.¹⁷ Also provided for in legislation were certain administrative arrangements relevant to hospitals boards, institutions that were generally not under government control at this time.

At the turn of the twentieth century certain hospitals were in government hands, notably the quarantine stations at North head and at Stockton near Newcastle and the Coast Hospital at Little Bay¹⁸ all of which dealt with infectious diseases. There were also five government hospitals for the insane and six asylums for the infirm.¹⁹ Presenting an overview of the hospital system, Tyler comments:

¹⁶ A Crichton, *Slowly Taking Control? Australian Governments and Health Care Provision 1788-1988* (1990), p 7.

¹⁷ For a commentary on the relevant legislation, dating from the *Dangerous Lunatics Act 1843*, see – CJ Cummins, *A History of Medical Administration in NSW 1788-1973*, 2nd ed (2003), pp 110-112.

¹⁸ After a royal tour by the Duke of Gloucester in 1934 it was renamed the Prince Henry Hospital.

¹⁹ PJ Tyler, *Humble and Obedient Servants: The Administration of NSW, Vol 2, 1901-1960* (2005), p 9.

Hospitals were mostly independent, run by religious orders, charities or local boards, although they generally received a government subsidy for about half their expenditure. Of the 119 general and maternity hospitals in New South Wales in 1899, all but eight received this support. The balance came from bequests, charitable donations and subscriptions.²⁰

Hospitals were mainly for the indigent,²¹ with those who could afford it preferring to be treated at home. However, pressure on the hospital system was growing, largely as a result of the widening gap between what could be done in the home and in the hospital, a gap created by advances in medical knowledge. According to Dickey:

In 1901, nearly 31,000 people were admitted to the hospitals of the State; by 1910 the figure was nearly 52,000. Sometimes these people made donations as thanks offerings for the help which was given to them. But this did not amount to much. The largest source of financial support for the hospitals was the government, which contributed £91,400 of their total income of £182,200 in 1901 and £146,700 of £314,400 in 1910. While the hospital boards retained their independence and continued their work as charitable institutions, community demand and government support were undermining their traditional position.²²

Resistance to increasing government involvement in the provision of health care services came mainly from doctors, who were trenchant in their criticism of any attempt to place hospitals on a business footing, thereby reducing ‘Medicine to the level of a Trade’.²³ The main source of countervailing pressure was the Labor Party, representing a wide section of the working classes in NSW who were ‘eager to enjoy free medical services, but who found them increasingly difficult to obtain because of their scarcity’.²⁴ With Labor in power in its own right in 1910, the Labor MLC, Fred Flowers, told his audience at the South Sydney Hospital site:

Any idea that they [hospitals] are to be regarded as charitable institutions is altogether erroneous. Hospitals are a necessity of civilization, and the Government should see to their upkeep and control. Hospitals should be as free as the Art Gallery or Public Library...and there should be no taint of pauperism.²⁵

²⁰ Tyler, n 19, p 8.

²¹ Since 1902 this included the Dental Hospital.

²² B Dickey, ‘The Labor Government and Medical Services in NSW, 1910-1914’ (April 1967) *12 Historical Studies (Australia and New Zealand)* 541 at 542. Dickey’s figures would seem to exclude funding of government hospitals.

²³ Dickey, n 22, p 550

²⁴ Dickey, n 22, p 541.

²⁵ Speech from March 1911 quoted in Dickey, n 22, at 544.

Between 1914-18 a new range of wards were planned and built at the government's Coast Hospital. Around the same time, with support from Flowers, five clinics available to indigent persons for the prevention and cure of consumption were opened in Sydney with government financial aid. Also outside the hospital system, Flowers moved to extend the scheme already in place providing free home visits by nurses to new mothers in the poorer districts. A further significant development under Labor was the establishment of free baby clinics, eight of which operated in suburban Sydney by the end of 1915, 'the forerunner of a Baby Health care network throughout the State'.²⁶

It was Flowers, the first Minister for Public Health in April 1914, who was responsible for the newly established Department of Public Health. Before then, from a public administration standpoint, the health system was in its infancy. Golder writes that in the 1880s the Treasurer was responsible for quarantine 'because it affected commercial interests, while the rest of a very rudimentary "health system" remained in the Colonial Secretary's Department, where the police were used to document and deal with outbreaks of disease in remote areas'.²⁷ Tyler describes the division of ministerial responsibilities as a 'hotchpotch', saying 'Typically, political rivalries prevailed over rational administration for a long time'.²⁸ Complex administrative arrangements remained even after 1914, described by Tyler as 'labyrinthine' in nature and guaranteed 'to lead to considerable misunderstanding, with consequent confusion and delays'.²⁹

Health services themselves also remained something of a hotchpotch, with Crichton writing:

The reforms introduced by Labor in NSW were not taken further after the war. The public was not ready to support greater change and so the traditional system was allowed to drift along, although a Hospital Commission was set up as a coordinating body in 1929.³⁰

As Tyler explains, the Commission was established under the *Public Hospitals Act 1929* to regulate the management of 175 scheduled hospitals and 34 other institutions. Under the legislation, public hospitals were authorised to charge fees to patients who could afford it,

²⁶ Tyler, n 19, p 57.

²⁷ H Golder, *Politics, Patronage and Public Works: The Administration of NSW, Vol 1, 1842-1900* (2005), p 191.

²⁸ Tyler, n 19, p 9.

²⁹ Tyler, n 19, p 55. For a diagrammatic representation of the organization of the Ministry of Health up to 1938 see – Cummins, n 17, p 142. According the NSW Year Book, the Department of Public Health was organised in two branches, one directed by the Board of Health and the other by the Director General of Public Health. The Board of Health, of which the Director General was ex officio President, acted in a advisory capacity towards the Minister for Health and exercised general supervision in regard to public health matters. The Director General controlled the State medical services and the State institutions for the treatment of the sick and infirm.

³⁰ Crichton, n 16, p 29.

which led eventually to a graduated scale of public, intermediate and private wards, as well as to the establishment of hospital insurance funds.³¹ The Hospital Contribution Fund (HCF) of NSW originated in 1932.³² Established in 1947 was the Medical Benefits Fund (MBF) of NSW, sponsored by the British Medical Association, in respect of the cost of treatment by registered medical practitioners in private practice.³³ During the Depression, the State Lottery was introduced to help meet the shortfall in hospital funding, this after the failure of a plan to install poker machines in public hospitals for the same purpose.³⁴

In these difficult circumstances, self-help schemes flourished among the working classes, notably through the co-operative movement. To take one example, in the mid-1930s the Marrickville Dispensary, a prominent local co-operative organisation, had over 4,000 members and dispensed something like 80,000 prescriptions a year.³⁵ At the same time, by any measure government involvement in hospital funding was increasing. Using the *Year Book of NSW* as a guide, whereas in 1904 total expenditure by government on hospitals amounted to £218,498,³⁶ by 1946-47 subsidies to hospitals by the NSW government alone amounted to £2,934,945, a figure that excluded £1,058,000 advanced by the Commonwealth government under the *Hospital Benefits Act 1945*.³⁷

These figures pale into insignificance besides later funding levels, which have increased exponentially as health has taken centre stage in the public policy debate. Speaking in September 2006, the present Minister for Health, John Hatzistergos, reported that

the 2006-07 annual recurrent budget for the New South Wales health system has once again increased – to a record \$11.7 billion. In '06-'07, more than 27 per cent of the 2006-07 State budget is being allocated to Health. This year's State budget sees health expenditure increased by \$828 million or 7.6 per cent compared to last year's budget.³⁸

³¹ By June 1946, the number of beds in public hospitals included 13,804 in public wards, 1,071 for private and 2,465 for intermediate patients – SR Carver, *The Official Year Book of NSW 1945-46* (1948), p 835.

³² Originally as the Metropolitan Hospitals Contribution Fund – Carver, n 31, p 836.

³³ Carver, n 31, p 838.

³⁴ Tyler, n 19, p 117. For a commentary see – T Waites, *The Official Year Book of NSW, 1931-32* (1933), pp 262-64.

³⁵ D Clune, 'JJ Cahill' in *The Premiers of NSW, Vol 2, 1901-2005* edited by D Clune and K Turner (2006), p 295.

³⁶ WH Hall, *The Official Year Book of NSW 1904-05* (1906), p 691.

³⁷ Carver, n 31, p 815.

³⁸ NSWPD, *General Purpose Standing Committee No 2, Estimates Hearing - Health*, 4 September 2006, p 2.

2.2 The Commonwealth's constitutional powers

Before the Second World War the Commonwealth had only a limited stake in the health system. With direct responsibility for quarantine under s 51(ix) of the Australian Constitution, the Commonwealth had taken over North Head Quarantine Station in 1911, to be faced with an outbreak of smallpox two years later. Commenting on the inauspicious beginning to Commonwealth-State arrangements in this field, Tyler writes:

The Federal Director of Quarantine, Dr JHL Cumpston, decided to restrict travel to and from Sydney, creating considerable resentment. The New South Wales Board of Health said it was unnecessary harassment, as well as unlikely to be effective. Restrictions remained in force for nearly five months, and led to antagonism between the Commonwealth and State health authorities that would take many years to dissipate.³⁹

From the Commonwealth standpoint, the official line was that the outbreak of smallpox in NSW in 1913 and the later influenza epidemic in 1919 revealed two things: 'One was that there was no way in which to secure effective co-operation between the States during an emergency, the other that a co-ordinating authority in health matters was an urgent necessity'.⁴⁰ With State approval, the Commonwealth Department of Health was subsequently created in 1921, the Director of Quarantine becoming the Commonwealth Director General of Health and Permanent Head of the Department. The new Department's limited functions centred on quarantine, industrial hygiene and the conduct of medical research.⁴¹ The Federal Health Council was also established in 1926, consisting of the Commonwealth Director General of Health and the professional heads of the State Health Departments, 'to advise the Commonwealth and State Governments on health questions generally and to devise measures for co-operation and for promoting uniformity in legislation and administration'.⁴² In 1937, the Council was renamed the National Health and Medical Research Council, and its membership expanded to include representatives from the British Medical Association, the College of Physicians and Surgeons and others.

Generally, Commonwealth involvement in the provision of health care was subject to ideological and constitutional restraints. A Royal Commission on Health in 1926 noted that, in an era of increasing health consciousness, activity and hence expenditure, 'the

³⁹ Tyler, n 19, p 55. When the so-called Spanish Flu epidemic arrived in Sydney in 1919, as a result of the smallpox experience, the Board of Health 'had no confidence in the Commonwealth's ability to deal with the situation'. For the adjournment debate on the smallpox epidemic see – *NSWPD*, 28 August 1913, p 1037. For a Commonwealth point of view see – JHL Cumpston, 'Public health administration' (1953) 12 *Australian Public Administration* 1.

⁴⁰ PD Abbott and LO Goldsmith, 'History and functions of the Commonwealth Health Department 1921-1952' (1952) 11 *Australian Public Administration* 119.

⁴¹ By 1924-25 the Department's total expenditure amounted to £187,799 - CH Wickens, *Official Year Book of the Commonwealth of Australia, 1926*, p 343.

⁴² T Waites, *The Official Year Book of NSW, 1931-32*, p 258.

States found themselves with insufficient and decreasing financial resources’. On Commonwealth-State co-operation, the report stated:

The basis of these efforts at co-operation has been the tacit recognition of the fact that the States possess legislative powers necessary for health administration and the Commonwealth possesses financial and other resources that could materially help to make administration effective.⁴³

The Royal Commission was followed by the introduction of a National Health Insurance Bill in 1927, which was abandoned a year later in the face of opposition from the medical profession, the friendly societies and the States, the last fearing they would lose control over workers’ compensation.⁴⁴ Powerful and competing interests were at work. In 1938 a National Insurance Act was passed, never to be enforced, the result it is said of ‘intense political opposition and the lack of a large body of public opinion in favour of it’.⁴⁵

The scene shifted in the 1940s, pushed by two forces. One of these was fiscal, in the form of the uniform tax system which effectively prevented the States from raising income tax, thereby shifting financial power significantly in the Commonwealth’s favour.⁴⁶ The second force was political in nature, grounded in Labor’s determination to increase the role of the central government in social welfare and other areas. According to Galligan, Labor’s original goal was a ‘nationalized health service run by a salaried medical profession’. In 1942 the plan was to provide ‘Free Health, Medical, Hospital, Dental and Pharmacy Services’, in which the Commonwealth Government would assume direction, in collaboration with the States, of all public hospitals, asylums and public health services. Central to the plan was the attempt in 1944 to gain Commonwealth power over national health. When the referendum failed to win the necessary support, the Government had to fall back on a less ambitious scheme, the first instalment being the *Pharmaceutical Benefits Act 1944* (Cth), the object of which was the provision of free medicine. Under this system, doctors would prescribe drugs from a standardised formulary, which patients would then present at a pharmacy that would be subsequently reimbursed directly by the Commonwealth. When the scheme was struck down by the High Court, essentially on the ground that the Commonwealth lacked the necessary head of power to appropriate money for this purpose, the Chifley Government proposed another constitutional referendum.

Up to that time the only social welfare matters the Constitution expressly provided for were ‘invalid and old age pensions’ (s 51(xxiii)). By new s 51(xxiiiA), the ‘social services’ referendum of 1946 further empowered the Commonwealth to make laws with respect to:

⁴³ PD Abbott and LO Goldsmith, n 40, p 120.

⁴⁴ Crichton, n 16 ,p 35.

⁴⁵ PD Abbott and LO Goldsmith, n 40, p 124.

⁴⁶ For a comprehensive review of what is called ‘vertical fiscal imbalance’ see – N Warren, *Benchmarking Australia’s Intergovernmental Fiscal Arrangements, Final Report, NSW Government*, May 2006, Ch 3.

The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not do as to authorize any form of civil conscription), benefits to students and family allowances.

The referendum was carried overwhelmingly, with all States voting in favour. Despite this, with ideological positions hardening in the medical profession and on the conservative side of politics generally, the Pharmaceutical Benefits legislation ran into further trouble. By early 1949, with only 117 doctors participating in the scheme, the Government made it compulsory by legislating that all prescriptions for items listed on the formulary for drugs had to be made on Commonwealth prescription forms. This amended legislation was challenged in the High Court on the ground that it imposed a form of civil conscription on the medical profession. The *Second Pharmaceutical Benefits* decision⁴⁷ confirmed this interpretation, thereby declaring the scheme unconstitutional. Within weeks of the High Court's decision, the Chifley Government was voted out of office, heralding 23 years of Coalition government. In terms of the Commonwealth's constitutional power, Duckett writes that subsequent cases have weakened the restrictive interpretation of 'civil conscription', with the result that the Commonwealth 'now appears to have the power to impose reasonable conditions on medical practitioners as part of its management of the Medicare benefits arrangements'.⁴⁸

Summarising the historical development after 1949, Gray writes:

The incoming Menzies government abandoned the prepaid hospital scheme and introduced publicly subsidised, private health insurance in the early 1950s. The scheme came under intense criticism for its lack of coverage, heavy user charges, complexity and expense. In response, Labor developed plans for a national health insurance scheme, called Medibank, which the Whitlam government introduced in 1975. But Medibank was dismantled, step-by-step, by the Fraser Coalition government and the voluntary health insurance system was reinstated.

Gray continues:

When next in office, from 1983, Labor again introduced a national health insurance scheme, this time called Medicare, which began operation on 1 February 1984. Medicare is administered by the Health Insurance Commission. It provides prepaid hospital care for all citizens and reimbursement at 85 per cent of the schedule fee for out-of-hospital medical services. If medical practitioners choose to bulk bill...there is no charge to the patient at the point of service. Medicare also provides reimbursement of 75 per cent of the schedule fee for

⁴⁷ *British Medical Association v Commonwealth* (1949) 79 CLR 201.

⁴⁸ SJ Duckett, *The Australian Health Care System*, 2nd ed (2004), p 114. Duckett refers to *General Practitioners Society of Australia v Commonwealth* (1980) 145 CLR 532. For a discussion of the term 'civil conscription' see – *Final Report of the Constitutional Commission, Vol One* (1988), pp 625-628.

medical services delivered to private patients in hospital. The cost of the scheme is shared between the Commonwealth, states and territories, an arrangement which is governed by Australian Health Care Agreements, negotiated every five years.⁴⁹

Note that section 51(xxiiiA) is by no means the only source of Commonwealth power in this field. Especially significant is the power to make grants to States, notably the Commonwealth’s power to make tied or special purpose grants under s 96 of the Constitution. This grants power enables the Commonwealth to influence joint Commonwealth-State programs ‘by attaching conditions to Commonwealth funding, in particular hospital funding, to ensure that its policy aims are met’.⁵⁰ In health, as in other matters, the Commonwealth’s power of the purse is considerable. Even with the untied transfer of GST revenue to the States in recent years, the financial primacy of the Commonwealth is undoubted. The share of total tax revenues collected by the State (and local) governments has fallen from 87% in 1901-02 to 18% in 2004-05.⁵¹ Nor is the Commonwealth dependent on its financial power. Health policies can also be based on more specific heads of power, including: ‘insurance’ (s 51(xiv)), the corporations power (s 51(xx)); the defence power (s 51(vi)) which grants to the Commonwealth control over veterans’ affairs; and, as amended by the referendum of 1967, s 51(xxvi) which empowers the Commonwealth to make laws for ‘The people of any race, for whom it is deemed necessary to make special laws’.

The broader point to make is that constitutional responsibility for health care in Australia is divided between the Commonwealth and the States along lines that owe at least as much to the vagaries of history as to any principles of rational public administration. According to Wheelwright:

The states have comprehensive power over hospitals and other important services without the financial resources to fully fund those services, whilst the Commonwealth has the superior funding capacity unmatched by the constitutional power to comprehensively regulate the services it finances. These constitutional divisions are crucial to understanding the fragmentation which exists in the regulation and delivery of health services.⁵²

⁴⁹ G Gray, ‘Health policy in Australia’, *Australian Policy Online* - http://www.apo.org.au/webboard/results.shtml?filename_num=12309

⁵⁰ K Wheelwright, ‘Commonwealth and State powers in health – a constitutional diagnosis’ (1995) 21 *Monash University Law Review* 53 at 62.

