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MEDI-MESS: Rational Federalism and Patient Cost-Sharing for Public Hospital Sustainability in Australia

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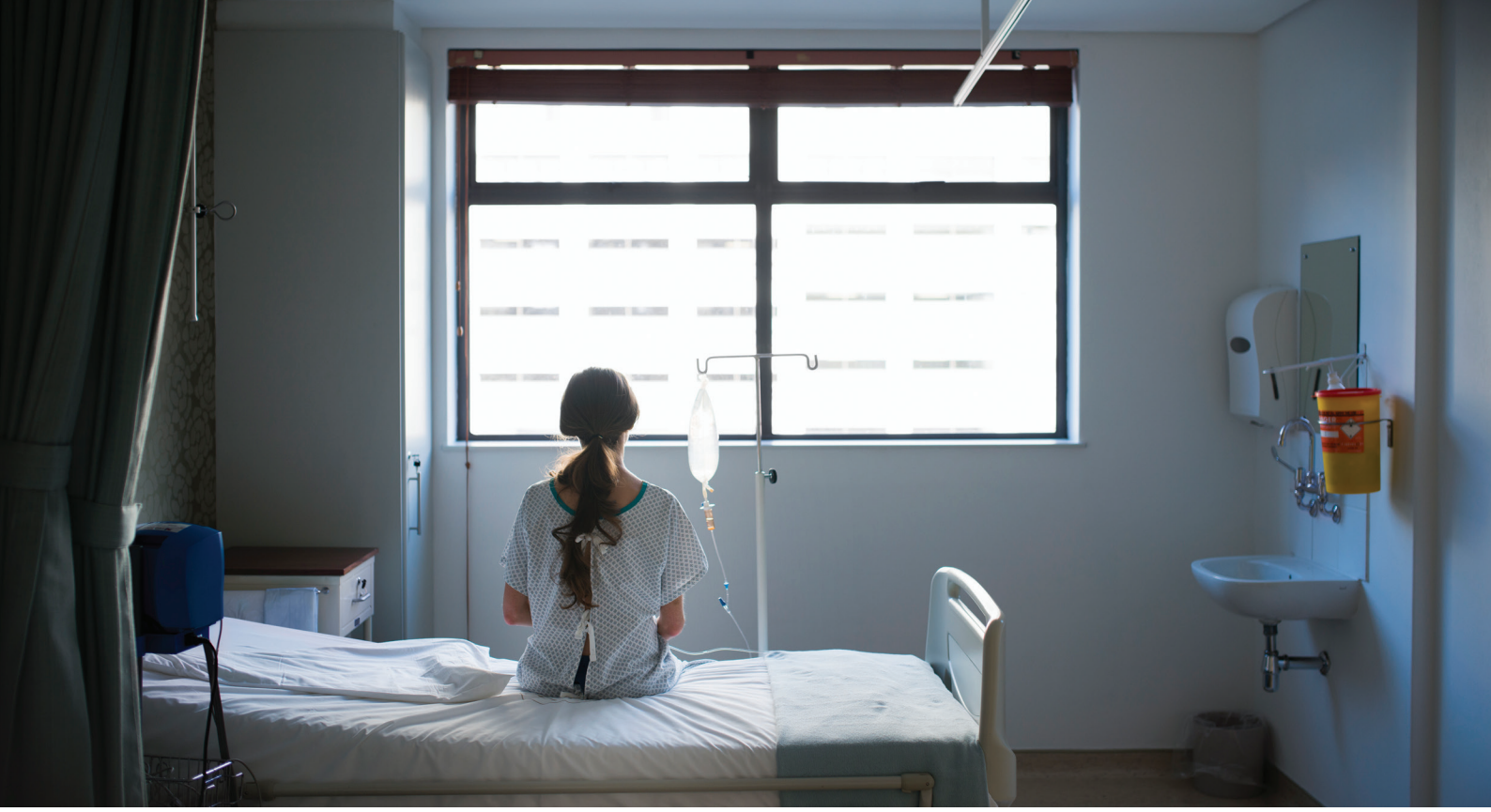


Executive Summary: A state income tax will save the states from Medicare

The latest attempt to 'end the blame game' between the state and federal governments over health funding was scuttled after state premiers rejected Prime Minister Malcolm Turnbull's 'tax swap' federalism reform proposal at the April 2016 COAG meeting.

The intransigence of the states — and the Turnbull government's subsequent abandonment of its White Paper on Reform of the Federation — was indicative of the states' reluctance to take back constitutional power to levy income tax; which they had relinquished (but did not abandon) to the federal government during World War II.

The rejection of federalism is a paradox: it shows state governments have yet to understand how their best interests would have been served by levying a state income tax to fund their health services.

Since the establishment of Medicare in 1984, the federal government has contributed funding to state health services on the condition that, in state-owned and operated public hospitals, care is delivered to eligible Australian residents without charge at the point of consumption.

The vertical fiscal imbalance in the Australian federation — the disparity between the federal government's control over the majority of taxing powers (including power over income tax), and fiscal demands placed upon states and territories to assume health and other service responsibilities — means the dwindling level of real federal funding for 'free' public hospital care has become a legitimate state grievance.

However, the story in health — and the solution for the health policy puzzle in Australia — is more complicated than a perpetual blame game over the lack of federal money for public hospitals.

Revision of the federation to end federal meddling in state health systems, which has jeopardised the state finances, is imperative to allow the states to reclaim full control over both funding and policy responsibility for health. It is essential for states to reclaim sufficient authority and incentive to make the rational decisions about health policy they currently cannot due to their rigid and financially onerous obligations under Medicare.

Federal government's control of national health policy prevents state governments from taking effective action to manage demand for hospital services by asking users to make an appropriate direct contribution to the cost of their care. As a result, unaffordable growth in public hospital services threatens to overwhelm state budgets in coming decades.

Under Medicare, the irreconcilable policy objectives of both increasing 'free' access, while containing the cost of a 'free' system, has created the public hospital 'mess' that has become an insoluble dilemma confronting state governments under the existing health policy settings.

Without price signals, demand for universal free access to hospital care will inevitably grow faster than supply, and the moral hazard inherent causes over-use and overservicing of doubtful health gain. Since 1984, the need to control the financial risk of paying for unlimited free public hospital care has forced state governments to ration access to public hospital services.

Rationing was implemented by imposing 'global' budget caps that restricted frontline hospital capacity, which in turn led to the emergence of lengthy waiting times for hospital treatment. This was accompanied by governance changes that centralised financial and operational control over hospitals in state health departments — a command-and-control, highly-bureaucratic administrative structure that has compromised public hospital efficiency and performance.

In an attempt to enhance efficiency, state governments began to introduce 'activity-based' casemix funding in the 1990s. Under terms of a 2011 federal health funding agreement, all Australian public hospitals are now funded on an activity basis, where possible, for each occasion of service they actually deliver, and they are remunerated at a 'national efficient price' (based on average costs across the public hospital system nationally).

Activity-based funding and other supply-side initiatives (including supply-side microeconomic reforms such as outsourcing the delivery of public hospital care to more efficient private sector providers) can be important as standalone policies to reduce waiting times, increase community access to care, and enhance policymakers' ability to achieve the best value for taxpayer's dollars by extracting the maximum level of services obtainable from available health resources.

However, the overall effect on the cost of hospital services to government budgets could prove more expensive. Since activity-based funding creates an incentive to treat more patients, the consequent higher service volumes mean the more productive hospitals become, even if funded at supposedly efficient prices, the greater the total cost of public hospital care. This intensifies the need to contain costs by rationing with queuing and intractable waiting times.

Hence the long-term projected cost of even 'efficient', 'free' public hospital services is unsustainable in an ageing and growing Australia. The scale of the 'hospital funding crisis' under the current Medicare setting is indicated by the states' unrealistic calls for the federal government to either fully restore the 2014 Budget '$50 billion cuts' over 10 years to federal hospital funding, or to increase the Goods and Services Tax (GST) from 10% to 15% to pay for state health services — a 50% tax hike that would represent the largest single peace time increase in taxation in Australian history.

To avoid the financial calamity of fundamentally unsustainable, free hospital systems that no government — state or federal — can afford, state governments must lead the way on reform of federal-state financial relations to safeguard their own budgets from Medicare. This would free them to undertake the demand-side policies essential to sustainable hospital services.

States should therefore honestly confront the unsustainability of the federal-state health and financial relations status quo. Reform of the federation can be driven only from the bottom up, when states exercise their right to take back their income tax powers —which would could be equivalent initially to the amount of federal hospital funding. This would effectively release a state from its obligation under Medicare to provide free public hospital care.

The percentage of the federal income tax surrendered could thereafter be designated 'state income tax', and could rise or fall as participating states determined, and as necessary to meet the cost of public hospitals. The political responsibility for raising the state income tax rate would encourage states to undertake the demand-side initiatives to control the use and contain the cost of public hospital care.

To better manage demand for hospital services, state health policy should therefore incorporate patient cost-sharing in the form of a compulsory co-payment for public hospital treatment, which should be introduced as a 'revenue neutral' measure to pre-empt equity and electoral concerns.

Quarterly compensation, equivalent to the actuarial cost of a typical household's expected co-payment charges, could be paid automatically to all households in the state, — regardless of whether they actually used a public hospital service.

The cost of the compensation would be recovered by the revenue generated by the co-payment, by the savings generated by more rational use of hospital services, and by encouraging the use of lower-cost, non-inpatient substitute treatment options.

Not all jurisdictions may have an appetite for a state income tax — let alone demand-side hospital reform. An alternative 'opt-out' approach might permit states individually and voluntarily to commit to assert their income tax powers and simultaneously reclaim authority over public hospital policy to pursue their own path in budgetary and hospital system sustainability (see Box 4).

To suggest tampering with the fundamentals of Medicare — the third rail of Australian politics — is sure to be branded 'courageous'. However, this must be assessed in light of not only the benefits (such as lower taxes and minimal waiting times compared to jurisdictions that remained under the status quo), but also the unpalatable alternatives: financially unsustainable hospital systems featuring high taxes or debt (or both), combined with ever-longer waits and queues for hospital treatment.

