

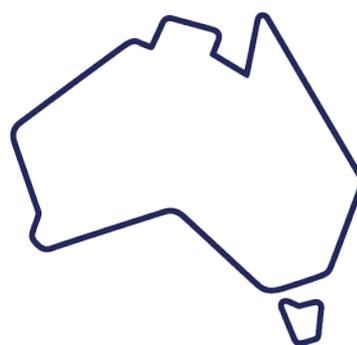


Australian Government
Department of the Prime Minister and Cabinet



Reform of the Federation

WHITE PAPER



Roles and Responsibilities in Health

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Getting involved and having your say

The Commonwealth Government would like as many people as possible to be thinking about how our federal system of government can be improved, particularly in relation to roles and responsibilities in health.

A Green Paper setting out options for reform will be published in the second half of 2015, ahead of the publication of the White Paper in 2016.

The Green Paper will allow the public the opportunity to make written submissions on the proposals put forward.

For more information, please visit the website www.federation.dpmc.gov.au

1. INTRODUCTION

Our own health, and the health of our family and friends, is vital to our sense of wellbeing. At different stages of our lives we rely on the delivery of the best possible health care. This might be advice from our local general practitioner or specialist care from a hospital emergency department.

For most Australians, our health care arrangements work well. Whether it's a simple procedure like a flu vaccination, or a complex procedure like neurosurgery, we have access to high quality care from a highly skilled workforce. Australia has one of the highest life expectancies in the world,¹ although there is still a gap of around ten years between Indigenous and non-Indigenous life expectancy.² Our health care is also delivered relatively efficiently.³

There are, however, a number of pressures on our health care arrangements. Increased demand for services is leading to rising health expenditure, which will increase pressure on governments' budgets in the future. This is being driven by the ageing population, increasing consumer expectations and the resulting growth in per capita use of health services, more expensive technology, and the growing burden of chronic conditions. All governments are facing health workforce pressures, which include shortages of some health professionals, particularly in rural and regional areas.

Some of these pressures are beyond the scope of any one government to fix. For example, governments can't stop the ageing of the population. What governments can do, however, is ensure that the allocation of roles and responsibilities in health is not holding back the system's performance in being able to deliver better outcomes for Australians.

In fact, part of the problem is that there is currently no single overarching 'health system' in Australia. Rather, health care is a complex web of services, providers and structures. All levels of government—the Commonwealth, the States and Territories, and local government—share responsibility for health. They have different roles (funders, policy developers, regulators and service deliverers) and in many cases those roles are shared.

The Commonwealth is predominantly responsible for primary care, which includes general practitioners and some medical specialists. Since the successful referendum on social services in 1946, the Commonwealth has become increasingly involved in almost all aspects of health care. The States and Territories are predominantly responsible for public hospitals, ambulances, community and mental health services, and health infrastructure. Both levels of government have a role in community health, mental health, public health programmes, and the health workforce. The not-for-profit and private sectors have significant roles in health care,

¹ Australian Institute of Health and Welfare, *Australia's Health 2014: in brief*, Cat. no. AUS 181, AIHW, Canberra, 2014, p. 2.

² Australian Institute of Health and Welfare, *Australia's Health 2014 – in brief*, 2014, p. 34.

³ We spend around 9.4 per cent of GDP on health care, which is close to the Organisation for Economic Cooperation and Development (OECD) average of 9.2 per cent. See Australian Institute of Health and Welfare, *Health Expenditure Australia 2012-13*, Canberra, 2014, p. 27.

particularly in service delivery; however, the focus of the White Paper is on government roles and responsibilities.

While there are strong incentives for all governments to improve people's health, the complex split of government roles means no single level of government has all the policy levers needed to ensure a cohesive health system. This particularly affects patients with chronic and complex conditions, such as diabetes, cancer and mental illness, who regularly move from one health service to another and can suffer if their care is not provided in a coordinated manner.

There are strong reasons for taking action now to address the challenge of providing better integrated and coordinated care for people with chronic and complex conditions. Chronic disease is already the leading cause of illness, disability and death in Australia. It is more likely to affect Indigenous Australians. It is expensive to treat, particularly because the current arrangements result in many unnecessary and avoidable admissions to hospital, which is the most expensive setting for health care. The cost of the four most expensive chronic diseases equates to around 36 per cent of all health expenditure.⁴ And the incidence of chronic disease is growing. With an ageing population, we can expect higher numbers of people with chronic disease in the future, something which has been called "Australia's greatest health challenge".⁵ Failure to address this challenge could mean poorer health and even greater pressure on governments' budgets in the future.

This issues paper lays out the development of Australia's health care arrangements since Federation, outlines the pressures on current arrangements, and canvasses questions about how the current split of roles and responsibilities between the Commonwealth and the States and Territories could be changed to alleviate some of the pressures and lead to improved health for Australians. The paper does not aim to sort out all of the problems in our health care arrangements. Consistent with the objectives of the White Paper, it seeks to identify areas where governments could make a difference, while being mindful of the wider pressures facing our health care arrangements.

This issues paper poses some questions, which are structured around the six principles in the Terms of Reference for the White Paper:

- accountability for performance in delivering outcomes, but without imposing unnecessary reporting burdens and overly prescriptive controls;
- subsidiarity, whereby responsibility lies with the lowest level of government possible, allowing flexible approaches to improving outcomes;
- national interest considerations, so that where it is appropriate, a national approach is adopted in preference to diversity across jurisdictions;
- equity, efficiency and effectiveness of service delivery, including a specific focus on service delivery in the regions;

⁴ Australian Institute of Health and Welfare, *Australia's Health 2014*, Canberra, 2014, p. 98. The four are cardiovascular diseases, oral health, mental disorders, and musculoskeletal.

⁵ Australian Institute of Health and Welfare, *Australia's Health 2014 – in brief*, p. 54. See also p. 103 of the full report.

- durability (that is, the allocation of roles and responsibilities should be appropriate for the longer-term); and
- fiscal sustainability at both Commonwealth and State and Territory levels.

An important aim of this issues paper is to encourage Australians to think about what type of health care arrangements will best meet future patient needs. The White Paper is an opportunity to consider how these arrangements can be structured to ensure Australians have the best possible health through a more rational allocation of roles and responsibilities that plays to the strengths of each level of government.

While not all of the pressures facing Australia's health care arrangements are a result of the split of government roles and responsibilities, clarifying the roles and responsibilities of the Commonwealth and the States and Territories could improve the operation of our health care arrangements. Every dollar wasted on managing an unnecessarily complex system, or in working at cross-purposes due to a lack of coordination, is a dollar diverted from frontline health care.

Specific reform proposals across a range of government activity, including health care, will be identified in the Green Paper to be released in the second half of 2015.

2. EVOLUTION OF GOVERNMENT INVOLVEMENT IN HEALTH CARE

Key points

- Health policy was not a focus of the constitutional conventions before Federation. Health care was the responsibility of the States, with the Commonwealth's involvement in health policy at Federation limited to quarantine (through section 51(ix) of the Constitution).
- The Commonwealth became increasingly involved in health following the Second World War, with a focus on ensuring equity of access to health care.
- The creation of Medicare in 1984 saw the Commonwealth and the States and Territories agreeing to provide free health care for all Australians in public hospitals.
- Since the introduction of Medicare, the Commonwealth's focus has been on areas not covered by major programmes, such as mental health. These interventions have at times been in areas of traditional State and Territory responsibility and have not always improved the overall effectiveness of the health care arrangements.
- In recent years, the States and Territories have also addressed areas of health care that are not working well, including the delivery of primary care and aged care in rural and remote areas. They have also led the development of many reforms, including activity based funding for public hospitals and deinstitutionalisation of patients with mental illness.
- Recent reforms have shifted the focus of health policy to public hospital funding, with agreements between governments focused on increased performance reporting and accountability.

While health was not a focus of the constitutional conventions in the lead up to Federation, it is now a major area of shared responsibility between the Commonwealth and the States and Territories.

1901-1949

At the time of Federation, health service provision was considered a local rather than a national issue. Government intervention in health services was limited and community attitudes to health focused on personal responsibility.⁶ The Constitution reflected this view and did not change the basic allocation of responsibilities for health care, which remained largely with the States. The Commonwealth's role was limited to quarantine.

Around the end of the First World War, the community began to realise there was a connection between poverty and poor health. Advances in medicine and technology gave rise to a community expectation that health services should be available to everybody, irrespective of their ability to pay.⁷ In 1921, the Commonwealth Department of Health was established

⁶ S Sax, *A Strife of Interests – politics and policies in Australian health services*, George Allen & Unwin, Sydney, 1984, p. 15.

⁷ Sax, p. 27.

following the Spanish Influenza epidemic in 1918 and 1919. The Department's early focus was on quarantine, disease prevention, and public health education.⁸

As Sidney Sax noted, in the early twentieth century public hospitals were ill-equipped and most Australians preferred to use private institutions.⁹ Demand increased for public hospitals between the World Wars. Private hospitals were too expensive for many people with a serious illness and public hospitals, with modern technology and well trained staff, became the best place to receive treatment. In most States, public hospitals provided public wards, administered with a means test, and private wards for those who could pay. Public hospitals struggled to raise revenue to cover their costs and many set up contribution schemes in the 1930s.¹⁰

Health was becoming a more important issue for all Australians and a compulsory national health insurance scheme was proposed in 1928. It was not implemented due to opposition from businesses, who were to provide contributions for their employees. The friendly societies (the early private health insurers) also opposed the scheme as they considered it compromised their business model.¹¹ A national health insurance scheme was again proposed in 1938, but the medical profession rejected the range of services to be covered and the proposed remuneration arrangements.¹²

The Second World War fundamentally changed the relationship between citizen and state, with public perceptions shifting about what governments should do.¹³ The landmark *First Uniform Tax Case* in 1942 enabled the Commonwealth to increase its tax raising capacity by offering financially attractive arrangements to the States and Territories.¹⁴ This was to have far-reaching consequences.¹⁵

A Pharmaceutical Benefits Scheme (PBS) was introduced in 1944 and a referendum was held the same year proposing to give the Commonwealth 14 new heads of power for post-war reconstruction, including one for 'national health'. Opponents of the proposed expansion of Commonwealth powers argued they went too far.¹⁶ The referendum was defeated.

The High Court found the PBS to be unconstitutional in 1945 following a challenge from the Victorian Government and the medical profession. It was argued the scheme was an infringement on the medical profession's freedom to prescribe medicines.¹⁷ A Constitutional amendment giving the Commonwealth new powers for a range of social services was proposed.

⁸ Sax, p. 16.

⁹ Sax, p. 25.

¹⁰ Sax, p. 26.

¹¹ Sax, p. 36.

¹² Sax, p. 42.

¹³ A Bashford and S Macintyre (eds), *The Cambridge History of Australia: Volume 2, The Commonwealth of Australia*, Cambridge University Press, Melbourne, 2013, pp. 89, 105.

¹⁴ *South Australia and Ors. v the Commonwealth* [The First Uniform Tax Case] (1942) 65 CLR 373, 417, Latham CJ.

¹⁵ Both the Commonwealth and the States and Territories levied income taxes between 1915 and 1942. Further information can be found in *Issues Paper 1 – A Federation for Our Future*.

¹⁶ Sax, p. 52.

¹⁷ F Beddie, *Putting life into years*, Department of Health and Aged Care, Canberra, 2001, p. 44.

The 1946 referendum was successful, with over 54 per cent of the population and all States supporting the amendment. A new PBS commenced and a national health insurance scheme was again proposed. Once again, the scheme was not implemented due to strong opposition from the medical profession, who did not support the proposed administrative and remuneration arrangements.¹⁸

In the mid-1940s the Commonwealth made its first venture into providing funding to the States and Territories for free treatment in public hospitals through the *Hospital Benefits Act*. The scheme ended in 1949 and only Queensland maintained free treatment for all in public hospitals.¹⁹

1949-1984

This period saw Australia's first national health scheme introduced by the Menzies Government in 1950. The support of the medical profession was critical to the successful implementation of the scheme. Individuals were free to choose whether they were covered by insurance. The Commonwealth also became involved in aged care in the early 1950s. With housing demand exceeding supply and accommodation limited (for age pensioners in particular), the Commonwealth provided funding to organisations to build accommodation for older people. This was soon extended to include nursing facilities.²⁰

Over the following decades, the costs of both the national health scheme and the PBS rose. A patient co-contribution was introduced for the PBS in 1960.²¹ In 1968, the Nimmo Inquiry found the national health scheme was complex, the benefits low, and the contributions above what many could afford.²²

The 1967 referendum marked an important point in government involvement in health care. The exclusion on the Commonwealth's ability to legislate with respect to Indigenous Australians was removed and specific grants for 'Aboriginal advancement' provided to the States. The early focus was on involving Indigenous communities in health care²³ and the first Aboriginal medical service was established in Redfern in Sydney in 1971.²⁴ By 2003-04, there were 140 Commonwealth funded Aboriginal health services across Australia.²⁵

From 1972, the Commonwealth greatly increased its involvement in health care, partly in response to concerns regarding the efficiency and effectiveness of the national health scheme. Universal health insurance was introduced with the creation of Medibank in 1975. As part of Medibank, the Commonwealth agreed to pay the States and Territories 50 per cent of the

¹⁸ Sax, p. 58.

