# AUSTRALIA'S STATE OF HEALTH

Current health care funding policies are not serving patients' interests, argues **Nick Coatsworth**

The past decade of conservative government in Australia has seen a seismic shift in a number of key public policy areas, most notably workplace relations, immigration and taxation. The government has used the mandate of four election victories to effectively shape its reform agenda. With over 60% of Australians believing that the Howard government will be returned for a fifth term in office there may even be scope for more change. Amidst all of this one must ask—whither health? One of the great paradoxes of Australian public policy is that the health sector, arguably most in need of reform, is the least likely to receive it. You don't need to be a brain surgeon to understand a politician's philosophy over health care reform. Touch health in any major way and carry the risk of being branded as an enemy of Medicare. In fact Medicare, the great political symbol of universal health care, has so much political inertia attached to it that meaningful reform to any sector of the health system is made difficult. This is now creating a system that is *less* universal. Australia's strong showing against other OECD nations in a number of health indicators belies growing health inequalities, particularly for those living in rural and regional Australia and those without private health insurance. The increase in health spending (5.4% per year over ten years) has not led to corresponding improvements in some of our most intractable health problems.

Reform is needed in a wide range of areas, but for many health commentators one of the key obstacles in the way of reform is the relationship between Commonwealth and state governments in the delivery of health care. The need for greater cooperation in the delivery of healthcare was one of the key areas for reform at the Council of Australian Governments (CoAG) meeting this year as the Commonwealth government extended funding olive branches in key areas such as mental health, aged care and disease prevention. Nonetheless the debate over funding arrangements, duplication of services, unwieldy bureaucracies and control of our health care system is, if anything, even more vigorous entering the election year of 2007. Key political figures including both the federal

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health minister and his shadow counterpart, the former NSW premier Bob Carr and a number of respected health academics have publicly or privately supported bringing the public hospital system under direct federal funding. Even some state premiers have been sympathetic to the idea. On the other hand the Business Council of Australia advocated strengthening the Commonwealth-state relations in their report *Modernising the Australian Federation* and senior Liberal party figures remain supportive of the current federal system in health.

In an ideal world the debate would have one simple litmus test—whether state control of the health sector adds anything to the health of Australians. However there are other issues at stake beyond simply quality of patient care. The federal health minister Tony Abbott has pointed out that significant changes to our federal model would need to occur if public hospitals were to be funded directly by the federal government. Therefore even if the case for a better health care system under Commonwealth control can be made, the debate may be swayed for other reasons related to our federal system of government.

## Federalism and health care

The traditional demarcation of service delivery and the new taxation environment of the GST complicate the funding dynamics of health care in Australia. The system is broadly divided into Medicare, which provides for universal access to primary care (general practice), the Pharmaceutical Benefits Scheme (PBS), aged care, indigenous and mental health care, and public hospitals. The first two are funded directly by the Commonwealth, whereas mental health, aged care and Indigenous health are a confusing mix of Commonwealth and state funding with a resulting overlap in responsibility for service provision. Public hospitals receive funding from both the Commonwealth (revenue derived from income tax and GST) and state government taxes (stamp duty, etc), however control of those funds is with the state health departments.

The influence that the Commonwealth can exert on state policy comes from its control over the majority of taxation revenue, creating the notion of vertical fiscal imbalance. Given the limited capacity of states in Australia to raise their own revenue one may expect a greater shift of power toward the centre, but in practice Commonwealth power has been limited by a lack of monitoring or enforcement mechanisms to ensure that funds are spent as planned.[1] This is particularly the case in health where state bureaucracies determine their own spending priorities without significant Commonwealth intervention. Even in the case of specific purpose grants from the Commonwealth to the state, which are 'tied' to certain outcomes, the reporting and accountability mechanisms are weak.