The only recourse open to state governments to save themselves from the financial blight of Medicare is by advocating rational federalism and genuine reform in health, and entering into 'hard conversation' with their electorates about the future of public hospitals.

To make public hospital systems sustainable, state government must urge citizens to accept greater personal responsibility for health through co-payments and —potentially in conjunction with health savings accounts —implement cost-sharing strategies. Instead of encouraging voters to ask what public hospitals can do for them for 'free', politicians need to start asking them what they can — and must — do for public hospitals.

Introduction: the 'blame game' redux

Under Australia's complex federal system, public hospital services are owned and operated by state and territory governments, but are funded jointly.* These mixed financial and operational responsibilities mean that a constant feature of the health policy landscape is the 'blame game'. The states blame service delivery problems, including lengthy wait times for emergency and elective public hospital care, on inadequate federal health funding. In response, the federal government attributes these problems to inefficient and ineffective state government public hospital management.

Before the 2007 federal election, then-Opposition leader Kevin Rudd promised to implement national health reforms that would "end the blame game" over public hospitals. Under the new federal health funding agreement eventually negotiated by Prime Minister Julia Gillard in 2011, the federal government agreed to increase its funding for state health services, and the states agreed to a national system of 'activity-based', casemix funding for public hospital services. This means, where possible, that public hospitals are paid for each occasion of service they actually deliver, defined according to casemix (based on separations grouped according to ICD-10-AM into Australian Refined Diagnosis Related Groups), for which they are remunerated at a 'national efficient price' (based on cost weights allocated in accordance with average variable inputs such as clinical labour, length of stay, etc). Some separations, such as for mental health, are still subject to block grant funding. The so-called 'efficient' price is periodically determined by an Independent Hospital Pricing Authority (IHPA) based on national averages across the public hospital system.[1]

The Gillard government's 'National Partnership' funding formula committed the federal government to fund set proportions of the cost of public hospital care at 44% of the 'efficient' cost of each inpatient public hospital separation by 2020–21. This included 50% of the 'efficient' cost of growth in activity from 2017–18. The agreement meant the federal government was expected to increase hospital funding to the states by $26 billion over the ten years between 2013–14 and 2024–25 — causing its contribution to public hospital funding to rise by 185% from $14 billion to $40 billion.

However, the blame game re-emerged with a vengeance following the change of government from Labor to the Coalition in September 2013. The Abbott government rightly deemed the promise of 50% federal government 'growth funding' to be unaffordable on even the most optimistic projections of future revenue, and especially in the context of seeking to repair the federal budget and reduce the deficit and debt. The Gillard deal and activity-based funding formula was replaced with the standard funding arrangement — a capped, or fixed, annual federal contribution to the cost of state health services, indexed by CPI and for population growth, unrelated to activity.[2] In response to further protests by the states and territories, these decisions have effectively been reversed, in the short-term at least, by the new activity-based growth funding agreement introduced by the Turnbull government covering the period 2017–2020 (see below).[3]

* For those unfamiliar with the full jurisdictional complexity of Australia's division of public health responsibilities: medical services provided outside hospitals are the principal responsibility of the federal government and receive separate federal funding on a fee-for-service, open-ended basis. Federal money also partially funds the operation of public hospitals — on condition that all Australians are entitled to receive 'free' public hospital care at point of access. State and territory governments are responsible for hospital governance and administration.

While the Abbott government's 2014 Budget funding changes were presented in the media as an annual 'cut' to hospital funding totalling $50 billion over the 10 years to 2024–25, federal funding for hospitals remained destined to increase to $25 billion by 2024–25. The Coalition had also suggested — via its 2014 *Commission of Audit* and 2015 *Competition Policy Review* processes — that to limit the call on public resources, market-based policies were needed. These included greater involvement of more efficient private sector providers in the delivery of health and hospital services.[4]

The focus on efficiency was understandable. In all jurisdictions, health consumes around a third of the state budget, and public hospitals account for around two-thirds of total health spending. Between 2003–04 and 2013–14, total federal, state and territory government expenditure on public hospitals increased by 80% in real terms, and more than doubled in all states and territories except NSW and Victoria (Table 1). All states and territories have recorded substantial increases in real spending, and the rising cost of public hospital care has been a major source of pressure on government budgets.[5]

Lack of productivity was a major issue because additional 'inputs' were being absorbed without a proportional increase in 'outputs'[†] (as is typical in the public sector). This was tacitly acknowledged by the Gillard funding agreement. The creation of a national funding system based on defined hospital 'products', priced on national 'efficiency' criteria, may be used to justify improving public hospital productivity by encouraging them to realise gains at least to reach average levels of efficiency — thereby lowering the overall cost of hospital services to both federal and state budgets.

Table 1: Increase in recurrent federal, state and territory government expenditure on public hospitals, 2003–04 ($ billion), 2013–14 dollars

	2003-04	2013-14	Real increase % *
NSW	$7.78	$13.27	70.5%
Vic	$6.32	$9.75	54.4%
Qld	$3.81	$7.96	108.8%
WA	$2.21	$4.47	102.5%
SA	$1.77	$3.59	102.9%
Tas	$0.44	$0.90	103.6%
ACT	$0.43	$0.96	124.7%
NT	$0.31	$0.73	132.3%
Aust	$23.07	$41.63	80.4%

Sources: Productivity Commission, *Report on Government Services 2013,* Table 10A.2 & Productivity Commission, *Report on Government Services 2016*, Table 11A.2

http://www.pc.gov.au/research/ongoing/report-on-government-services/2013/2013

http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/health/public-hospitals

[†] This problem was well demonstrated by the findings of the 2013 Queensland Commission of Audit headed by Peter Costello. The Commission found that while expenditure on public hospitals in Queensland had 'increased 43% in the five years since 2007, activity increased by less than half — only 17%. Queensland Commission of Audit, Final Report (Brisbane: Government of Queensland, 2013), 22.

Dilemma of a 'free' system

The 2011 introduction of the national activity-based funding system appears, at face value, to have had an impact on public hospital finances. But it is hard to distinguish evidence of the impact from the effect of parallel administrative measures to ration access to free care.

As a component of its estimates of Australian health expenditure, the Australian Institute of Health and Welfare (AIHW) shows that over the period 2009-10 to 2014-15, recurrent growth in real public hospital expenditure was 3.4%, compared with 4.4% over the longer period 2004-05 to 2014-15. This compares with a higher comparable growth over the period 2004-05 to 2009-10 of 5.4%, immediately prior to the introduction of activity-based funding.[6] These estimates of comparative expenditure growth are roughly consistent with a heavily qualified, equivalent time series on levels of expenditure in the AIHW's *Hospital Resources* report. However, there is lack of consistent continuous time series data on total recurrent hospital expenditures for the years 2010-11 to 2014-15. Due to the lack of year-to-year consistency in the collection of the latter, the AIHW has declined in this instance to use them to publish figures for the behaviour of expenditure growth — choosing not to calculate figures for average change in recurrent expenditure 'since 2010-11' and 'since 2013-14.'[7]

Even if we were to admit expenditure data (of better quality than available) as evidence of the impact of activity funding in controlling hospital expenditure growth, we would need to allow for the confounding effect of rationing through use of public hospital waiting lists.

Between 2011-12 and 2014-15, admissions from public hospital elective surgery waiting lists increased by 1.9%; but between 2013-14 and 2014-15 they fell by 0.2%. These figures are more significant given that three-quarters of public hospital surgery is performed in larger public hospitals. Between 2011-12 and 2014-15, admissions from 'principal referral and women's and children's hospitals' and 'public acute group A hospitals' increased by 1.6% and 2.8% respectively; but between 2013-14 and 2014-15 their respective growth rates fell to 0.8% and to 0.6%.[8]

The reduced growth in admissions (which does not take into account increased demand due to population growth and ageing) may indicate activity-based funding has contributed to hospital activity, but to the extent of eventually precipitating a curb on the rate of elective admissions to enable hospitals to remain within overall budget caps. Administrative controls at hospital level (in lieu of price signals) —including patient waits, rationing of surgical lists and temporarily closing operating theatres and wards — can limit access to care and control expenditure (regardless of how hospitals are remunerated) much in the same way as expenditure caps imposed at state or national levels, but they are not a mark of efficiency.