¹⁹ Sax, p. 56.

²⁰ Beddie, pp. 50-51.

²¹ Beddie, p. 59.

²² Sax, pp. 81-83.

²³ Beddie, p. 64.

²⁴ G Palmer and S Short, *Health Care and Public Policy: An Australian Analysis*, 4th edn, Palgrave Macmillan, South Yarra, 2010, p. 302.

²⁵ National Aboriginal Community Controlled Health Organisation, *NACCHO History*, NACCHO, Canberra, viewed November 2014 <<http://www.naccho.org.au/about-us/naccho-history/>>.

operating costs of public hospitals in return for services being provided to all Australians free of charge and without a means test.²⁶

The Commonwealth also expanded into other parts of health care, including Indigenous health²⁷ and community health and welfare in local communities.²⁸ At the same time, increasing community expectations regarding improved health care led to South Australia establishing a health commission to improve coordination of health services.

A series of changes were made to Medibank from 1976 to 1981 to lower rapidly rising Commonwealth expenditure and ensure the sustainability of the scheme. A voluntary health insurance scheme replaced Medibank's universal coverage in 1981, with individuals once again free to choose whether they had health insurance. Free hospital and medical care was restricted to those deemed by the Commonwealth to be disadvantaged and a private health insurance rebate introduced.²⁹

Those who chose not to be covered by public or private health insurance had to meet their own costs for medical care. Queensland continued to offer free hospital care. Some States, including New South Wales, Victoria, and South Australia, levied (or proposed to levy) health insurance funds to ensure individuals covered by hospital insurance received free hospital care.³⁰

1984-2007

This period marked the return of universal health insurance with the creation of Medicare in 1984. The reintroduction was in part a response to concerns that some members of the community faced barriers in obtaining health insurance.³¹ The Commonwealth signed agreements with the States and Territories to provide funding for public hospitals on the condition free inpatient accommodation and care was available to all Australians.³²

Since 1984, successive Commonwealth governments have been committed to universal access to subsidies for medical services and pharmaceuticals. The Commonwealth and the States and Territories have increased their focus to those parts of health care where universal schemes do not address the needs of the entire population. This has included the health of Indigenous Australians, mental health, rural health, preventive health, and immunisation.

Preventive health became a focus of governments in this period. The Commonwealth established the Better Health Commission in 1985 to change the direction of health policy from illness to prevention.³³ Around the same time, several States and Territories increased taxes on tobacco to discourage smoking and fund public health activities.³⁴ A National Immunisation Strategy was

²⁶ Palmer and Short, p. 82.

²⁷ Beddie, p. 69.

²⁸ M Oppenheimer, 'Voluntary Action, Social Welfare and the Australian Assistance Plan in the 1970s', *Australian Historical Studies*, June 2008, Vol 39, Issue 2, 2008, pp.168 and 174.

²⁹ Sax, p. 171.

³⁰ Sax, pp. 169-173.

³¹ Sax, pp. 172-173.

³² Sax, p. 176.

³³ Palmer and Short, pp. 228-229.

³⁴ S Duckett, *the Australian Health Care System*, 3rd edn, Oxford University Press, South Melbourne, 2007, pp. 209-210.

introduced in 1993 to address concerns regarding inconsistencies in funding and access to vaccines across the States and Territories.³⁵

Mental health became a more pressing concern for all governments following the influential New South Wales Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (the Richmond Report) in 1983.³⁶ The National Mental Health Strategy was developed in 1992 and provided Commonwealth funding to support State and Territory reforms. Mental health expenditure grew by 30 per cent between 1993 and 1998 as the States and Territories shifted to providing care in the community rather than in institutions.³⁷

The Commonwealth also increased its involvement in health services for Indigenous Australians around this time. A national strategy was developed and the National Aboriginal Community Controlled Health Organisation replaced the National Aboriginal and Islander Health Organisation in 1992.³⁸ In 1995, responsibility for most aspects of Indigenous health services was transitioned from the Aboriginal and Torres Strait Islander Commission to the Commonwealth Department of Health.

In 1996, the Commonwealth also turned its focus to addressing the variable quality and high cost of aged care. Capital charges were introduced to finance improvements in aged care facilities, as well as a means test.³⁹

Throughout the 1990s the Commonwealth focused on strengthening the role of general practitioners. Divisions of General Practice were introduced in 1992 to better organise primary care.⁴⁰ The Practice Incentives Programme introduced financial incentives for general practitioners to improve the quality of services in 1996. From 1997 to 1999, Coordinated Care Trials tested whether pooled funding and coordinated treatment could lead to better care. These trials improved the quality of care, however an evaluation showed further work was required to manage costs.⁴¹

In 1999, the Enhanced Primary Care Programme was introduced to encourage multidisciplinary care of patients with chronic disease⁴² and was the forerunner to Chronic Disease Management items in the Medicare Benefits Schedule (MBS). Victoria took a similar approach in 2000 through the Primary Care Partnerships programme, designed to improve people's health through improved service coordination, integrated health promotion, and integrated chronic disease management.

³⁵ Department of Health, *National Immunisation Strategy for Australia 2013-2018*, Department of Health, Canberra, 2013, p.13.

³⁶ Mental Health Committee, *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*, Parliament of New South Wales, Sydney, 1983.

³⁷ Beddie, p. 103.

³⁸ National Aboriginal Community Controlled Health Organisation, *NACCHO History*, NACCHO, Canberra, viewed September 2014 <<http://www.naccho.org.au/about-us/naccho-history/>>.

³⁹ Beddie, p. 102.

⁴⁰ P Davies, 'Divisions of General Practice: will they transform, or die?' *the Medical Journal of Australia*, vol. 193, Number 2, 75-77, 2010, p. 75.

⁴¹ Beddie, p. 100.

⁴² M Foster, et al, 'Does Enhanced Primary Care enhance primary care? Policy-induced dilemmas for allied health professionals', *the Medical Journal of Australia*, vol. 188 (1), 29-32, 2008, p. 29.

During the late 1990s and early 2000s, the Commonwealth introduced a series of measures to encourage the take up of private health insurance to reduce pressure on public health arrangements. Income tested rebates, the Medicare Levy Surcharge, and Lifetime Health Cover were all introduced during this period. The proportion of privately insured people increased from 30 per cent in 1999 to 45 per cent in 2000.⁴³

The level of expenditure on public hospitals remained an important issue for all governments. Casemix funding was introduced in Victoria in 1993 and South Australia in 1994 to increase the efficiency of hospital funding. Under Casemix, funding was distributed to hospitals based on the type and number of patients treated, rather than as a set amount of funding.⁴⁴ In the late 1990s, Victoria introduced the Hospital Admission Risk Program to address increased demand on public hospital services and the Better Health Channel to provide health and medical information. In 1996, health ministers from all jurisdictions agreed to target a number of health priority areas, including cardiovascular health, cancer, mental health, and diabetes.⁴⁵

Concerns with rising public hospital costs remained and in 1998 the Commonwealth and the States and Territories negotiated new public hospital funding arrangements. The accountability of the States and Territories for service delivery was increased and Commonwealth funding could be varied to reflect changes in private health insurance rates.⁴⁶ Further funding arrangements were agreed in 2003 which focused on reporting requirements with potential financial penalties for the States and Territories.⁴⁷ However, the levels of Commonwealth funding for public hospitals declined and the States and Territories expressed concerns about their increasing share of the costs of public hospital services.⁴⁸

2007- current

By 2007 health policy, and in particular public hospital funding, was frequently part of the national debate. The Commonwealth rationalised multiple health payments to the States and Territories into a single payment as part of wide ranging reforms to federal financial relations in 2009.⁴⁹ Additional Commonwealth funding was provided to the States and Territories for public hospitals as part of this process.⁵⁰

The early part of this period marked a renewed push for cooperative federalism. Between 2008 and 2013, numerous national partnership agreements were signed between the Commonwealth and the States and Territories to address, for example, public hospital funding, Indigenous health, health workforce issues, and mental health reform.

⁴³ Beddie, p. 99.

⁴⁴ S Duckett 'Casemix funding for acute hospital inpatient services in Australia', *the Medical Journal of Australia*, vol. 169(8), 17-21, 1998.

⁴⁵ Palmer and Short, p. 229.

⁴⁶ S Duckett 'Australian hospital services: An overview', *the Journal of the Australian Healthcare Association*, Australian Health Review, Funding of Hospitals in Australia, Vol. 25 No. 1, Canberra, 2-18, 2002, pp. 14-15.

⁴⁷ Duckett, 2007, pp. 51-52.

⁴⁸ J Anderson, 'Health Policy as Contested Terrain in the Australian Federation' in P Kildea, A Lynch, G Williams (eds.), *Tomorrow's Federation: Reforming Australian Government*, Federation Press, Sydney, 2012, p. 259-260.

⁴⁹ The National Healthcare Specific Purpose Payment was supplemented with some National Partnership payments.

⁵⁰ Anderson, p. 253.

Successive Commonwealth governments committed to providing funding for medical infrastructure in this period. In 2007, the Commonwealth established the Health and Medical Infrastructure Fund for new medical facilities.⁵¹ In 2009, the \$5 billion Health and Hospitals Fund was established to provide capital works funding for major health infrastructure projects. Around 220 projects were funded through four funding rounds between 2009 and 2011.

Mental health continued to rise in importance for all governments. In 2010, Western Australia established the first mental health commission in Australia⁵² and in 2012 the Council of Australian Governments endorsed the Roadmap for National Mental Health Reform 2012-2022. The Commonwealth established the National Mental Health Commission in 2012 to provide advice to the community and government on mental health policy.⁵³ Tasmania introduced new mental health legislation in 2014 to enable those individuals who can to make their own treatment choices.

Public hospitals were never far away from the centre of the health debate. In 2010-11, revised public hospital funding arrangements were negotiated between the Commonwealth and the States and Territories. For the first time, Commonwealth funding was tied to the number and type of patients treated through activity based funding. The Independent Hospital Pricing Authority was established to independently determine the national efficient price to inform Commonwealth funding.

The Commonwealth also committed to funding 45 per cent of the growth in efficient hospital costs from 2014-15 to 1 July 2017, at which time it was to rise to 50 per cent. The additional funding was guaranteed to be at least \$16.4 billion from 2014-15 to 2019-20.⁵⁴

As part of the National Health Reform Agreement, Medicare Locals were established with Commonwealth funding with the intention of improving coordination and integration of health care in local communities.⁵⁵ The States and Territories established Local Hospital Networks as geographically based networks to deliver decentralised and specialised hospital services across jurisdictions and work with Medicare Locals to deliver integrated care.⁵⁶

In recent years, States and Territories have become increasingly involved in integrating health services, particularly through preventive health and primary care activities. In 2011, Victoria established the Healthy Together Victoria preventive health programme to reduce the growing levels of obesity and associated preventable chronic diseases. South Australia has recently

⁵¹ P Costello (Treasurer) and T Abbott (Minister for Health and Ageing), *Preliminary 2006-07 Budget Outcome, Future Fund, Higher Education Endowment Fund, Health and Medical Infrastructure Fund*, media release, Commonwealth Parliament Offices, Sydney, 21 August 2007 <<http://ministers.treasury.gov.au/DisplayDocs.aspx?doc=transcripts/2007/123.htm&pageID=004&min=phc&Year=&DocType=2>>.

⁵² Mental Health Commission, *Mental Health Commission*, Mental Health Commission, Perth, 2014, viewed November 2014, <http://www.mentalhealth.wa.gov.au/about_mentalhealthcommission.aspx>.

⁵³ National Mental Health Commission, *About Us*, National Mental Health Commission, Canberra, 2014, viewed November 2014, <<http://www.mentalhealthcommission.gov.au/about-us.aspx>>.

⁵⁴ National Health Reform Agreement, clause 12.

⁵⁵ J Horvath, *Review of Medicare Locals: Report to the Minister for Health and Minister for Sport*, Department of Health, Canberra, 2014, p. 2.