The attitude of the incumbent governments toward federalism is the other major variable in the balance of power. In recent times, federalism's star has not shone as brightly as during the early 1990s when Hawke and Greiner championed 'new federalism'. The formation of CoAG and development of the National Competition Policy (NCP) marked a high-point in federal-state relations. This was based around the formation of a National Competition Council which regulated state funding for reforms based on adherence to the terms of the Policy. This increased the fiscal power of the Commonwealth in comparison to tied grants, but the states were kept happy because the NCC was accountable to CoAG and not to Canberra. The Business Council of Australia has referred to this level of cooperation as a model for policy reform in all sectors (including health) where responsibility and funding are jointly shared.[2]

Despite the apparent success of the NCP, support for cooperative federalism seems to have waned. Paul Keating shared less enthusiasm for it than his predecessor, and the Howard government, faced with a Labor government in every state, has indicated that states rights come a poor second to a federal government with a voter mandate to pursue policy agendas.[3] Interestingly, though Howard has personally supported greater Commonwealth power in education and environmental policy, he has not done so in health care. No structure similar to NCP exists in health and the ability of the Commonwealth to influence state spending in health is limited to Specific Purpose Grants and national health guidelines.

As it stands, the management of public hospitals is arguably one of the largest areas of state responsibility to its citizens, and taking control of health budgets away from state governments would have a significant impact on their role in the federation. While the strengths and weaknesses of

federalism can be assessed purely in terms of the health sector, any new model for health funding would have to ensure an ongoing role for the states as players in the health system.

## Strengths of federalism

The strengths of federalism as it relates to health are threefold: multiple governments can simultaneously try different policies within the same nation and produce better policy faster than a single government; states can act as a brake on federal government power, especially as it relates to the ethical aspects of health care; and finally, states are ostensibly in a better position to deal with health problems of their local communities than a Canberra government.

The formation of public policy in our democracy is, by its very nature, a messy process that comes from years of trial and error. Federalism has the advantage that multiple policies can be tested concurrently within the one nation. Western Australia has begun to take the policy advice of 'citizens juries' to determine local priorities in health, a project that is being replicated in other states. New South Wales has announced new incentives to lure doctors, nurses and other healthcare workers back to rural practice.

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Federalism can also limit the policy agendas of a single government. This brake on central power may be important when considering health policy with far-reaching ethical implications. Recently Steve Bracks' Victorian government came into conflict with the federal health minister over the stem cell debate. Euthanasia is the other notable example of a state or territory moving against the Commonwealth over health ethics. This is not to say that funding public hospitals and legislating to allow research into stem cells is the same thing—however, it can be argued that any further diminution of states' responsibility in health would severely limit their capacity to influence such issues.

Finally, the smaller states have long argued that Canberra bureaucracy could not possibly respond to the needs of Australia's most isolated urban and rural communities. The WA Health Minister Jim McGinty was vociferous in his opposition to handing over its public hospitals to Canberra when NSW and Victoria offered to do just that early this year.

Unfortunately, regionalism is a particularly weak argument for the states to use in the health debate. In the first instance, no recent model of a single-funder system has advocated managing hospitals in distant states from Canberra alone. All models have suggested a tier of bureaucracy exist between Canberra and the patient in the form of regional health networks. Secondly, it is debatable whether the states themselves are providing adequate health care, particularly to rural and Indigenous populations living in remote state areas or along state borders. No state or territory can claim to have found the answer to the appalling state of health of Indigenous Australians. Non-indigenous Australians living in rural Australia have a lower life expectancy than their urban cousins. These statistics would suggest that McGinty and his fellow state health ministers are failing in the very area that they claim is their strength, that is, protecting the rights of populations far from the Melbourne-Canberra-Sydney axis.

## Weaknesses of federalism

Without clear lines of responsibility and accountability the strengths of federalism quickly become weaknesses. The clouding of responsibility at different levels in the health system puts needless strain on the system. Instead of developing new and innovative policy, governments bicker over who should bear responsibility for policy failure. Attempts to introduce new policy are hampered by demands for increased funding. Shortcomings in performance are blamed on insufficient funding or cost-shifting. Two notable examples are in the medical workforce where a Commonwealth decision to restrict medical student places in the early 1990s has left a dangerous gap in the states' ability to staff their hospitals; and in aged care where the interface between hospital, community and nursing home care is a hodge-podge of disconnected services funded by different Commonwealth and state programs with little integration.

Disputes over responsibility are rooted in the question of which government will fund which service. State health departments can indefinitely make the accusation that they receive insufficient funding from the Commonwealth, treating federal taxation revenue as a kind of bottomless pit. In turn the Commonwealth accuses the states of being inefficient in resource allocation. The cycle continues with neither side having an incentive to develop more efficient policy.