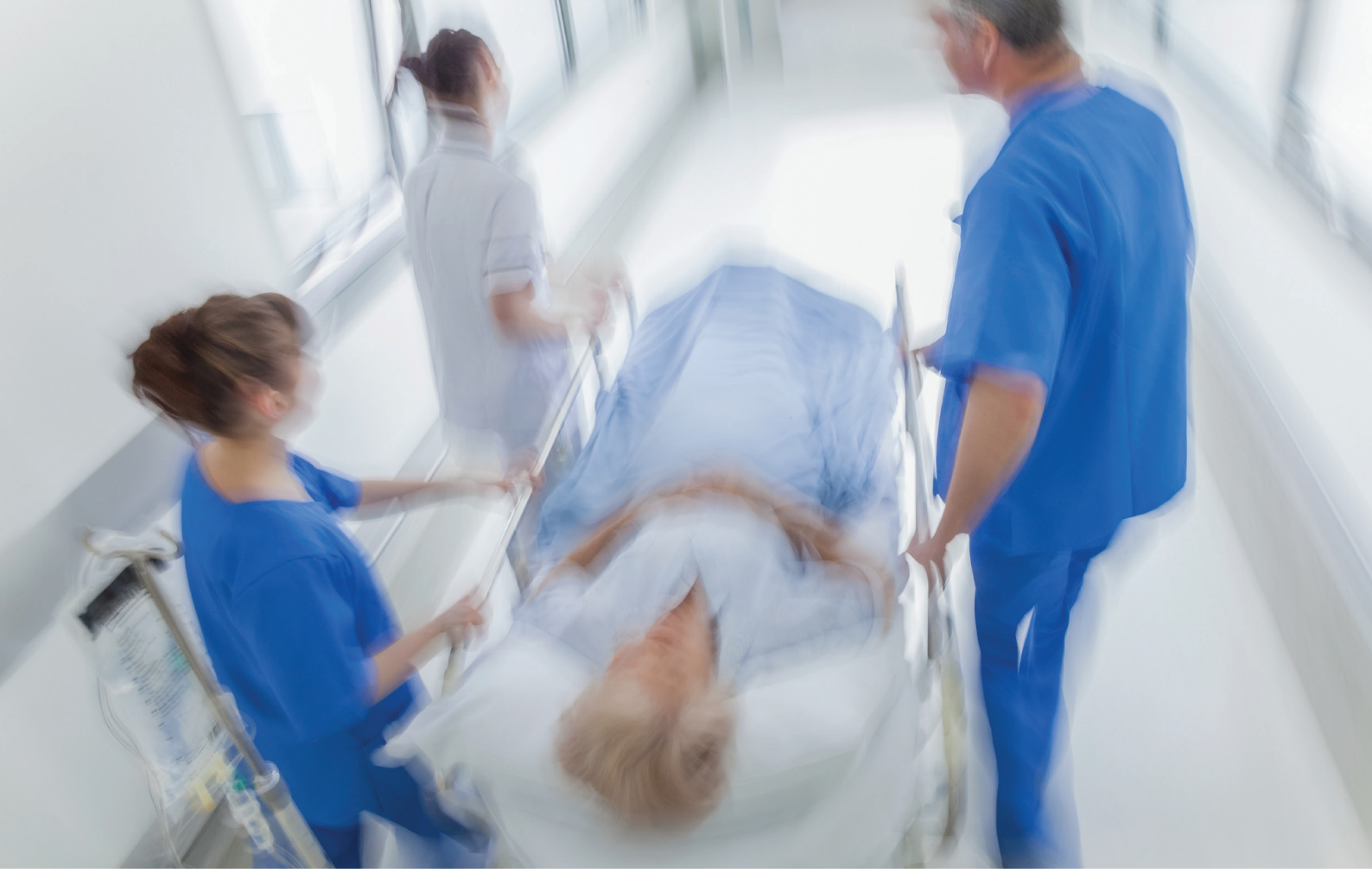
As things stand, the states are still demanding the federal government fully restore the $50 billion 2014 Budget cuts — which would see public hospital expenditure grow well above forecast GDP — or increase the GST rate to 15% to fill the 'funding gap'.[9]

There is no clarity about the impact of activity-based funding on hospital expenditure since 2011. Moreover,

there is the likelihood its effect could ultimately prove equivocal in controlling health costs. To the extent it makes resources more productive, activity-based funding (without the distortion of administrative rationing) creates an incentive to treat more patients and increase community access to care. Activity funding may thereby yield health consumption gains that know no bounds — as might be expected of any uncapped fee-for-service payment mechanism.[10] The associated higher service volumes — even if they are remunerated at supposedly efficient prices — could thus cause the total cost of public hospital care to increase. Perversely, but understandably, more efficient and productive public hospitals with more patient throughput will not necessarily prove less expensive. As we shall show, under Medicare funding arrangements (all other things remaining equal) it may in fact cause overall public hospital expenditure to increase.

Box 1. Australian health federalism: 1975, 1984, and thereafter

- State and territory governments have always been responsible for their public health services. But before the 1970s, the federal government had limited involvement in state health and hospital systems. The successful referendum on social services in 1946 gave the federal government the authority to fund state-run health services. Under the National Health Scheme of the Menzies government of the 1950s, federal government 'hospital benefits' were made available to the states to contribute to the cost of public hospital care. Prior to this in 1942, the states had agreed to refer their constitutional power to levy income taxes to the federal government, which levied the first uniform national income tax in return for offering the states what appeared to be a financially attractive funding deal — a portent of the health policy upheavals of the 1970s and thereafter.[11]
- In the 1950s, membership of a private health fund was mandatory to be eligible to receive federal government hospital benefits — a policy that led to around 85% of Australians either being covered by private insurance, or having their health care paid for by the federal government-funded Pensioner Medical Service. A safety net for the disadvantaged unable to afford private health premiums took the form of free, means-tested public hospital care. The federal government benefit was paid to patients as a rebate through their health funds, not to state governments. In combination with fund benefits, this covered the cost of treatment in public hospitals, and offset the (still considerable) operational grants that state governments provided.[12] In essence, however, public hospital services actually rendered were remunerated by a dual private and public financed 'activity' payment system, ensuring a guaranteed 'steady and reliable' flow of clinically-based income and minimal waits for treatment.[13]
- But this was no golden age of public hospitals. State governments continued to struggle with the interrelated problems of funding and governing their hospital services: each public hospital was independently administrated by their own board of governors, but with the state holding ultimate financial responsibility for budget overruns. Public hospitals were a major public administration challenge, since hospital boards frequently overran their budgets and left the state to underwrite the bill. The challenges of achieving financial control and containing the cost of health to state budgets set the stage for the introduction of Medibank (forerunner to Medicare) by the Whitlam Labor government in the mid-1970s.
- In 1975, the federal government offered to share the recurrent net operating costs of public hospitals with state governments on a 50/50, open-ended, dollar-for-dollar basis. This is to say, the Whitlam government persuaded the states to sign up to Medibank — and to agree to provide 'free' public hospital care — by committing the federal government to pay for 50% of real cost of providing all the public hospital services demanded and delivered each year, without rationing, queues, and waiting lists. The promise of having their mouths stuffed with gold and alleviating the financial burdens imposed by public hospitals was an offer the states could not refuse — and turned out to be too good to be true.[14]
- The Whitlam promise quickly proved unaffordable. The cost-sharing arrangement was immediately scrapped by the Coalition government under Prime Minister Malcolm Fraser, which agreed instead to fund only 50% of hospital costs 'approved' in consultation in the states. In 1981, the federal government withdrew entirely from the cost-sharing arrangement, which was replaced with 'identified' (fixed or capped) health grants to the states, and was justified on the grounds of making the states more financially accountable. When the Hawke government re-branded and re-introduced Medibank as Medicare in 1984, it extended the Fraser government's approach and continued to limit the federal government financial exposure to the cost of 'free' public hospital care by giving the states only capped health grants.
- Given the intractable vertical fiscal imbalance in the federation, the division of health policy and funding responsibilities was far from ideal. The federal government, with the bulk of the taxing powers, was not responsible for financing anything like the actual cost of the real demand for public hospital care. The Whitlam promise of Canberra paying 50% of the real operating cost of 'free' public hospital care was the fool's gold. Though no federal government under Hawke, Keating, Howard, Rudd, Gillard, Abbott, or Turnbull was ever close to fulfilling this promise — the federal share of hospital costs has traditionally hovered somewhere around 40% of the total cost of (rationed) public hospital services — the states have been committed to delivering 'free' hospital care with major budgetary and political consequences.[15]



The imperfect path to public hospital expenditure control since 1984

Since the establishment of Medicare in 1984, the federal government has funded state and territory health services on the condition that public hospital care is delivered to all Australians without charge at the point of consumption. This onerous obligation to guarantee universal free access has exposed states to the risk of paying for unlimited free public hospital care. Without price signals, there is a presumption that demand will inevitably grow faster than supply. The ability to access free hospital services creates moral hazard. There is a risk of over-use and over-servicing, with unlimited demand for separations matching (if not overwhelming) any efficiency gains. Because increases in supply can never be fully accommodated, the efficiency gain may be lost to inflated and wasteful health expenditure.

The states' financial exposure to the cost of public hospitals has been heightened because federal health funding has always been capped (never demand-driven) to limit the federal government's financial obligations. Federal government funding for state health services has also been capped to offset the increasing cost of its open-ended, on-demand, 'own program' Medicare fee-for-service expenditure on the Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS).[16] Federal government funding for state health services has thus dwindled in real terms since Medicare's inception.[17] Moreover, the federal government has the majority of taxing powers in the federation. This includes full power over income tax. During World War II the states relinquished — but did not abandon — their constitutional power to levy income tax to the federal government. The resulting chronic vertical fiscal imbalance in the Australian federation means the states' ability to meet their demanding health and other service responsibilities has remained heavily dependent on the federal government; and since 2000, on the share of the federal government-levied Goods and Services Tax (GST) revenue distributed to each state and territory.

The federation's disparity between revenue powers and health service responsibilities, combined with the federal government's overarching control of the health policy framework, means the states have legitimate grievances about federal-state financial relations in executing their public hospital services management and delivery responsibilities. But the story in health is more complicated than the simplistic blame game over 'lack of money'.

In the mid-1970s, state governments were promised that creation of a universal, taxpayer-funded national health scheme would alleviate the funding and governance burdens associated with operating public hospitals, because the federal government would bear half the real cost of 'free' hospital care — a promise never fulfilled (Box 1). In reality, the coming of Medicare has left the states in financial straits.

State governments with relatively small and independent sources of revenue, and large and competing service

delivery obligations, have shouldered the financial consequences of increasing public hospital use. This began when a large fall in private health fund membership was precipitated by the establishment of Medicare and the end of the public hospital means test. This shifted the full cost of treatment for formerly privately-insured patients onto state government budgets. PHI coverage fell from 64% of the population in 1983, to 47% in the late 1980s, to 30% in the late 1990s. The rate recovered to 47% only following the introduction of 'Lifetime Cover' rules, the PHI tax rebate, and Medicare surcharge arrangements by the Howard government in the early 2000s.

Since 1984, financial realities have forced state governments to make hard decisions about access to 'free' public hospital care. The predictable response — to limit the threat of Medicare unleashing unlimited health expenditure on over-stretched state budgets — was to implement blunt expenditure controls. These consisted of frontline 'global' budget caps that bore little relationship to the actual demand for 'free' care, but which rationed access to services (chiefly by cutting hospital bed numbers and surgical lists). This in turn, led to the emergence and blowouts in waiting times for emergency and elective treatment.[18]

Given that states have severely limited macro-political authority over health, they sought to control their share of the cost of Medicare by rationing services. Rationing by queuing was achieved by funding hospitals through the traditional block payment mechanism, with funding caps imposed to restrict operational capacity and limit the amount of care provided. Rationing was implemented in conjunction with governance changes that centralised financial and operational control over hospitals in state health departments — an administrative structure that has compromised the efficiency of public hospital systems (see below).