⁵⁶ National Health Reform Agreement, Schedule D.

established GP Plus Health Care Centres to work closely with general practice to respond to the needs of local communities and avoid unnecessary hospitalisations.⁵⁷

In 2012, the Commonwealth and Tasmanian governments provided funding to establish cancer treatment centres in Tasmania. In the same year, Victoria launched Koolin Balit, an initiative to bring together efforts across government to improve the health of Indigenous Australians.

Another important step toward the integration of health services occurred in 2012 when the personally controlled electronic health record (PCEHR) system was launched. When fully implemented, the PCEHR will enable individuals to register and health care providers to connect to the system to share patient data and health records.

To further improve the integration of health services, the Commonwealth announced in the 2014-15 Budget that Medicare Locals will be replaced with a reduced number of Primary Health Networks in July 2015, following concerns some were not fulfilling their intended role.⁵⁸ The Commonwealth also announced funding to the States and Territories for public hospitals will be indexed by a combination of growth in the Consumer Price Index and population from July 2017 and will no longer be provided on the basis of activity.

⁵⁷ SA Health, *GP Plus Health Care services and centres*, SA Health, Adelaide, 2014, viewed November 2014 <<http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+services/GP+Plus+health+care+services+and+centres/>>.

⁵⁸ Horvath, p. ii.

3. PRESSURES ON CURRENT HEALTH CARE ARRANGEMENTS

Key Points

- Increased demand for services is leading to rising health expenditure. This is being driven by the external pressures of the ageing population, more expensive technology, growing rates of chronic disease, and increasing consumer expectations. This, in turn, is placing pressure on the health care arrangements.
- The existing health care arrangements work well for most people. However, the arrangements are not well placed to address the growing burden of chronic disease. They do not work as well for the growing number of people with complex and chronic health conditions.
- Australia's health care arrangements are complex.
- Health services are provided by the government, private, and not-for-profit sectors.
- The Commonwealth and the States and Territories share responsibility for health, but have different roles for different health services.

3.1 Pressures

There are a number of pressures on our health care arrangements. Some of these pressures are beyond the scope of any one government to fix. What governments can do, however, is ensure that the allocation of roles and responsibilities in health care is not holding back the health system's performance in being able to deliver better outcomes for Australians.

3.1.1 Increased demand (leading to rising health expenditure)

Health expenditure comprises a significant portion of all governments' budgets and is expected to be the main source of budgetary pressure over the next 50 years.⁵⁹ Commonwealth health expenditure is estimated to increase by 3.9 per cent in real terms from 2014-15 to 2017-18.⁶⁰ Prior to the 2014-15 Commonwealth Budget, Commonwealth health expenditure was projected to rise from around 4.1 per cent of GDP in 2011-12 to around 7 per cent in 2059-60, while State and Territory health expenditure was projected to rise from around 2.4 per cent of GDP to 3.8 per cent.⁶¹

Health expenditure is rising for a number of reasons. The median age of our population is projected to continue rising as more people live into very old age and the number of older Australians grows as a proportion of the total population. Population ageing is not a problem in

⁵⁹ Productivity Commission, *An Ageing Australia: Preparing for the Future* (Commission Research Paper), Canberra, 2013, p. 136.

⁶⁰ Commonwealth Government, *Budget Paper No. 1: Budget Strategy and Outlook*, Budget 2014-15, Statement 6, Canberra, 2014, p. 21.

⁶¹ Productivity Commission, *An Ageing Australia: Preparing for the Future*, p. 136.

itself. Indeed, there are benefits that come from having a healthy and engaged aged population.⁶² But ageing does give rise to economic and fiscal impacts that pose challenges for all levels of government. The incidence of sickness and disability rises with age. Older people tend to be higher consumers of health care services. They are more likely to suffer from chronic diseases such as arthritis, dementia and cancer.⁶³ This increases demand for health services.

However, non-demographic factors, particularly the increasing utilisation of services across all age groups and the use of new and more expensive technologies, have been the major historical source of cost pressures in Australia and many other developed countries.⁶⁴ People of all ages are “seeing doctors more often, having more tests, treatments and operations, and taking more prescription drugs”.⁶⁵

Increasing consumer expectations are also contributing to increases in health expenditure. The Productivity Commission has noted that as incomes grow, people demand more, and better quality, health services.⁶⁶ As real incomes have risen, households have tended to devote more of their disposable incomes to health care.⁶⁷ Australia’s health care arrangements have responded to these increasing consumer expectations, but at a cost to governments’ health budgets.

Australians are also increasingly living with chronic disease, which is the leading cause of illness, disability and death in Australia. It is also expensive to treat, with the cost of the four most expensive chronic diseases equating to around 36 per cent of all health expenditure in 2008-09.⁶⁸ With an ageing population, we can expect higher numbers with chronic disease in the future, something which has been called “Australia’s greatest health challenge” by the Australian Institute of Health and Welfare.⁶⁹ Failure to address this challenge could mean poorer health and even greater pressure on governments’ budgets in the future.

3.1.2 Equity challenges

Equity in health outcomes remains a concern for all governments. Some groups in Australia have lower life expectancy and poorer health than the average, such as Indigenous Australians, people living with severe mental illness, people living in rural and remote Australia, and people in lower socioeconomic circumstances.⁷⁰ Over the period 2010 to 2012, Indigenous life expectancy at birth was 69.1 years for males and 73.7 years for females. This was lower than for non-Indigenous Australians by 10.6 years for males and 9.5 years for females. Large gains will be needed in future years to meet the target to close this gap by 2031.⁷¹

⁶² Productivity Commission, *Economic Implications of an Ageing Australia* (Research Report), Canberra, 2005, p. xii.

⁶³ National Commission of Audit, *Towards Responsible Government*, Appendix to the Report of the National Commission of Audit, Volume 1, Commonwealth Government, Canberra, 2014, p. 194.

⁶⁴ Productivity Commission, *An Ageing Australia: Preparing for the Future*, p. 128.

⁶⁵ Grattan Institute, *Budget Pressures on Australian Governments 2014 edition*, Melbourne, 2014, p. 20.

⁶⁶ Productivity Commission, *Impacts of Advances in Medical Technology in Australia*, Canberra, 2005, p. xxx.

⁶⁷ National Commission of Audit, *Towards Responsible Government*, Appendix Volume 1, 2014, p. 193.

⁶⁸ Australian Institute of Health and Welfare, *Australia’s Health 2014*, p. 98.

⁶⁹ Australian Institute of Health and Welfare, *Australia’s Health 2014: in brief*, p. 54. See also p. 103 of the full report.

⁷⁰ Australian Institute of Health and Welfare, *Australia’s Health 2014*, pp. 24-26.

⁷¹ COAG Reform Council, *Indigenous Reform 2012-13: Five years of performance*, Sydney, 2014, p. 9.

Government roles in Indigenous health services

There have been some improvements in the health of Indigenous Australians in recent years. However, Indigenous Australians still generally experience poorer health than non-Indigenous Australians. Indigenous Australians have lower life expectancy, higher mortality rates, and more infant and child deaths.⁷² Indigenous Australians are hospitalised for potentially preventable conditions nearly four times as often as non-Indigenous Australians.⁷³ This may relate to poor access to or use of non-hospital health care services.⁷⁴ Indigenous Australians are also more likely to be daily smokers⁷⁵ and more likely to die from a number of chronic conditions, including circulatory diseases, diabetes, and respiratory diseases.⁷⁶

The Commonwealth and States and Territories all deliver mainstream and Indigenous-specific health services. The Commonwealth provides a number of mainstream health services, including the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). In addition, in 2011-12 the Commonwealth funded around 300 organisations to deliver Indigenous-specific health services, including primary health care, substance use, social and emotional wellbeing, and mental health services, around 60 per cent of which were community-controlled or managed.⁷⁷ The Commonwealth also funded specialist services and health infrastructure for rural and remote communities. The States and Territories provide funding for and deliver a range of health services for Indigenous Australians, including some Indigenous-specific services, such as community clinics, mental health programmes, specialist palliative care, public hospital services, and public dental services.⁷⁸

In 2010-11, total expenditure on both mainstream and specific health services for Indigenous Australians was estimated to be around \$4.6 billion. The Commonwealth provided around 44.8 per cent, with the States and Territories providing 46.6 per cent of the funding. The remainder was provided by the private sector.⁷⁹

Evidence suggests some mainstream services may be underutilised by Indigenous Australians. Indigenous Australians' access to some health services, including MBS for general practitioner services, is only marginally higher than non-Indigenous Australians, despite experiencing poorer health on average. For other health services, such as mainstream medical specialist services,

⁷² Australian Institute of Health and Welfare, *Australia's health 2014*, pp. 301-303.

⁷³ Australian Institute of Health and Welfare, *Australia's health 2014*, p. 315.

⁷⁴ Australian Institute of Health and Welfare, *Australia's health 2014*, p. 332.

⁷⁵ Australian Institute of Health and Welfare, *Australia's health 2014*, p. 307.

⁷⁶ Australian Institute of Health and Welfare, *Mortality and life expectancy of Indigenous Australians: 2008 to 2012*, Cat. no. IHW 140, AIHW, Canberra, 2014, pp. 17-19.

⁷⁷ Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander health services report 2011-12: Online Services Report – key results*, Cat. no. IHW 104, AIHW, Canberra, 2013, p. 1.

⁷⁸ Productivity Commission, *Report on Government Services*, Indigenous Compendium 2014, Volume E Health Sector, 2014, p. E.3.

⁷⁹ Australian Institute of Health and Welfare, *Expenditure on health for Aboriginal and Torres Strait Islander people 2010-11*, Health and welfare expenditure series no. 48, Cat. No. HWE 57, AIHW, Canberra, p. vii.

Indigenous Australians' access is much lower.⁸⁰ In 2010-11, PBS expenditure per Indigenous Australian was around 80 per cent of the level of non-Indigenous Australians. This is a significant improvement from 2002 levels.⁸¹

There is a high degree of overlap between the Commonwealth and State and Territory health services for Indigenous Australians. The effect of this overlap on Indigenous health is unclear.

While some improvements have been made in recent years, particularly in child mortality rates, significant work is still required to close the gap between the health of Indigenous Australians and non-Indigenous Australians.

The health of Indigenous Australians is heavily influenced by a range of social determinants, including education, employment and housing. Both levels of government have different roles in addressing these social determinants. This adds to the complexity of Indigenous health arrangements.

3.1.3 Regulatory complexities

Regulatory complexity is another challenge facing Australia's health care arrangements. Many processes are unnecessarily complex for providers and users alike, meaning significant time and money is spent navigating regulatory processes rather than providing health care. Overly restrictive authority prescription arrangements can act as a burden for some medical practitioners.

Governments have cooperated in recent years to remove some regulatory barriers to increased productivity in health care. This includes the creation of a national regulator for health professions. But duplication still exists in other areas. For example, overseas trained doctors must submit applications to the States and Territories for 'area of need' registration, and also to the Commonwealth for a Medicare provider number. The approval criteria are not aligned.

A variation on regulatory complexity is overly burdensome reporting requirements placed on one level of government by another. Some funding agreements between the Commonwealth and the States and Territories contain overly prescriptive reporting requirements. There is room to reduce the regulatory burden as long as patient safety and care quality is not compromised.

3.1.4 Health workforce

The Commonwealth and the States and Territories both play roles in workforce planning, education, training, health practitioner regulation and reform. Only workforce regulation is currently undertaken in a coordinated way. This is achieved through the Australian Health Practitioner Regulation Agency, which is responsible for regulating 14 professions that are registered under the National Registration and Accreditation Scheme.

⁸⁰ Australian Institute of Health and Welfare, *Australia's health 2014*, pp. 314-315.

⁸¹ Australian Institute of Health and Welfare, *Australia's health 2014*, p. 314.

National workforce planning is largely uncoordinated and focused on individual professions rather than holistic workforce design. The Commonwealth influences workforce training through the higher education system, including by limiting the number of medical student places in universities. This has a downstream effect on the States and Territories, whose public health services provide the vast majority of clinical training and rely on university trained graduates to deliver public health services. An increase in domestic medical and other health enrolments in recent years has seen increasing pressures on the availability of clinical placements which are largely provided by States and Territories.

States and Territory influence is restricted to the vocational education and training sector. The States and Territories also largely control workforce training beyond university, where medical professionals generally undergo training in hospital environments. In recent years, the Commonwealth has sought to influence the training of medical professionals by funding the expansion of training into settings outside hospitals for some professions (such as dermatologists). There is no formal mechanism for national coordination across the health and education sectors regarding workforce supply and demand issues.