⁵¹ Warren, n 46, pp 17-18.

⁵² K Wheelwright, ‘Commonwealth and State powers in health – a constitutional diagnosis’ (1995) 21 *Monash University Law Review* 53 at 54.

3. CO-OPERATIVE FEDERALISM AND HEALTH

3.1 Fragmentation of accountability

The erosion of State financial autonomy since federation raises the important issue of the nexus between the responsibility for the raising of funds and the accountability of government for the way these funds are spent. One might say that the fragmentations of Australian federalism are many and varied, but the most profound are between the funding and actual delivery of services, a fragmentation that carries important implications for the responsible government. Often discussed in this context is what is called the ‘vertical fiscal imbalance’ between the Commonwealth and the States.⁵³ The Constitutional Commission commented:

The present situation in which the States are not responsible for the raising of most of the funds they spend has an obvious serious effect on the accountability and responsibility of those Governments. Expenditure decisions cannot in those circumstances take full account of the tax cost of the decisions. So, not only does the high fiscal imbalance impair the functioning of the State as an independent unit of federation, it tends to sap at least some of the duties of responsibility and sound decision-making that are the concomitants of governmental power. This in turn severs the link between policy making and electoral control.⁵⁴

With a fragmentation in accountability, added to the disparities between funding and delivery arrangements, there is ample scope for ‘buck passing’, with one level of government blaming the other for deficiencies in health resources and services. Ross Gittins put it this way:

When you have two people responsible for something, you end up with no one accepting the blame for anything. Tackle any health minister – federal or state – about a problem and all you get is a lecture about what rotten sods they are at the other level.⁵⁵

It might be argued that the problems identified in the debate are not with federalism *per se*, but rather with the particularly centralist version that had evolved in Australia. In effect, the constitutional arrangements agreed to the time of federation assume that the States will have the lion’s share of responsibility for those matters not expressly granted to the Commonwealth, including health. By the way those arrangements have been interpreted and applied, however, the States are left with insufficient means to adequately perform

⁵³ ‘Vertical fiscal imbalance’ is defined as a situation in which the central government in a federation raises more revenue than it expends. A federation’s rate of vertical fiscal imbalance is calculated as the ratio of the federal government’s revenue (measured as a percentage of total government revenue) to its expenditure (measured as a percentage of total government expenditure). The imbalance is corrected by transfers from the central to the regional governments: Victorian Parliament, Federal-State Committee, n 60, p 150.

⁵⁴ *Final Report of the Constitutional Commission, Volume Two*, AGPS 1988, p 826.

⁵⁵ R Gittins, ‘Unhealthy approach to system’s ills’, *SMH*, 27 October 2004, p 13.

their constitutional functions.

From another perspective, the fragmentations that federalism permits can be viewed in a positive light, as providing a geographic separation of powers with the State governments constituting ‘restraining centres of power and influence’.⁵⁶ Practically, the strength of federalism is that it can promote diversity and innovation. An example often cited in the health context is the introduction in Australia of casemix funding for public hospital inpatient services, pioneered in Victoria in 1993-94 and subsequently taken up in most other States, with each jurisdiction adapting it to its own circumstances. Casemix was not taken up in NSW, although this jurisdiction does use part of the framework (Diagnosis Related Groups, or DRGs) for tracking and research purposes.⁵⁷

3.2 Co-operative federalism

What has emerged in Australia, in health as in other areas, is described as a form of ‘co-operative federalism’, defined by Roger Wilkins as a system where the States and the Commonwealth both have responsibility for a good many areas of government, and rather than being able to act separately and distinctly have to cooperate and come together to get things done’. He continues:

So, for example, both the Commonwealth and the States have responsibility for health. The Commonwealth is more or less responsible for what happens outside hospitals and the States are more or less responsible for what happens inside hospitals. In Canada, by way of contrast, you find basically a coordinate system. With the exception of indigenous healthcare, the provinces are responsible for all aspects of health services.⁵⁸

3.3 Negotiating and coordinating mechanisms

The version of co-operative federalism that operates in respect to health in Australia, as in other areas, is maintained by complex bureaucratic and political mechanisms, some informal, other formal in nature, that allow for negotiation and a degree of coordination. Established in 1992, as a successor to the Special Premiers’ Conferences of previous years, the peak political intergovernmental forum is the Council of Australian Governments (COAG), comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association. At the time of writing, COAG last met on 14 July 2006 and before then on 10 February 2006. Health issues figured prominently in the communiqués from both meetings, the July meeting agreeing to a National Action Plan on Mental Health totalling, approximately \$4 billion over five years.

⁵⁶ G Craven. ‘Similar diversity: the Australian States and the Australian nation’ in *Unity and Diversity* edited by H Irving (2001), p 187.

⁵⁷ V FitzGerald, ‘Health reform in the federal context’ from Productivity Commission, *Productive Reform in a Federal System, Roundtable Proceedings, Canberra 27-28 October 2005*, p 118.

⁵⁸ Wilkins, n 14, p 9.

Also agreed to at the meeting was a response to the Productivity Commission's report, *Australia's Health Workforce*.⁵⁹ As noted, from the meeting of June 2005 a major statement on health reform was issued, recognising the need to clarify Commonwealth-State roles and responsibilities.

The significance of COAG for the States was discussed in the 1998 report of the Federal-State Relations Committee of the Victorian Parliament, commenting:

When questions of demarcation between the levels of government arise, the Council of Australian Governments provides a forum for the States to lobby the Commonwealth Government. In those policy areas where national uniformity is necessary, it provides State Governments with an opportunity to take part in shaping national policy solutions.⁶⁰

In the spirit of co-operative federalism, in an attempt to foster a more effective health system, in February 2006 COAG agreed that Commonwealth-State Specific Purpose Grants (SPPs):

that significantly affect the health system should be reviewed prior to their renegotiation. The reviews are intended to identify any elements of SPPs that, if changed, could contribute to better health outcomes.

Established under the auspices of COAG is the Health, Community and Disability Services Ministerial Council. This last body includes the Australian Health Ministers' Conference (AHMC) which meets on an annual basis. Ministerial Conference meetings are attended not only by health ministers from Australia and New Zealand but also by the Minister for Veteran' Affairs. Advisers from their personal offices, and senior officials of their departments usually including the chief executive of the department also attend these conferences.⁶¹ The role and objectives of the AHMC are to:

- Provide a forum for Australian government, State and Territory governments and the government of New Zealand to discuss matters of mutual interest concerning health policy, health services and programs;
- Promote a consistent and coordinated national approach to health policy development and implementation; and
- Consider matters reported to the Conference by the Australian Health Ministers' Advisory Council.

Supporting the AHMC are meetings of the chief executives of the respective departments, usually meeting twice yearly and called the Australian Health Ministers' Advisory Council

⁵⁹ For further information see the COAG website - <http://www.coag.gov.au/>

⁶⁰ Victorian Parliament. Federal-State Committee, *Australian Federalism: The Role of the States, Second Report on the Inquiry into Overlap and Duplication*, October 1998, p 137.

⁶¹ Duckett, n 48, pp 117-118.

(AHMAC)⁶² AHMAC advises the AHMC on policy, resources and financial issues. Its charter is to: advise on strategic issues relating to the coordination of health services across the nation and, as applicable, with New Zealand; and to operate as a national forum for planning, information sharing and innovation.⁶³ Specific national bodies (currently under review) have been established by AHMAC or AHMC to coordinate information, advice and program implementation, as follows:

- National Health Priorities Action Council, which oversees government activities to promote better services and achieve better results in priority health areas;
- Australian Safety and Quality Commission in healthy Care, which leads national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error;
- National Public Health Partnership, which plans and coordinates national public health activities; and
- National Health Information Group, which coordinates and directs the implementation of the National Health Information Agreement.⁶⁴

First established in the 1930s, the National Health and Medical Research Council (NHMRC) continues to operate, since 1992 under a Commonwealth statute,⁶⁵ with an annual research budget of close to \$400 million and comprising Commonwealth ministerial appointees drawn from the health professions and other areas. Its scope and function have remained largely unchanged over 70 years, as witnessed by the Council’s mission statement: ‘to ensure that excellence in research, research and health ethics, and health advice improves the health of all Australians’.⁶⁶ Since July 2006 the Chief Executive Officer of the NHMRC reports directly to the Commonwealth Minister for Health and Ageing who has approved the compositions for the following four Principal Committees: the Research Committee; the National Health Committee; the Australian Health Ethics Committee; and the Human Genetics Advisory Committee. The Minister for Ageing is responsible for the NHMRC Licensing Committee.⁶⁷

Reflecting on the overall effectiveness of these cooperative arrangements, the Productivity Commission’s downbeat assessment is:

⁶² Duckett, n 48, p 118.

⁶³ <http://www.ahmac.gov.au/site/home.asp>

⁶⁴ Australian Institute of Health and Welfare, *Australia’s Health 2006*, 21 June 2006, pp 7-8.

⁶⁵ *The National Health and Medical Research Council Act 1992* (Cth).

⁶⁶ On 4 September 2005, the Commonwealth Minister for Health announced that from 1 July 2006 the NHMRC would become a fully independent statutory agency within the Health and Ageing portfolio. Of this organisational reform Van der Weyden warned: ‘It will potentially place the NHMRC under the complete control of the Minister and, indirectly his political or departmental advisors’ – MB Van Der Weyden, ‘Modernising the National Health and Medical Research Council’ (October 2005) 183(7) *Medical Journal of Australia* 340 at 342.

⁶⁷ <http://www.nhmrc.gov.au/about/role/index.htm>

Not surprisingly, given joint responsibility for service provision, there is already some discussion and coordination between governments on health care issues through the existing Ministerial Councils and, on occasion, through COAG. But, with some exceptions (for example, the recent decision to seek review of health workforce issues), this appears to have focused largely on ‘crisis management’, rather than on exploring options for more fundamental and enduring change.⁶⁸

3.4 Australian Health Care Agreements

A major player in all intergovernmental relations in Australia is the Commonwealth Grants Commission, which provides expert advice on the formula for the distribution of Commonwealth funding to the States and Territories. As noted, special purpose grants are particularly significant in the health care sector, in relation to which a multiplicity of agreements are in place between the Commonwealth and the States, 39 for Queensland alone.⁶⁹ Most notable is the Australian Health Care Agreements, negotiated bi-laterally with each State, providing Commonwealth monies to the States in exchange for ensuring the States continue to provide free hospital care. Building on the earlier Medicare agreements, the first Australian Health Care Agreement covered the years 1998-2003, the second from 2003-08. This last agreement was presented to ‘as a *fait accompli* to the States with strong financial incentives on States to sign, which they did on the deadline’. The most significant elements of new funding arrangements are:

- a base grant, which is increased for weighted population increases, a further 1.7% increase for utilisation drift,⁷⁰ and indexation for wage movements;
- a withheld amount of 4% of the grant paid on compliance with reporting schedules and funding growth matching requirements;
- a capital funding scheme to facilitate improvements in services involved in the transition from hospital to home (‘Pathways Home Program’); and
- funding for palliative care, mental health, and safety and quality initiatives.

According to Duckett:

⁶⁸ Productivity Commission, *Review of National Competition Policy Reforms, Productivity Commission Inquiry Report No 33*, 28 February 2005, p 332. As discussed later, this is said in the context of an argument for a national review of health care.

⁶⁹ ‘Health economist questions federal hospital funding’, *The 7:30 Report*, 14 November 2006 - <http://www.abc.net.au/7.30/content/2006/s1788665.htm> Duckett argued for a single funding arrangement for the States, similar to that in place for the private sector. See also – M Metherell, ‘Health chief’s plan to close \$500m gap’, *SMH*, 14 November 2006, p 3.

⁷⁰ That is, increases in utilisation in the hospital sector over and above that which can be explained by population growth and ageing. This utilisation drift was in part the result of new technologies that allowed for treatments for conditions for which there was previously no hospital treatment – SJ Duckett, ‘The Australian Health Care Agreements 2003-2008’ (2004) 1 *Australia and New Zealand Health Policy* - <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=546402>

The 2003–08 Agreements also addressed an ongoing concern of Commonwealth Governments (both Labor and Coalition): its perception that when the Commonwealth increased expenditure on hospital services, this often had no discernible impact on hospitals as State Governments withdrew funding concomitantly. As Deeble points out, the reality is more complex, but the evidence is that an increased Commonwealth share is associated with growth in spending. The new Agreements provided that the States were required to increase their funding of hospitals at the same rate as the Commonwealth increases, otherwise the increases available to the State would not be paid. These stronger reporting frameworks built on the trend from the previous agreements and responded to a critical Auditor-General's report that concluded that the Commonwealth did not have all the performance information required to administer the Commonwealth funding allocated under the agreements.⁷¹

Specifically, this second Health Care Agreement commits the Commonwealth and States to work towards reform in such areas as: the interface between hospitals, primary care and aged care; continuity in cancer care and mental health services; and exploring setting up a single national system for pharmaceuticals.⁷²

One procedural innovation was the involvement of the clinical workforce in the agreements process, with the establishment of nine national reference groups to address major policy issues, co-chaired by a clinician and a senior bureaucrat. Reid, a former Director General of the NSW Health Department, writes that this was initiated by Craig Knowles, the then NSW Health Minister, at the meeting of the Australian Health Ministers Council in April 2002, based on a similar process introduced in NSW.⁷³

3.5 **The regulation of the health system**

The regulatory mechanisms operating in the Australian health system are a reflection of its overall complexity. State and Territory governments are responsible for licensing or registering private hospitals (including free-standing day hospital facilities), medical practitioners and other health professionals. Each State and Territory has legislation relevant to the operation of public hospitals. The Commonwealth Government's regulatory roles include overseeing the safety and quality of pharmaceutical and therapeutic goods and appliances, managing international quarantine arrangements, ensuring an adequate and safe supply of blood products, and regulating the private health insurance industry.⁷⁴

⁷¹ Duckett, n 70.

⁷² For the 2003-08 Australian Health Care Agreement with NSW see - http://www.health.nsw.gov.au/policies/ib/2005/pdf/IB2005_005.pdf

⁷³ MA Reid, 'Reform of the Australian Health Care Agreements: progress or political ploy?' - http://www.mja.com.au/public/issues/177_06_160902/rei10464_fm.html

⁷⁴ Australian Institute of Health and Welfare, n 64, pp 9-10.

3.6 Administration of health care in the States

In administrative terms the health systems of the States and Territories are all different and in recent years most, if not all, have been restructured. In NSW major restructuring was undertaken in 2004, the first since 1986.⁷⁵ This occurred in the aftermath of a scandal at MacArthur Health Service, specifically relating to claims of mismanagement at the Campbelltown and Camden Hospitals.⁷⁶ It resulted in the amalgamation of the 17 Area Health Services into eight larger areas, managed by CEO's reporting directly to the Director-General for Health. According to Judith Dwyer, this reform reflected a trend in most States and Territories towards a more centralised model of administration, a direction taken by Queensland in 1996, Tasmania in 1997 and Western Australia in 2001-02. Dwyer notes that more regionalised systems have endured in South Australia and Victoria.⁷⁷

According to Dwyer, the various State reviews underpinning reform

tell a familiar story of the need to bring increases in state health spending to sustainable levels, set against the trend of increasing costs due to increasing incidence of chronic disease, and more technologies for intervention, in an ageing population.⁷⁸

⁷⁵ NSW Health, *Planning Better Health: Background Information*, July 2004.

⁷⁶ BW Walker, *Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals*, 30 July 2004.

⁷⁷ JM Dwyer, 'Australian health system restructuring – what problem is being solved?' (2004) 1(6) *Australia and New Zealand Health Policy* at 2-3.

⁷⁸ JM Dwyer, n 77, p 3.

4. HEALTH FUNDING IN AUSTRALIA

4.1 Commonwealth dominance

Behind the façade of co-operative federalism lies the reality of Commonwealth financial power and the concomitant decline of the States. The dependency of the States on the Commonwealth was expressed by Greg Craven in these colourful terms:

Anyone who has observed the degrading rituals of the a Council of Australian Governments, where state leaders line up like so many resentful curs to snatch at morsels dangling from the hand of the commonwealth, has an accurate idea of the current dignity of the states. They also have some idea of the penury underlying it, with the states forced to supply their own deficiencies of revenue by prostituting themselves for commonwealth largesse. As a consequence, the legislative territory of the states on areas like health and education is increasingly invaded by the commonwealth on the most principled of all grounds: that it can afford it. Little wonder that many Australians now regard the states as sad, sixty-pound weaklings.⁷⁹

By one means or another, from the most limited involvement at the start of federation, the Commonwealth has become a major player in the health care system. Financially, it is the principle player, even in those areas where the States have primary responsibility for the delivery of health services. Any discussion of the federal division of responsibilities for health must start with the ‘power of the purse’.

4.2 Terminology – funding and expenditure

‘Health funding’ and ‘health expenditure’ are described by the Australian Institute of Health and Welfare as ‘distinct but related’ concepts. *Health funding* is reported in terms of who provides the funds that are used to pay for health expenditure. In the case of public hospital care, for example, the Commonwealth and the States and Territories together provide over 90% of the funding. *Health expenditure* is reported in terms of who incurs the expenditure rather than who ultimately provides the funding for that expenditure. In the case of public hospital care, all expenditures are incurred by the States and Territories, but a considerable proportion of those expenditures is funded by transfers from the Commonwealth.⁸⁰

4.3 Selected issues in health funding

4.3.1 Health inflation: A major issue in health funding is that expenditure in health is growing as a proportion of GDP and this growth is likely to continue in the near future. It is estimated that public and private spending on health accounted for 9.8% of GDP in 2004-05, up from 9.4% in the previous year and from 8.1% in 1994-95. Total health expenditure

⁷⁹ G Craven, *Conversations with the Constitution; Not Just a Piece of Paper* (2004), pp 76-77.