To minimise waiting times and enhance financial control over public hospitals, activity-based funding was introduced initially in Victoria in 1993,[19] and thereafter indicatively, or in piecemeal fashion, in other jurisdictions. Supply-side initiatives — in general and including effectively designed activity-based funding (if strictly enforced) — can be important to address productivity lags and enhance policymakers' ability to achieve the best value for taxpayer's dollars by extracting the maximum level of services obtainable from available health resources. State government-led microeconomic reform initiatives to the extent the Medicare framework permits, including outsourcing delivery of publicly-funded hospital care to private operators where possible, can also partly mitigate governance (or public sector management) issues that impede public hospital performance.

In this vein, the national activity-based funding system may be interpreted as an exercise in seeking 'efficient' terms on which the proportion of hospital costs are distributed between federal and state budgets. It is likely to have an impact on the unit-cost of care and on waiting times by using resources more intensively and productively — but most likely restricted to the least efficient hospitals (Box 2). A more justifiable supply-side option would simply have been to define unit outputs according to casemix criteria and to permit hospitals to compete on price within an 'internal market'. The very notion of a 'national efficient price' conveys something of a Stakhanovite flavour.

In any event, the new funding system will not alter the fundamentals of a 'free' system, or eliminate blame shifting over waits and funding. The blame game will continue while ever the federal government continues to write blank cheques for 'free' hospital care that the states can never hope to cash. While the existing Medicare framework remains, rationing of access to hospital care by queuing will remain an unavoidable feature of a 'free' system, with total budget and service limits imposed by state health department 'system managers' to contain the cost to the public purse.

The real problem with Australia's public hospitals is that federal involvement in state health systems has jeopardised state finances. However efficiently hospital services are produced, it is simply unaffordable for governments to pay for 'free' hospital care on demand. Certainly, activity-based funding may help accommodate an increasing demand for public hospital services caused by an ageing and growing population and new medical technology,[20] because there is a presumption that higher volumes of services can be delivered for a given quantity of health funding. But paying public hospitals at what purports to be the efficient price does not guarantee their financial sustainability in an ageing Australia, since states must fund larger outputs of hospital services at zero prices. When hospitals exceed their budgets, there is always a risk of states having to bail them out by supplementing their share of activity funding from other state budgetary sources (Box 2). When this occurs, it saps the incentive for managers to improve efficiency and defeats the purpose of activity funding. There will hence always be the risk of efficiency gains being squandered on unnecessary or excessive services in feeding (at zero prices) an infinitely elastic demand for hospital care that is underwritten by ballooning state expenditure.

Box 2. Centrally-planned technical inefficiency

- Enforcing budget caps and rationing care, as necessitated by Medicare, required altering the governance arrangements of public hospitals by centralising financial and administrative control over hospitals in state health departments. Local hospital boards were abolished and 'area health' authorities were established to administer hospitals in designated regions. This command-and-control structure involves detailed micro-management of day-to-day hospital activities and centralised setting of policies (especially of industrial agreements) by remote centralised agencies. This has made public hospital systems by-words for bureaucracy and high administrative overheads, and resulted in well-documented negative effects on hospital management, efficiency and costs — lengthening waiting times by compromising the ability of the public system to deliver timely and cost-effective care.[21]
- The need for devolution of independent and accountable management responsibility to the local level has been a policy goal articulated for many years by state and federal politicians. Regrettably, in practice this has not been achieved; despite periodic and repeated redesign of governance arrangements. Instead, public hospitals in all jurisdictions continue to be run as branch offices of state health departments, which operate as both the funder and provider of centrally coordinated hospital services. Though public hospitals are currently under the nominal control of 'Local Health District' (LHD) agencies and their government-appointed boards of directors, state health departments remain the 'system managers' and retain high levels of involvement in the operational affairs of hospitals.[22]
- The principal reason for continuing with highly centralised hospital management is because state treasuries carry the financial risk for the operating budgets of public hospitals. These governance arrangements — despite being subject to perennial and persistent criticism — have proved impervious to change. This is because, ultimately, the financial risk for 'free' hospital care is carried by the purchaser (state governments) not the provider — individual hospitals, which remain responsible to health departments whose primary task is to try to prevent or limit budget overruns.
- In practice, this environment creates a public sector monopoly that guarantees public hospitals will receive government custom, while dulling incentives for operational efficiency and good management, since public hospitals are not properly accountable for their financial performance. Because standard practice is for additional allocations to be made by Treasury to cover operating deficits, there is no real requirement for hospital managers to exert proper control over hospital finances. This can make a mockery of 'national efficient pricing', which is the hallmark of activity funding, because it is always open to states to effectively underwrite higher prices by increasing their share of the funding. In addition to undermining financial accountability, centralisation also impedes productivity and innovation, due to the lack of independent management. Frontline managers are expected to meet centrally mandated KPIs, but have limited managerial autonomy and prerogatives, and little ability to overcome workplace rigidities that impede the efficient operation of public hospitals.
- Centralised control of human resources has invited provider 'capture' in the form of high labour cost, inefficient work practices and rigid demarcations that impede cost-effective management and efficient delivery of quality hospital care. Many restrictive work practices are entrenched by state-wide industrial agreements between health departments and powerful health trade unions (including ASMOF, controlled by the Australian Medical Association, and the Australian Nursing Federation) which set the terms and conditions for employment for doctors, nurses, and allied health professionals. Hospital managers seeking innovative ways to deliver hospital care lack authority over their clinical workforces; multi-skilling, task-substitution and redeployment of the clinical workforce are prohibited by rigid demarcations inherent in industrial agreements.
- State-wide nursing awards, combined with the freedoms visiting medical officers (VMOs) and staff specialists may exercise over their own schedules and work practices, deny managers the flexibility to secure efficient and effective care. Nursing is the largest single area of recurrent hospital cost, and nurses' awards uniformly fix scales of remuneration across the entire state as well as conditions of employment that protect public nursing jobs — such as the strict nurse-to-patient ratios of one nurse per four patients that are a standard feature of nurse award conditions across Australia and a major barrier to productivity. Nurse-to-patient ratios exacerbate staff shortages, raise costs, and limit patient throughput because inefficiently using a hospital's nursing workforce limits the number of beds available.
- Hence the so-called 'national efficient price' terminology associated with the national activity-based funding system is a misnomer. The so-called efficient price is calculated by averaging the cost across all services, which means the national activity-based funding system will implicitly under-write the existing inefficiencies embedded in the public hospital system. It would help to discover the true efficient price of public hospital services and deliver the best value for the ever-increasing amount of taxpayer's money spent if the kind of structural reforms that have been commonplace in other government instrumentalities in the last 30 years were implemented. However, state governments have been reluctant to undertake them in relation to public hospitals for fear of the political repercussions.

Medicare is the problem

According to the 2016 NSW Government Inter-Generational Report, the rising cost of 'efficient' public hospital services is unsustainable. The report shows that under current tax and health policy settings, by 2055–56 rising health expenditure — driven mainly by the increasing cost of public hospital care to the NSW budget — will be responsible for 60% of the forecast 'fiscal gap' between revenue and expenditure of 3.4% of Gross State Product.[23] Former NSW premier Mike Baird described health funding as an "unbelievable challenge and the numbers continue to be daunting."[24] In response, the NSW Government has led calls by state governments for the federal parliament to increase the rate of GST from 10% to 15% to fund (in part at least) the state health burden.[25] This would represent the largest peacetime increase in taxation in Australian history and is an indication of the scale of the 'hospital funding crisis'.

The federal government's Inter-Generational Report (IGR) also shows the rising cost of health in coming decades will be primarily responsible for placing unbearable fiscal pressure on the federal budget — necessitating either substantial tax rises, cuts to services, larger deficits and debts, or their combination.[26] Ironically, the fiscal projections in the IGR exclude the impact of current federal policy on state budgets — even though the federal government, as architect of Medicare, is imperilling state and territory public hospital systems.

For more than three decades, state and territory governments of all persuasions have struggled to operate 'free' public hospitals effectively amid rising demand, escalating community expectations, and growing public dissatisfaction. In the long run, public hospital services are unaffordable under current policy settings. No level of government, state or federal, with or without activity funding, will have sufficient money to pay for the projected cost of all the 'free' hospital care the community will want to consume out of taxes it is willing and able to pay. Therefore, what is fundamentally unsustainable about the Australian public hospital system is the federally-mandated policy of 'free' public hospital care that has prevailed since the start of Medicare in 1984. The operation of Medicare has prevented state governments from taking effective remedial action to address jointly the supply-side defects with the demand-side issues critical to the sustainability of hospital services.

Because 'free' health care has become a 'sacred cow', too little attention has been paid to the role Medicare has played in creating the public hospital 'mess'. The irreconcilable policy objectives of increasing 'free' access, while containing the cost of a 'free' system, is a dilemma that state governments understandably find impossible to solve under the existing health policy settings

The standard view in health public policy circles is that a uniform national health policy is intrinsically meritorious. The principle of subsidiarity — that full policy, funding, and political responsibility should reside with the level of government closest to the point of service — is consequently sacrificed to the populist cause of 'free' public hospital treatment.