This lack of coordination makes it difficult to address emerging workforce issues. These include a projected shortage of 85,000 nurses by 2025 and 123,000 by 2030,⁸² and shortages of medical practitioners in rural and regional Australia. Despite the efforts of successive governments, there is still a shortage of general practitioners in rural Australia.⁸³ Around 41 per cent of rural doctors were trained overseas.⁸⁴ This is also reflected in other parts of the system like public hospitals. Some local councils have assumed a role in ensuring and retaining general practitioner services, including by providing premises and guaranteeing general practitioner incomes, at considerable cost from limited revenue sources.

A wide range of Commonwealth, State and Territory government funding aims to support clinical training in the public, non-government, not-for profit, and private sectors. This includes funding streams administered through health and higher education departments at the State and Commonwealth levels. Commonwealth clinical training funding programmes include (and are not limited to) funding to support rural clinical schools, and the Practice Incentives Programme payments to general practices. This is supplemented by State and Territory funding.

Health workforce issues pose a real challenge to maintaining the quality of health services that Australians currently enjoy. Around 70 per cent, or \$25 billion a year, of recurrent hospital expenditure goes to the health workforce.⁸⁵ The remuneration arrangements in public and private hospitals offer different incentives in order to attract medical practitioners.

⁸² Health Workforce Australia, *Australia's Future Health Workforce – Nurses Overview*, 2014 (forthcoming).

⁸³ Australian Institute of Health and Welfare, *Australia's health 2014*, p. 367. See also S Duckett, P Breadon & L Ginnivan, *Access all areas: new solutions for GP shortages in rural Australia*, Grattan Institute, Melbourne, 2013, p. 10.

⁸⁴ National Health and Hospitals Reform Commission, *A Healthier Future for All Australians: interim report*, Canberra, 2008, p. 321.

⁸⁵ S Duckett, P Breadon and J Farmer, *Unlocking skills in hospitals: better jobs, more care*, Grattan Institute, Melbourne, 2014, p. 4.

Reallocation of roles and responsibilities for the health workforce, to clarify which level of government is responsible for planning, training and reform, could make emerging issues, like the maldistribution of health professionals, easier to address.

3.1.5 Fragmentation of the health sector

Currently, our health care arrangements do not work well for Australians with complex and chronic conditions, such as diabetes, cancer and mental illness. This is because Australians with chronic and complex conditions often require coordinated care across multiple health settings. The growing chronic disease burden will require not only greater focus on prevention, but also innovative treatment of multiple chronic conditions and complex health care needs.⁸⁶ As noted earlier, there is no single overarching ‘health system’ in Australia to provide this care. Health care is a complex web of services, providers and structures. Some of these parts are not well connected or coordinated, especially where different levels of government are involved.

While there are strong incentives for all governments to improve people’s health, the complex split of government roles means no single level of government has all the policy levers to ensure a cohesive health system. This particularly affects patients with chronic and complex conditions, who regularly move from one health service to another and can suffer if their care is not provided in a coordinated manner. Even when supported by their general practitioner, they are affected by “information gaps, fragmented services, and duplication of clinical interventions”.⁸⁷ For example, a person with a serious mental illness may receive support and access services that are provided through multiple different programmes run independently of each other by different levels of government, with little or no coordination.

The National Health and Hospitals Reform Commission reported in 2009 that the fragmentation of the health sector had led to a complex division of funding responsibilities and performance accountabilities between the levels of government. This had resulted in “confusion and uneven access to services and quality of care for the consumer” as well as “cost, blame and service shifting by providers”.⁸⁸

The shift from acute to chronic conditions means current arrangements, which focus on acute care delivered through hospitals on an episodic basis, struggle to coordinate patient care across care settings inside and outside hospitals. They tend to focus on sickness, not a ‘wellness’ model of care such as through preventive health initiatives. This is partly driven by funding flows.⁸⁹ Service providers, such as general practitioners and hospital wards, are funded on the basis of activity, which can result in a focus on episodic treatment rather than long-term multidisciplinary care and prevention.

The ‘clinical handover’ between primary care and acute care is also complex. There is no agreed process between the Commonwealth and the States and Territories to manage and coordinate

⁸⁶ Australian Institute of Health and Welfare, *Australia’s health 2014*, p. 103.

⁸⁷ Horvath, p. 2.

⁸⁸ National Health and Hospitals Reform Commission, *A Healthier Future for All Australians: final report*, Canberra, 2009, pp. 56.

⁸⁹ National Health and Hospitals Reform Commission, *A Healthier Future for All Australians: final report*, p. 58.

funding, policy, governance or the safety and quality of these areas. Each area is managed independently. This shows how the States and Territories and the Commonwealth do not always collaborate effectively towards achieving a cohesive health system. This increases the risk of governments developing policies in relation to their own responsibilities without necessarily taking account of health care arrangements in a holistic way.⁹⁰

It also exacerbates the incentive for governments to cost-shift to the other level of government. One government can benefit financially through measures that impose a financial burden on another government.⁹¹ For example, if Commonwealth policy influences the take up of private health insurance coverage, this may affect the States and Territories through changing rates of admissions to public hospitals. Conversely, the States and Territories have been criticised in the past for shifting the cost of some public hospital out-patients to the MBS (which the Commonwealth funds directly), when these costs should arguably be met through public hospital funding.⁹² However, it should be noted that the States and Territories are essentially the providers of 'last resort care', in that people will be admitted to hospital when they are too sick for alternative care. This means that, where cost-shifting is a problem, the States and Territories eventually bear the cost of an inefficient system.

Coordination problems and cost shifting are features of many large service systems, regardless of whether they are the responsibility of a single level or multiple levels of government. Health professionals often work tirelessly to help their patients to navigate the system. Nevertheless, coordination problems can be exacerbated by the complex split of health roles and responsibilities between two levels of government. Deloitte Access Economics has found that:

the health system is fragmented with a complex division of funding responsibilities and performance accountabilities between different levels of government. The COAG reforms have not resulted in a solution to the structural challenge of clear roles and responsibilities in health... Clear boundaries have not been achieved, nor has the shared territory in the system been addressed meaningfully yet.⁹³

Shared roles do not always create inefficiencies. There are examples of governments cooperating successfully in number of areas, such as the National Registration and Accreditation Scheme. However, complex roles and responsibilities are making it harder for governments to respond to emerging pressures on our health care arrangements, such as the growing burden of chronic conditions. This makes it difficult to achieve a whole-of-sector approach to health policy and more integrated care, both of which are critical to reducing duplication, fostering better use of health resources and ultimately improving patient experience and people's health.

The fragmentation of our health care arrangements and information gaps can hinder policy analysis and decisions. Improving the use of patient data could benefit individuals, providers,

⁹⁰ National Health and Hospitals Reform Commission, *A Healthier Future for All Australians: final report*, p. 146.

⁹¹ J Dwyer and K Eagar, *Options for reform of Commonwealth and State governance responsibilities for the Australian health system*, commissioned paper for the National Health and Hospitals Reform Commission, Department of Health and Ageing, Canberra, 2008, p. 5.

⁹² Department of Health and Aged Care, *Health Financing in Australia: the objectives and players*, Occasional Papers: Health Financing Series Volume 1, Canberra, 1999, p. 37.

⁹³ Deloitte Access Economics Report to the COAG Reform Council, quoted in COAG Reform Council, *Lessons for Federal Reform: COAG reform agenda 2008-2013*, Sydney, 2013, p. 47.

and governments. It could lead to better coordination of health services for patients and reduce the overall cost of the system, relieving pressure on expenditure for all governments. The Commonwealth and the States and Territories have been working towards an e-health system for some time. Its implementation will provide benefits including better follow-up care and reduced hospital readmissions.

The following case study illustrates some of the challenges that people with a complex condition can face.

3.1.6 Case study

Clarinda

Clarinda is a 35 year old single mother living with two children. She has been managing her mental illness since her early 20s, although as is commonly the case, it took some years for her to be accurately diagnosed. Clarinda can look after her children most days, but her illness is episodic and can worsen at any time. Clarinda is entirely dependent on income support, although she hopes to return to work one day.

Clarinda sometimes thinks of harming herself, and four years ago she overdosed on painkillers after a domestic violence incident. Her neighbour called an ambulance and she was taken to a public hospital. She spent 12 hours in emergency awaiting a psychiatric assessment, but her situation was not deemed sufficiently serious to warrant admission to a psychiatric ward. She was discharged after 24 hours in a short stay bed in the emergency department. Nobody had notified her children that she was at the hospital, but luckily the neighbour saw them returning from school and looked after them. Clarinda didn't hear from the hospital again.

Clarinda told her current general practitioner (GP) about her mental health issues after bringing her sick child in for a check-up. After seeing the GP a few times she began to trust him and he is now her first point of contact when her symptoms worsen. The mental health nurse at the GP clinic put Clarinda in touch with a local council service to help her get to the shops. None of the services that Clarinda uses communicate with each other and there is no complete record of all the services that are providing assistance.

When she is particularly unwell, Clarinda sometimes forgets to pay her rent on time. Her landlord has just issued an eviction notice, and Clarinda is trying to figure out where to live. Clarinda also has some pain in her shoulder from an injury. She knows that something is wrong, and her GP has referred her to the orthopaedic clinic. She has now been waiting four months for an appointment and has been using strong painkillers to manage the pain.

Clarinda's situation demonstrates a lack of coordination—both within different parts of health care and also between health care and other systems accessed by people with mental illness. Those services are variously supported by the Commonwealth Government (through Medicare, Medicare Locals and programmes in different portfolios), State and Territory Governments (through public hospitals, local hospital networks and community grants in different portfolios), local governments, and subsidised non-profit organisations.

Clarinda is at a crossroads. If any of these services were to intervene now to help Clarinda avoid a mental health crisis—by dealing with the specific pressures she is now facing and linking her to the right help—then she may recover and hope to eventually find work. But if these systems are too fragmented to respond to Clarinda's complex situation, then she may well end up receiving expensive hospital care, and be much further away from recovery.

3.2 Current Arrangements

Under the current allocation of roles and responsibilities, one level of government (the Commonwealth) is responsible for most of primary care and another level of government (the States and Territories) is responsible for acute care (in public hospitals).

The non-government sector also plays a significant role in health care in Australia, primarily through delivering health services and providing funding (through patient co-contributions and private health insurance). While it is important to acknowledge this, the following pages focus on the roles and responsibilities of the different levels of government.

It is important to distinguish between responsibilities and roles. Governments can share responsibility for a policy area (health), but roles within that policy area (funder, policy developer, regulator and service deliverer) can be performed distinctly or on a shared basis.

3.2.1 Funding

Australia's health funding arrangements are complex. There are different levels of public and private expenditure across a range of different health services, including hospitals, medical and allied health services, and pharmaceuticals. The Commonwealth and the States and Territories provide the majority of funding for health care. In 2012-13, all governments provided \$100.8 billion for health care, or 68.3 per cent of total health expenditure.⁹⁴

The Commonwealth is the largest government funder of health services, providing 60.5 per cent of total government funding in health.⁹⁵ The Commonwealth has a distinct role in funding medical and pharmaceutical benefits through the MBS and the PBS. The Commonwealth also provides the Private Health Insurance Rebate to encourage people to take out and maintain private health insurance. People on high incomes without private health insurance pay a Medicare levy surcharge.

The States and Territories are the majority funders of emergency care, including ambulance and retrieval services, and follow-up community care services.

Local government plays a small but important role in funding health care, providing around \$388 million in 2012-13.⁹⁶

Public hospitals are the most significant area of shared funding between the Commonwealth and the States and Territories. Both governments also provide funding to private hospitals, although the role of the States and Territories is largely restricted to purchasing medical services for individuals who would otherwise be treated in public hospitals.

Primary and community care, Indigenous health, preventive health (including immunisation), public health activities, and mental health are all funded by both the Commonwealth and the

⁹⁴ Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, Health and welfare expenditure series no. 52, Cat. no. HWE 61, AIHW, Canberra, 2014, p. 35.