⁸⁰ Australian Institute of Health and Welfare, n 64, p 287.

grew by 10.3% between 2003-04 and 2004-05 to \$87.3 billion or \$4,319 per person. This represents an \$8.2 billion increase from 2003-04, or \$361 more per person than the previous year. Between 1994-95 and 2004-05 the average rate of general inflation was 2.5% per year. Health inflation during that period averaged 2.9% per year, giving an excess health inflation rate of 0.4% per year. From 2003-04 to 2004-05, health inflation was 4.2%, the highest it has been over the decade.⁸¹ Real growth in expenditure on health averaged 5.3% between 1994-95 and 2004-05, with real growth in 2004-05 being 5.9%.⁸²

The Productivity Commission projects growth in public spending on health (excluding aged care) from 6% to over 10% over the next 40 years, with public spending on aged care increasing from under 1% to around 2.5%.⁸³

4.3.2 Ageing and health expenditure: This last figure is obviously related to the ageing of the Australian population. Whether that is an underlying cause of the more general increase in health spending is less clear. Access Economics has warned about attributing all of the expected increase in health expenditure to the ageing population: 'It is not so much ageing as it is the cost increasing quality in health that threatens to blow a hole in the nation's public finances'.⁸⁴ On the issue of health inflation, Gray argues that propensity of health care costs to increase faster than other prices is 'due largely to the introduction of new technologies and also because of increased utilisation'.⁸⁵

The Productivity Commission has also said that, relative to income growth and technological change, population ageing has so far played a relatively minor role in the increase in per capita spending on health care. However, the Commission warns that, in future, ageing is expected to be a much stronger influence on expenditure levels, both in its own right and as it interacts with other pressures. The Commission concluded that:

- demand and technology are having a greater impact on per capita spending in the older age cohorts, suggesting that population ageing will compound the underlying growth in health expenditure arising from income growth and technology;
- foreseeable trends in disease prevalence and disability seem likely to alleviate the fiscal pressure associated with ageing; and
- available data support the view that costs rise with age rather than being largely

⁸¹ Australian Institute of Health and Welfare, *Health Expenditure Australia 2004-05*, p 14.

⁸² Australian Institute of Health and Welfare, *Health Expenditure Australia 2004-05*, p 5.

⁸³ A Podger, 'A model health system for Australia', *Inaugural Menzies Health Policy Lecture*, 3 March 2006, p 6; Productivity Commission, *Australia's Health Workforce, Productivity Commission Position Paper*, September 2005, p xxvi.

⁸⁴ Access Economics, *Population Ageing and the Economy*, Commonwealth Department of Health and Aged Care, January 2001, p 40. See generally – T Drabsch, *Ageing in Australia*, NSW Parliamentary Library Briefing Paper No 12/2004, pp 13-17; J Richardson, 'Ageing and health care: inexorable costs versus modest adaptation', *Working Paper 150, Centre for Health Economics, Monash University*, November 2004.

⁸⁵ Gray, n 49.

concentrated at the end of life.⁸⁶

4.3.3 Funding by government and non-government sources: The complex system of public and private funding of health in Australia gives rise to debates about the relative contributions from government and non-government sources. The two sectors are related of course, with changes in one often affecting the other. For example, it is said that while the Commonwealth provided the bulk of funding for medical services, ‘the effect of the increase in private health insurance coverage fuelled a growth in spending on doctors by the non-government sector’.⁸⁷ In the decade to 2004-05, the area that attracted the most rapid real growth in government funding was private hospitals – 24.4% per year. This was mostly due to the Commonwealth introducing subsidies for private health insurance, which is the main funding for private hospitals.⁸⁸

Broadly, in 2004-05, government funding of health expenditure was \$59.6 billion, compared with \$27.7 billion from non-government sources. In the decade to 2004-05, funding of health expenditure by governments grew at an average annual rate of 5.7%. This was higher than total expenditure on health funded from all sources which averaged 5.3% per year. As a result, the contribution of governments to the funding of total health expenditure increased from 66.3% in 1994-95 to 68.2% in 2004-05, while the non-government contribution declined from 33.7% to 31.8% over the same period.⁸⁹

In 2004-05, out-of-pocket recurrent expenditure by individuals on health goods and services was an estimated \$16.9 billion: 28% of this was spent on medications; and 20.1% on dental services.⁹⁰ Private health insurance funding of \$5.7 billion in 2004-05 was mainly spent on private hospitals (48%), dental services (12%), administration (10%) and medical services (10%).

4.3.4 Funding by the Commonwealth and State/Territory governments: The relative share of health funding by the different levels of government is a source of perennial contention, as is the Commonwealth contention that the States should manage their money better. As discussed by a Commonwealth Parliamentary Library Research Note in September 2005, these issues are now bound up with the contentious debate about the distribution of GST revenue among the States. As the Research Note says, the ‘windfall’ from GST revenue varies greatly from one State to another, most notably in NSW which ‘is not projected to receive gains in 2006-07 to 2008-09’. The Research Note goes on to observe:

⁸⁶ Productivity Commission, *Australia’s Health Workforce, Productivity Commission Position Paper*, September 2005, p xxv.

⁸⁷ M Metherell, ‘Health bill rises faster here than overseas’, *SMH*, 29 September 2006, p 9.

⁸⁸ Australian Institute of Health and Welfare, n 82, p 25.

⁸⁹ Australian Institute of Health and Welfare, n 82, p 22.

⁹⁰ Australian Institute of Health and Welfare, n 81, p 41.

Nor is it clear, as implied by the Commonwealth, the states are avoiding their responsibilities in funding health services. Data from the Australian Institute of Health and Welfare shows that total expenditure on public hospitals across the states has risen in recent years. This trend is set to continue, given the ageing of the population and advances in medical technology which often lead to more expensive treatments. As such, the proposition that the states can address their health funding problems simply through better management of their resources is far from straightforward.⁹¹

According to the Australian Institute of Health and Welfare, in the past decade, the Commonwealth's recurrent funding of health increased by an average of 5.5% a year, compared to 6.3% for State, Territory and local government funding.⁹²

4.3.5 Public hospital funding: Particularly contentious is public hospital funding, where the figures presented by the Australian Institute of Health and Welfare show that, between 1994-95 and 2004-05, the Commonwealth's funding dropped from 47.6% to 44.2% (a decrease of 3.4 percentage points), whereas the States and Territories lifted their share from 43.3% to 48% (an increase of 4.7 percentage points). Further, between 2002-03 and 2004-05, in the first two years of the second Australian Health Care Agreements, the Commonwealth share of public hospital funding declined 1.8 percentage points from 46% to 44.2%, whereas State and Territory government funding during this period increased 1.2 percentage points from 46.8% to 48%.⁹³ It is said in this respect that, 'The Institute's figures include evidence that will make it harder for the Federal Government in its fight with the States over the share of funding for public hospitals'.⁹⁴

The funding of public versus private hospitals is another facet of this debate. The Australian Healthcare Association, the national industry body for the public and not-for-profit health sectors, has argued in this context that a disproportionate amount of Commonwealth funding goes to the private sector, with the approval of a 6% increase in 2006 in the private health insurance premium on top of a 7.96% and 7.5% increase in 2005 and 2004. Against this, it is argued that 'during the last two years Federal funding for the public system only increased by 2.1% annually'. The Association went on to say 'Increasing subsidies to the private system without equivalent increases to public hospital funding will attract scarce resources, such as medical specialists, away from the public system'.⁹⁵

⁹¹ L Buckmaster and A Pratt, *Not on my account! Cost-shifting in the Australian health system*, Research Note No 6 2005-06, Commonwealth Parliamentary Library, p 4.

⁹² Australian Institute of Health and Welfare, n 82, p 5.

⁹³ Australian Institute of Health and Welfare, n 82, p 6.

⁹⁴ M Metherell, 'Health bill rises faster here than overseas', *SMH*, 29 September 2006, p 5.

⁹⁵ Australian Healthcare Association, *2006-07 Policies*, p 17 - http://www.aushealthcare.com.au/documents/publications/133/AHA_Policies_06-07.pdf The Association called for the Commonwealth to 'Match its funding increases to the private sector with a similar increase to public hospitals' (page 18).

The most comprehensive and authoritative source of data is *Australian Hospital Statistics*, published annually by the Australian Institute of Health and Welfare. According to the 2004-05 report:

- recurrent expenditure on public acute and public psychiatric hospitals was \$21,758 million in 2004-05. After adjusting for inflation, this represented an increase of 4.9% compared with 2003-04; and
- the largest share of this expenditure was for salary payments, which accounted for 61.7% (\$13,428 million) of recurrent expenditure.⁹⁶

In 2001, the National Health Performance Committee developed a framework to report on the performance of the Australian health system which has been adopted by Health Ministers. *Australian Hospital Statistics* uses this National Health Performance Framework to present performance indicator information.⁹⁷

4.3.6 Horizontal equalisation: A different issue in health funding relates to the disparities between the States in terms of socio-demographic factors, including age, gender and aboriginality, as well as such factors as the proportion of population in rural and remote areas, income distribution and fluency in English. As Duckett says, ‘The different proportion of people in each of these categories will affect the expenditure requirements of a state and thus, according to the Grants Commission methodology, the states deserve more for these purposes’.⁹⁸ This refers to the process of horizontal equalisation undertaken by the Grants Commission, for the purpose of correcting the ‘horizontal imbalance’ between the different Australian jurisdictions in terms of their health needs and available resources.

⁹⁶ Australian Institute of Health and Welfare, *Australian Hospital Statistics 2004-05*, pp xix-xx.

⁹⁷ Australian Institute of Health and Welfare, n 96, Chapter 4.

⁹⁸ Duckett, n 48, pp 121-122.

4.4 Commonwealth health funding

The Australian Institute of Health and Welfare reports that, in 2004-05, the Commonwealth's funding of health expenditure was an estimated \$39.8 billion, up from \$35.7 billion the year before. This was 45.6% of total funding for health by all sources of funds. State, Territory and local government sources provided \$19.7 billion, or 22.6% of the total from all sources, with the remaining \$27.7 billion or 31.8% coming from non-government sources. In percentage terms, these figures had not altered greatly since 1993-94 when the relative figures were as follows: Commonwealth 45.1%; State, Territory and local government 21.3%; and non-government sources 33.6%.

In 2004-05 the Commonwealth provided 66.8% of estimated *total government funding* of recurrent health expenditure. This included funding for:

- payments through the Department of Veterans' Affairs in respect of eligible veterans and their dependants. In 2002-03, this totalled \$3,340 million, nearly two-thirds of which (61.1%) was for institutional service, mainly hospital and high-level residential care services. In 2003-04 this funding accounted for 4.5% of the estimated total Commonwealth recurrent health expenditure.
- Services provided by GPs and medical specialists and other professional services covered or partly covered by Medicare.
- High-level residential care.
- Pharmaceuticals covered or partly covered under the Pharmaceutical Benefits Scheme (PBS). Pharmaceuticals consistently experienced the greatest growth in total funding, with real growth averaging 10.5% between 1994-95 and 2004-05.⁹⁹
- specific purpose payments (SPPs) to the States and Territories for health purposes. Most of these are provided under the Australian Health Care Agreements between the Commonwealth and each of the States, with payments being primarily directed to expenditure in the public hospital systems of the States and Territories. Other SPPs that were regarded as expenditure on public hospitals included payments for high-cost drugs and blood transfusion services. In 2003-04, SPPs accounted for 15.9% of total Commonwealth recurrent expenditure on health.
- rebates and subsidies under the *Private Health Insurance Incentives Act 1997*. Health expenditure funded by private health insurance subsidies rose from zero (1996-97) to \$2.5 billion in 2003-04. The 30% rebate on such insurance premiums can be claimed in one of two ways: by paying a reduced premium to the insurance fund, or by paying the full premium and claiming the 30% rebate directly from the Commonwealth government through the taxation system.
- taxation expenditures. In 2003-04, the total value of non-specific tax expenditures was \$291 million, which includes a tax rebate of 20 cents in the dollar that can be claimed for health expenditures that exceed a prescribed threshold (in 2003-04 that threshold was \$1,500 per taxpayer).

Excluding Department of Veterans' Affairs funding and tax expenditures, general recurrent outlays on *health goods and services by the Commonwealth* for 2002-03 and 2004-05, by

⁹⁹ Australian Institute of Health and Welfare, n 82, p 7.

type of funding, was as follows:¹⁰⁰

Area of expenditure	2002-03	2004-05
Medical services	29.5%	30.6%
Public hospitals	26.9%	25.4%
Pharmaceuticals	16.1%	15.8%
High-level residential care	9.9%	10.1%
Other health services	6.9%	3.7%
Administration and research	6.7%	6.5%
Private hospitals	3.9%	4.4%

Almost all expenditure on *medical services* related to services provided by practitioners on a ‘fee-for-service’ basis. Of the \$12 billion spent on medical services in 2002-03, 78.4% was funded by the Commonwealth; this figure had risen to \$14.6 billion in 2004-05, of which the Commonwealth funded 78.7%. The bulk of this relates to medical benefits paid under Medicare, with some funding from the Department of Veterans’ Affairs for medical services to eligible veterans and their dependents, as well as payments to general practitioners under alternative funding arrangements.

Breaking the figures down further, *recurrent expenditure on medical services, by source of funds* for 2002-03 and 2004-05 was as follows:¹⁰¹

Funding source	2002-03	2004-05
Commonwealth	78.4%	78.7%
Individuals	11.9%	11.1%
Other non-government	5.6%	6.3%
Health insurance funds	4.1%	3.9%

¹⁰⁰ Included are both non-psychiatric and psychiatric hospitals. See Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, Figure 7 (page 29); Australian Institute of Health and Welfare, n 82, Figure 8 (page 35).

¹⁰¹ Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, Figure 19 (page 57); Australian Institute of Health and Welfare, n 82, Figure 21 (page 62).

4.5 State and Territory health funding

Again, based on figures reported by the Australian Institute of Health and Welfare, in 2004-05, State, Territory and local government sources provided \$19.7 billion, or 22.6% of the total estimated health expenditure. Expressed as a proportion of GDP this amounted to 2.2%, compared to the Commonwealth's 4.5%.¹⁰² It is estimated that, during 2004-05, 58.5% (\$51 billion) of total national health expenditure was incurred in the two most populous States, NSW and Victoria. These two States account for 58.1% of the total Australian population.¹⁰³ These figures are marginally down on those for 2003-04, when 59.7% of total national health expenditure was in these two States, which accounted for 58.3% of the total population.¹⁰⁴

State and Territory governments are the main providers of publicly provided health goods and services in Australia, primarily through public hospitals. Those health goods and services are financed by a combination of SPPs from the Commonwealth, funding by the States and Territories out of their own fiscal resources, and funding provided by non-government sources (usually in the form of user fees). State and Territory governments also provide or purchase ambulance, dental and community health services, for which they provide most of the funding. Further, they are a major source of public health activities, such as infectious disease control and health promotion campaigns.¹⁰⁵

As for local government funding of health care, its contribution is combined for statistical purposes with those of the States and Territories. The Australian Institute of Health and Welfare states:

Local governments also finance certain health care services from their own revenues or from general-purpose funds provided by state governments. But it is often difficult to distinguish funding provided by local governments themselves from that provided to them by state governments.¹⁰⁶

For 2002-03 and 2004-05, recurrent funding of *health goods and services by State, Territory and Local governments from their own resources*, by broad areas of expenditure, was as follows:¹⁰⁷

¹⁰² Australian Institute of Health and Welfare, n 82, Tables 12-14 (pages 23-24).

¹⁰³ Australian Institute of Health and Welfare, n 82, p 16.

¹⁰⁴ Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, p 12.

¹⁰⁵ Australian Institute of Health and Welfare, n 64, p 288.

¹⁰⁶ Australian Institute of Health and Welfare, n 64, p 300.

¹⁰⁷ Included are both non-psychiatric and psychiatric hospitals. See Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, Figure 8 (page 31); Australian Institute of Health and Welfare, n 82, Figure 9 (page 36).

Area of expenditure	2002-03	2004-05
Public hospitals	61.9%	62.9%
Community health and other	22.0%	19.5%
Administration and research	3.9%	3.9%
Public health	3.5%	3.1%
Ambulance	2.9%	3.9%
Dental services	2.3%	3.0%
Private hospitals	2.1%	2.5%
High-level residential care	1.5%	1.3%

For 2004-05, the last year for which complete figures are available, *total health expenditure, by area of expenditure and source of funds, for the whole of Australia* was as follows:¹⁰⁸

Area of expenditure	Commonwealth	State/Local government	Non-government sources	Total health expenditure
Total hospitals (including private)	12,163m	11,033m	5,831m	29,026m
High-level residential care	4,183m	215m	1,187m	5,586m
Ambulance	166m	657m	611m	1,435m
Medical services	11,505m	-	3,105m	14,611m
Other health practitioners	655m	-	1,794m	2,448m
Total medications	6,051m	-	4,805m	10,857m
Aids and appliances	336m	-	3,286m	3,622m
Dental, community health, administration, public health	3,002m	4,757m	5,194m	12,953m
Research	1,085m	201m	353m	1,639m
Total capital	289m	2899m	1,930m	5118m

Note that the figures for total capital expenditure include both capital expenditure and consumption (depreciation).

Note, too, that the figures for hospitals include *private hospitals*, where the Commonwealth contributed \$2.4 billion, State and Local Government \$418 million and non-government sources \$4.1 billion. The above figures for hospitals are also inclusive of *public (psychiatric) hospitals*, which are stand-alone institutions operated by, or on behalf of, State and Territory governments. Total expenditure on these hospitals in 2004-05 was \$588 million, with \$324 million of that total funded by State and Territory governments, \$234 million by the Commonwealth and the remainder from non-government sources. The total expenditure was comparable to the figure for 2003-04 (\$557), which reflected a sharp increase on the previous year (\$287).

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Australian Institute of Health and Welfare, n 82, Table A3 (extract only).