Another view is that federal government meddling in state public hospital systems since 1984 has created the public hospital mess by imposing on state governments the Sisyphean task of delivering 'free' hospital care to all comers, while restricting the states' policy authority over their hospitals. This has created unintended but predictable consequences, including rationing and related governance and productivity issues that have compromised the performance of state hospital systems. The need to contain the financial risk inherent in a 'free' system has contributed to high levels of bureaucracy with centralised state health department control over the daily activities of public hospitals. This has bequeathed a command-and-control structure that — in combination with productivity-killing, state-wide industrial agreements covering a highly unionised clinical workforce — thwarts independent, accountable and innovative management at the local level. (Box 2)

Even if states summoned the political will to undertake meaningful microeconomic reform to address governance problems, improving the productivity and technical efficiency of public hospitals (Box 3), this would be insufficient to ensure the long-term future of public hospitals and the solvency of state budgets. The affordability challenges in state health systems cannot reduce simply to states applying sound principles of public administration. There are underlying structural causes that have been exacerbated over the last three decades by federal interference in state hospital systems, associated with the service responsibilities of Medicare. The blame game over the inadequacies of federal funding for health has gifted states a perpetual excuse to not confront overdue microeconomic reform.[27] Yet this should not distract from the role that federal-state financial relations inherent in Medicare have played in creating the public hospital mess.

A comprehensive solution to the public hospital crisis requires a federalist solution that will resolve the public hospital mess by permitting states to address not only the supply-side challenges in a meaningful way, but also to deal with the crucial demand-side challenges. This requires new federal-state financial relations that will safeguard state budgets by allowing states to assume simultaneous control over public hospital funding, policy and service responsibilities.

Federalism and demand-side reform

Federalism could play a constructive role in encouraging states to make rational decisions about health policy. The key to creating affordable public hospital systems is to endow the states with sufficient authority and incentive to make these decisions — and to take their electorates with them towards sustainable health and hospital systems. As we have remarked above, this requires realignment at the state level between financial (tax) policy and political and health service responsibilities. States and territories have yet to comprehend it is in their best interest for the federal authorities to cease dictating health policy and to take back their income tax responsibilities, recognising, as this report argues, that taxing and service responsibilities should go hand in hand.

The states' reluctance to seek or accept a return of these responsibilities was evidenced when Prime Minister Malcolm Turnbull sought in vain to germinate his model of 'competitive federalism', announced as a curtain raiser to the COAG meeting with state leaders in April 2016.

The Prime Minister proposed that the federal government would reduce the federal income tax by an agreed percentage to allow the states to levy an income tax equal to that amount, thereby enabling the termination of existing federal grant programs such as funding for state hospital services. This 'tax swap' idea was based on a proposal canvassed in 2014 by the Abbott government's National Commission of Audit, which suggested that the marginal rate of federal income tax be cut from 32.5% to 22.5% to allow the states to collect the remaining 10% as a "state income tax surcharge". [28§] As the then Prime Minister rightly argued, a state income tax would address the central conflict: the inability of a state directly to raise revenue sufficient for their own responsibilities, while making them directly accountable to voters and taxpayers in their states for how revenue was spent. While there would initially be no overall increase in taxation, in the longer term a state income tax would also enable states to exercise financial autonomy with freedom to increase or lower taxation as necessary — ending once and for all the blame game over federal-state financial relations.[29]

When the states rejected the tax swap deal, the hospital funding can was kicked down the road for political reasons. To remove the issue from the agenda ahead of the 2016 federal election, the Turnbull government struck an interim Heads of Agreement with the states that restored some of the 'savings' cut from the Gillard funding deal by the 2014 budget. For a period of three years from 1 July 2017 to 30 June 2020, the federal government agreed to fund 45% of the efficient growh of activity-based services, with overall growth in federal funding capped at 6.5% (in line with the reduction of growth in hospital costs under the national activity-based funding system), with a longer-term funding deal to be negotiated and to commence thereafter.[30] The deal was subsequently supplemented by an additional commitment by the Turnbull Government of $2.8 billion over the four-year forward estimates announced in the 2017 Budget. [31]

The outcome of the April 2016 COAG meeting — along with the Turnbull government's subsequent abandonment of the White Paper on Reform of the Federation — suggests recasting federalism is unlikely to proceed through a top-down, Procrustean approach imposed from above. Instead, such initiatives may perhaps ultimately more plausibly be instigated from below — that is, by the states facing reality about the unsustainability of the federal-state health and financial relations status quo.

To avoid the financial calamity of fundamentally unsustainable free hospital systems that no government — state or federal — can afford, state governments must lead the way on reform of the federation to safeguard their own budgets from Medicare, and to endow themselves with the means to undertake the demand-side policies key to sustainable hospital services. States should therefore demand the right and opportunity to take back their income tax powers — equivalent initially to the quantum of hospital funding they would sacrifice as specific purpose grants and the federal government share of activity funding, met from federal government tax collections. The percentage of the federal income tax scales so surrendered would thereafter be designated 'state income tax', including the Medicate levy.

The method of its collection would remain the same, with both the state and federal income tax collected by the Australian Taxation Office (ATO). However, the extent of income tax raised on behalf of participating states could rise or fall as necessary to meet their health and other service responsibilities. The political responsibility for the state income tax rate would encourage reform in health on the supply-side (as above), as well as focus attention on the demand-side policy dilemma still confronting public hospitals.

The logical corollary of a state's decision to reclaim its income tax powers would effectively release it from its obligation under Medicare to provide free public hospital care. But after the debacle of April 2016, to advocate for such reform may even charitably be interpreted as 'courageous'. Tampering with the fundamentals of Medicare is the third rail of Australian politics. Yet the feasibility and case for restoring state income tax, in conjunction with public hospital charging, needs to be assessed in light of its unpalatable alternatives.

Even if states were to embark upon microeconomic reform, supply-side initiatives and productivity gains

§ A two-step transition process was proposed by the NCOA: initially, a fixed percentage of income tax in each state would be allocated to state governments with a commensurate reduction in tied federal grants; over time, states would exercise their power to vary the rate of the 'state income tax'.

Box 3. Microeconomic reform

- The supply-side strategies that can address the interrelated governance and productivity problems in public hospitals are well-known. These entail a three-stage microeconomic reform agenda involving: (1) Creating a purchaser-provider split; (2) Corporatising public hospitals with truly independent and accountable boards; (3) Introducing competition and contestability (competitive pricing) via privatisation or corporatisation of public hospital facilities[32].
- Reorientating the system towards market-based arrangements requires transforming the traditional role of state health departments into purchasers of hospital services. Instead of acting as both funder and provider of centrally coordinated hospital services as under the existing public monopoly model, central agencies should instead act as informed and discriminating purchasers, responsible for negotiating service agreements and contracts with local hospitals, with the ability to direct custom (without sacrifice to quality care) to better performing hospitals to contain expenditure and maximise the state's return on health spending.
- The first stage of microeconomic reform — a legitimate, arms-length purchaser-provider split arrangement — depends on the second stage: the meaningful devolution of financial and managerial authority via privatisation or corporatisation of public hospitals. This requires devolving managerial and financial responsibility (including financial risk) for each public hospital to their own board of management, with full control over all operational matters and full responsibility for the hospital's entire budget. Incentives for operational efficiency would be enhanced as budgetary responsibility, including financial risk for 'core' clinical services (covering nurses, doctors and allied health), were carried (at least in part) by the provider instead of the purchaser (the state government). This could be achieved by emulating the ideals of the Foundation Trust hospital governance model of the National Health Service in England. Foundation Trust boards have the power to borrow and are responsible for debt incurred and can accumulate reserves as a reward for efficiency. Their solvency is monitored by an independent regulator. Trusts nevertheless have been marred by chronic insufficient capacity to meet burgeoning demand at NHS zero prices. (Independent administrators, for example, were obliged to take over the Mid Staffs Foundation Trust in 2013 to avert its insolvency).
- Ideally, each hospital board and CEO would have full administrative and budgetary control and be responsible for setting the price of its services in competition with other private and public facilities. Importantly, managerial autonomy and financial accountability under a corporatised system of hospital governance would mean giving hospital managers full control over the employment terms and conditions of their workforces. Independent managerial authority would include the freedom to negotiate enterprise agreements with staff that take local conditions and financial realities into account. Workplace flexibility would eliminate restrictive and inappropriate 'one size fits all' industrial agreements, and facilitate the implementation of innovative ways of delivering cost-effective services—a process encouraged by the incentives created by financial accountability and competition.
- A purchaser-provider split would also allow for a new model of private sector involvement in the delivery of public hospital services. Selective privatisation via Public Private Partnerships, for new or redevelopment hospital projects, would create a competitive and contestable market for public hospital services, and give state health departments the ability to act with discretion as informed purchasers of all capital and variable inputs, including clinical labour. The ability to purchase services from better performing operators in contestable environments would encourage public facilities that remained in state hands to lift their performance and to emulate the more efficient and business-like practices of privatised or corporatised competitors. Microeconomic reform has the potential to deliver greater efficiency gains by encouraging the adoption of business axioms usually foreign to public hospitals. These include a culture of competition and innovation; more efficient, customer-focused service delivery; more flexible health labour work practices; and superior managerial accountability.
- State governments should no longer allow public hospitals to be quarantined from structural reform. Political will is needed to confront and dilute the vested interests of health labour employed in public hospitals that has long benefited from government-funded public hospital employment on privileged terms. The introduction of market disciplines and incentives into the public hospital sector would improve productivity and encourage innovations that lower costs and improve quality. As in other areas of the economy subject to structural reform, the community would receive more and better hospital services for what — as the cost pressures of coming decades become apparent — will be our increasingly scarce health dollars. A microeconomic reform agenda will therefore help to control escalating health expenditure, improve access and increase the volume of services at least cost.

can never in themselves suffice to sustain public hospital Medicare. We have shown how the effect of unconstrained demand in a more supply-side efficient, but 'free', hospital system would be more expensive. It would perpetuate — and possibly intensify — the need to contain costs by rationing with queuing or bailing out inferior hospital management. Further, supply-side reform as a stand-alone policy without price signals would inevitably create a vortex for further spiralling demand excesses, augmented by the impact of population ageing and advances in medical technology.

The sustainability of public hospitals can be addressed ultimately only with demand-side initiatives as an ingredient in reform and as a component of rational federalism — which Medicare now precludes. State governments accordingly need to address this by reasserting their income tax powers in conjunction with a release from the requirement to deliver 'free' public hospital care. Restoration of full financial and policy responsibility for public hospitals would allow states discretion in designing their own strategies for their own hospitals' public policy, subject as always to the will of the electorate.