For those who appreciate the complexity of health funding in Australia this may seem like an over-simplification of the problem. However our federal system fails at two points: firstly, the Commonwealth pours good money after bad into public hospitals that no longer function effectively in today's health environment but has no control over their reform; and secondly, funding does not follow the patient in their journey through the health system.

### *Too much emphasis on public hospitals*

The public hospitals we know today, and their relationship to general practice, are based on an antiquated structure known as 'hierarchical regionalism'. In the 1950s the tertiary hospital formed the backbone of medicine in terms of care delivery, training and research, whereas general practice was in its infancy. Infectious disease was still a major cause of morbidity and if hospitalisation was required it was for severe, acute illness or surgery, not the chronic diseases we see today. The position of the public hospital has changed little but the landscape of medicine is vastly different. What is needed now is a strong focus on primary care and preventive medicine, sufficient GPs to provide long term care plans for the chronically ill, and high quality residential aged care facilities that can care for the elderly.

Public hospitals cannot adequately provide these services. Their focus is on throughput, an overwhelming desire to discharge patients in the shortest possible time to make space for overcrowded emergency rooms. They are not the best places for rehabilitation of the elderly and yet at any one time between 800 to 2000 Australians are waiting in hospital beds for aged care services. They cost millions of dollars in hospitalisation of Australians with chronic disease yet play absolutely no part in the prevention of those same diseases.

In political terms state governments in Australia have no incentive to change the way public hospitals work. This is due in part to public and media perceptions of the 'health care crisis' which is vastly different to that of clinicians and bureaucrats. It is indisputable that investing in preventive medicine to avoid the complications of diabetes, obesity and smoking could save large amounts of money. The equations less obesity = less hip and knee replacements or less diabetes = less vascular disease seem so simple as to defy description, but public attention is on hospital waiting times for elective surgery or emergency department catastrophes. In other words, media scrutiny is on the performance of health's biggest and least efficient spenders, the public hospital. It's no surprise then that when election time comes around the states start to bleed revenue into more emergency department beds or building another district hospital. New South Wales is the best example, where any attempts to close or merge district hospitals have been met with stiff community opposition. While it may be good public policy to divert funds away from expensive hospital care, the political imperative for state governments results in spiralling health costs.

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### *Funding not following the patient*

Shifting funding to preventive medicine and primary care, and away from public hospitals is made even more difficult by the unclear division of responsibility that federalism has created. For years emergency departments suffered from a high number of non-acute presentations that could be dealt with by a general practitioner, however it is only recently that the Commonwealth has agreed to fund after-hours GP services close to hospital emergency departments to ease this pressure. The transfer of information between public hospitals and GPs is hampered by a reliance on antiquated, non-integrated information technology systems. There are countless other examples of public

hospital problems whose solutions lie in areas outside state jurisdiction.

Andrew Podger, former health adviser to the Howard government, has described this as 'allocative inefficiency', that is, the 'balance of funding between functional areas is not giving the best value, and the inability to shift resources between the functional areas at local or regional areas is reducing the effectiveness of the system'.[4] Funds cannot easily follow a patient in their journey through the health system. For example, consider a diabetic patient who has their GP visits and drugs paid for by the Commonwealth. If he or she presents to the emergency department the cost moves to the state. The state hospital invariably uses older IT systems that prevent transfer of information on admission or discharge. On discharge the patient needs community nursing services (paid for by the state) and an outpatient visit which, though being at the same hospital they were admitted, is covered by the Commonwealth. In a few years the patient becomes infirm and requires a 'hostel in the home' package (contracted to independent providers and paid for by either the state or Commonwealth). The patient has crossed and re-crossed service boundaries several times and will continue to do so during their journey through the system.

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Any attempt to redistribute funds to benefit the patient is rendered difficult and time-consuming (if not impossible) because of the artificial demarcation of program boundaries resulting from multiple funders. But what happened to the benefits of federalism? Can the current system be manipulated to enhance its benefits, preserve the sanctity of states rights as in the case of competition policy? Or do we require a rethink of the entire structure and move to greater Commonwealth control?