Generally, the shares of funding for *public (non-psychiatric) hospitals* met by the Commonwealth on one side and the States and Territories on the other have fluctuated from year to year. Over the life of the Third Medicare Agreement (1993-98), the Commonwealth share fell back 6 percentage points from 51.1% in 1993-94 to 45.1% in 1997-98. It rose again by 2.6 percentage points in 1998-99, under the first Australian Health Care Agreement, and ended 2.1 percentage points higher in 2002-03, compared with 1997-98.¹⁰⁹ Complicating the situation, a proportion of the 30% rebate on private health insurance was included in 2002-03 as funding by the Commonwealth for public hospitals. In that year payments relating to public hospital care accounted for more than one-quarter (26.9%) of total general recurrent outlays by the Commonwealth for health.

For the first two years of the current Australian Health Care Agreement (2003-08) the Commonwealth share of funding fell, by 1.2 percentage points in the first year and 0.5 percentage points in the second year. Conversely, there was an increase in the share provided by the State and Territory governments, by 1.2 percentage points and 0.1 percentage points respectively.¹¹⁰

The figures for *dental services, community health, administration and public health* can be broken down further as follows:

Area of expenditure	Commonwealth	State/Local government	Non-government sources	Total health expenditure
Dental services	450m	503m	4,110m	5,064m
Community health	407m	3,283m	445m	4,135m
Administration	1,286m	449m	585m	2,320m
Public Health	858m	521m	55m	1,434m

¹⁰⁹ Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, p 53.

¹¹⁰ Australian Institute of Health and Welfare, n 82, p 58.

4.6 NSW health funding

For 2004-05, *total health expenditure, by area of expenditure and source of funds, for NSW only* was as follows:¹¹¹

Area of expenditure	Commonwealth	State/Local government	Non-government sources	Total health expenditure
Total hospitals (including private)	4,083m	3,897m	2,039m	10,019m
High-level residential care	1,458m	30m	417m	1,904m
Ambulance	63m	244m	161m	469m
Medical Services	4,061m	-	1,277m	5,338m
Other health practitioners	228m	-	603m	832m
Total medications	2,089m	-	1,526m	3,615m
Aids and appliances	121m	-	955m	1,076m
Dental, community health, administration, public health	987m	1,020m	1,906m	3,913m
Research	293m	55m	99m	448m
Total capital	67m	977m	499m	1,543m
Total health expenditure	13,605m	6,224m	9,326m	29,155m

Again, note that the figures for total capital expenditure include both capital expenditure and consumption (depreciation).

The NSW figures for *dental services, community health, administration and public health* can be broken down further as follows:

Area of expenditure	Commonwealth	State/Local government	Non-government sources	Total health expenditure
Dental services	172m	143m	1,460m	1,775m
Community health	93m	778m	185m	1,056m
Administration	433m	-	220m	653m
Public Health	288m	99m	41m	428m

¹¹¹ Australian Institute of Health and Welfare, n 82, Table B3 (page 116) (extract only).

Clearly, the bulk of health expenditure in NSW from the State's own resources relates to hospitals and community health. The figures for total hospital spending set out above can be further broken down as follows:

Area of expenditure	Commonwealth	State/Local government	Non-government sources	Total health expenditure
Public non-psychiatric hospitals	3,292m	3,750m	760m	7,802m
Public psychiatric hospitals	87m	148m	16m	251m
Private hospitals	703m	-	1,263m	1,966m

Compared to the figures for 2002-03, these figures show a marked increase in funding for public psychiatric hospitals. For that year, total expenditure was only \$4m, with the NSW Government providing \$3m of that total, and the remaining \$1m coming from non-government sources.¹¹² In December 2002 the Legislative Council Select Committee on Mental Health reported that 'NSW is the second lowest spending state per capita in Australia on mental health'.¹¹³ As noted, funding of mental health is undergoing reform, notably following the pledge made by Morris Iemma on becoming Premier of NSW to improve mental health and to make this a priority for his government. In October 2005 the Premier wrote to the Prime Minister on this subject, a move that brought mental health to the agenda of COAG. As noted, at the July 2006 meeting there was agreement on a National Action Plan on Mental Health totalling approximately \$4 billion over five years.¹¹⁴

The difficulties involved in providing comparable data across the jurisdictions is highlighted by the fact that NSW, unlike Queensland for example, would appear not to spend anything on private hospitals. The apparent discrepancy relates to the different processes involved in each State. In NSW it is the individual public hospital, not a central body, that purchases patient services from private hospitals, with the result that NSW expenditure on private hospital services are, in fact, included under the figures for public hospitals. Likewise, unlike the Commonwealth, administration costs in NSW are set against particular areas or categories of expenditure.¹¹⁵

If nothing else, the arrangements in place at present inhibit the gathering of truly comparable data. This, in turn, might be said to inhibit meaningful performance assessment between one State and another, a factor that impinges on the accountability of the health

¹¹² Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, Table B3.

¹¹³ Parliament of NSW, Legislative Council, *Select Committee on Mental Health, Inquiry into mental health services in NSW*, Final Report, December 2002, p 82.

¹¹⁴ For a commentary on these reforms see – P Hanlon, 'NSW: a new direction for mental health', *Mental Health Matters*, September 2006, Issue 9, 5-8; N O'Connor, 'COAG 2006: risks and opportunities for Australian mental healthcare', *Mental Health Matters*, September 2006, Issue 9, 9-14.

¹¹⁵ This is based on telephone advice from the Australian Institute of Health and Welfare.

system generally. Indeed, it points to the conclusion that in certain key respects there is no single Australian health system but, rather, a series of distinct systems, each organised along somewhat different lines.

4.7 Reform of funding arrangements

Clearly, the funding of health care in Australia is complex, reflecting the fragmentation of the system as a whole. The inadequacies of current arrangements are a source of constant debate, as various commentators seek to formulate a financial basis for a more integrated system of health care. Some of the suggestions for the pooling of funds and other reforms are discussed in later sections of this paper. There is no shortage of proposals for reform.¹¹⁶ One question is which, if any, is likely to be adopted? Another is whether the present system, despite its problems and complexities, fails to deliver reasonable health outcomes? To put it another way, which of the various alternatives that have been proposed is most likely to meet such key criteria as:

- efficiency;
- equity of access and quality of health care;
- positive health outcomes;
- patient satisfaction;
- sustainability; and
- affordability, both for individuals and the community at large.

¹¹⁶ On 17 November 2006 the Commonwealth Health Minister, Tony Abbott, as part of the negotiation process in preparation for the next round of Australian Health Care Agreements, foreshadowed a plan to publish league tables showing comparative performance of public hospitals – M Franklin, ‘Hospital plan gains support’, *The Weekend Australian*, 18-19 November 2006, p 2.

5. COMMONWEALTH-STATE RESPONSIBILITIES AND HEALTH ISSUES

5.1 Roles and responsibilities

Reporting on funding shortages and cost shifting by both the Commonwealth and the States in the public hospital system in December 2000, the majority report of the Senate Community Affairs References Committee commented:

Evidence presented to the inquiry has indicated that the key problem that needs to be addressed as a priority is the fragmented nature of the roles and responsibilities of the Commonwealth and the State and Territory Governments in the funding and delivery of public hospital services.¹¹⁷

Taking up this theme, the COAG communiqué of 3 June 2005 relating to the Australia's health system stated that:

The Australian State and Territory Governments recognised that many Australians, including the elderly and people with disabilities face problems at the interface of different parts of the health system. Further, the governments recognised that the health system can be improved by clarifying role and responsibilities, and by reducing duplication and gaps in services.¹¹⁸

The Commonwealth government's major responsibilities for the health system include:¹¹⁹

- the two national subsidy schemes, Medicare, which subsidises payments for services provided to doctors, and the Pharmaceutical Benefits Scheme, which subsidises prescription medicines;
- shared responsibility for funding for public hospital services through the Australian HealthCare Agreements with State and Territory governments;
- subsidisation of private health insurance through the 30 per cent rebate on the cost of private health insurance premiums;
- funding for a range of other health and health related services, including public health programs, residential aged care, and programs targeted at specific populations;
- undertaking health policy research and policy coordination across the Commonwealth, State and Territory governments;
- funding hospital services and the provision of other services through the Department of Veterans' Affairs;

¹¹⁷ Senate Community Affairs References Committee, *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p x.

¹¹⁸ <http://www.coag.gov.au/meetings/030605/index.htm - health>

¹¹⁹ This list roles and responsibilities is drawn from – Productivity Commission, *Report on Government Services 2006*, pp E3-E4 and L Buckmaster and A Pratt, *Not on my account! Cost-shifting in the Australian health system*, Research Note No 6 2005-06, Commonwealth Parliamentary Library, p 2.

- funding Indigenous-specific primary health; and
- regulation of various aspects of the health system, including the safety and quality of pharmaceuticals and other therapeutic goods, and the private health insurance industry.

State and Territory governments contribute funding for, and deliver a range of health care services, including:

- management of a shared responsibility for funding public hospitals;
- funding for and management of a range of community health services (including services specifically for Indigenous people);
- management of ambulance services;
- public health programs (such as health promotion programs and disease prevention);
- public dental services;
- mental health programs;
- health policy research and policy development;
- specialist palliative care; and
- regulation of various aspects of the health system, including licensing and registration of private hospitals, medical practitioners, and other health professionals.

5.2 A complex system

The Australian system of health care is obviously complex. Not surprisingly, almost every aspect of the system is the subject of contested debate, from the adequacy of funding from various sources, to the efficiency of the processes and outcomes concerned. The potential for dispute is seemingly endless. In 2005, Buckmaster and Pratt wrote:

The vexed question of joint financing of public hospital services provides several examples. For instance, the state premiers and territory chief ministers often argue that the Commonwealth does not provide an adequate contribution to the funding of public hospitals. The Commonwealth Government argues that state governments should manage their resources more efficiently, for example, by making better use of GST revenue (though the question of distribution of GST revenue among the states and territories is also a contentious issue).¹²⁰

5.3 Cost shifting

No matter how much funding is made available, there are always calls for more. Constantly, the different levels of government argue over the supposedly disproportionate share of their contribution to health funding. Public hospitals have been a particular area of conflict in this respect, with claims and counter claims made at Commonwealth and State level. Particularly significant in this context is the issue of cost shifting, with each level of

¹²⁰

L Buckmaster and A Pratt, n 119, p 2.

government arguing that responsibilities for health services are transferred from one level to another without their agreement.

5.3.1 The Allen Consulting Group: It is argued in this context that, with the Commonwealth responsible for subsidising private medical services and the States funding public hospital services, there is an incentive for each level of government to design their program arrangements so that services will be delivered in such a way that the other level of government meets the cost. Vince FitzGerald of the Allen Consulting Group presents the following examples:

- public hospitals (State funded)¹²¹ may refer patients being discharged to their GP (Commonwealth subsidised) instead of providing post-hospital services directly;
- conversely, if patients have difficulty in accessing GP services (for example, after hours), they may attend public hospital emergency departments to receive primary care services (State funded); and
- shortages of Commonwealth subsidised residential aged care places are resulting in public hospital beds being inappropriately occupied on a long-term basis by elderly patients.¹²² Podger commented in October 2005 that ‘State Government claims of around 2000 elderly people in hospitals who are awaiting residential aged care is about right’.¹²³

In its 2004 report the Allen Consulting Group commented:

Difficulties with access to emergency departments are an example of the potential flow-on implications of one government’s health policies for another government’s health services. According to the AHCA [Australian Health Care Agreement] Reference Group, lack of access to affordable primary care leads to an ‘ED for GP’ substitution effect; or, to put it another way, a State for Commonwealth substitution effect. Public hospitals report significant increases in the number of patients presenting at emergency departments in categories 4 and 5, the semi- and non-urgent cases for which treatment by a GP would often, though not always, suffice.¹²⁴

The report continues:

¹²¹ With Commonwealth assistance of course.

¹²² V FitzGerald, ‘Health reform in the federal context’ in Productivity Commission, *Productive Reform in a Federal System, Roundtable Proceedings*, Canberra 27-28 October 2005, p 109. See also The Allen Consulting Group, *Governments Working Together: A Better Future For All Australians*, 2004, p 50.

¹²³ A Podger, ‘Directions for health reform in Australia’ in Productivity Commission, *Productive Reform in a Federal System, Roundtable Proceedings*, Canberra 27-28 October 2005, p 142. Podger restated this on 3 March 2006 in his Inaugural Menzies Health Policy Lecture.

¹²⁴ The Allen Consulting Group, *Governments Working Together: A Better Future For All Australians*, 2004, p 58.

One estimate is that one in five people who attend emergency departments would more appropriately be treated by a GP. A recent analysis of 60 towns in NSW showed that in towns where GPs do not bulk-bill, people use public hospital emergency departments at a rate of around 60 per cent more than in those towns where GPs do bulk-bill.

5.3.2 Commonwealth Parliamentary Library Research Note: Along similar lines, a Commonwealth Parliamentary Library Research Note from September 2005 offered further examples of potential cost-shifting, including:

- the increasing trend for public hospitals (State funded) to discharge patients after fewer bed days than in previous years is largely the result of improvements in medical technology. Nonetheless if a patient is discharged with a script for medicine to be taken at home, then the cost of the medicine shifts from the State to the Commonwealth;
- conversely, with the decline in Medicare bulk-billing rates in recent years (Commonwealth funded) it is argued that people who cannot afford or do not want to pay for GP services present at emergency departments seeking GP-style care, which puts pressure on the public hospital system.¹²⁵

5.3.3 Senate Community Affairs Reference Committee: In its First Report of July 2000 the Senate Community Affairs Reference Committee, chaired by the ALP’s Rosemary Crowley, noted that the issues around cost shifting are ‘contested’, with both the Commonwealth and the States arguing that cost shifting occurs to their detriment. Examples of cost shifting brought to the Committee’s attention included:

Commonwealth to States and Territories:

- failure of medical workforce policy results in fewer GPs in rural and remote areas, with State funded public hospitals or community health centres required to address and fund the primary care needs of these communities;
- inadequacies in the funding and delivery of health services for Indigenous Australians may mean that the States and Territories are required to provide extra

¹²⁵

L Buckmaster and A Pratt, n 119, p 3. Note in this respect that *Medicare Statistics – June Quarter 2006* states that: ‘While the level of bulk billing for Australia increased from 45.2 per cent in 1984/85 to 72.3 per cent in 1999/00, it then fell to 67.8 per cent in 2002/03 and to 67.5 per cent in 2003/04. The level of bulk billing in 2004/05 and 2005/06 reversed this trend, with bulk billing up 2.7 percentage points in 2004/05 and a further 1.5 percentage points to 71.7 per cent in 2005/06. All States and Territories experienced increases in bulk billing in 2005/06 on 2004/05. Queensland experienced the largest increase (+2.3 percentage points to 70.7 per cent), followed by Tasmania (+1.9 percentage points to 65.5 per cent) and Victoria (+1.7 percentage points to 69.6 per cent). In 2005/06 (12 months to June) the level of bulk billing in Australia was 26.5 percentage points higher than in 1984/85 (12 months to June). For the Australian Capital Territory the level of bulk billing in 2005/06 was 35.7 percentage points higher than in 1984/85, followed by Victoria and Tasmania (both 29.1 percentage points higher)’ - <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/medstat-jun06-analysis-a-per>

- services (and therefore funding) through the public hospital system; and
- changes to priorities at the Commonwealth level can force changes at the State and Territory level. For example, increased patient expectations driven by the Commonwealth Dental Health Scheme led to a blow-out in waiting lists for public dental care when the Commonwealth ceased funding for the scheme in 1996.

State and Territories to the Commonwealth:

- limitations on and privatisation of outpatient services in public hospitals shifts costs because these services are then billed to (Commonwealth funded) Medicare;
- small quantities of pharmaceuticals provided to patients on discharge from public hospitals means that the patient will need to consult a GP (Commonwealth funded) in order to obtain a prescription to be filled at a community pharmacy (also Commonwealth funded); and
- in accident and emergency units of public hospitals, patients who do not require admission may be directed to a (Commonwealth funded) GP.¹²⁶

The Committee reported that perceptions of cost shifting varied dramatically, with governments treating it as a very serious problem, whereas several non-government contributors only saw it as a problem ‘if it actually results in adverse outcomes for patients’.¹²⁷ In both its first and final reports the Committee discussed the difficulties involved in arriving at any clear view of the issue, stating:

Although participants in the inquiry offered many views on cost shifting, little evidence was available, with most comments being of an anecdotal nature...The Committee found that it was a difficult task to estimate the value of cost shifting that occurs because so little data is available on its extent.¹²⁸

Cited by the majority in the final report were the views of the Queensland Government that cost shifting is an inevitable outcome of the current mix of roles and responsibilities of the different levels of government in the health system. The views of the NSW Health Department were also discussed, notably its argument that whether cost shifting was perceived as good or bad depended on the view of the beholder: ‘there is a terminology of cost shifting which implies an illegality and there is a terminology of cost shifting which implies maximising the benefits’.¹²⁹

In its way the debate over cost shifting highlights some of the difficulties involved in

¹²⁶ Senate Community Affairs References Committee, *Inquiry into Public Hospitals, First Report*, July 2000, p 19.

¹²⁷ Senate Community Affairs References Committee, *Inquiry into Public Hospitals, First Report*, July 2000, p 24.

¹²⁸ Senate Community Affairs References Committee, *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 21.

¹²⁹ Senate Community Affairs References Committee, *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 21.

discussing the health system. Clearly, tensions exist between the different perspectives involved, including the patient-oriented approach that asks whether health outcomes for patients are adversely affected by cost-shifting, as against the governmental perspective which seeks to ensure that a particular level of government is not made to bear an unreasonable funding burden. The difficulty, as the majority of the Senate Committee, found, is in moving beyond anecdote and rhetoric to reliable information and data. One question is whether cost shifting is, in reality, a major issue? If reasonable health outcomes for patients are achieved, does it matter which level of government foots the bill? Further, is there evidence showing that cost shifting does result in fact in waste and inefficiency? The point is asserted often enough, but is it true? Outside the relevant Treasury Departments, does it matter if the pharmaceutical bill is passed from the States to the Commonwealth, or vice versa? Obviously the answer is ‘yes’ if cost shifting has an effect on the quality of other services.