Rational federalism would invite state governments to seek political support for local income taxes to fund public hospitals. There is a presumption that state leaders would already have been in 'hard' conversation with their electorates about the future of their public hospital systems. Once adopted, state income tax would become an immediate spur to hospital efficiency. Fear of increasing state income tax to cover the cost of badly managed hospitals would encourage local politicians not only to make effective decisions about how to run public hospitals, but also to adopt realistic dialogue with voters about the real demand-side challenges.

Many states already make it their business to charge for public hospital care, but as revenue measures, wherever the letter of the law permits.[33] At admission, all patients are routinely exhorted to elect to be treated as private, fee-paying patients (even in emergency situations), especially where it can be established that they possess an entitlement to third-party payer support such as private health insurance, workers' compensation or a motor accident or tort liability claim. Most patients who incur fees thus willingly accept a double cost burden. As taxpayers under Medicare, everyone pays for their free hospital entitlement but any private fees additionally incurred represent a further layer of direct or indirect charges, depending upon any right of recourse to claim a private benefit.

Miscellaneous charges, such as to Medicare-ineligible patients and for outpatient pharmaceutical charges, are meticulously enforced; hospital car parking operates at full capacity on commercial principles and attracts high charges from franchise operators that customers are evidently willing to pay as a proxy co-payment (although starting in July 2017, the NSW government is proposing to introduce concessions for certain patients and carers); ambulance fees apply to the general population and may be pursued through debt collection agencies if necessary. Charging by public hospitals is thus extensively employed; it represents a boundary already crossed. The pathway to wider adoption of this principle may not be as far-reaching as its critics will try to claim.

If more formally, widely and explicitly adopted, charging for all public hospital care as a demand-side policy, rather than as a purely revenue measure, would become self-reinforcing. States would clearly be reluctant to turn back the clock to wear the political odium of perpetually drip-feeding unconstrained hospital utilisation (of doubtful health gain) with higher state income taxes or debt or both. Rather, they would be encouraged to continue to court electoral favour with lower taxation. This would reinforce effective hospital policy embodying supply side and managerial efficiency with minimal patient waiting times. The extent of hospital charges that patients cost-shared would reflect the efficiencies realised. States would be better placed to retire their debt, lower their income taxes and thereby to provide a magnet for population increase, private investment and economic growth.

Not all jurisdictions may have an appetite for the discipline of a state income tax — let alone demand-side hospital reform. A more palatable alternative could be an 'opt-out' approach that might permit states individually and voluntarily to assert their income tax powers and to reclaim authority over health policy to pursue their own path in budgetary and hospital system sustainability (Box 4).

The benefits of economic growth in states that adopted these new fiscal principles would deliver them greater capacity (through all tax collected) to support the delivery of high quality health services and to open new opportunities for innovative hospitals operating in generally more contestable settings.

On the other hand, states not introducing their own income tax and who neglected the chance to embark on rational hospital management strategies would be confronted with the risk of ensuing 'backwash' effects of economic growth in states participating in reform. States opting for the status quo would ultimately feel obliged to consider competing with reformist jurisdictions by synchronising for themselves the adoption of state income taxes linked to hospital policy reform. Alternatively, they could risk their investment and economic growth stagnating. The re-birthing of health financing could, moreover, provide a blueprint for financial reform in other high-spending portfolios for which states are responsible, such as education, that — like hospitals — have become addicted to federal funding as a matter of expedience.

Box 4: An opt-out model for federalism reform

- Achieving universal agreement among the states on reform of the federation would be difficult. In the absence of consensus, one solution could allow states individually and voluntarily to reclaim their income tax powers and authority over health policy, in conjunction with a tax swap with the federal government. However, this would involve the federal government striking differential rates of income taxes across states. This would be unconstitutional: sections 99 and 51(ii) of the Australian Constitution prohibit unequal treatment of states by the Commonwealth with respect to taxation.
- Optional reform of the federation, state-by-state, in an indirect but constitutionally valid form would still be possible. For states acting alone, this could be done if the federal government were to agree to:

  A. Convert the existing federal specific purpose payment for state health services into a general purpose payment. This would simultaneously release the state from its Medicare obligation to provide free public hospital care inherent in the conditions of the specific purpose grant.

  B. Index the general purpose payment to the amount of health funding the state would otherwise receive according to the formula used to distribute health funding to other states.

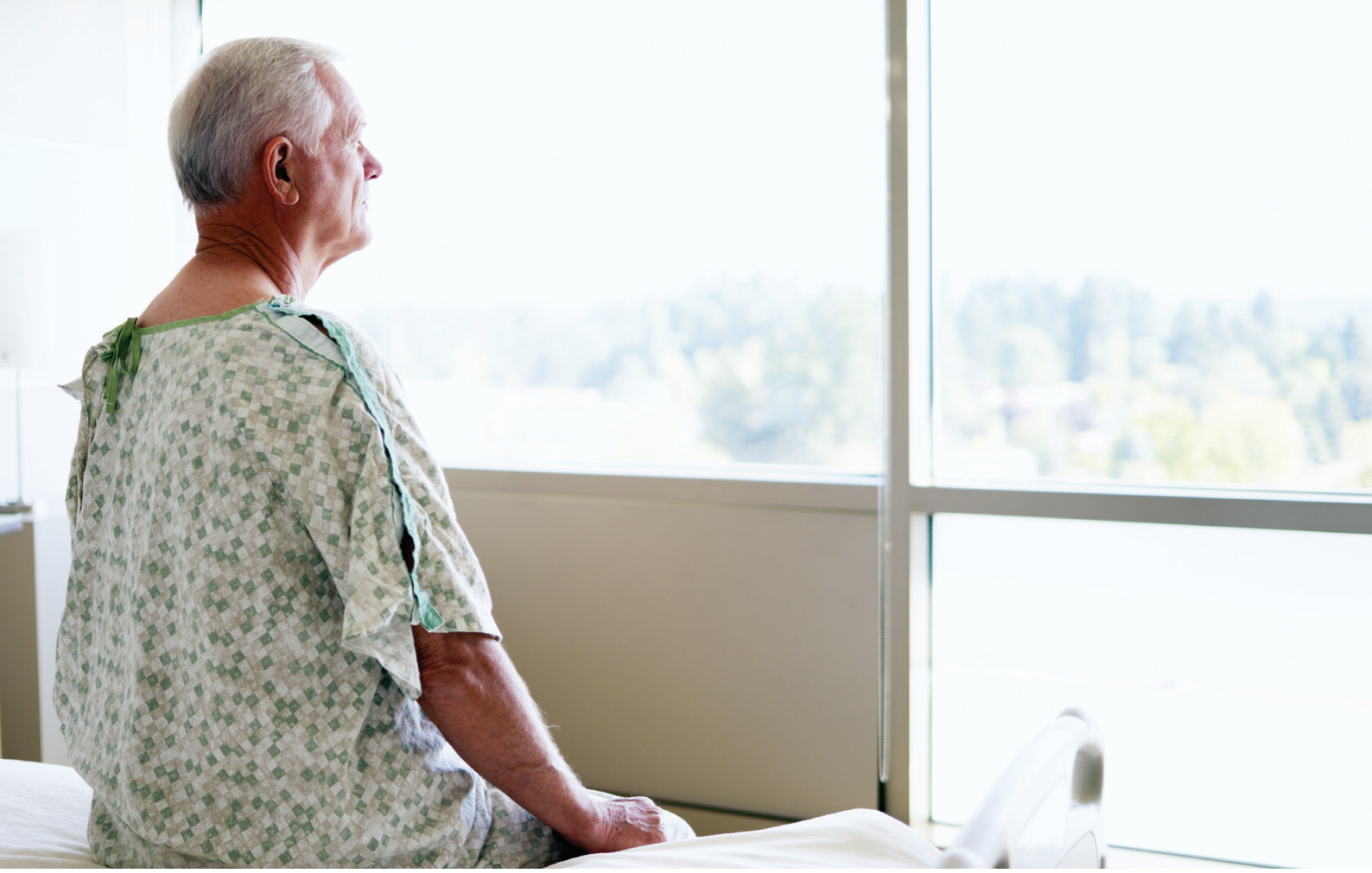
  C. Identify the value of the general purpose payment with the equivalent percentage of federal income tax revenue collected in the state. This would become the 'public hospital levy' in all but name.

  D. A state could, if it wished, supplement the federal public hospital levy either by imposing its own income tax surcharge or levy or by issuing a tax rebate under its own legislation but administered by the ATO.

- The opt-out federalism model proposed here has the potential to achieve the following beneficial outcomes:

  1. Establishing an indexed general purpose 'health' grant transparently linked to a specified percentage of the federal income tax collected in the state would end the blame game by making it clear that the citizens of the opt-out state were paying for public hospitals. The percentage of federal income tax so identified as the de facto 'public hospital levy' would represent the real cost of operating public hospitals. Publication of the real public hospital levy would immediately make the state more accountable to voters for how this money were spent on public hospitals.

  2. Under an opt-out model, the restoration of state accountability for health would be further enhanced if participating states chose to supplement the federal public hospital levy with their own additional surcharge through a state income tax, as their needs dictated. A hospital surcharge would give opt-out states powerful political incentives to undertake supply- and demand-side reforms. On the other hand, opt-out states would win voter acclaim were they to reduce income tax or perhaps rebate part of federal income tax/state hospital levy to taxpayers as an 'efficiency dividend' for operating sustainable hospital systems. Attention could be drawn to the extent of the gain that each household could derive by specifically inviting them to claim the hospital efficiency rebate as part of their annual tax return.



Strategy for implementing hospital cost sharing

Demand-side health policy in states introducing state income tax could include various forms of patient cost-sharing. However, the default 'roadmap' for these jurisdictions would highlight at least two immediate imperatives.