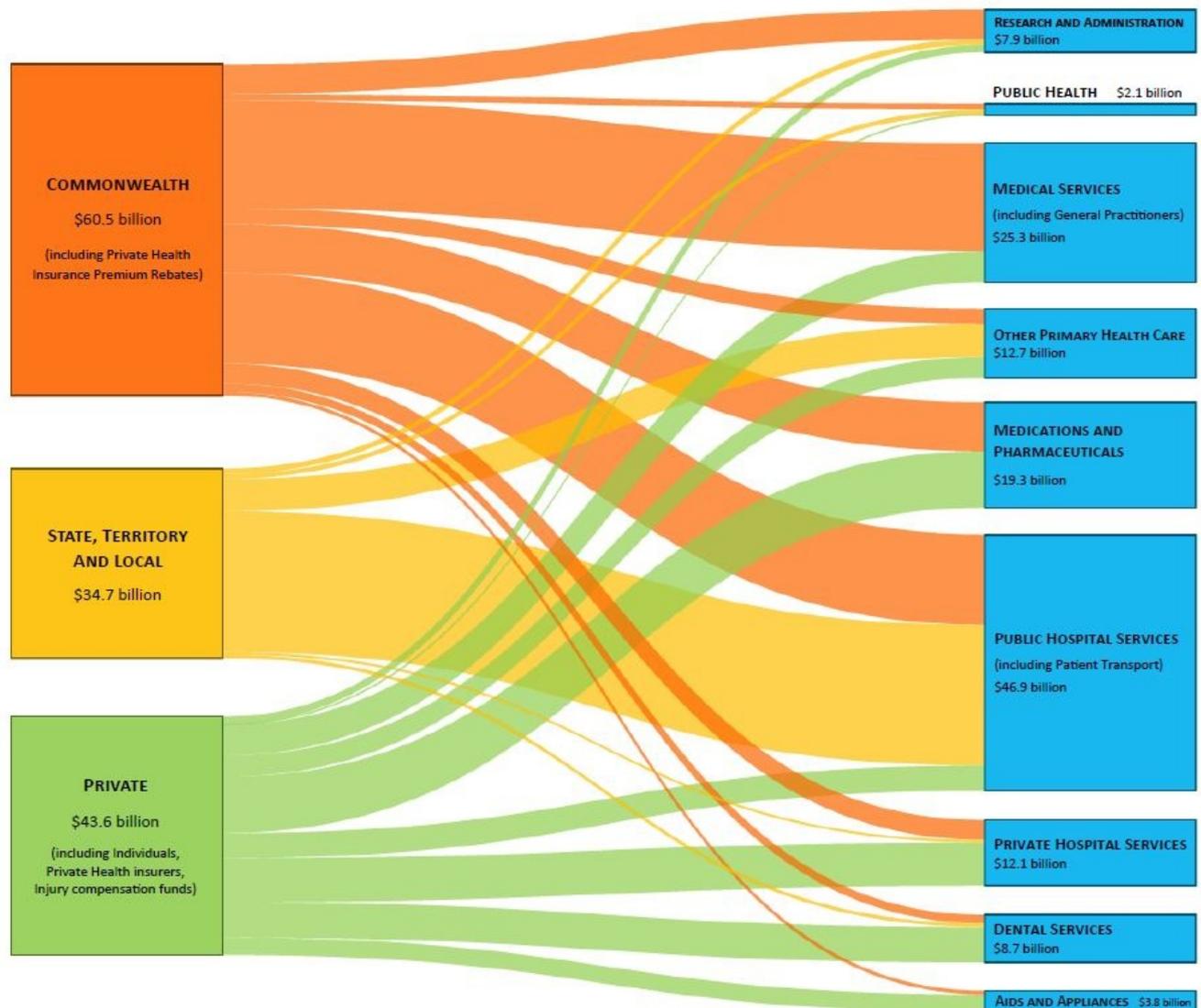
⁹⁵ Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, 2014, p. 43.

⁹⁶ Australian Bureau of Statistics, *Government Finance Statistics, Australia, 2012-13*, Cat. no. 5512.0, Australian Bureau of Statistics, Canberra, 2014.

States and Territories. The establishment of an electronic health record system is also being funded by both governments.

Figure 1 below demonstrates the funding flows in Australia’s health care arrangements.

Figure 1: Funding flows in Australia’s health care arrangements 2012-13⁹⁷



Source: Department of Health

More information on government roles in funding health care is at Appendix B.

As Figure 1 above demonstrates, the private sector contributes significantly to funding health care in Australia. This includes patient contributions, primarily through out-of-pocket costs and

⁹⁷ This diagram does not include capital expenditure of \$8.6 billion (\$5.1 billion from the States and Territories, \$3.4 billion from the non-government sector, and \$72 million from the Commonwealth) or tax transfers through the medical expenses tax rebate which would reduce private expenditure by \$422 million and increase Commonwealth expenditure by the same amount.

private health insurance premiums. Individuals accounted for 17.8 per cent of total health expenditure in 2012-13, a proportion which has remained relatively stable since 2002-03, when it was 16.7 per cent.⁹⁸

3.2.2 Policy

The majority of policy roles in health are shared between the Commonwealth and the States and Territories. Shared policy areas include primary care, Indigenous health, mental health, preventive health, and the health workforce.

While the Commonwealth has responsibility for a large part of primary care through the MBS, the States and Territories also play a role (for example, through community health centres). The States and Territories are the system managers of public hospitals, but the Commonwealth also has a policy role (for example, through compensating the States and Territories for providing free care in public hospitals, and administering national performance measures for elective surgery and emergency department waiting times).

While both the Commonwealth and the States and Territories share policy roles in many areas, they often undertake different and sometimes complementary activities. For example in mental health, the States and Territories fund and deliver specialised public mental health services, including admitted patient care in public hospitals and community based residential care. The Commonwealth funds mental health services through the MBS and medications through the PBS, as well as a number of community based mental health programmes.

The involvement of both the Commonwealth and the States and Territories in a policy area can also lead to overlap and duplication, which is evident in areas such as alcohol and drug services as well as some areas of mental health. For example, both the Commonwealth and the States and Territories fund mental health programmes and services in an ad hoc way.⁹⁹

Policy decisions taken by either level of government can also affect the other level of government. For example, Commonwealth policy in primary care can have an effect on demand for public hospital services, an area where the States and Territories are system managers.

3.2.3 Regulation

Most aspects of health are regulated by both the Commonwealth and the States and Territories. The Commonwealth and the States and Territories jointly regulate some areas, such as health professional eligibility (for some professions), food standards (along with local government), and the health workforce. The Commonwealth and the States and Territories also regulate different areas within certain parts of the health care arrangements, as occurs in primary care. This can limit the extent of overlap and duplication and reduce the regulatory burden.

⁹⁸ Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, 2014, pp. 49-50.

⁹⁹ Mental Health Australia, *Blueprint for Action on Mental Health*, Mental Health Australia, Canberra, 2014, p. 10, viewed November 2014 <<http://mhaustralia.org/submission/blueprint-action-mental-health>>.

The States and Territories regulate the ownership of pharmacies, as well as the operation of pharmacies at particular premises. The Commonwealth regulates pharmaceuticals and where pharmacies that dispense scripts under the PBS can be located.

Preventive health activities are jointly regulated by the Commonwealth and the States and Territories. Jointly, governments also regulate mental health, food standards, medical research, health products, blood products, tobacco products, industrial chemicals, and radiation. The States and Territories regulate public health programmes and are primarily responsible for regulating organ and tissue donation, but the Commonwealth also has a national coordination role through the Organ and Tissue Authority.¹⁰⁰

The Commonwealth is responsible for regulating private health insurance, as well as therapeutic goods and genetically modified organisms, but the States and Territories can set additional standards. Quality and safety in health care is overseen by the Commonwealth through the Australian Commission on Safety and Quality in Health Care, in addition to the States and Territories who have their own safety and quality measures.

The States and Territories regulate public and private hospitals, including private hospital ownership and the standard and quality of care. The regulation of hospitals differs across the States and Territories.

3.2.4 Service delivery

Most medical services are delivered by the non-government sector, including not-for-profit and community organisations. The States and Territories have a significant role in delivering health services, primarily through their role as system managers of public hospitals. Local government also plays an important role in delivering health services, including preventive health and immunisation. The Commonwealth has only small involvement in direct service delivery, however it plays an important role in indirect service delivery and providing supporting services to health care providers and the public.

3.2.5 Summary

As can be seen from Figures 2 and 3 below, the Commonwealth and the States and Territories share many roles in policy, funding, and regulation. Service delivery is largely undertaken by the States and Territories and the non-government sector.

While each of the health care arrangement areas in Figure 2 are separate, they are connected, if not well integrated. Prevention is connected to primary care, and primary care is connected to specialist care and hospital services and so on.

Health care is not a 'continuum' in the same way other policy areas are, such as education. In education, a student starts at pre-school and moves to primary school and then secondary school. A patient does not start at one part of health care and automatically end up in another. A patient's first interaction with health care may be with a general practitioner, or in an emergency

¹⁰⁰ The Organ and Tissue Authority will be merged with the National Blood Authority with the view to establishing a new independent authority by 1 July 2015.

department, or at a community health organisation. There is no single citizen experience of health care.

The term 'shared' in the figures demonstrates areas where both the Commonwealth and the States and Territories play a significant role. Governments may work collaboratively in some instances and in other areas may undertake activities in a separate and uncoordinated way. The colour in the figures refers to the level of involvement of both governments, with red indicating a high level of overlap.

The figures on the following pages do not include aged care and disability, or cover mental health services delivered outside the health portfolio. Aged care and disability are closely connected with health care arrangements and emerging issues in these areas may affect the health sector. The Commonwealth has primary responsibility for aged care, while responsibility for disability is shared between the Commonwealth and the States and Territories.

People with disability depend on the health care arrangements to a great extent. The interaction between the disability system and health is a complex area, especially with the impending implementation of the National Disability Insurance Scheme. Clarifying roles and responsibilities in health will need to have regard for the way patients transition between these two systems.

Further information on the interactions between health care arrangements and mental health services are at Appendix C.

The Commonwealth also provides significant funding for private health services, including rebates for private health insurance and Medicare rebates for visits to general practitioners. There is also significant private expenditure on health through co-payments for medical and pharmaceutical services, private health insurance premiums, and co-payments for private hospital and many non-medical health professional services.

Figure 2: Map of government roles and responsibilities in health

| Australia's Health Care Arrangements | | Funding | Policy | Regulation | Service delivery |
|--------------------------------------|---|---|--|---|------------------------|
| Medical & pharmaceutical benefits | Prevention: Preventive health measures, including health promotion, food safety, immunisation, cancer screening | Shared* | Shared | Shared | Shared* |
| | Primary care: The initial services received by patients, including from general practitioners, dentists & allied health professionals | Commonwealth lead, State & Territory role* | Shared | Shared | States & Territories* |
| | Specialist care outside hospitals: Care delivered by specialists outside of hospital settings, including managing long term chronic illness | Commonwealth* | Commonwealth | Commonwealth lead, State & Territory role | States & Territories* |
| | Emergency care: Care provided in an emergency including ambulance services, retrieval services, and emergency departments in hospitals | States & Territories lead, Commonwealth role* | States & Territories | States & Territories | States & Territories* |
| | Hospital services: Care provided by hospitals, including admitted patients, non-admitted patients, rehabilitation, and nursing-home type care | Shared* | States & Territories lead, Commonwealth role | States & Territories | States & Territories** |
| | Community care: Care to avoid hospital (re)admissions and other complex post-hospital care, including rehabilitation and palliative care | States & Territories lead, Commonwealth role* | Shared | Shared | States & Territories* |

*non-government sector also plays a role

** elective surgery is also delivered in private hospitals

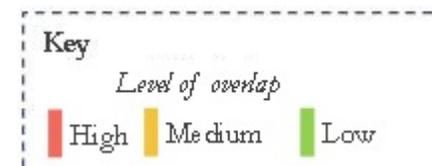
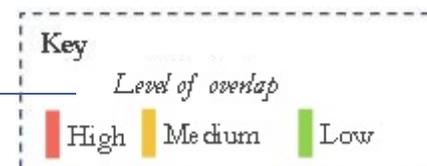


Figure 3: Map of cross cutting areas of health care responsibility

| Cross-cutting areas of health care responsibility | Funding | Policy | Regulation | Service delivery |
|--|---|---|---|------------------------|
| Health workforce The funding, training, and regulation of health professionals | Shared | Shared | Shared | States & Territories* |
| Therapeutic goods Regulation of therapeutic goods, standard setting and enforcement | Commonwealth | Commonwealth lead, State & Territory role | Commonwealth lead, State & Territory role | N/A* |
| Indigenous health Aboriginal community health organisations | Shared* | Shared | Shared | States & Territories** |
| Mental Health Specialised care in public hospitals, private psychiatric hospitals, community services | Shared* | Shared | Shared | States & Territories* |
| Private health insurance Regulation of private health insurance industry and provision of subsidies | Commonwealth* | Commonwealth | Commonwealth | N/A* |
| e-Health Personally Controlled Electronic Health Record, standards, terminology, telehealth | Commonwealth lead, State & Territory role | Shared | Shared | Shared |
| Health research & information AIHW, NHMRC, other Commonwealth and State & Territory information bodies | Shared | Shared | Shared | Shared |

*non-government sector also plays a role

**Aboriginal Community Controlled Health Organisations also play a significant role



4. QUESTIONS FOR CONSIDERATION

4.1 Overview

The OECD has argued that improved consistency in the allocation of health sector responsibilities across levels of government in Australia could lead to less duplication and better accountability.¹⁰¹

The principles from the White Paper's Terms of Reference provide a lens for considering the appropriateness of the current allocation of health roles and responsibilities. While clarifying roles and responsibilities will not by itself address all of the pressures facing health care, it will provide a stronger, more reliable platform for governments to act on those issues.