## Conclusion

Over the past decade there have been calls by respected health academics for wide ranging reforms of our health system. This has included an overhaul of state and federal relations as they relate to health care, and some have suggested that the Commonwealth take over full responsibility for funding health. Any large-scale restructure of health funding arrangements would not only affect the health system, but have more far reaching implications in terms of balance of power and may even call into question the function of the states in Australia.

Given these issues caution should be exercised in the reform of federal-state relations in health. Radical change, that is, the states relinquishing their control over health, would see the loss of the considerable advantages of federalism. There may be a loss of policy diversity and ability to experiment, fewer checks on central government with regard to medical ethics and a possible decrease in responsiveness to needs of voters. Radical change may also be so unpalatable to the states that they refuse any type of reform at all.

I see two possible models emerging from the debate. The first model would be to preserve the current funding arrangements while creating an oversight body similar to the National Competition Council. The Council, consisting of health experts (academics and clinicians) with federal and state health bureaucrats in an advisory role would be able to set national practice standards and ensure compliance with national guidelines by making funding contingent upon their achievement. Improved reporting and accountability to the Council would accompany the flow of funds from Commonwealth to states. The total amount of funding for hospitals would be determined using the same model across all states (there has been more than ample time since the introduction of casemix funding in the early 1990s to develop a uniform structure between states).

A council, being to some degree independent of the respective health bureaucracies, may have more success in clearly defining jurisdictional boundaries and decreasing duplication of services. Like the NCC, a national health council could report to CoAG rather than the Commonwealth and this would hopefully be seen by the states as preserving their role in health, though ultimately an NCC type of model would give the Commonwealth greater power to set policy objectives. Whether such a model could improve some of the allocative efficiency problems of our current system is unclear—the demarcation of different health

sectors based on funding source would remain in place and the ability to switch funds between sectors may remain difficult.

Another model has been advocated by both Podger and, more recently, by *New Matilda* in 'A Health Policy For All Australians'.[5] The main thrust of this policy relates to reversing the cost of perverse private insurance incentives created by the private health insurance rebate and increasing the equitable distribution of care. The public–private debate is beyond the scope of this paper but the implications for Commonwealth-state funding structures are important. The model aims to pool funding and create a single national-insurer to 'purchase' care from either public, not for profit/charity or private services providers. Public hospitals would no longer be run by the states. However this model needn't raise concern regarding centralising 'control' of local services because the Commonwealth itself is not a 'provider' of care. Decisions regarding the needs and distributions of local communities could still be made by the states (presumably under joint Commonwealth–state administrative bodies) with voters still being able to hold states responsible if they purchase insufficient or undesirable services for a region. The *New Matilda* policy has some merit in its theoretical solution to the problems of allocative efficiency while retaining a key role for the states in distribution of funds, but given its wider implications beyond federal-state relations it will need to be debated further.

The two models have a common path recognising that Commonwealth-state relations in health is a key reform for our health system and that there is a need for some sort of central health commission, be it as an allocator of funds to the states to continue to run health services or as a purchaser of regional health services run by independent providers. While such a body would invariably centralise power it is hard to see a bottom-up approach working to improve the lines of responsibility and accountability in health. The states have failed to deliver in policy areas where they are supposed to hold the advantage, most notably in rural and regional health care, and are going to have to accept an increased degree of Commonwealth intervention over the coming years to resolve the problems of increased public hospital expenditure and poor distribution of resources. However our federal system still has much to offer health and history has shown that cooperative federalism can assist rather than detract from reform of a sector.

## Endnotes


[1] Robyn Hollander, 'National Competition Policy, Regulatory Reform and Australian Federalism', *Australian Journal of Public Administration* 65:2 (June 2006), pp 33–47.

[2] Business Council of Australia, 'Modernising the Australian Federation: A discussion paper', June 2006, http://www.bca.com.au/content.asp?newsID=100278.

[3] Greg Craven, 'Federalism and the States of Reality', *Policy* 21:2 (Winter 2005), pp 3–9.

[4] Andrew Podger, 'A Model Health System for Australia', Inaugural Menzies Health Policy Lecture at the Menzies Centre for Health Policy, 3 March 2006, http://www.ahpi.health.usyd.edu.au/pdfs/events2006/apodgerlecture.pdf.

[5] *New Matilda*, 'A Health Policy for Australia: reclaiming universal health care', 2006, http://www.newmatilda.com//page/default.asp?PageID=53.