First, patients exercising their right to public hospital treatment as public patients — including for any form of non-inpatient care that had previously carried an entitlement to admission or treatment without charge under Medicare — would henceforth be obliged to face a compulsory co-payment at the point of consumption. The impact of this would be designed to remove the distortion that (publicly available) insurance introduced between insured hospital services and other health services that may be equally effective. It would cause health service users to adopt greater rationality in their use of hospital services — for example, by perhaps seeking a second opinion for non-emergency elective surgery, or by substituting alternative non-hospital care.

Second, as purely a demand management policy, the intention should be to employ hospital co-payments as far as possible as a 'revenue neutral' measure for both governments and households. This could be achieved by automatically paying quarterly compensation to all households in the state, equivalent to the actuarial cost of a typical household's expected public hospital co-payment disbursements. These payments would reflect the probability of public hospital use, with the amount calibrated according to the characteristics of the household — regardless whether or not the household had actually accessed any public hospital services (much in the same way as Centrelink at the time of writing paid an analogously-calculated compensatory Energy Supplement to all eligible households in Australia). The cost of the compensation may be amortised with the revenue generated by the co-payment (depending upon the price elasticity of demand for hospital services at prices above zero). And the co-payment's deadweight welfare loss would be minimised to the extent of households substituting other goods for hospital services and other lower-cost care (such as GP or other primary care services) for inpatient care or other hospital services.

Automatic compensation paid to all state residents would minimise the risk of compulsory co-payments for public hospital treatment being branded as unfair, regressive or inequitable. It would preserve the Medicare principle of 'universality' for public hospital treatment since compensation would not be means tested, thereby minimising the risk of political backlash. Compulsory co-payments for hospital services feature in some European national health systems including in France,[34] but they are not compensated (or claimable from health

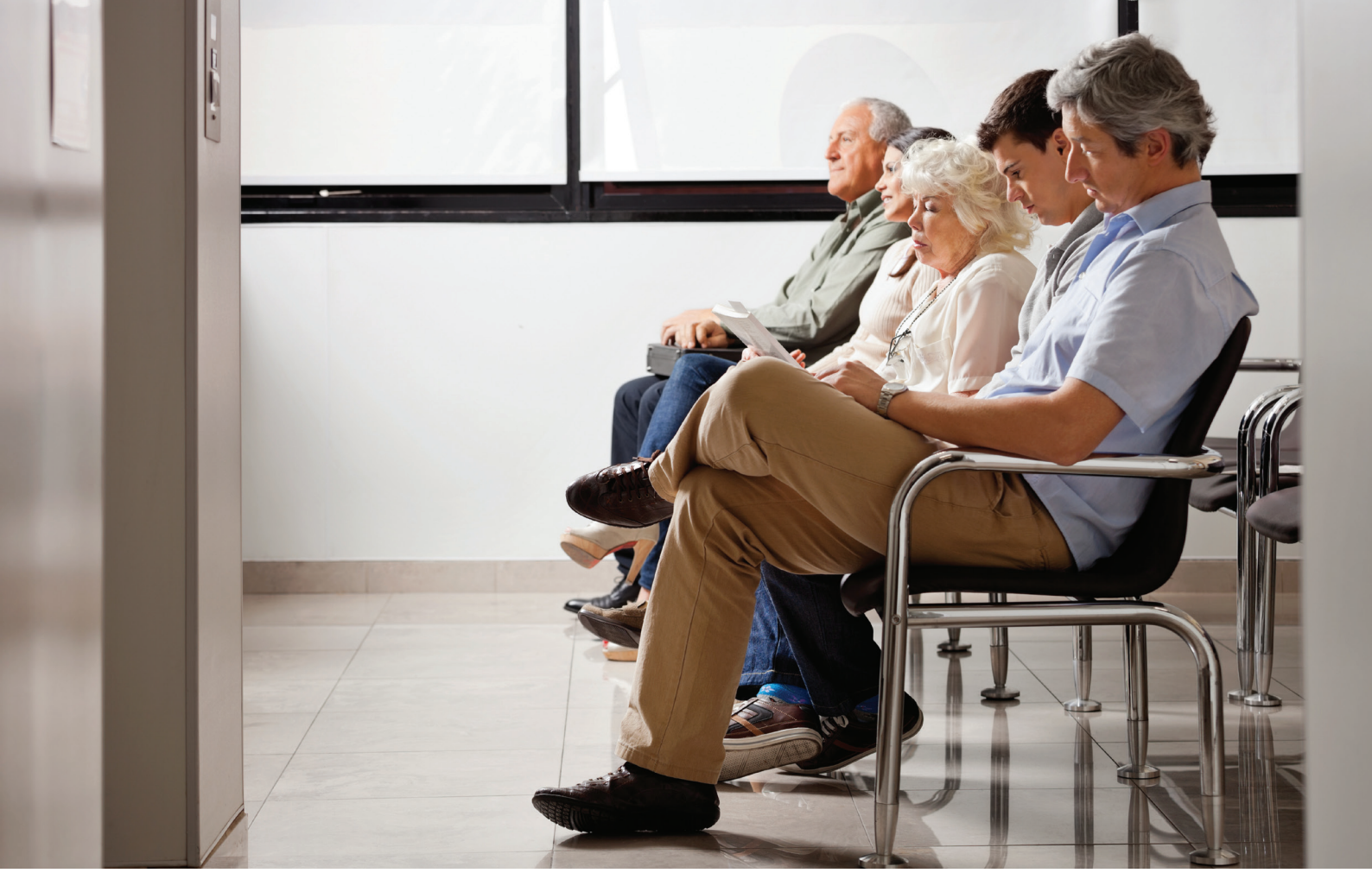
insurance). The French *forfait hospitalier*, for instance, is a daily fee for the "hotel services" component of acute public and private hospital stays. It is is currently set at €18 per day (AUD27). This could serve as a model for hospital co-payments in Australia.[35]

Universal hospital co-payments for which everybody is compensated would be politically superior to the Abbott government's ill-fated co-payment plan. Although this exempted low-income groups, it was perceived as violating the principle of 'universality' of entitlement that was originally designed to support the integrity and quality of Medicare. It also encountered a strong electoral blacklash from voters resentful of having to contribute directly out of their own pockets to the cost of health services already funded by taxes.[36]

Private treatment in a public hospital would remain charged and paid for as under existing arrangements without attracting a further layer of compensatory entitlement. However, for consistency between publicly and privately insured hospital services, participating states would need to ensure (with federal government approval) first-dollar coverage was banned for all private health insurance tables offered by registered benefit organisations for any form of private care in both public or private hospitals. Health funds would thus need to amend their rules to eliminate gap payments for services related to private patient admissions, including for accommodation, theatre fees, prostheses and specialist medical and laboratory services. All such services would henceforth become subject to specified mandatory co-payments or other acceptable forms of cost sharing. Just as for enhancing the integrity of the public system, the application of like measures to private patients analogously would provide for greater stability in health insurance contribution rates.

Further, for private admissions to public hospitals, abolition of first dollar coverage tables would introduce uniformity and equity between co-payments incurred by public and private patients. For private hospital admissions, co-payments would reduce the risk of patients substituting first-dollar covered private hospital treatment for treatment that would have otherwise occurred privately in a public hospital. In the short run, had it deflected the private caseload away from public hospitals, this may have created more space for treating public patients in public hospitals. However, any such short-lived gain would be likely more than offset by a substantial escalation in health insurance contribution rates — especially in NSW which carries a much larger private patient caseload in public hospitals than other states — since it is much cheaper for health funds to write benefits for private treatment in public hospitals than for equivalent care in private hospitals (to the extent that it is offered in private hospitals).

If higher premiums were precipitated, private insurance coverage may fall, further reinforced in turn by a consequential deterioration of the risk pool of privately insureds, and so on — thereby exposing the public hospital system to the spiralling burden of a growing population disenchanted with health insurance and deflected into public care.



Lessons from Singapore for Australian HSAs

In summary, for states that were to adopt it, rational federalism could introduce profound changes to their health economies. If properly implemented, it could transcend political resistances and priority would immediately attach to synchronising hospital supply- and demand-side efficiency measures that would permanently change the character of 'hospital Medicare'. Singapore provides an example of a high-income country with extremely good health outcomes. An important part of Singpore's success derives from policies aimed at making patients conscious of the cost of their health services through cost-sharing.

Singapore spends some 4% of its GDP on health, compared with 9% in Australia for the same or better health outcomes. Gadiel and Sammut have shown that Singapore's efficiency is in part attributable to its distinctive health system, the centrepiece of which is a national system of account-based, contributory, personal Health Savings Accounts (HSAs). These are tax-effective savings vehicles that can be used to pay for health services and health insurance,[37] administered through Singapore's Central Provident Fund (CPF).

High levels of personal financial accountability for health expenditure, mandated by use of prices at point of consumption, differentiate Singapore's health system from the likes of Australia's. In Singapore, individuals are required to fund minor health costs for GP care, allied health services, and basic medicines as out-of-pocket expenses. The extensive use of direct patient charges is complemented by the use of insurance deductibles and co-payments for all inpatient care, charged to HSAs, with households thereby sharing in the cost of all hospital services.[38]

The design of Singapore's HSAs has assisted in the extremely effective use of its hospital system through more effective pricing of hospital services at the point of consumption. For example, its hospital separation rate per person year of 0.08 compares favourably with 0.4 in Australia; and the respective comparative hospital bed days used per person year are 0.51 and 2.36[39]

The CIS Health Innovations Program has proposed that Australia emulate the Singapore model by allowing households to opt out of Medicare by cashing out their current taxpayer-funded Medicare entitlements into an annual 'voucher' for deposit into a 'superannuation-style', tax-advantaged HSA. The value of the voucher would be the annual, indexed per-person federal, state and territory government Medicare spending (on the MBS, PBS, & Public Hospitals), around $3,000 in 2014–15.[40]

As an additional element in hospital cost-sharing, Singapore-type HSAs could offer a useful vehicle for states adopting rational federalism to adapt, in different scenarios, to their own respective demand-side strategies for pricing hospital care. Accordingly, states that embraced rational federalism might unilaterally

permit their residents to establish HSAs for themselves to pair with their hospital co-payments.