Threshold questions

- What is the appropriate role of government, as well as non-government and private providers, in health care?
- What should we change in the allocation of roles and responsibilities between the Commonwealth and the States and Territories to improve the health of Australians? Why?
- Should any roles be shared? If so, which ones, and how can they be clarified and coordinated to minimise overlap, duplication and blame-shifting and improve service delivery?
- What aspects of our health care arrangements involving the Commonwealth and the States and Territories are working well and should be maintained or extended?

4.2 Accountability

Accountability is the overarching principle for the White Paper. Good public accountability mechanisms allow the public to hold the appropriate level of government to account for the quality and efficiency of services delivered and outcomes achieved. To achieve this, it must be clear which level of government is responsible for what aspects of health care. The current arrangements make it difficult for the public to know who to hold accountable for policy successes and failures.

As the National Health and Hospitals Reform Commission found in 2009, “lack of clarity of accountability and definition of responsibilities creates the environment for a blame game, as each government is able to blame the other for shortcomings attributed to each other’s programs”.¹⁰² The National Commission of Audit found the complex funding arrangements between the Commonwealth and the States and Territories for public hospitals result in “a lack of clarity when it comes to political responsibility and accountability”.¹⁰³

¹⁰¹ OCED, *Health care systems: Getting more value for money*, OECD Economics Department Policy Notes, No. 2. OECD, Paris, 2010, p. 8.

¹⁰² National Health and Hospitals Reform Commission, *A Healthier Future for All Australians: final report*, p. 58.

¹⁰³ National Commission of Audit, *Towards Responsible Government*, the Report of the National Commission of Audit, Phase One, Canberra, 2014, p. 20.

Recent national reforms have improved national reporting and the flow of information between governments and to the public. The health sector generates a significant amount of data in some areas of health care, like public hospitals. Compared with other sectors, health data is generally extensive and reliable, assisting policy makers and the public to know whether services are effective. National minimum data sets have been agreed between jurisdictions and recently there has been a focus on measuring performance at the local level. Although health data is generally extensive and reliable, the complexity of health care can make it difficult to identify with certainty whether a particular policy or programme had a measurable impact on overall health outcomes for the population.

Questions

- How could roles and responsibilities be reallocated or redefined to ensure the public is better able to hold a specific level of government accountable for the performance of particular health care arrangements and health outcomes?
- If shared roles continue, how could accountability be ensured without imposing unnecessary reporting burdens and overly prescriptive controls?

4.3 Subsidiarity

The principle of subsidiarity means responsibility should lie with the lowest level of government possible, allowing local and flexible approaches to improving outcomes. The overlap in roles and responsibilities adds to the complexity of health care arrangements and can make it hard for governments, particularly the States and Territories, to respond to emerging pressures in flexible and innovative ways.

While the States and Territories have an unambiguous role as system managers of their public hospitals, some have argued that Commonwealth involvement through tied hospital funding has constrained flexibility and innovation (see Appendix D for a list of health funding agreements between the Commonwealth and the States and Territories as at June 2014). For example, the National Partnership Agreement on Improving Public Hospital Services (due to end in 2014-15) tied funding to the achievement of emergency department and elective surgery targets. This agreement, along with broad public concerns regarding hospital waiting times, caused the States and Territories to focus on achieving the targets. It is understandable that the States and Territories focus on public hospitals as it is the main element of health care they are responsible for as system managers. However, the targeting of reward funding in this way has skewed performance monitoring to particular areas of hospital care. This includes hospital waiting times, which are important to the public, but are actually symptoms of a more important structural problem in health care which can only be addressed by a more holistic focus. If public hospitals focus on reducing waiting times to meet national targets, those resources cannot be deployed in other areas of the sector where they may have had a greater effect on the overall health of the population, such as in early intervention and prevention.

Subsidiarity can also mean that the Commonwealth may be the lowest level of government that can be responsible for issues. For example, to ensure efficiency the Commonwealth uses its

monopsony buying power to purchase medicines listed on the PBS, resulting in lower prices than if there were multiple State and Territory purchasers.

Questions

- How could Commonwealth involvement in health occur in a way that doesn't limit the ability of the States and Territories to respond flexibly to issues?
- How could the Commonwealth remain involved in funding aspects of the health sector that are the responsibility of the States and Territories in a way that ensures accountability while still providing flexibility?
- Would a model of subsidiarity with local/regional bodies organising and delivering health services work in Australia?

4.4 The national interest

While some responsibilities, such as hospital management, are better managed locally, others can benefit from being managed nationally, such as the purchasing of pharmaceuticals. Benefits include economies of scale (including for purchasing and payment systems, like the PBS) and avoiding economic inefficiencies (such as variation of regulation across the States and Territories, like professional registration). Nationally consistent approaches are often warranted, including for managing the spread of disease (through quarantine and immunisation programmes) and ensuring the safety of blood products.

National interest does not mean Commonwealth interest. For example, the States and Territories could agree to health professional standards without Commonwealth involvement. The Commonwealth and the States and Territories worked together to establish a national health practitioner registration scheme in 2010. This has resulted in most health professionals no longer requiring registration in multiple jurisdictions. The States and Territories passed the relevant legislation and are responsible for administering the scheme.

While often seen as conflicting, the national interest and subsidiarity are actually manifestations of the same principle. Issues ought to be handled by the lowest level of government capable of addressing them effectively and delivering the optimal balance between equity and efficiency. In some circumstances, this may be the Commonwealth, as is the case for the PBS and international quarantine.

Even when 'clean lines' of responsibility can be achieved, the responsible government needs to be mindful of how decisions it makes in its areas of responsibility affect other levels of government in their areas of responsibility. In some cases, governments may have a shared interest in a particular area, especially if there are spill over effects from one level of government to another. An example of this is aged care, for which the Commonwealth has primary responsibility. The spill over effects of aged care into other areas, such as public hospitals, means the States and Territories also have an interest. Most health-related goods and services, apart from public hospitals, are delivered by private providers. There are arguments for national legislation to support safety, quality, and efficient national markets. Australia also has binding international obligations in some areas of health (communicable disease, tobacco control).

Questions

- What is the best way to ensure the national interest is advanced in health?
- How can the national interest be better defined so it is clearer on what basis, if any, the Commonwealth should become involved?
- What, if any, elements of the health care arrangements should the Commonwealth retain responsibility for in the national interest?

4.5 Efficiency, effectiveness and equity in service delivery

4.5.1 Efficiency and effectiveness

It is important to assess the efficiency and effectiveness of roles and responsibilities in the health sector. *Technical* efficiency, achieving more ‘outputs’ with less ‘inputs’, is important in health. Major gains can also be made through *allocative* efficiency, which is concerned with ensuring resources are invested where they are most needed.

As previously mentioned, our health care arrangements are fragmented and coordination between the different parts of the sector is often poor. Governments can fail to consider the spill over effects of their policies onto other governments, reducing the allocative efficiency of the health sector. While collaboration and partnership between the levels of governments can have positive effects, shared roles (such as funding and policy setting) risk duplication and reduced allocative efficiency.

In mental health alone the Commonwealth funds more than 500 non-government organisations through around 60 programmes. The States and Territories also fund numerous providers, adding to the overall number of mental health providers across the country. The existence of multiple providers, including providers only receiving small amounts of funding, can benefit the sector. It can enhance competition and allow small providers to respond flexibly to local issues. However, multiple providers adds complexity to an already complex system. Resources are tied up in the particular mental health programme or service provider being funded and cannot be redeployed to the parts of the health sector where they are more needed.

Both levels of government share roles as funders, purchasers, providers (along with the private sector), and regulators for different parts of the health sector (see figures in section 3.2). These overlapping roles can reduce the efficiency and effectiveness of service delivery and allow governments to shift costs to another government (rather than reducing costs).¹⁰⁴

For example, patients who cannot access Commonwealth funded residential or transitional care may occupy beds in public hospitals administered by the States and Territories.¹⁰⁵ Public hospital beds are more expensive than residential care beds, increasing costs for the States and Territories and of health care overall. In another example, public hospitals may refer patients

¹⁰⁴ National Commission of Audit, *Towards Responsible Government*, the Report of the National Commission of Audit, Phase One, 2014, p. 20.

¹⁰⁵ Dwyer and Eagar, p. 5.

being discharged to their Commonwealth subsidised general practitioner instead of providing post-hospital services directly.

As noted earlier, the clinical handover between types of care is often complex, particularly between primary and acute care. This can make it harder to coordinate treatment and can lead to a reduction in the efficiency and effectiveness of services. Chronic Disease Management plans (formerly Enhanced Primary Care plans) are an attempt to overcome these problems. They enable general practitioners to coordinate care for patients with chronic or terminal medical conditions, including those who require multidisciplinary, team-based care.

The complex arrangements are not just a problem for patients. Providers must often deal with multiple regulators, funders, and purchasers for different parts of their business. Requirements are sometimes duplicative or inconsistent. Experienced managers and clinicians can find it hard to access funding for which they are eligible.¹⁰⁶ Some health providers operating across State and Territory borders have to comply with eight separate regulatory schemes, including different requirements for the specifications of medicine cabinets and fridges.

Health care arrangements are largely structured around providers, not patients. Different government funders for different programmes exacerbate this. There are no incentives for the most appropriate and cost-effective care.¹⁰⁷ Instead, there are perverse incentives for one level of government to create measures where it benefits financially and the other level of government incurs additional costs.¹⁰⁸ The result is health care arrangements that are ill-equipped to respond to the challenges outlined in the previous section.

Questions

- How could shared responsibility for health be better managed to reduce duplication and overlap?
- What is the best way to ensure there is improved coordination of different parts of our health care arrangements (mental health, primary care, acute care and so on)?
- What are the appropriate incentives for governments to reduce or eliminate cost-shifting? What are the current barriers to creating such incentives?
- What is the best way to ensure policy decisions in one area consider the health system as a whole?
- How could the technical efficiency of the health sector be improved? How could the allocative efficiency of the health sector be improved?
- How could changes to roles and responsibilities for health improve outcomes for Indigenous Australians? What sort of changes would be required?
- Is there a case for treating the allocation of roles and responsibilities for Indigenous-specific health services differently from mainstream health services?

¹⁰⁶ Dwyer and Eagar, p. 5.

¹⁰⁷ A Podger, *The Case for Increased Commonwealth Involvement in Health*, Proceedings of the twenty-second conference of the Samuel Griffith Society, Perth, 2010, p. 5.

¹⁰⁸ Dwyer and Eagar, p. 5.

4.5.2 Equity

It is well established that Australians living in rural and remote areas, Indigenous Australians, and Australians from low socioeconomic groups are more likely to have poor health than those living in urban areas. Australians in rural and remote areas have less access to health services, travel greater distances for medical attention, and generally have higher rates of ill health and mortality than Australians in larger cities. They also have higher rates of potentially preventable hospitalisations and are more likely to defer access to dental services and general practitioners due to cost. The supply of some medical practitioners decreases with remoteness, along with dentists, psychologists, pharmacists, and other allied health professionals. While the supply of general practitioners increases with remoteness, this does not necessarily mean there are enough general practitioners in rural areas.¹⁰⁹

Commonwealth involvement in a policy area is sometimes argued on equity grounds. While the Commonwealth may be best placed to address equity concerns in some circumstances, the States and Territories also work to improve and ensure equity for their communities. The States and Territories are closer to where services are being delivered and are often best placed to know how equity concerns can be addressed. Ensuring equity for the small percentage of people with complex chronic conditions is also important. These patients have complex care needs and use many different health services. When different levels of government are involved, there can be a lack of coordination and patient care can suffer.

A focus on programmes and the way they are funded, rather than on what the patient needs, allocates resources inequitably as well as inefficiently.¹¹⁰ In mental health, there are overlapping funding and service delivery responsibilities and a lack of coordination and integration. At the same time a person's mental health condition worsens, care arrangements become harder for them to navigate. This can make it harder to provide effective treatment to those most in need.