The lack of hard evidence on cost shifting is a surprising finding in itself. After all, so much research is undertaken in this field, one might expect to find a plethora of examples and case studies, an embarrassment not a dearth of hard evidence. It begs a number of questions. For example, how much relevant research remains unpublished in this area, locked away in departmental files, to be accessed only by bureaucratic insiders? Has new evidence come to light since the Committee reported in December 2000?

The Committee was told by Professor Hindle of the UNSW School of Health Services Management:

very little work is done on this issue of cost shifting. I have tried to understand why, but I suspect there are two obvious answers. The first one is that everybody knows...Secondly, there is a sense in which researchers say, ‘If I were to produce the authoritative description of the nature, size and total cost of cost shifting in Australia, who would listen?’¹³⁰

In its final report the majority of the Committee stated:

On the basis of the evidence received...it is not a productive exercise to pursue issues around cost shifting. Governments have and are shifting costs...However, this does not mean that the Committee is unconcerned by cost shifting; on the contrary, it remains most concerned about the effects of cost shifting, particularly any effects on patient care.

The issues involved are capable of analysis from alternative perspectives. Take, for example, the cost shifting that occurs when hospital beds are filled by elderly patients, as a result of the lack of residential aged care facilities. At one level this would seem to point to the problems arising from Australia’s fragmented health system. On the other hand, is it not really about the Commonwealth’s failure to adequately provide for the increased demand for aged care? If this occurred under a uniform, national health system what centres of

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Senate Community Affairs References Committee, *Inquiry into Public Hospitals, First Report*, July 2000, p 24.

countervailing power would exist to challenge the Commonwealth government, arguing the case for higher levels of funding? Presumably, it would be left to lobby groups, with the States having little or no say in the matter. One point of view is that at least under the present arrangements the cost shifting issue brought the subject of aged care funding to the forefront of a vigorous national debate, in which reform was demanded of one level of government by another level of government. Dysfunctional though it may appear, Australian federalism may sometimes work in strangely beneficial ways.

5.4 Issues in the health debate and Commonwealth-State responsibilities

An obvious point but one that is worth making is that not all the problems and challenges facing the health care system in Australia are the product, directly or otherwise, of the complex division of Commonwealth-State responsibilities. These structural factors may impact on certain, perhaps most, issues, but that is not to say that a re-modelling of the health system, along instrumental or ‘big bang’ lines, will solve many of the problems concerned. Questions to do with Indigenous health care, poverty, the role played by private health insurance and many other issues are highly complex in themselves; a whole range of factors outside the structural framework of public administration impact on these matters, including demographic changes and party political ideology. Indeed, problems relating to cost shifting may prove easier to deal with than other issues where the difficulties involved are more intractable in nature.

The issues facing the health system are enormously varied, as are the strategies needed to respond to them; some may be resolved, in part at least, by reform of Commonwealth-State responsibilities, other may not. In other words, health reform and structural reform of the health system are not one and the same thing. The prospect of shifting responsibility from one level of government to another, or some other form of structural re-modelling, may not solve healthcare problems and could potentially have an adverse effect. A further observation is that if the costs of duplication cannot be clearly defined and quantified, *ipso facto* it is hard to say what their removal will solve.

What follows is a brief overview of the major issues in health, with a view to identifying which are more closely connected to the debate about fragmented Commonwealth-State responsibilities.

5.4.1 Spending trends – health inflation: Certain issues in the health debate have already been mentioned, including health inflation, the ageing population and rising costs associated with technological development. These were discussed in relation to the key financial challenges facing health. Often proposals for structural reform are made in the context of these challenges, the argument being put that health is ‘at the crossroads’ and without fundamental change costs will blow out to unsustainable levels in the not too distant future. Broadly, this was the view the Productivity Commission dealt with directly in its 2005 review of national competition policy reforms.¹³¹

¹³¹ Productivity Commission, *Review of National Competition Policy Reforms, Productivity Commission Inquiry Report No 33*, 28 February 2005, pp 326-327.

5.4.2 Spending trends – private health insurance: Another spending trend relates to the increased premiums set by the private health insurance industry, which at present is the beneficiary of a taxpayer funded rebate, running to billions of dollars. The impact of the private health insurance industry itself on rising health costs is a matter of debate, one that is embedded in ideological commitments and subject to powerful lobbying by interested parties. Is private health insurance part of the problem or part of the solution?¹³²

This is a controversial and politically charged subject, in which context any research findings are likely to be questioned from one standpoint or another. The current House of Representatives Standing Committee on Health and Ageing inquiry is predicated on the assumption that the ‘strong mix of public and private funding and service delivery’ is to continue, albeit with some modification. The Committee’s terms of reference include:

while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior’s Private Health Insurance Rebates, and Lifetime Health Cover, [to] identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

Suggesting a different perspective, the Allen Consulting Group in its 2004 report to the Victorian Premier referred to findings indicating ‘that there is an increased possibility of “over utilisation” of private hospital care due to the impact of private health insurance in Australia’.¹³³ Reference was made in this context to research conducted by the Melbourne Institute of Applied Economic and Social Research on the impact made by the 30% premium rebate on both existing and new health insurance policies introduced by the Howard Government in January 1999. The findings of this review are wide-ranging, including

hospital utilisation data suggest little evidence that the policy changes have alleviated the burden of public hospitals. In light of the 30 per cent premium rebate becoming a significant and rising fiscal burden for the Commonwealth government, the performance of the recent PHI [private health insurance] policy changes clearly leaves much to be desired.¹³⁴

In a similar vein, Ian McAuley who is a lecturer in public finance at the University of Canberra writes, ‘In Australia, there is no evidence that the private health insurance subsidies have resulted in any savings in Commonwealth or state hospital budgets’.¹³⁵ The

¹³² Duckett claims that private patients receive benefits worth an extra \$500 million from the Commonwealth compared with its contribution to public hospitals - M Metherell, ‘Health chief’s plan to close \$500m gap’, *SMH*, 14 November 2006, p 3.

¹³³ The Allen Consulting Group, *Governments Working Together: A Better Future for All Australians*, May 2004, p 52.

¹³⁴ P Dawkins et al, *Recent Private Health Insurance Policies in Australia: Health Resource Utilization, Distributive Implications and Policy Options*, Melbourne Institute Report No 3, Melbourne Institute of Applied Economic and Social Research, 17 March 2004, p iii.

¹³⁵ I McAuley, ‘Private health insurance: still muddling through’ (2005) 12(2) *Agenda* 159 at

only success that can be claimed for that Howard Government's policy, McAuley claims, is in rescuing the private health insurance funds – 'Their coverage, at 43 per cent, is restored to where it was in 1991, and is falling more slowly'.¹³⁶ *New Matilda*, the online magazine and policy portal, has argued that 'private insurance brings none of the benefits one may usually expect from privatisation; rather it is associated, as in the US, with price inflation and with health care access based on the generosity of one's insurer...rather than need'.¹³⁷

For the Australian Healthcare Association, the question is more one of getting the balance right between the private and public sectors, with the Association calling for the Commonwealth to match its funding increases to the private sector with a similar increase to public hospitals. In this context, the Association acknowledges that the Commonwealth's 30% rebate for private health insurance is founded on the argument that, by supporting private health insurance, this reduces the strain on the public hospital system. On the question of the 'over utilisation' of private health care, the Association states:

The 2006-07 Federal Budget included changes to PHI facilitating health funds to cover a broader range of health services including services delivered outside of hospital, to be effective from April 2007. The new products will continue to attract the Government's PHI rebates. These changes are intended to remove the incentive for fund members to be hospitalised in order to use their insurance. There will be a new emphasis on preventative health care.¹³⁸

5.4.3 Systemic issues - Indigenous Australians: To concerns about spending trends can be added significant concerns about what might be called systemic problems, notably the health status of Indigenous Australians who, as the Productivity Commission note, have much lower life expectancies than other Australians and much higher levels of morbidity from a wide range of health problems and diseases. Overall, Indigenous mortality rates and infant mortality rates are twice the national average.¹³⁹ The extent to which structural reform, major or minor in nature, would impact on this situation is hard to say.¹⁴⁰

171.

¹³⁶ I McAuley, n 135, p 176.

¹³⁷ *New Matilda, A health policy for Australia: reclaiming universal health care*, 2006, p 15.

¹³⁸ Australian Healthcare Association, *2006-07 Policies*, p 17 - [http://www.aushealthcare.com.au/documents/publications/133/AHA Policies 06-07.pdf](http://www.aushealthcare.com.au/documents/publications/133/AHA_Policies_06-07.pdf) The Association argues that 'a higher take-up of private health insurance is associated with longer public waiting lists'. Among other things, it calls for 'Funding currently used to subsidise private health insurance to be paid directly to public hospitals on the basis that this will more effectively decrease public hospital waiting times' (page 18).

¹³⁹ Productivity Commission, *Review of National Competition Policy Reforms, Productivity Commission Inquiry Report No 33*, 28 February 2005, p 327.

¹⁴⁰ For an analysis of relevant issues see – I Anderson and W Sanders, *Aboriginal health and institutional reform within Australian federalism*, Centre for Aboriginal Economic Policy Research No 117/1996.

5.4.4 Systemic issues – remote and rural Australia: A further systemic issue discussed by the Productivity Commission relates to remote and rural Australia where people have higher than average illness and mortality levels and, like their Indigenous counterparts, often face difficulty in accessing key medical services. Inequities between rural and metropolitan areas can be discussed across a number of contributing factors, including lower rates of bulk-billing and a lower ratio of doctors and other health professional to population. A Victorian Council of Social Service report from 2004 observed:

The decline in bulk billing rates has resulted in reduced and uneven access to GP services across Victoria. There is a marked difference between rural, regional and metropolitan rates of bulk billing, and in many communities there is no access to GPs who bulk bill. Access to GPs who bulk bill is particularly limited in many rural and regional areas and some outer metropolitan areas.¹⁴¹

The problems in terms of accessibility and affordability of medical services are clear enough; formulating effective strategies to deal with them is another matter altogether. For instance, the same Victorian Council of Social Service report doubts whether the Commonwealth’s Medicare Plus policy ‘will do little to improve the rate of bulk billing in many Victorian communities’.¹⁴² As noted, overall bulk billing rates have increased in recent times. Again, quite how this problem, or set of problems, impacts on the whole Commonwealth-State debate is hard to say. Clearly, any thought that a bureaucratic clarification of responsibilities would somehow solve the issues involved is problematic.

5.4.5 Systemic issues – socio-economic disadvantage: The rural-metropolitan dichotomy is largely about inequities in access to health services and their affordability. The same issues are found in the debate about the health status of what are called ‘socio-economically disadvantaged people’. To take one example of the effect of poverty on health, years of life lost due to premature mortality in the most disadvantaged quintile is 41% higher for males and 26% higher for females than in the least disadvantaged quintile. Likewise, men in the bottom quintile of socio-economic disadvantage have a 40% higher chance of dying between ages 25 and 65 than men in the top quintile.

As discussed by the Allen Consulting Group in 2004, the factors to be considered here are complex:

¹⁴¹ D Griggs and C Atkins, *The Bulk Billing Crisis: a Victorian Perspective*, Victorian Council of Social Service, 2004, p 27.

¹⁴² D Griggs and C Atkins, *The Bulk Billing Crisis: a Victorian Perspective*, Victorian Council of Social Service, 2004, p 6. The *Medicare Statistics - June Quarter 2006* state: ‘In the June quarter 2006 over the June quarter 2005...the level of bulk billing for all services increased by 1.0 percentage point to 72.3 per cent’. More specifically, ‘In the June quarter 2006, 72.3 per cent of services were bulk billed, an increase of 0.1 of a percentage point on the March quarter 2006. The Northern Territory had the highest rate of bulk billing with 76.8 per cent, followed by New South Wales (76.0 per cent), Queensland (70.9 per cent), South Australia (70.8 per cent), Victoria (70.4 per cent), Western Australia (69.8 per cent), Tasmania (67.5 per cent) and the Australian Capital Territory (59.3 per cent) - <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/medstat-jun06-analysis-a-per>

The reasons for the relationship between socio-economic status and health status is not always clear. The mechanisms by which socio-economic status influences health status are many and varied. However, those most often postulated are diet, health behaviour (including smoking and lack of exercise), education, access to health services (both preventive and treatment), occupational exposures, quality of housing, and psychological factors.¹⁴³

These are not factors that can be addressed wholly, or even mainly, by consideration of the split between Commonwealth-State responsibilities for health. As with the debate about private health insurance, the subject is replete with political controversy.

5.4.6 Systemic issues – a two-tiered health system? A distinct, but related and equally controversial, issue refers to the possibility of a growing rift between health care for the poor and others. With the gap between rich and poor widening in Australia and with health costs rising in advance of general inflation, there is an argument that a two-tiered health system is developing, one for the relatively wealthy who can afford private health insurance and the benefits in access to elective surgery and other services it brings, and one for the poor who must rely on the ‘safety net’ provided by Medicare and the public hospital system.¹⁴⁴ In support of this claim, Gray notes that a 2003 report commissioned by the Royal Australasian College of Surgeons found that ‘elective surgery was increasingly being moved to private hospitals and that citizens without private insurance were being denied access to a range of surgical procedures’.¹⁴⁵

Again, the extent to which these issues are related to the Commonwealth-State division of responsibilities is a matter for debate.

5.4.7 Systemic issues – health workforce shortages: Shortages of doctors and nurses and allied health professionals are a major challenge facing Australia’s health system. As noted, this is especially true in rural and remote areas, with a disproportionate share of health

¹⁴³ The Allen Consulting Group, *Governments Working Together: A Better Future for All Australians*, May 2004, p 55.

¹⁴⁴ Australian Healthcare Reform Alliance, Submission to Parliament of Australia House of Representatives Standing Committee on Health and Aging- Inquiry into Health Funding, Submission 127, p 13; I McAuley, ‘What health care system?’ - <http://www.newmatilda.com/policytoolkit/policydetail.asp?PolicyID=525&CategoryID=7> - McAuley states: ‘What we really want is a universal system. We don’t have that at the moment – we have a fragmented system. In hospital care we are rapidly developing a two-tier system; a private system funded by private insurers for the well-off, and a public system that is rapidly becoming a charity system. This fragmentation did not start with the Coalition, although they have embedded it a bit more. It really started back in the early nineties with Graham Richardson saying ‘we’ve got to do a few deals at the top end of town’. The redefinition started then, and it has become more entrenched, defining health care as charity rather than as something universal which we all share’.

¹⁴⁵ G Gray, *The Politics of Medicare: Who Gets What, When and How*, UNSW Press 2004, p 12. Cited is B Birrell et al, *The Outlook for Surgical Services in Australasia*, Centre for Population and Urban Research, Monash University, June 2003.

workers practising in the major cities. However, the problem is more general in nature, with the Productivity Commission stating in December 2005, ‘Though precise quantification is difficult, there are evident shortages in workforce supply – particularly in general practice, various medical speciality areas, dentistry, nursing and some key allied health areas’.¹⁴⁶

As discussed by the Productivity Commission, this is an issue that impacts directly on the division between Commonwealth and State responsibilities for health. It comments in this respect that Australia’s health workforce arrangements are extraordinarily complex and interdependent, involving the Commonwealth, State and Territory governments. More than 20 bodies are involved in accrediting health workforce education and training, and over 90 registration boards. In addition, a host of professional boards administer codes of conduct which complement formal regulation, or provide for self-regulation. While agreeing generally on a ‘holistic’ review of Australia health care system, the Productivity Commission proposed an integrated reform program, to which COAG responded in July 2006, including with the announcement of measures to strengthen the health workforce in rural and remote areas and in Indigenous communities. The initiatives to be undertaken by each level of government were spelt out in the COAG communiqué, with the States and Territories committing themselves to ‘attracting, retaining and developing the health workforce.’ Whether these and related initiatives are a sufficient response to challenges facing the health workforce remains to be seen. At least one source has reported that ‘A wrangle between the Federal and NSW governments over indemnity costs is thwarting the effectiveness of a program designed to encourage junior doctors to enter general practice’.¹⁴⁷

Of course the Commonwealth and States are not the only players in this field, where the regulatory arrangements are, in the words of the Productivity Commission, ‘subject to considerable influence from the professional groups concerned’. According to the Commission:

This is widely perceived as inhibiting changes to scopes of practice and the development of new competencies that could help to better meet changing health care needs. Moreover, inconsistencies in regulatory approaches across professions and jurisdictions again inhibit an integrated approach to policy development.¹⁴⁸

5.4.8 Operational issues: It is probably fair to say that the major impact of the Commonwealth-State division in responsibilities is felt at the operational level, in myriad

¹⁴⁶ Productivity Commission, *Australia’s Health Workforce*, Productivity Commission Research Report, 22 December 2005, p xvi.

¹⁴⁷ A Ramachandran, ‘Indemnity row hits GP placement program’, *Australian Doctor*, 17 November 2006, p 4. The program in question is the Prevocational General Practice Placement Program, which allows doctors undertaking hospital training who are yet to enroll in a specialty to complete a 12-week general practice placement in rural and remote areas or urban areas of workforce shortage.

¹⁴⁸ Productivity Commission, *Australia’s Health Workforce: Productivity Commission Position Paper*, September 2005, p xxviii.

contexts where health related decisions are made by bureaucrats, health professionals and patients. Stephen Duckett, a former Secretary of the Commonwealth Department of Human Services and Health, has observed in this context:

Although it might be argued that the overlap in responsibilities provides the opportunity for vertical competitive federalism, there is no doubt that the current division of responsibilities in the health sector is not acting in the best interests of an efficient and equitable health system.¹⁴⁹

Health workforce planning was one example he discussed. The other related to the changing profile of the health issues facing the system, notably the growing number of people who will have chronic illnesses. In Duckett's view:

the principal problem here is not primarily one of the federal-state division of responsibilities, but rather is that primary medical care practitioners are principally remunerated on a fee for service basis: a system which characterises the interactions between the general practitioner and the patient as being episodic and acute rather than a longitudinal relationship appropriate to people with chronic disease. Primary and secondary care services are also not integrated: in part due to different status and orientation of the two sectors.