In one scenario, the baseline value of vouchers the state would deposit into HSAs would be limited to public hospital funding, set at per-person state expenditure on public hospitals. Voucher baseline payments would be supplemented with the value of the compensatory payment that would automatically apply to everyone in the state to neutralise the impact of default hospital co-payments, regardless of whether they established an HSA.

Voucher funds would be also supplemented with accumulated superannuation-style contributions deposited into the HSA during a person's working life. Households opting out of their states' Hospital Medicare would transfer their public and their private hospital entitlements (depending on the level of private insurance) into their HSA, equivalent to not less than the entitlements of households remaining in Medicare. HSA funds could thus be available to pay for all charges arising from both public and private hospital care, including private insurance premiums.

In this scenario, the baseline value of the voucher would be equivalent to public hospital funding in each participating state. Under the proposed revision of federal tax and health responsibilities, states would be directly and solely responsible for determining such funding from amounts collected as state income tax by the federal government on their behalf.

Whereas the cost of the public patient entitlement to hospital care (equivalent to Hospital Medicare) together with co-payment compensation would be fully incorporated in the value of the annual voucher, the cost of insurance for households choosing private cover as an add-on would be debited to account-held savings without compensation, and paid (as necessary) from account-holder contributions.

Table 2: Source and application of hospital funding under Rational Federalism

Type and source of funding / **Patient status**	Default household payment arrangements	HSA household payment arrangements
	State public hospital funding sourced from state income tax (default state system)	Households opt out of entitlement to state hospital subsidies in exchange for an annual voucher funded from state income tax and paid into an HSA account, supplemented with occupational contributions
PUBLIC	Entitlement to free public hospital care as a public patient, subject to co-payment (compensated), paid out-of-pocket	Entitlement to public care in public hospitals with liability for state subsidised public fees, paid either out-of-pocket, from HSA money or from health insurance (purchased with HSA money) plus co-payment (compensated), paid either from HSA money or out-of-pocket
PRIVATE	Entitlement to private care in public hospitals, with liability for state-subsidised private fees raised by public hospitals paid either out-of-pocket or by private health insurance, plus private insurance co-payments / cost-sharing (compensated at the public rate), paid out-of-pocket	Entitlement to private care in public hospitals with liability for state subsidised private fees paid either out-of-pocket, from HSA money or from private health insurance (purchased with HSA money) plus private insurance co-payments / cost-sharing (compensated at the public rate), paid either from HSA money or out-of-pocket

Table 3: HSA Vouchers ($) 2014-15

	State + Federal Public Hospital ($ billion)	Per Person State + Federal Public Hospital	Federal Health (MBS & PBS) ($ billion)	Per Person State & Federal Public Hospital + Federal Health
NSW	13.11	$1,697	9.79	$2,965
VIC	10.08	$1,662	7.06	$2,825
QLD	8.13	$1,678	5.72	$2,858
WA	4.82	$1,841	2.53	$2,809
SA	3.55	$2,080	2.08	$3,298
TAS	1.00	$1,936	0.65	$3,204
ACT	0.98	$2,482	0.37	$3,416
NT	0.75	$3,075	0.20	$3,900
Aust.	42.44	$1,759	28.41	$2,937

Source: Australian Institute of Health and Welfare, Health Expenditure Australia 2014-15 Report, Tables B27, B30, B33, B36, B39, B42,B45, and B48 of Appendix B; Table A6 of Appendix A http://www.aihw.gov.au/publication-detail/?id=60129557170&tab=3

In summary, all hospital admissions in states concerned would remain subject to co-payments and other cost-sharing as described in the previous section, paid either from HSA balances, or — in the case of those remaining in the default arrangements under state-financed Hospital Medicare — as out-of-pocket expenses. (Table 2.)

In another more comprehensive scenario, states could implement HSAs by incorporating all Medicare expenditure into the value of the voucher. This would require both the state and federal governments to cash out their entire Medicare spending for households opting for HSAs into a jointly-funded voucher that could be integrated into the new division of federal-state responsibilities. Federal government agreement to include the federal government's 'own program' Medicare expenditure on the MBS and PBS in the voucher could then be negotiated as components of the state income tax package. The illustrative per-person value of an annual HSA voucher under each of the scenarios is shown in Table 3.

There is much to recommend in incorporating HSAs into the Australian health system. Allowing individuals to self-fund their own healthcare and to save over time to pay for health would contribute to off-budget, non-tax sources of health funding, thereby reducing health-related fiscal pressures on government budgets. In Singapore, for example, government health spending accounts for 40% of total health expenditure compared to 70% in Australia.

In addition, households and government would financially gain both from lower resource costs flowing from containing the moral hazard effects of wasteful and excessive service demands, and from supply-side discipline exerted upon public hospital managers. Insofar as such savings accrued to households in the form of higher HSA balances that merged with superannuation balances on retirement (as occurs in Singapore and proposed in the CIS model), they would be available to fund both rising age-related health costs and/or retirement incomes.

There are analogies between the principle of employing superannuation-style account-based savings vehicles as a stepping stone to health funding and the application of voluntary superannuation contributions to assist in purchasing a first home. Tax effective assistance for home purchase through superannuation is intended to become available to Australians from 1 July, 2017.[41] Like health savings accounts, the notion of housing assistance accounts is borrowed from the Singapore CPF model of superannuation. For young members of the workforce whose retirement could be many years distant, access to their savings to meet current housing needs, if it were available in conjunction with a similar arrangement for health purposes, would constitute a new savings suite that could further motivate them to take greater interest in their superannuation earlier in their lives and to become more discriminating about their choice of fund to serve their more immediate needs[§§].

[§§] We offer no opinion as to use of superannuation savings as a policy to address "housing affordability". Our argument relates to the general principle of broadening its use as a source of savings other than for the "sole purpose" test as defined in s62 of the Superannuation Industry (Supervision) Act 1993.

Conclusion: Ask not what public hospitals can do for you…

To advocate for HSAs is to emphasise how they can ultimately contribute to household savings. Health reform can thus be presented not simply as confiscating 'free' health care from voters in the name of government budgets, but as giving them something more than Medicare: a personal financial stake in their use of necessary healthcare. But there is also a public interest argument to recommend demand-side focused health reform.

The real priority for states is to save themselves from the financial and political calamity of Medicare by securing genuine reforms that address the health system's financial integrity. State governments could save themselves from Medicare's problems by taking back their tax powers and reclaiming their authority over public hospital policy. States need to acknowledge how they can become champions of genuine structural change in the public health sector. Health system affordability relies on the demand-side intervention; so in the interests of fiscal and political self-preservation, states should recognise the gain from becoming advocates not only for rational federalism, but also for pairing such interventions with a cost-sharing (and potentially a 'health savings') approach to health financing. To save themselves from Medicare and to make public hospitals affordable, states ultimately must encourage their citizens to contribute to the cost of their own health care.

It is frequently observed in relation to the health debate that Australia needs an honest and open national conversation about the future of its health system to address unrealistic community expectations about the constraints that dog a 'free' health system. Most governments and politicians, federal and state alike, avoid this subject; they live in fear of the electoral consequences of belling the cat about the true limitations of Medicare. Yet at the state level especially, by the time rampant public hospital demand eventually culminates in uncontrollable hospital budgetary overruns in the face of intractable waiting times, dissembling will no longer suffice.

Sustainable provision of hospital services would be possible under a rational federal system of devolved income tax and health responsibilities, which include reform on the demand-side that embrace cost sharing — if not within the shield of a 'health savings' vehicle, then at least within a stand-alone, compensated environment. Either option would preserve horizontal equity and enhance the financial integrity of hospital services without jeopardising universality of coverage.

But to create an affordable health system, the collective cultural expectations that surround a 'free' healthcare must yield to the principle of greater personal responsibility for health. This is diametrically opposed to the expectation that normally prevails in public life in Australia: that governments must do all things for all people. Because this expectation can never be fulfilled, it nourishes deep-seated popular distrust of the political process.

The popular perception, therefore, is that politicians are cynical partisans, susceptible to raising false expectations in pursuing their self-interested agendas. The political class in general repays public disdain by treating the average voter as a complaining mendicant with an insatiable appetite for government entitlements. The mutual disregard and contempt between politicians and voters is consecrated by unfulfillable slogans such as 'free hospital care for all'. Looking ahead, the continued operation of 'free' public hospital systems in Australia will almost certainly require a combination of higher taxes, higher deficits and debt, and greater rationing — with cuts to health and other services. As the 'credibility gap' between the promise of 'free' health and the reality grows, it will magnify and potentiate voter disenchantment with politicians.

The chasm between perception of private gain and public good is always vulnerable to exploitation by populism. This creates fertile territory for public disaffection with government. Populists protest loudly (often on single issues) to harvest the discontent of disillusioned voters, but are bereft of solutions. However, political opportunists could prosper by filling the void left by 'establishment politicians' afraid to admit Medicare has defects that require remedies which may be electorally distasteful. Saying and doing nothing about Medicare will leave the governing parties in Australia vulnerable to populist assault over health while ever the demand and cost pressures seem destined to remain uncontrollable. The political class can either allow themselves and their successors to remain hostages to fortune — or to exercise the foresight to pursue owning both the problem and solution to the future of the public hospital system.

To avoid the former fate, politicians must cease gulling voters with the unattainable and acknowledge that 'free' hospital care can never occur. Australia is unworthy of a political class that habitually beguiles voters with falsehoods about the panacea of Medicare, and doggedly panders to them as inherently selfish and venal. If such base expectations come to lie at the heart of the democratic process, it will surely govern how politicians and voters behave towards each other. Health reform presents an opportunity to reassert a civil society in which government becomes truly responsible to the people, and consents to share the burdens of real self-government by, of, and for the people.

If the public hospital system is to be sustainable, the real reform challenge is to enlist the help of the people to realise this goal. Instead of encouraging voters to ask what public hospitals can do for them for 'free', politicians need to start asking citizens what they can — and must — do for public hospitals.

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