Ensuring more efficiency and effectiveness in the allocation of roles and responsibilities in health should enhance equity to the extent that unnecessary costs can be avoided and resources can be freed up to target those most in need, particularly those in rural and regional areas.

Questions

- Could changes to roles and responsibilities improve equity of access to health services?
- How can shared government roles be better coordinated to improve equity of access to services, particularly in the regions?

4.6 Durability

Health care arrangements have been subject to significant change over a number of years. This has led to uncertainty for service providers and the general public and undermines planning, the efficiency of the health sector, and international competitiveness. Previous solutions have rarely

¹⁰⁹ Australian Institute of Health and Welfare, *Australia's health 2014*, 2014, p. 367.

¹¹⁰ Podger, p. 6.

been enduring.¹¹¹ A recalibration of roles and responsibilities in health should be sufficiently robust and compelling to attract and sustain a high level of bipartisan political support.

There have been large changes in the health system since 2007, including in hospitals funding, the health workforce, and mental health. In recent years, the Commonwealth and the State and Territories have signed time-limited national partnership agreements to address specific service delivery issues like treating more public dental patients. There may be a level of reform fatigue within the health sector and across levels of government. But the public expectations of reduced surgery waiting times, improved services, and accessibility to health care endure.

Significant changes may have weakened the durability of Australia's health care arrangements. It is difficult for service providers to plan in a constantly changing environment. Providers and the public are unsure of what the future health landscape will be. This uncertainty can create a disincentive for non-government sources to invest in health. Reforms to improve efficiency of systems require a degree of certainty over the longer term. When this certainty does not exist, it is hard for governments to make major changes to their own arrangements to improve efficiency over the long term. Future changes to health care arrangements need to be made for the long term.

Question

- What configuration of roles and responsibilities between the Commonwealth and the States and Territories would be most likely to be sustainable in the long term and why?
- What sort of arrangements between governments is likely to lead to the new configuration being long lasting?
- What would be required to provide greater incentives for the non-government sector to invest more in health?

4.7 Fiscal sustainability

Health expenditure growth is rising for all governments and is projected to be the main source of pressure on all governments' budgets over the next 50 years.

At a time when governments are facing overall fiscal constraints, health care costs are rising, along with the Australian public's expectations around the provision of high quality universal health care. These factors are combining to challenge the fiscal sustainability of health care arrangements. There are expectations from the community that governments will ensure everyone has access to affordable health care.¹¹² Due to the mismatch between revenues and responsibilities in our federal system (the vertical fiscal imbalance), the States and Territories rely on Commonwealth funding to provide public hospital services.

In the past, governments have taken different approaches to addressing rising health expenditure. For example, the Commonwealth has encouraged the use of private health

¹¹¹ Anderson, p. 267.

¹¹² Anderson, p. 250.

insurance to take pressure off public health care and has at times reduced the amount of medical benefits payable for some procedures. The States and Territories (with Commonwealth support) were at the forefront of developing new public hospital funding systems like activity based funding and in some cases have enabled localised decision making for funding.

Questions

- If one level of government assumed full responsibility for government funding of the health sector, would this improve fiscal sustainability? If so, what could this look like?
- If shared funding roles continue, how can this be best managed to ensure the fiscal sustainability of the health care arrangements for all levels of government?
- How can governments manage community expectations on the level (and cost) of health care provided?

APPENDIX A: KEY FACTS—HEALTH CARE IN AUSTRALIA

- In 2014-15, Medicare is expected to fund 373 million medical and associated services, an average of 15.6 services per Australian.¹¹³ This is not evenly spread across the population — it is estimated that 10 per cent of patients account for around 45 per cent of MBS expenditure and 60 per cent of PBS expenditure.
- There were 9.4 million hospitalisations in 2012-13, with three in five people admitted to public hospitals.¹¹⁴
- In 2013, there were around 750 public hospitals and almost 600 private hospitals.¹¹⁵ There were around 87,300 hospital beds in Australia in 2012-13, about 3.9 beds per 1,000 people. Around 65 per cent of beds were in public hospitals.¹¹⁶
- Public hospitals employed 275,000 full time equivalent staff in 2012-13, 45 per cent of which were nurses, with 13 per cent salaried medical officers and 14 per cent diagnostic and allied health professionals. Private hospitals employed around 53,800 full time equivalent staff in 2012-13, 56 per cent of which were nurses, 2 per cent salaried medical officers, and 5 per cent diagnostic and allied health professionals.¹¹⁷
- In 2012-13 there were around 6.7 million reported presentations to public hospital emergency departments, around 18,000 each day.¹¹⁸
- In 2012, there were 290,000 nurses and 79,000 medical practitioners employed in Australia. These were the two largest groups of professions in the health workforce.¹¹⁹ Indigenous Australians in the 35-44 age group died at five times the rate of non-Indigenous Australians between 2007 and 2011. Indigenous Australians were most likely to die from circulatory conditions, cancer, and external causes like suicides, falls, and assaults.¹²⁰
- Medicare Benefits claiming rates for general practitioner visits were 17 per cent higher for Indigenous Australians than non-Indigenous Australians in 2010-11, but claim rates for specialist services were 39 per cent lower.¹²¹
- As at December 2013, around 47 per cent of Australians had private hospital insurance.¹²²

¹¹³ Department of Health, *Portfolio Budget Statements 2014-15*, p. 79.

¹¹⁴ Australian Institute of Health and Welfare, *Australia's hospitals 2012-13 at a glance*, Health services series no. 55 Cat. no. HSE 146, AIHW, Canberra, 2014, p.12.

¹¹⁵ Australian Institute of Health and Welfare, *Australia's hospitals 2012-13 at a glance*, p.1.

¹¹⁶ Australian Institute of Health and Welfare, *Australia's hospitals 2012-13 at a glance*, p.2.

¹¹⁷ Australian Institute of Health and Welfare, *Australia's hospitals 2012-13 at a glance*, p.4.

¹¹⁸ Australian Institute of Health and Welfare, *Australia's hospitals 2012-13 at a glance*, p.7.

¹¹⁹ Australian Institute of Health and Welfare, *Australia's health 2014*, p. 60.

¹²⁰ Australian Institute of Health and Welfare, *Australia's health 2014*, p. 302.

¹²¹ Australian Institute of Health and Welfare, *Australia's health 2014*, p. 314.

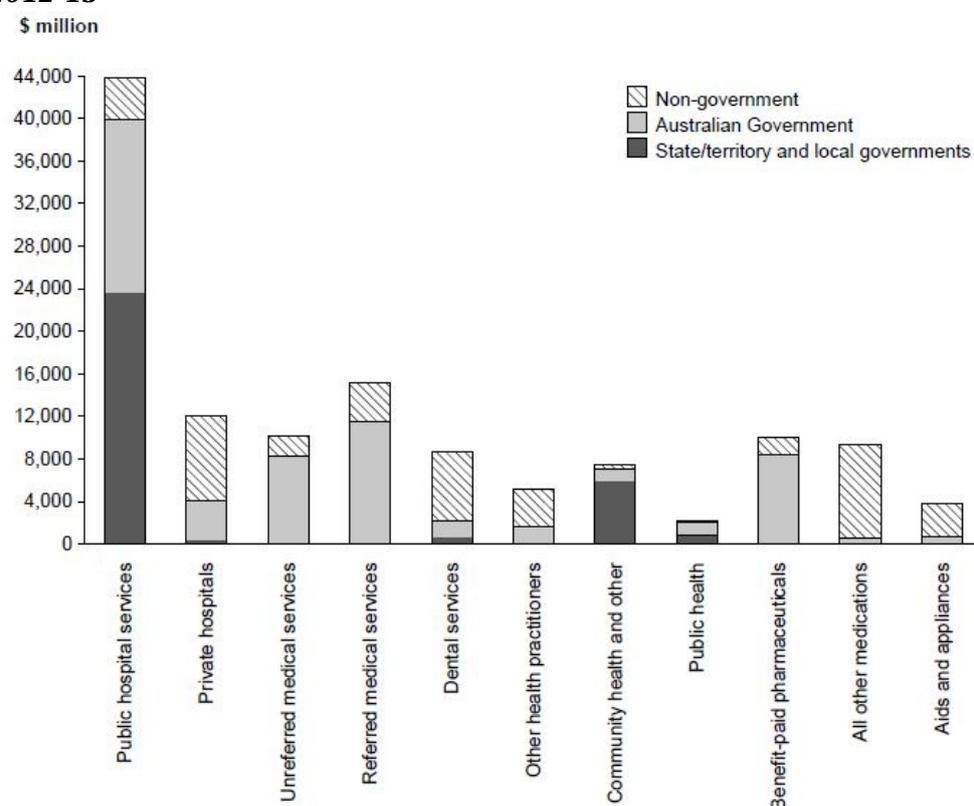
APPENDIX B: HEALTH FUNDING ARRANGEMENTS

Australia's health funding arrangements are complex. Expenditure comes from both the public and private sectors across multiple professions and institutions.¹²³

Together, governments funded around 68.3 per cent of total health expenditure in 2012-13. The Commonwealth's contribution to overall health expenditure was 41.4 per cent in 2012-13, down from 43.6 per cent in 2002-03. The contribution from the States and Territories to overall health expenditure grew from 24.3 per cent to 26.9 per cent over the same period.¹²⁴

Figure 4 demonstrates who funds what health care arrangements.

Figure 4: Recurrent health expenditure by area of expenditure and source of funds 2012-13¹²⁵



Source: Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, 2014, p. 38

¹²² Private Health Insurance Administration Council, *Privately Insured People with Hospital Treatment Cover Annual Analysis, Sex, Age and State*, Private Health Insurance Administration Council, Canberra, 2013, p. 5.

¹²³ Duckett, 2007, p. 37.

¹²⁴ Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, p. 35.

¹²⁵ The AIHW *Health expenditure Australia 2012-13* report excludes certain services undertaken in hospitals in the 'public hospital services' category. Chapter 5 of the report provides more information.

The Commonwealth is the largest government funder of the health system, providing 60.5 per cent of total government funding in health. The most significant area of Commonwealth expenditure is in funding Commonwealth programmes and activities, including medical and pharmaceutical benefits.¹²⁶

The Commonwealth encourages the take up of private health insurance through rebates offered to individuals, as well as the Medicare levy surcharge and the Lifetime Health Cover initiative. The Commonwealth provided an estimated \$5.5 billion for the private health insurance rebate in 2013-14.¹²⁷

Significant aspects of the health sector are funded by both the Commonwealth and the States and Territories, including preventive health activities, primary care, community care, emergency care, and hospital services.

Public hospitals are the most significant area of overlapping funding roles between the Commonwealth and the States and Territories. In 2012-13, the State and Territories provided 53.9 per cent of hospital funding, while the Commonwealth's share was 37 per cent (including funding from the Department of Veterans' Affairs).¹²⁸

The Commonwealth and States and Territories both provide funding to private hospitals. The Commonwealth provided around \$3.6 billion for private hospital care and services in 2012-13, largely in the form of private health insurance rebates.¹²⁹ The States and Territories provided around \$450 million to private hospitals in 2012-13,¹³⁰ mainly for purchasing medical services for individuals who would otherwise be treated in public hospitals.

In recent years, the States and Territories have been able to bid for Commonwealth funding for priority health infrastructure through the Health and Hospitals Fund.

The funding of preventive health activities is shared between the Commonwealth and the States and Territories. The States and Territories provide significant funding for community and public health, including through immunisation programmes, food safety initiatives, and disease prevention campaigns. The Commonwealth also funds some community and public health activities, including cancer screening services, the National Immunisation Programme, and communication campaigns regarding the use of potentially harmful substances such as alcohol, tobacco and illicit drugs.

Primary and community care is funded by both levels of government. The Commonwealth subsidises the provision of care by general practitioners and some allied health professionals through the MBS. Commonwealth-funded Medicare Locals help coordinate primary care services. The States and Territories provide primary and community care directly through local health services and also fund a number of non-government services. Public hospital emergency

¹²⁶ Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, p. 43.

¹²⁷ Department of Health, *Portfolio Budget Statements 2014-15*, Budget related paper no.1.10, Health portfolio, Department of Health, Canberra, 2014, p. 120.

¹²⁸ Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, pp. 38-39.

¹²⁹ Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, p. 78.

¹³⁰ Australian Institute of Health and Welfare, *Health expenditure Australia 2012-13*, p. 78.

departments also provide some general practitioner-type services. Dentists and community health centres receive funding from both levels of government. Specialist care in the community is funded mostly by the Commonwealth through the MBS and the PBS.