He continued:

However, these differences are exacerbated by different funding arrangements and responsibilities: primary medical care is essentially funded by the Australian Government, with acute in-patient services being funded through State Governments for public hospitals or private health insurance, subsidised by the Australian Government, for private hospital care.

His conclusion was that 'These fragmented arrangements mean that no single authority has responsibility for all the care of the person with a chronic illness'. Likewise, in the second edition of his influential text book, Duckett writes of the lack of both co-ordination and uniformity in primary and community care. He says that primary care has 'developed differently in each state with different links to specialist services (such as alcohol and drug services and mental health), different regional structures, and different relationships to state government'.¹⁵⁰ The one exception to this rule, in his view, is the nationally coherent development under Commonwealth auspices of community services specifically for the aged. This might be contrasted with his suggestion, specifically in relation to the treatment of chronic illness, that in Albury-Wodonga 'there are different levels of community services available on different sides of the border'.¹⁵¹

¹⁴⁹ S Duckett, 'Discussant' in Productivity Commission, *Productive Reform in a Federal System, Roundtable Proceedings*, Canberra 27-28 October 2005, p 161.

¹⁵⁰ Duckett, n 2, p 223.

¹⁵¹ S Duckett, 'Discussant' in Productivity Commission, *Productive Reform in a Federal System, Roundtable Proceedings*, Canberra 27-28 October 2005, p 163. But query in this context whether a similar observation might also apply in the United Kingdom where

The Allen Consulting Group also reported on the problems encountered in continuity of care, stating:

Current funding and delivery arrangements also create barriers to continuity of care. Because of the complexity of the health system, it is difficult for people to identify the services they require, arrange to receive those services, and navigate their way through the health system without expert help. For example, health promotion, early intervention, and chronic disease management activities are undertaken through a variety of programs. Care is fragmented and people need to navigate a range of programs with different objectives, eligibility criteria, availability and funding arrangements in order to access services.¹⁵²

These views are echoed in the policies outlined recently by the Australian Healthcare Association, the national industry body for the public and not-for-profit health sector. Its policies are predicated on the assumption that ‘Australia’s dual health funding system... is a major barrier to achieving quality and cost effectiveness in the health system’. According to the Association, this results in:

- duplication of bureaucratic, administrative and clinical services arising from the lack of role delineation between the two levels of government. This leads to lack of accountability and inefficiencies, as well as cost and blame-shifting between governments;
- reduced quality of patient care. Patients are not necessarily treated in the setting most appropriate to their needs; and
- compromised continuity of care for patients moving between the hospital and community or aged care sectors due to a lack of coordination.

On this last issue, the Association comments that ‘These transitions are critical in a person’s healthcare journey because they occur at periods of significant illness or emotional stress’. For the Australian Healthcare Association the solution is a ‘single funder’ model to provide ‘the capacity to overcome duplication of effort and reduced quality of patient care’, as well as ‘improve allocative efficiency’.¹⁵³

5.5 Comment

This paper does not purport to present an inventory, so to speak, of the operational issues affecting the health system. What is clear is that the federal arrangements contribute to the complexity of that system, as do other factors, including the mix of public and privately

community services and the terms upon which they are offered might differ from one local government area to another.

¹⁵² The Allen Consulting Group, *Governments Working Together: A Better Future for All Australians*, May 2004, p 51.

¹⁵³ Australian Healthcare Association, *2006-07 Policies*, p 17 - [http://www.aushealthcare.com.au/documents/publications/133/AHA Policies 06-07.pdf](http://www.aushealthcare.com.au/documents/publications/133/AHA_Policies_06-07.pdf)

funded health services. For some, the hope is that a tidier system, politically and otherwise, would deliver better outcomes in terms of efficiency, accessibility, patient satisfaction and other criteria. However, as some of the comments made above suggest, not every health related issue should be viewed primarily through a Commonwealth-State prism. To put it another way, a useful starting point for the reform debate may be to distinguish those issues which are more directly related to the federal division of responsibilities, from those which are less directly related to the federal question, if at all.

On the subject of duplication, it is as well to bear in mind that the vast majority of those employed by State and Territory health departments are front-line health professionals whose services would still be required under any alternative administrative arrangements. Also, any alternative arrangements, including one based on a stronger connection between the centre and the regions, will incur its own administrative costs. With more regions than States, these costs may even prove greater than those incurred under the present arrangements. Has any modelling been done in this respect to assess the costs involved?

A further observation is that more hard evidence in the form of detailed case studies of the gaps, duplications and other problems arising from the federal division of responsibilities may not go amiss. Much of the literature tends to be at a rather high level of generality, a statement which can be assessed further in relation to the major proposals for reform, as discussed in the next section of this paper. There is also a strong political element to the debate, with the Commonwealth Parliamentary Library Research Note commenting:

The example of public hospital funding demonstrates that while the issues and problems associated with cost-shifting in the health care system are rhetorical rather than evidence-based. This is also the case for many of the debates about cost-shifting in other areas of the health system.¹⁵⁴

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L Buckmaster and A Pratt, n 119, p 7.

6. RESEARCH FINDINGS AND PROPOSALS FOR REFORM

This section of the paper outlines the findings of major research on the Australian health system, taking as its theme the question of the reform of the federal arrangements in place. In particular, do the reports looked at here recommend a ‘big bang’ or incremental solution to the problems they identify? The evidence upon which these recommendations are based is also considered in each instance.

6.1 Report of the NSW Health Council (March 2000)

A Better Health System for NSW was published in 2000 with a foreword from the then Chairman of the NSW Health Council, John Menadue. It is an example of what might be called governmental research, written from a State perspective, at the request of the Minister for Health.

One of the broad assumptions it operated upon was that a review of any State health system ‘can only deal with part of the picture and that some changes will need Commonwealth, State and private sector cooperation’.¹⁵⁵

Its underlying finding was that ‘The State’s health care system performs very well and generally provides excellent, accessible and affordable health care to the people of NSW’. However, this finding was qualified by a number of further observations, relating to the challenges facing the system, not least those arising from the ‘pressure of increased patient demand and rising costs’.¹⁵⁶ Specifically in relation to the State’s health system, the NSW Health Council commented:

During the course of our review we met with many clinicians and Area Health Service managers. They explained the pressures they were facing in meeting growing demand in a climate of budget uncertainty, annual budget reviews and a lack of predictable growth funds. We were also aware of the problems facing Area Health Services whose funding did not reflect the growth in their populations.¹⁵⁷

The report’s recommendations in this respect included: first, the need for budget certainty and three-year budgets; secondly, the need for real growth funds and a predictable growth formula to meet future demand; thirdly, the urgent need to address the problems of some Area Health Services whose funding has not kept pace with growth in population; and, fourthly, the need for stability in specific areas of the State, such as isolated rural health services. The NSW Health Council reported that, at the time of finalising its recommendations, the Minister for Health advised that the NSW Government had given approval to growth funding over three years, three-year budgets and recurrent funds in addition to growth funds to support the service improvements it had recommended.¹⁵⁸

¹⁵⁵ Report of the NSW Health Council, *A Better Health System for NSW*, March 2000, p 2.

¹⁵⁶ Report of the NSW Health Council, n 155, p xi.

¹⁵⁷ Report of the NSW Health Council, n 155, p 3.

¹⁵⁸ Report of the NSW Health Council, n 155, p 3.

On the wider front, the Council did not see its role as including the making of recommendations on reforming the broader Australian health system. Generally, its view was that:

Existing health funding structures involving Commonwealth and State Governments are sometimes confused and can create limitations in the ability to link health providers (such as GPs) with services funded by the State (such as hospitals). Despite these difficulties the Australian system generally works well, delivering high quality, accessible services at a moderate cost.¹⁵⁹

The need for reform was acknowledged, however. On one front the Council recommended that certain ‘incremental but important reforms could be progressed’. For example, the Council observed:

Depending on whether a patient elects to be a ‘public’ or ‘private’ patient, there is a different source of Government funding for exactly the same medical service. This distortion creates inappropriate incentives which elevate the issue of ‘who pays’ above the issue of ‘what is the best means of delivering a service’, to the detriment of patients and of public patients in particular. Similar issues apply in the case of pharmaceutical benefits. To remove these distortions, one level of Government - the Commonwealth – should be responsible for all public funding for medical and pharmaceutical services.¹⁶⁰

Beyond this, the NSW Health Council argued the need for a national health policy, stating:

Australia does not yet have in place a national health policy that clarifies the respective roles and responsibilities of the State and Commonwealth Governments, the desired health outcomes for NSW and Australian communities and the most effective ways of delivering patient care. Cooperative arrangements are required to allow Governments to focus on linked shared objectives, for a healthy community to the financing and delivery of health services.¹⁶¹

¹⁵⁹ Report of the NSW Health Council, n 155, p 61.

¹⁶⁰ Report of the NSW Health Council, n 155, p 61.

¹⁶¹ Report of the NSW Health Council, n 155, p 61.

6.2 Senate Community Affairs References Committee report (December 2000)

The Senate Committee’s views on cost shifting were discussed in an earlier section of this paper. Basically, in the unanimous First Report of July 2000 it was agreed that cost shifting was a major concern but that hard evidence was difficult to find. The Committee’s final report of December 2000 was a more complex document, reflecting the fact that Government Senators produced a minority report in which they disputed the conclusions arrived at by the non-government majority, complaining that its findings were political in nature and that they intruded into ‘specific areas which are the responsibility of the State and Territory Governments’.¹⁶² The majority and minority recommendations as expressed in the report of December 2000 can be summarised separately.

6.2.1 Majority recommendation for pooled funding: Even within the majority report itself a certain disjunction is evident. Its basic assumption was that cost shifting is an ‘inevitable’ and ‘endemic’ part of the current system. From there, however, the majority view diverged. At one point it reported that ‘little evidence was available’ on cost shifting, ‘with most comments being of an anecdotal nature’.¹⁶³ At another, it was confidently stated that ‘The Committee heard extensive evidence of cost shifting with examples where the States shifted costs to the Commonwealth and where the Commonwealth shifted costs to the States’. On this basis, the Committee concluded ‘It is clear that the needs of patients are not advanced by these arrangements and the community is tired of the endless squabbles over funding’.¹⁶⁴

This second formulation was the one preferred by the majority which went on to consider three major proposals for reform of the health system: (a) Commonwealth to take responsibility for funding and delivering services; (b) States to take responsibility for funding and delivery of services; and (c) Commonwealth and States/Territories to pool funds. It was this last option that the majority preferred, stating:

The option for reform of the current funding arrangements that received the most support was a ‘single fund’ or ‘joint account’ model at a State-wide level. This would combine State and Federal funds across a number of programs, which are currently partially funded by both levels of Government. This would also provide flexibility to enable funds to be delivered to the most appropriate and effective forms of care.¹⁶⁵

While acknowledging that pooled funding would represent a ‘major change’ to the current Commonwealth-State funding arrangements, the majority nonetheless saw it more as a form of incremental change than a ‘big bang’ option. It was said that the proposed reform

¹⁶² Senate Community Affairs References Committee, *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 185.

¹⁶³ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 21.

¹⁶⁴ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p x.

¹⁶⁵ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p xi.

would build on ‘developments already underway, or being trialed in the health sector’, for example, the trials of coordinated care which draw on pooled funding from all the Commonwealth, States and Territories. The majority further stated that ‘existing programs could continue, so that patients would be unlikely to notice any change to the provision of health services’,¹⁶⁶ a statement which seems to sit uncomfortably alongside the majority’s view that the needs of patients are not advanced by current arrangements.

6.2.2 Australian Democrats – supplementary report: Written by Meg Lees, the supplementary report noted its support for reformed funding mechanisms based on the pooled funding model. Where it differed from the ALP members was in advocating that pooled funding should be allocated on a regional (not State-wide) basis. The argument was that provision would be made within this system for rural and remote regions where health care costs are higher, with each region controlling the allocation of funding within its area.¹⁶⁷ The majority disagreed therefore over the details of the pooled funding model it proposed.

6.2.3 Majority recommendation for a national health policy: The recommendation for pooled funding, based either on a State wide or regional model, was one amongst a number of proposals suggested by the majority. These included a recommendation for a national health policy, with the majority saying:

The Committee acknowledges that Australia already has a substantial set of health policies but believes that the lack of a national health policy reflects the fragmented nature of the health system. The Committee believes that Australia needs a genuinely national health system. It regards the development of an overarching national health policy, informed by community consultation, as a necessary prerequisite for health policy reform.¹⁶⁸

With this last goal in mind, recommended was the establishment of a National Advisory Council to bring together the major players in the health sector, providing them ‘with a voice in the formulation and development of new Commonwealth-State health funding arrangements’.¹⁶⁹

6.2.4 Minority view of Government members: The Committee’s Government members disputed the conclusions arrived at by the non-government majority across a whole range of issues. Predictably, this included the majority’s conclusion that the Commonwealth Government should be required to provide additional funding for hospitals. As for the ‘funds pooling’ proposal, according to the minority it overlooked certain fundamental points: first, the difficulty in the different levels of government agreeing on what funds are to be pooled and how this is to be done; and, secondly, the majority ‘failed to identify

¹⁶⁶ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 32.

¹⁶⁷ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 210.

¹⁶⁸ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 40.

¹⁶⁹ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 20.

whether pooled funding is really a necessary and sufficient condition for change. Evidence presented to the Committee suggests that it is neither sufficient nor necessary’.

Government Senators believed that even with pooled funding for public hospitals, the manager of the single fund would still have to contend with the same issues as the current funding system, for example, how to provide primary medical care in rural and remote areas, or how to provide residential aged care in those areas. Pooled funding was not a panacea, therefore.

The minority recommended certain reforms of an incremental kind, such as strategies for the better management of chronic illness in the community, thereby reducing demand on the public hospital system. However, it did not believe that major, systemic changes were required. It said in this respect:

Most significantly, it should be noted (as it was in the Committee’s First Report) that the hospital system is not in ‘crisis’. When we look at Australia’s system, its professionalism, its facilities and its outcomes it is hard to imagine, compared to the rest of the western world, that the overwhelming majority of people are not satisfied with the treatment they receive.¹⁷⁰

As for the proposal to establish a National Advisory Council, the minority said this would ‘promote an extra layer of bureaucracy and duplication that would not contribute to improved outcomes for patients in hospital care’.¹⁷¹

If nothing else, the Senate Committee report underscores the political difficulties involved in formulating an agreed pathway for the reform of the health system.

6.3 Senate Select Committee on Medicare (October 2003)

6.3.1 Minority report: The same conclusion emerges from the 2003 report on Medicare where, again, a majority report from non-government members was presented by the chair, the ALP’s Jan McLucas, with Government Senators producing a dissenting report which opened with the statement that the ‘opposition parties have skewed the inquiry, resulting in a narrow ideological debate about the concept of universal health care and the ensuing belief that bulk billing is its embodiment’. The Government members stated:

Throughout this inquiry, opposition Senators have painted a bleak picture of health care in Australia. But Australia’s health system is not in crisis – claims of a crisis are an overreaction. Medicare can certainly be improved, and the Government A *Fairer Medicare* package has been created to do this, but it is important to keep in mind that Australia’s health care system is either the best or among the best in the world.¹⁷²

¹⁷⁰ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 206.

¹⁷¹ *Healing Our Hospitals: Report on Public Hospital Funding*, December 2000, p 203.

¹⁷² Senate Select Committee on Medicare, *Medicare- healthcare or welfare?* October 2003, p 208.

6.3.2 Majority report: Generally, the Committee report did not focus on Commonwealth-State responsibilities. Rather, the concern was with the Commonwealth funded Medicare scheme and, in particular, with the decline in bulk-billing by GPs. One recommendation with federal implications was that the Commonwealth

commence negotiations with State and Territory governments to put in place arrangements which permit bulk-billing general practice clinics to operate either co-located or closely located to public hospitals in areas of low bulk-billing.¹⁷³

In a brief debate on funding mechanisms, the majority cited with approval evidence from various quarters on the need for greater cooperation between the Commonwealth and the States. A good working example, albeit on a small scale, of such cooperation was the GP Access After Hours service, developed as a cooperative scheme in the Hunter Urban Region. The majority noted that ‘The scheme serves a population of 450,000, using five GP clinics situated adjacent to emergency departments or in community health facilities, and sees 60,000 patients per year after hours’.¹⁷⁴

The majority did not address the broader issues of health reform directly. However, it recommend the establishment of a ‘new national health reform body’, along the lines of the Canadian Commission on the Future of Health Care, to ‘conduct a comprehensive process of engagement with the community that will provide a forum for a well-informed discussion on the values, outcomes and costs of Medicare and the Australia health system’.¹⁷⁵

6.4 The Allen Consulting Group, Governments working together (May 2004)

Commissioned by the Victorian Premier, the report was prepared by the Allen Consulting Group. Its focus is on Australian families and how governments affect their lives, especially in the areas of health and education. It was said that ‘Health, in particular, presents daunting challenges given the ageing of Australian society and other factors driving health care needs and costs’. It was in the areas of health and education specifically that the report saw it was ‘imperative for the two levels of government [Commonwealth and State] to work together more effectively’ and found the ‘opportunity to forge the basis of a new and more truly collaborative Federal system’.¹⁷⁶ A new Australian Federation Council, to replace COAG, was proposed to provide top level direction and drive, comprising the heads of all Australian governments and meeting on a regular basis to consider regular agenda items associated with the development of national strategies.¹⁷⁷

¹⁷³ *Medicare- healthcare or welfare?* October 2003, p 194.

¹⁷⁴ *Medicare- healthcare or welfare?* October 2003, p 196.

¹⁷⁵ *Medicare- healthcare or welfare?* October 2003, p 206.

¹⁷⁶ The Allen Consulting Group, *Governments Working Together: A Better Future for All Australians*, May 2004, p iii.

¹⁷⁷ The Allen Consulting Group, n 176, pp 183-184.

In summary, the report’s case for the need to reform the health system was based on the following findings:

- the complex split in responsibilities for the funding and provision of health care between the Commonwealth and the States leads to problems, including poor coordination of planning and service delivery, barriers to efficient substitution of alternative types and sources of care, and scope for cost shifting between governments. Funding arrangements do not encourage continuity of care, provision of multidisciplinary care, or provision of care in the most clinically appropriate setting;
- generally, Australians enjoy good health, but there is much scope for improvement, particularly in the health of indigenous and poorer people;
- public hospital accident and emergency departments are overloaded;
- there are significant delays in access to elective surgery in the public system, while people with private health insurance have increased their access, which raises equity concerns; and
- there is a shortage of institutional aged care places and community-based aged care is underdeveloped, leading to long-stay occupation of acute beds, which in turn puts additional pressure back on emergency departments and elective surgery.

On the question of the split between Commonwealth and State responsibilities, the report noted:

In many cases the way the two levels of government interact does little for the quality of services received by the community, due to duplication, inefficiency and lack of coordination.¹⁷⁸

Certain immediate reforms to improve health care were suggested, including: the co-location of primary care clinics adjacent to emergency departments; additional funding to improve access to elective surgery for public patients; and additional funding for aged care programs.¹⁷⁹

On the other hand, a major overhaul of government responsibilities was not considered by the Allen Consulting Group, largely because of the ‘unlikelihood that the Commonwealth and the States could reach agreement on the process and on the issues’.¹⁸⁰ The assumption therefore was that the Commonwealth and the States would retain joint responsibility for health care.

In principle, an integrated health care system was preferred, but again a specific model for implementation was not put forward. This was on the basis that this would only lead to

¹⁷⁸ The Allen Consulting Group, n 176, p xiii.

¹⁷⁹ The Allen Consulting Group, n 176, p 148.

¹⁸⁰ The Allen Consulting Group, n 176, p 125.

debate about the details of the model, instead of focusing debate on seeking agreement to the directions of reform. Various reform models were noted in the report, including:

- a Joint Commonwealth-State Health Commission (proposed by John Menadue in 2004) in each State, which would receive a negotiated allocation of funds from the Commonwealth and the relevant State Government covering acute, primary and community health care services. The Commission would manage the funding and planning of all health services in that State, purchase various services from providers, and monitor performance against agreed targets; and
- managed competition (proposed by Richard Scotton)¹⁸¹, which would also involve the pooling of Commonwealth and State funds. However, in addition, it would involve more significant structural reform of the health system as it would integrate private sector funding and service provision into a national program.¹⁸²

It was said that similar approaches were being explored or implemented in the United Kingdom and New Zealand. Indeed, it was claimed that

There is now emerging evidence that closer integration of clinical decision-making and purchasing for enrolled populations through funds-pooling and local purchasing has the potential to increase innovation, reduce costs and improve health.¹⁸³

The key features of these emerging approaches are:

- a regional population model, with a regional health authority responsible for the health of all residents within a defined geographical region;
- the regional health authority having control over a budget and a mandate to purchase all health services for the defined population;
- the health authority negotiating performance-based contracts with providers of health care services; and
- universal coverage, with financing for health care provided from taxpayer funds, at least in the main.

For the Allen Consulting Group, the essential first step in establishing a fully integrated system was the formation of a joint Commonwealth-State national body, the Australian Health Commission. Its first task would be the development of a framework for an

¹⁸¹ R Scotton, *Managed competition: the policy context*, Melbourne Institute Working Paper No 15/1999.

¹⁸² The Allen Consulting Group, n 176, p 126. The Scotton model, or 'managed competition' model, would involve total Commonwealth and State moneys being available for channeling through private health insurance funds by way of 'vouchers' equal to each individual's risk-rated premium which the individual may pass to the fundamental of their choice. The fundamental then has full responsibility as funder/purchaser of all their health and aged care services.

¹⁸³ The Allen Consulting Group, n 176, p 126.

integrated health system, under which regional health agencies would control a budget of pooled Commonwealth and State funds for acute, primary and community care, pharmaceuticals and aged care. These regional health agencies could be based, it was said, on existing entities such as health care networks of State Health Departments.¹⁸⁴ Under this proposal, the regional health agencies would:

- purchase the required health services from a given budget of pooled Commonwealth and State funds;
- negotiate and contract with providers for the health care needs of the population; and
- develop accountability arrangements and monitor performance.¹⁸⁵

The report’s findings and conclusions were presented by Vince FitzGerald of the Allen Consulting Group at the roundtable proceedings on reforming the federal system, held in Canberra in October 2005. In the context of arguing for an integrated health care system, FitzGerald noted these general considerations:

While in theory an integrated health care system would seem an obvious way to go to address Australia’s problems of fragmentation of health care funding and delivery, in practice implementing an integrated health care system would be very complex, difficult and time consuming. It would require a great deal of collaboration among the Australian and State Governments in respect of governance system, organisational and workforce development. Considerable institutional effort would also be required to support change. In the United Kingdom for example, a Modernization Agency has been established for the NHS.¹⁸⁶

6.5 Productivity Commission, Review of National Competition Policy Reforms (2005)

In February 2005 the Productivity Commission, a Commonwealth body, issued a strong call for health care reform. Its view was that:

Though Australia’s health care system still performs adequately against a number of overall outcome indicators, it is beset by widespread and growing problems. Inefficiencies in resource use, poor outcomes for some community groups and increasing difficulties with access are all indicative of scope for significant improvement. Overlapping roles and responsibilities between the Australia and

¹⁸⁴ The Allen Consulting Group, n 176, p xiv and p 135.

¹⁸⁵ The Allen Consulting Group, n 176, p 136.

¹⁸⁶ V FitzGerald, ‘Health reform in the federal context’ in Productivity Commission, *Productive Reform in a Federal System, Roundtable Proceedings*, Canberra 27-28 October 2005, p 123.

State and Territory Governments either cause or contribute to some of these problems.¹⁸⁷

As discussed in an earlier section of this paper, significant problems and emerging challenges were discussed in support of these conclusions, including issues associated with health inflation and the ageing population, as well as significant concerns about the health status of Indigenous Australians and (to a lesser extent) of people living in regional Australia, particularly in remote areas. Other indicators of problems were also discussed, including declining levels of access to public hospital services and bulk-billed medical services, even within major population centres, plus apparent shortages in key health workforce areas, such as nurses, GPs, some medical specialities and dentists.

Further, the Productivity Commission noted that ‘it is generally accepted that the design of financing and delivery arrangements give rise to considerable inefficiency and waste in the health system’. In support of this claim the views of the health economist Richard Scotton are cited to the effect that the intrinsic difficulties in finding efficiencies in the health system are compounded in Australia: (a) by the division in funding responsibility between the Commonwealth and the States; (b) by the multiplicity of separate programs; and (c) the conflicts between the incentive systems of private and public sector funders and providers.¹⁸⁸

Without proposing a reform model of its own, the Productivity Commission called for a ‘nationally coordinated reform approach under the auspices of COAG or another national leadership body’. The first step should be an independent public inquiry into Australia’s health care system. With health care reform ‘at the crossroads, the Productivity Commission argued that ‘A circuit breaker is needed’.¹⁸⁹

6.6 Dawkins et al report on private health insurance policies (2004)

The focus of this independent report on Recent Private Health Insurance Policies is specific to its immediate subject. However, some of its findings have broader implications and are worth noting for that reason in this context. Taking a long-term perspective and looking at private insurance policy within the ‘whole health system’, the report concluded that ‘the soundness of the 30 per cent premium rebate appears to be highly questionable’. Outlining the health policy goals for the long term that they considered important, Dawkins et al stated:

First, there are strong arguments that policy efforts should be directed at bringing a better integration of the health system, and in particular the private and public funding and private and public hospital systems. Serious consideration should be given to bringing about a system in which PHI [private health insurance] plays a

¹⁸⁷ Productivity Commission, *Review of National Competition Policy Reforms, Productivity Commission Inquiry Report No 33*, 28 February 2005, p xxxv.

¹⁸⁸ Productivity Commission, n 187, pp 326-329.

¹⁸⁹ Productivity Commission, n 187, p xxxv.

much more complementary role with the public system. Specifically, there is a strong argument for a setting in which Medicare and the public system provide a base coverage for all health needs of Australians, encompassing primary as well as hospital care. PHI would then become a form of ‘top up’ to the public system.¹⁹⁰

Comments of this nature underline the point that health care reform is a much broader subject than the debate about jurisdictional responsibilities might suggest. The message Dawkins et al have for the Commonwealth, State and Territory governments was that they ‘should focus efforts in managing the overall health care resource utilisation of the system as a whole not the shifting of utilisation from one sector of the system to another’. In their view, ‘The existing PHI arrangements appears to aim at shifting the financing of hospital care from public to private hospitals, so as to relieve capacity and financial pressure from the public hospitals’.¹⁹¹ They say it is questionable whether a shift has actually occurred, but that the evidence does suggest an increase in overall utilisation of hospital resources as a result of what is called ‘moral hazard’ at both the demand and supply sides. By sharing risk, health insurance enables individuals to consume health care at greatly reduced costs when they need it. This, however, creates a tendency for individuals to consume more health care than they would otherwise.¹⁹²

6.7 Podger’s model health system for Australia (2005-06)

Andrew Podger, a former Secretary of the Commonwealth Department of Health and Ageing, was head of the Prime Minister’s Health Taskforce in 2005. While the taskforce’s report has not been made public, elements of it have surfaced in various presentations made by Podger, notably at the roundtable proceedings organised by the Productivity Commission in October 2005¹⁹³ and, subsequently, in the inaugural Menzies health policy lecture delivered by Podger at the University of Sydney in March 2006.

¹⁹⁰ P Dawkins et al, *Recent Private Health Insurance Policies in Australia: Health Resource Utilization, Distributive Implications and Policy Options*, Melbourne Institute Report No 3, Melbourne Institute of Applied Economic and Social Research, 17 March 2004, p iii.

¹⁹¹ P Dawkins et al, n 190, p iii.

¹⁹² Dawkins et al discuss what is meant by ‘moral hazard’ at Appendix A of their report. Basically, the proposition is that health insurance creates an incentive for individuals to consume more health goods than they would. This is because individuals typically do not face the full price when buying health goods under insurance coverage, which means that marginal costs to individuals are out of line with marginal benefits. According to Dawkins et al, ‘In the Australian health insurance system, moral hazard is likely to be a serious problem. Compared to Medicare, private health insurance plans typically provide wider coverage, and are purchased by higher income individuals. The wider coverage is often in the form of ancillary cover such as dental and eye-care products. To the extent that health care demand tend to rise with income, and private health insurance provides cover for health services and goods that can be considered normal, having higher income individuals under wider coverage means that utilization will be high. The 30 per cent premium rebate further encourages higher income individuals to join the private insurance pool, thus exacerbates the moral hazard problem’ (pages 52-53).

¹⁹³ A Podger, ‘Directions for health reform in Australia’ in Productivity Commission, *Productive Reform in a Federal System, Roundtable Proceedings*, Canberra 27-28 October 2005.

The assumptions underlying Podger's analysis are that (a) with the notable exception of Indigenous health, Australia ranks highly on a number of indicators of system performance, including life expectancy, waiting times for emergency departments and for elective surgery; (b) but that the system will come under increasing financial pressure; and (c) despite its strengths, the system has significant structural problems. Podger lists four of these problems, as follows:

- *a lack of patient-oriented care* or continuity of care that crosses service boundaries easily with funds following patients, particularly those with chronic diseases, the frail aged and Indigenous people;
- *allocative inefficiency* with the allocation between different types of care not always achieving the best health outcomes possible, and with obstacles to shifting resources for individuals or communities to allow different mixes reflecting different needs. While acknowledging that the 'scale of this inefficiency is hard to measure', Podger sees this as the most significant contribution to the system's inefficiency - 'where the balance of funding between functional areas is not giving best value, and the inability to shift resources between the functional areas at local or regional levels and to link care services to individuals across program boundaries is reducing the effectiveness of the system';
- *poor use of information technology*, where better investments and useage could not only reduce administration costs but also support more continuity of care, better identification of patients at risk, greater safety and more patient control; and
- *poor use of competition*, with an uneven playing field in the acute area, a reluctance to use competition to ensure best access to medical services at reasonable cost, and less choice than should be possible (in aged care in particular).

Discussed by Podger are various incremental options for reform, including strengthening general practice further, particularly to improve its links to allied health care, so that it is able not only to help with care planning for the chronically ill and frail aged, but also to play a larger role in prevention. His preferred option, however, is for a 'big bang' solution to these structural problems. This is in the form of the Commonwealth taking full financial responsibility for the health system, as both funder and purchaser. Basically, the structure recommended by Podger is for a National Health Minister whose department would fund health care and articulate the relevant policy objectives. Various regulatory authorities and a national advisory body are also proposed, in a system that would draw on existing arrangements where such bodies as Medicare Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council provide research and other functions. A further element in Podger's proposed model health system is an operational or executive agency, supported by a national information and payments agency, which would be responsible for the purchasing of services and the supervision of regional purchasing units. Ideally, Podger envisages a regional administrative structure based on around 20 to 30 regional purchasers of health goods and services, with the possibility of sub-regional arrangements to assist community responsiveness. Of these proposed regional arrangements, Podger writes:

The key to improving allocational efficiency is the incentive framework created by regional purchasers who have responsibility for the health objectives for their regional population, and the flexibility to allocate funds according to their most cost-effective use.¹⁹⁴

In essence, Podger presents a two-tiered model, in which national administrative structures, responsible for funding, regulation and oversight, are supplemented by regional purchasing authorities. Under this model, provider arrangements would not be substantially changed, at least in the immediate future. Podger does, however, speculate on a range of possible innovations. For example, he writes that ‘The more integrated and patient-focused approach will require further strengthening of primary care arrangements, with GP practices becoming increasingly multi-skilled, supported by nursing staff and linked more closely with allied health professionals, as well as certain specialist medical practitioners’.

Further, in the model he envisages private health insurance would continue to play a significant role in a mixed system with ‘both public and private funding contributing to ensure universal health care with a degree of choice’. On this issue, Podger writes:

I strongly suspect that the desire for choice is likely to grow further, rather than diminish, and that we should therefore be looking to ways to improve competition both amongst health care providers and amongst funds, and to improve the capability of funds to operate as effective purchasers meeting the requirements of their members at best price.¹⁹⁵

Podger concludes:

I believe the Australian health system is generally very good, but it faces new challenges which require substantial reform if the system is to remain affordable and effective. There are some sensible, practical incremental improvements that can and should be made, but I would like to see the national government also grasp the nettle to accept full financial responsibility.¹⁹⁶

¹⁹⁴ A Podger, *A model health system for Australia*, Inaugural Menzies Health Policy Lecture, Sydney University, 3 March 2006, p 15.

¹⁹⁵ A Podger, *A model health system for Australia*, n 194, p 26.

¹⁹⁶ A Podger, *A model health system for Australia*, n 194, p 34.

6.8 New Matilda's health policy for Australia (2006)

Founded in August 2004, *New Matilda.com* describes itself as 'an online magazine and policy portal', founded 'to promote truth and accountability in government, to provide an independent media outlet, and to develop policies based on the public good'. Under its auspices, on 10 October 2006 a health policy for Australia was launched. Addresses in support of the policy were given by John Menadue, John Dwyer and Ian McAuley, all of whom have had a long association with the debate on health care reform in Australia. Before looking at *New Matilda's* proposed health policy, the individually expressed views of Menadue, Dwyer and McAuley can be noted.

6.8.1 Menadue's case for a joint Commonwealth-State Health Commission: John Menadue, formerly Chair of the NSW Health Council (2000) and of the South Australian Generational Health Review (2003), is currently the Chair of *New Matilda.com*. Ideally, he would like to see a national health system under Commonwealth authority.¹⁹⁷ However, recognising the problems involved in achieving that goal, Menadue has proposed, as a step in the journey, the formation of a joint Commonwealth-State Health Commission. In his submission to the inquiry of the House of Representatives Standing Committee on Health and Ageing into health funding, he stated:

The issue of blame and cost shifting is of growing public concern. I have seen estimates of the cost of fragmentation between Commonwealth and State programs ranging from \$1b to \$20 billion per annum. I think it is much nearer the former figure.

On the subject of Commonwealth-State relations, he continued:

There are major health dividends in the solution to this Commonwealth and State fragmentation. The community would welcome change. I don't think the community is particularly concerned who delivers the service, provided it is delivered well. It seems to me important that the Commonwealth set national policies and standards and that as far as possible, services are delivered at the most local level possible. The principle of subsidiarity means that a function should be carried out at the lowest level of government able to exercise it effectively. It is important particularly in a country as large and diverse as Australia.

In support of a joint Commonwealth-State Health Commission, he submitted:

A Commonwealth takeover of State health functions is unrealistic, as is the reverse. I think it is also unlikely that all the states would together agree with the Commonwealth in the pooling of health functions and dollars across Australia. I believe that the best way forward would be to establish a joint Commonwealth-State Health Commission in any State where the Commonwealth and a particular

¹⁹⁷

J Menadue, 'Curing sick hospitals', *New Matilda.com*, 7 September 2005.

State could agree, eg Tasmania, South Australia. The joint commission would have agreed coverage of Commonwealth and State programs with the pooling of funds for all those programs. Agreed governance would be essential. Local government could also be included...It would be hoped that if the process could begin in one state, others would follow. Like almost every other issue in health, political leadership is the key. In my discussions with the ‘health industry’ there is widespread acceptance that there must be improved coordination of Commonwealth and State programs. The real obstacle is the lack of political leadership. That leadership is essential.¹⁹⁸

6.8.2 Dwyer’s proposal for federating health care: John Dwyer is Chair of the Australian Healthcare Reform Alliance and Professor of Medicine at the University of UNSW. In May 2004 he suggested a federal solution to the problems of the current health system, based on an idea not unlike Menadue’s proposed joint Commonwealth-State Health Commission, except that the latter would develop incrementally on a State-by-State basis.