Indigenous health programmes are also funded by both levels of government. The Commonwealth and the States and Territories together funded 91.4 per cent of health expenditure for Indigenous Australians in 2010-11. The Commonwealth funded 44.8 per cent of expenditure and the States and Territories 46.6 per cent. In 2010-11, publicly provided services, including public hospitals and community health services, were the highest health expenditure areas for Indigenous Australians.¹³¹

Both the Commonwealth and the States and Territories provide funding for mental health. The Commonwealth funds around 60 mental health programmes and also funds mental health services through the MBS and the PBS. Both the Commonwealth and the States and Territories provide funding to community-managed organisations to deliver mental health services. The Commonwealth also provides funding to the States and Territories for mental health, including indirectly through public hospital funding. The States and Territories also fund mental health specific programmes and provide mental health services in public hospitals.

The Commonwealth and the States and Territories also both provide funding for health research and information.

The States and Territories are the lead funders in community and emergency care, including community mental health services, although the Commonwealth provides some funding through the MBS and the PBS.

The Commonwealth is the lead funder for establishing an electronic health record system, although the States and Territories are also providing funding.

¹³¹ Australian Institute of Health and Welfare, *Expenditure on health for Aboriginal and Torres Strait Islander people 2010-11*, 2013, p. vii.

APPENDIX C: GOVERNMENT ROLES IN MENTAL HEALTH

Almost half the Australian population will experience the symptoms of mental illness at some point in their lifetime. There is large variation in what help they will need, from light-touch interventions like online self-help to intensive support for ongoing psychosocial disability over a lifetime. The cost of services varies greatly from one person to another and is very difficult to predict. Unlike physical conditions the cost drivers for mental illness are not associated with new technology or population ageing.

The exception to this is people with co-morbid physical conditions. People with mental illness are more likely to experience other health conditions and comorbidities, like heart or circulatory conditions and diabetes, and are more likely to die from chronic conditions such as cancer.

Mental health is distinctive from other health conditions as the impacts of mental illness are difficult to predict by clinical diagnosis. The range of services people might need varies enormously, going well beyond health to address issues like housing, employment and social participation. Promising clinical interventions can fail if someone's psychosocial support needs are not met. Similarly, services delivered outside health care can be ineffective without the right clinical treatment.

Because of its complexity, mental health is a compelling example of the challenges associated with assigning roles and responsibilities in Australia's broader health care arrangements. There is in fact no such thing as a mental health 'system'; instead, this 'system' is shorthand for the many systems and services consumers and carers may encounter. For the most part, these services and systems are poorly integrated, overseen by different parts of government, based on widely differing organising principles, and not working towards a common goal.

The Commonwealth and the States and Territories both have roles in policy, funding, and regulation in mental health. These roles have evolved in piecemeal fashion and have usually not been defined with respect to an overarching vision shared across governments and portfolios. It is therefore no surprise that consumers find the system enormously difficult to navigate.

Not-for-profit organisations and carers also make a substantial contribution to the mental health system, and even share the financial burden of service delivery – for example through unpaid informal care or charity-funded community-based services. Non-government organisations are often able to innovate to provide integrated approaches where government agencies tend to struggle – essentially helping to solve problems that governments cannot.

The Commonwealth and the States and Territories both bear the risk of avoidable costs arising from poor coordination of mental health services. Cross-portfolio interactions are particularly complex when applied to mental health. Downstream costs from State/Territory system failures are borne in other areas such as disability, income support and employment services – at the Commonwealth's expense. But when problems arise through Commonwealth-run systems, people with mental illness are more likely to require expensive treatment in a public hospital, interact with the justice system, or become homeless – at the cost of the States and Territories.

No level of government 'owns' mental health, which in turn has made it difficult to ensure accountability for mental health outcomes. The task of defining roles and responsibilities is therefore particularly important in mental health. Better governance conditions would improve service coordination within and across systems, address service gaps, reduce inefficiencies, and ultimately improve outcomes.

APPENDIX D: NATIONAL AGREEMENTS ON HEALTH

Below is a list of a number of National Agreements and National Partnership Agreements between the Commonwealth and the States and Territories on health as at June 2014:

| Agreement | Parties |
|---|--|
| <i>National Agreements</i> | |
| National Healthcare Agreement | All jurisdictions |
| National Health Reform Agreement | All jurisdictions |
| <i>National Partnership Agreements</i> | |
| Improving Public Hospital Services | All jurisdictions |
| Treating More Public Dental Patients | All jurisdictions |
| Improving Health Services in Tasmania | Commonwealth and Tasmania |
| Supporting National Mental Health Reform | All jurisdictions |
| Essential Vaccines | All jurisdictions |
| Expansion of BreastScreen Australia Programme | All jurisdictions |
| Management of Torres Strait/Papua New Guinea Cross Border Health Issues | Commonwealth and Queensland |
| National Perinatal Depression Initiative | All jurisdictions |
| Torres Strait Islander Health Projection Strategy – Mosquito control | Commonwealth and Queensland |
| Vaccine Preventable Disease Surveillance | All jurisdictions |
| Victorian Cytology Service | Commonwealth and Victoria |
| Improving Trachoma Control Services for Indigenous Australians | Commonwealth, Western Australia, South Australia, and Northern Territory |
| Rheumatic Fever Strategy – South Australia | Commonwealth and South Australia |
| Stronger Futures in the Northern Territory Health Implementation Plan – Oral Health element | Commonwealth and Northern Territory |
| National Critical Care and Trauma Response Centre | Commonwealth and Northern Territory |

| <i>Schedules to the National Partnership on Specified Projects</i> | |
|--|--|
| OzFoodNet | All jurisdictions |
| National Bowel Cancer Screening Program – Participant Follow-up function | Commonwealth, Victoria, Queensland, Western Australia, South Australia, Tasmania, Australian Capital Territory, and Northern Territory |
| Rheumatic Fever Strategy | Commonwealth, Queensland, Western Australia, and Northern Territory |
| National Coronial Information System | Commonwealth and Victoria |
| Torres Strait Islander Health Protection Strategy – Saibai Island Health Clinic | Commonwealth and Queensland |
| Delivery of Renal Services to Aboriginal and Torres Strait Islander People in the Central Region of the NT | Commonwealth and Northern Territory |

Below is a list of a number of agreements between the Commonwealth and the States and Territories under the Health and Hospitals Fund as at June 2014:

| Agreement | Estimated completion date |
|---|----------------------------------|
| <i>New South Wales</i> | |
| HHF 2010 Regional Priority Round in Bega, Port Macquarie and Tamworth | February 2016 |
| HHF 2010 Regional Priority Round in Dubbo and Wagga Wagga | September 2016 |
| HHF 2011 Regional Priority Round in Lismore and Kempsey | October 2016 |
| HHF 2011 Regional Priority Round in Hillston and Peak Hill | January 2015 |
| HHF 2011 Regional Priority Round in Yamba | July 2014 |
| Implementation Plan for Digital Technology for BreastScreen New South Wales | June 2014 |
| Implementation Plan for New England and North West Regional Cancer Centre | June 2014 |
| Implementation Plan for Shoalhaven Regional Cancer Centre | June 2014 |
| Implementation Plan for Illawarra Regional Cancer Centre | June 2014 |

| Agreement | Estimated completion date |
|--|---------------------------|
| <i>Victoria</i> | |
| Victorian Comprehensive Cancer Centre | February 2016 |
| Barwon Health – Integrated Regional Cancer Service | March 2016 |
| Statewide enhancements to Victorian regional cancer centres | June 2015 |
| Redevelopment of Kerang District Health | March 2016 |
| Ballarat Health Service Dental Clinic | March 2015 |
| Mildura Base Hospital | March 2015 |
| Kyneton District Health Service – Ambulatory Care Centre | June 2015 |
| Redevelopment of Echuca Regional Health | June 2015 |
| Albury Wodonga Regional Cancer Centre | December 2015 |
| Redevelopment of the Kilmore and District Hospital | June 2015 |
| HHF 2011 Regional Priority Round in Bairnsdale | June 2015 |
| HHF 2011 Regional Priority Round in Leongatha | December 2015 |
| HHF 2011 Regional Priority Round in Numurkah | June 2016 |
| HHF 2011 Regional Priority Round in Heathcote | June 2015 |
| HHF 2011 Regional Priority Round in Kyabram | Sept 2015 |
| HHF 2011 Regional Priority Round in Mansfield | Sept 2015 |
| HHF 2011 Regional Priority Round in Warracknabeal | March 2016 |
| Project Agreement for the Colac Area Health - Youth Health Hub | July 2014 |
| Project Agreement for the Gippsland Cancer Centre | August 2014 |
| Project Agreement for the Ballarat Regional Integrated Cancer Centre | June 2014 |
| Project Agreement for the East Grampians Health Service Dialysis Unit Upgrade (Ararat) | June 2014 |
| <i>Queensland</i> | |

| Agreement | Estimated completion date |
|--|---------------------------|
| Townsville Hospital Redevelopment | November 2014 |
| Implementation Plan for the Rockhampton Hospital Expansion Project | June 2014 |
| Implementation Plan for Central Integrated Regional Cancer Service, Queensland | July 2015 |
| Townsville and Mt Isa Integrated Regional Cancer Service | September 2014 |
| HHF 2010 Regional Priority Round in Cairns and Townsville | May 2015 |
| HHF 2010 Regional Priority Round in Sunshine Coast, Bundaberg, Rockhampton and Toowoomba | December 2014 |
| E-Health to Support Integrated Care in Regional Queensland | October 2017 |
| Acute Primary Care Clinic at Proserpine | October 2015 |
| Bowen Hospital Expansion | April 2016 |
| Charter Towers Primary Care Clinic | April 2015 |
| Staff Accommodation on Thursday Island | April 2016 |
| Project Agreement for Health and Hospitals Fund – 2010 Regional Priority Round Project For Remote Staff Accommodation for Health Care Professionals in Mount Isa | March 2014 |
| <i>Western Australia</i> | |
| Strengthening Cancer Services in Regional WA | July 2019 |
| Midland Health Campus | November 2015 |
| HHF 2010 Regional Priority Round in Busselton | October 2014 |
| Implementation Plan for Digital Technology for BreastScreen Western Australia | May 2014 |
| Implementation Plan For New State Rehabilitation Service at Fiona Stanley Hospital | May 2014 |
| <i>South Australia</i> | |
| HHF 2010 Regional Priority Round in Mount Gambier and Port Lincoln | January 2015 |

| Agreement | Estimated completion date |
|---|---------------------------|
| Project Agreement for the Murray Bridge Community Dental Clinic | January 2015 |
| Project Agreement for the South Coast Primary Health Care Precinct | October 2015 |
| Implementation Plan for Whyalla Regional Cancer Centre | October 2015 |
| HHF 2010 Regional Priority Round in Mount Gambier and Wallaroo | September 2014 |
| <i>Tasmania</i> | |
| Tasmanian Cancer Care Project | July 2015 |
| Acute Medical and Surgical Unit Launceston General Hospital | March 2015 |
| Redevelopment of the Royal Hobart Hospital | December 2016 |
| Implementation Plan for Digital Technology for BreastScreen Tasmania | June 2014 |
| <i>Australian Capital Territory</i> | |
| Implementation Plan for the Capital Region Cancer Care Centre | June 2014 |
| Project Agreement for Improving Critical Care Outreach and Training in the ACT and South East New South Wales | May 2014 |
| Implementation Plan for Digital Technology for BreastScreen Australian Capital Territory | May 2015 |
| <i>Northern Territory</i> | |
| HHF 2010 Regional Priority Round in Five sites in the NT | May 2017 |
| Implementation Plan for Digital Technology for BreastScreen Northern Territory | May 2014 |
| Project Agreement for the Redevelopment of the Emergency Department – Tennant Creek Hospital | June 2014 |
| 2010 Regional Priority Round in Remote Northern Territory | June 2016 |
| Project Agreement for the Health and Hospitals Fund – 2011 Regional Priority Round Project in Alice Springs | June 2016 |

| Agreement | Estimated completion date |
|--|---------------------------|
| Project Agreement for the Cancer Support Clinic in Katherine | June 2015 |
| Project Agreement for the Health and Hospitals Fund – 2010 Regional Priority Round Project in Palmerston | June 2016 |
| Project Agreement for the Health and Hospitals Fund – 2011 Regional Priority Round Project in Darwin | June 2017 |
| Project Agreement for Five Health and Hospitals Fund – 2010 Regional Priority Round Projects in the Northern Territory | June 2016 |

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