Basically, Dwyer proposed the establishment of an Australian Healthcare Corporation, to be jointly owned and funded by the State, Territory and Commonwealth governments. He commented:

The corporation will assume all the health care responsibilities currently discharged by Commonwealth, State and Territory governments. All the taxpayer dollars used for hospital, community services and primary care would be ‘cashed out’ by current stakeholders to be placed in the AHC ‘Pot’. The corporation would then use those dollars to create the integrated, fairer and more cost effective service we need.¹⁹⁹

This proposal was revisited by Dwyer in the submission he wrote on behalf of the Australian Healthcare Reform Alliance to the House of Representatives Standing Committee on Health and Ageing. Echoing Menadue’s ‘domino’ model of reform, Dwyer commented that the journey towards a single source of funding should start with individual States and the Commonwealth agreeing to pool funds.²⁰⁰

However, the first step proposed by Dwyer in the submission was for the Commonwealth to establish an Australian Health Care Reform Commission, composed of leading policy bureaucrats from State and Commonwealth departments of health, experts in change management, and clinical and consumer leaders. The Commission’s job, it was said, ‘would not be to generate policies, but to work on implementation of strategies (eg, if State

¹⁹⁸ House of Representatives Standing Committee on Health and Ageing, *Inquiry into Health Funding*, Submission 140. See also J Menadue, ‘Coalition of the willing’, *New Matilda.com*, 9 September 2004; and J Menadue ‘Getting Better Value for Money in Health’, *New Matilda.com*, 30 August 2006.

¹⁹⁹ J Dwyer, ‘Federating health care would mend our health system’, *On Line Opinion*, 10 May 2004 - <http://www.onlineopinion.com.au/view.asp?article=2194>

²⁰⁰ House of Representatives Standing Committee on Health and Ageing, *Inquiry into Health Funding*, Submission 127.

and federal funds are to be pooled, how can historical rates of spending be determined?)’.

6.8.3 McAuley’s critique of private health insurance: Ian McAuley, a lecturer at the University of Canberra, has been a long term critic of Australia’s private health insurance arrangements. His views are encapsulated in an article he co-authored in June 2005 with Stephen Leeder, the Director of the Australian Health Policy Institute at the University of Sydney, where it is said:

Private health insurance, in the form currently operating in Australia, is not sustainable. Each year premiums increase ahead of general inflation. Premiums have increased on average 7.5 per cent in the past four years and Australia’s largest private hospital operator has announced that consumers should expect private health insurance premiums to keep rising by twice the inflation rate every year. This is because private insurance has no capacity to control the costs of the services it covers. Consequently, inflation of health costs follows.

Leeder and McAuley continued:

By supporting private insurance with its annual \$2.5 billion subsidy, the government loses a measure of control over health care costs. This loss of control of health costs covered by private insurance diminishes the capacity of the nation to control health costs in toto. The more private health insurance there is, the less control there is over health care costs, the greater the national health bill and the less sustainable the entire health care system.²⁰¹

At the launch of *New Matilda’s* policy initiative on health, McAuley stated his opposition to private health insurance in these trenchant terms:

We need to de-link the private sector from the private insurance industry. One of the great myths which the private health insurance industry has been very good at perpetrating, and which the government has played along with, is that if we don’t have private insurance we won’t have a private sector. That is absolute rubbish. A single national insurer can fund people to use private hospitals and private resources. There is no need for this massive financial intermediary. It’s a cancer that is eating away at our health care provision, pushing up our health care costs and making them unaffordable. And an unaffordable system is inevitably an inequitable system.²⁰²

6.8.4 *New Matilda’s health policy for Australia – reclaiming universal health care:* This policy proposal has a number of distinct aspects. Fundamentally, it is an argument for a more integrated system. While describing the current arrangements as ‘absolutely bamboozling’, resulting in a ‘huge misallocation of resources’, McAuley warned against

²⁰¹ S Leeder and I McAuley, ‘Why health insurance is unsustainable’, *New Matilda.com*, 1 June 2005.

²⁰² I McAuley, ‘What health care system?’, *New Matilda.com*, 13 October 2006.

the line of reasoning which says ‘all you’ve got to do is sort out the Commonwealth-State issues’. He commented:

Certainly that is important, but even within the Commonwealth for example, the pharmaceutical benefits scheme and Medicare don’t work together – they’re quite separate schemes. They’ve got their own safety nets, their own administrations, and their own criteria. So even within the Commonwealth there isn’t any coordination, let alone any sort of integration.²⁰³

In terms of the federal division of responsibilities, *New Matilda’s* key recommendations are that:

- the Commonwealth should have responsibility for the collection of revenue and its distribution to the States, as well for such functions as research, setting standards for services, performance monitoring and negotiating prices with services providers;
- in each State there should be a body responsible for health care program administration and the distribution of funds. This is to be under joint Commonwealth/State control;
- within States services are to be regionalised, with funds delivered along needs-based demographic lines, and with local advisory bodies providing advice and feedback; and
- the only compelling case for special services outside this model is for services for Indigenous people, particularly those living in remote regions.²⁰⁴

Underlying the broader policy proposals is an assumption that the status quo is highly inequitable and that a first principle of a viable and fair health system should be ‘universalism’. The term universalism is defined to mean, not a form of nationalised medicine, but that ‘regardless of means or location, all have access to the same professional staff, clinics, pharmaceutical and other resources’.

As for the mix of the public/private sector provision of services and the role played by private health insurance in the funding of those services, it was stated:

While we see the private sector maintaining a strong role in the provision of services, we see problems when private financial agencies – health insurance funds – become involved in the funding of health care. To the extent that we share our health care costs, we should do so through a single national insurer. Private insurance should be confined to peripheral services where its presence does not distort equity or resource allocation.²⁰⁵

²⁰³ I McAuley, n 202.

²⁰⁴ New Matilda.com, *A health policy for Australia: reclaiming universal health care*, 2006, pp 20-21.

²⁰⁵ New Matilda.com, n 204, p 4.

6.9 Comment

There is no shortage of proposals for reform. Some measure of consensus exists on the need for a more integrated health system, to achieve more co-ordinated care. Exactly how this is to be achieved is more problematic. There are arguments for limited incremental changes and others for a more wholesale reform of the current arrangements. Within the last category there are differences between those who propose a truly ‘big bang’ solution, in the form of a Commonwealth takeover of health, as against more half-way house proposals in which joint Commonwealth and State responsibility is embodied in a single overarching administrative body. Podger belongs to the ‘big bang’ school of thought, whereas Menadue is more pragmatic, preferring that model in principle, but recognising that a joint Commonwealth-State Health Commission is a more politically viable option at this stage, to be achieved on a gradual State-by-State basis. On the other hand, Podger would not seek to disturb the funding role played currently by private health insurance, whereas Menadue as part of the *New Matilda* project seeks fundamental reform in this area, thereby transforming the balance of public and private funding of health goods and services. It has been said again that the health debate has many dimensions to it, not all of which are reducible to a critique of Commonwealth-State responsibilities.

In terms of the federal division of responsibilities, many of these reviews begin by setting out the major options for reform, usually in terms of: (a) the Commonwealth assuming responsibility for health care; (b) the States assuming responsibility for health care; and (c) some kind of combined administrative structure, based on the pooling of funds for allocation at the regional level. Option (a) is of course very appealing to many, as are different versions of option (c). Option (b), however, seems to have no champions and is so politically unviable that it can be discounted for all practical purposes.

The assumptions these reviews are founded on are in a sense as revealing as the conclusions they arrive at. For some, the health system works well at present but faces significant challenges in the immediate future, for which incremental or more systemic reforms are suggested. Whereas some say there is no crisis and that a modest rejigging will suffice, Podger and the Productivity Commission argue that, while there is no crisis now, one will be upon us very soon. For others, the present health system is a dysfunctional mess, sorely in need of a major overhaul if systemic inequities and inefficiencies are to be overcome. This is the *New Matilda* viewpoint which seeks a general makeover of more than the federal division of responsibilities, one that would remodel funding arrangements generally.

These contrasting viewpoints are themselves the product of the different weight that is given to certain factors in the health debate, including issues associated with poverty. Indeed, one might say that, to a greater or lesser degree, the various reviews of the health system are expressions of contrasting institutional and ideological perspectives. This is especially true of the governmental and parliamentary reports reviewed in this paper, but it can also apply more widely in a debate which is unavoidably political in nature. Of these reports and reviews one might echo the comment about Xenophon’s *A History of My Times*, namely that

What it says, and the way it says it, is always to be weighed against what it does not say, and the reason why it does not.²⁰⁶

In some respects the reports discussed in this section provide more questions than answers. For example, if a joint Commonwealth-State Health Commission, or some other hybrid administrative model, were established, which Minister would be responsible for it?²⁰⁷ Who would be responsible for errors and failures in the final analysis? Much is said in the debate about good governance and accountability, the mantras of contemporary public administration, but in the end of the day would a system of this sort undermine the traditional mechanisms of oversight and scrutiny, particularly those associated with parliamentary scrutiny? To put it another way, what would joint responsibility really mean in terms of the established mechanisms of ministerial responsibility? One can see that the fragmentation found under the current arrangements creates very serious problems in this respect. Would a model such as the one proposed by Menadue only create problems of its own? He states that the Board of his proposed Commonwealth-State Health Commission ‘would be responsible to Commonwealth and States ministers, with one financial report to both’.²⁰⁸ How would this work in a practical sense? Would the Commonwealth assume *de facto* financial control as a result of its financial power?

Of course, a fully national health system, as proposed by Podger, would address such concerns. Realistically, however, would the Commonwealth Health Minister welcome direct responsibility for every mishap or worse occurring in the nation’s hospital emergency departments? As Podger acknowledges, his national model involves risks, ‘not least being the political risk for the Commonwealth Minister in taking responsibility for individual patients’ care in hospitals’.²⁰⁹ This may seem a dubiously political perspective from which to view an issue of such national importance. But, then, reform of the health system is an undeniably political process.

²⁰⁶ G Cawkwell, ‘Introduction’ to *A History of My Times* by Xenophon (1979), p 43.

²⁰⁷ A precedent of a kind may be found in the Joint Coal Board, established in 1946 under Commonwealth and NSW legislation. The Board was required to report on policy and other matters to both the Premier of NSW and the Prime Minister. The Prime Minister could also issue a policy direction to the Board, but only with the Premier’s agreement – *Coal Industry Act 1946* (NSW), s 15; *Coal Industry Act 1946* (Cth), s 18.

²⁰⁸ J Menadue, ‘Coalition of the willing’, *New Matilda.com*, 9 September 2004.

²⁰⁹ A Podger, n 194, p 9.

7. CONCLUSION

You can love it, you can hate it, but...federalism thwarts uniformity and universalism, frustrates responsiveness and policy analysis, limits large scale innovation while churning more localized mills of idea generation and promotion, and offers a permanent employment plan for health policy researchers.²¹⁰

It is fair to say that the present health system is as much a product of historical vagaries and political accommodation as it is of rational public administration. It is also reasonable to assume that any sensible person presented with the opportunity to build a health system from scratch would be unlikely to replicate the Heath Robinson arrangements we now have under the federal division of responsibilities.

Generally speaking, in health as in other areas, the case for federalism is hard to make. Why have nine health departments, one for each of the States and Territories, plus one for the Commonwealth, when one central department would suffice? Why bother with the administrative and regulatory complexity that inevitably flows from the federal arrangements? For many, the case on behalf of a 'big bang' solution in the form of a national system under a single Commonwealth health minister is unanswerable. Federalism has produced as a dysfunctional mess, it is argued; for Duckett, the current arrangements render coherent policy making 'almost impossible'.²¹¹ This is said in what is probably the most influential student textbook in this area, in a work that is likely to influence a whole generation of health administrators.

While the force of this critical assessment is to be acknowledged, from another perspective it should not blind us to the system's capacity for meaningful incremental change, among other things in response to cost shifting and other problems. Nor should the potential for experimentation and innovation in the federal scheme be underestimated. In this context, the one example that is cited with almost tedious regularity of innovation produced at the State level is the introduction of Casemix in Victoria. Is there a stronger and more varied case to be made on behalf of the State health systems as engine rooms of innovation on a trial and error basis?²¹²

Several issues arise. One relates to a defence of federalism generally as a system of government. Federalism's costs are more apparent than its benefits. The argument for administrative tidiness comes more readily to hand than that for creative complexity; the virtues of uniformity are easier to extol than those of difference. Generally, the case for the existence of countervailing powers can be hard to make. Sometimes it only becomes apparent after the checks and balances have been eroded. A tidier, more concentrated

²¹⁰ MA Peterson, 'Health politics and policy in a federal system' (2001) 26 *Journal of Health Politics, Policy and Law* 1222.

²¹¹ SJ Duckett, n 2, p 112.

²¹² See for example the evaluation of Commonwealth and State cancer plans in – C Anderiesz, M Elwood and DJ Hill, 'Cancer control policy in Australia' (2006) 3(12) *Australia and New Zealand Health Policy*. - <http://www.anzhealthpolicy.com/content/pdf/1743-8462-3-12.pdf>

system might be a positive force in certain circumstances, sweeping away duplication and inefficiency, a less positive one in others. At the very least, a Commonwealth Government with a Senate majority may seek to introduce highly controversial reforms, as shown by the recent changes to industrial relations.

More specifically, has Australian federalism performed so badly in respect to health? One might reasonably argue that the present system works surprisingly well. It is undoubtedly complicated and can be confusing for patients. For all that, it might yet be considered a triumph of organic incremental adaptation, giving the lie to the case for rationalist plans of wholesale, mechanistic reform. There are of course notable exceptions. The most obvious relates to Indigenous health care, but it would take a brave reformer to suggest that those problems are likely to be resolved by a change in Commonwealth-State responsibilities for health. Beyond this, the system would seem to perform quite well, at least across most OECD criteria such as life expectancy. This might seem a broad-brush approach. At the micro level, of waiting lists for elective surgery in public hospitals and so forth, performance measurements will invariably point to delays and a certain level of underperformance. Undoubtedly, there are and always will be problems, including in the recruitment of the health workforce, a subject very much in the news over recent times.

The main case of the Productivity Commission and others for major reform is founded on the contention that the big challenges to the health system lie in the near future, as funding pressures increase. In which case, the distinction between those systemic and other problems that are caused in whole or part by the federal division of responsibilities, as against those caused by other factors needs to be clearly drawn. Of course, it could be argued that the Commonwealth-State division of labour exacerbates whatever problems that are likely to arise, or that it permeates every aspect of the health debate. That may be so, but the case for reform still needs to be presented in a way that links demonstrable effects to probable causes. Otherwise, the entire discussion is likely to be founded on false premises, giving rise to hopes that cannot be realised.

None of this is to suggest that a plausible case for some kind of ‘big bang’ reform cannot or should not be made. Rather, viewed from a layperson’s perspective, it is an argument on behalf of a debate that is both comprehensive and detailed in nature. The case for reform needs to be presented both as a big and small picture, in a form of analysis that demonstrates real familiarity with actual working of the system. The relative lack of hard evidence about such a highly publicised issue as cost shifting is surprising.

Some proponents of reform, such as the Allen Consulting Group, point to structural developments abroad, particularly in New Zealand and the United Kingdom. Comparative analysis is of course important, but it must be applied carefully, with due caution. One might say that the report card on the United Kingdom’s NHS issued recently by the Healthcare Commission points in several directions, some positive, some less so. On one side, the report is highly critical of the NHS services delivered by certain hospital trusts, finding for example that almost half of those that provide acute care were rated only ‘fair’ or ‘weak’ on quality. On the other hand, the structures in place do form the basis, however complicated, of meaningful performance appraisal and genuine accountability for the

delivery of health services at the regional level.²¹³ It is in such a context that the British media can report that ‘inefficiency is costing the NHS £2 billion every year’.²¹⁴ Could a similar audit even be attempted in Australia at present? Menadue writes that he has ‘seen estimates of the cost of fragmentation between Commonwealth and State programs ranging from \$1b to \$20 billion per annum’.²¹⁵ What are the sources of these estimates and how reliable are they? Are they available to the public? The very fact that the estimates are so far apart suggests that the cost of the federal division of responsibilities is not and cannot be calculated to any reasonable degree of precision.

For the moment, the balance of political opinion in Australia would appear to favour incremental reform. That at least is the Prime Minister’s declared position. But things change. Even if the Australian health system is performing reasonably well in most respects, there is certainly no cause for complacency. The health debate is one that will exercise the minds of all developed countries as the cost of medical care continues to rise. Whether the present arrangements in Australia survive that challenge is a question that remains in the balance. An added ingredient is the recent decision of the High Court in the *Workplace Relations case*, confirming an expansive interpretation of the Commonwealth’s constitutional power over corporations, a development which may have significant implications in the long term for the health system.²¹⁶ In dissent, Kirby J offered these reflections both on the costs inherent in federalism and on the dangers implicit in the unbridled centralisation of power:

No doubt, viewed strictly from an economic perspective, such features of the Australian constitutional design may sometimes result in inefficiencies. Doubtless, they import certain costs, delays and occasional frustrations. Yet such divisions and limitations upon governmental powers have been deliberately chosen in the Commonwealth of Australia because of the common experience of humanity that the concentration of governmental (and other) power is often inimical to the attainment of human freedom and happiness.²¹⁷

²¹³ ‘A poor report card’, *The Economist*, 14 October 2006, p 66.

²¹⁴ M Frith, ‘Inefficiency is costing the NHS £2bn every year, report says’, *Independent Online Edition*, 23 October 2006; C Hall, ‘Labour blamed for £2bn wasted by NHS’, *Telegraph.co.uk*, 23 October 2006.

²¹⁵ House of Representatives Standing Committee on Health and Ageing, *Inquiry into Health Funding*, Submission 140.

²¹⁶ *NSW v Commonwealth; Western Australia v Commonwealth* [2006] HCA 52 (14 November 2006).

²¹⁷ [2006] HCA 52 at para 555.

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