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**Health reforms: how will recent reforms impact on our ageing populations?**

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## Health reforms: how will recent reforms impact on our ageing populations?

### Abstract

#### Overview

- Caveat: focus is on health system
- Experts throughout the day will overview ageing and aged care issues and proposed reforms
- Structural design of the Australian health system
- The constitution and its implications
- Recent health reform under Labor (Rudd, Gillard)
- Current Coalition health reform agendas
- What it might all mean on the ground

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# Health reforms: how will recent reforms impact on our ageing populations?

Professor Kathy Eagar

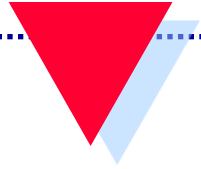
Director, Australian Health Services Research  
Institute (AHSRI) Sydney Business School

Health Reform and Older People – National Changes, Local Impacts –  
A Perspective from the Illawarra.

*AAG Illawarra, Wollongong, 25 July 2014*

# Overview

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- ◆ Structural design of the Australian health system
- ◆ The constitution and its implications
- ◆ Recent health reform under Labor (Rudd, Gillard)
- ◆ Current Coalition health reform agendas
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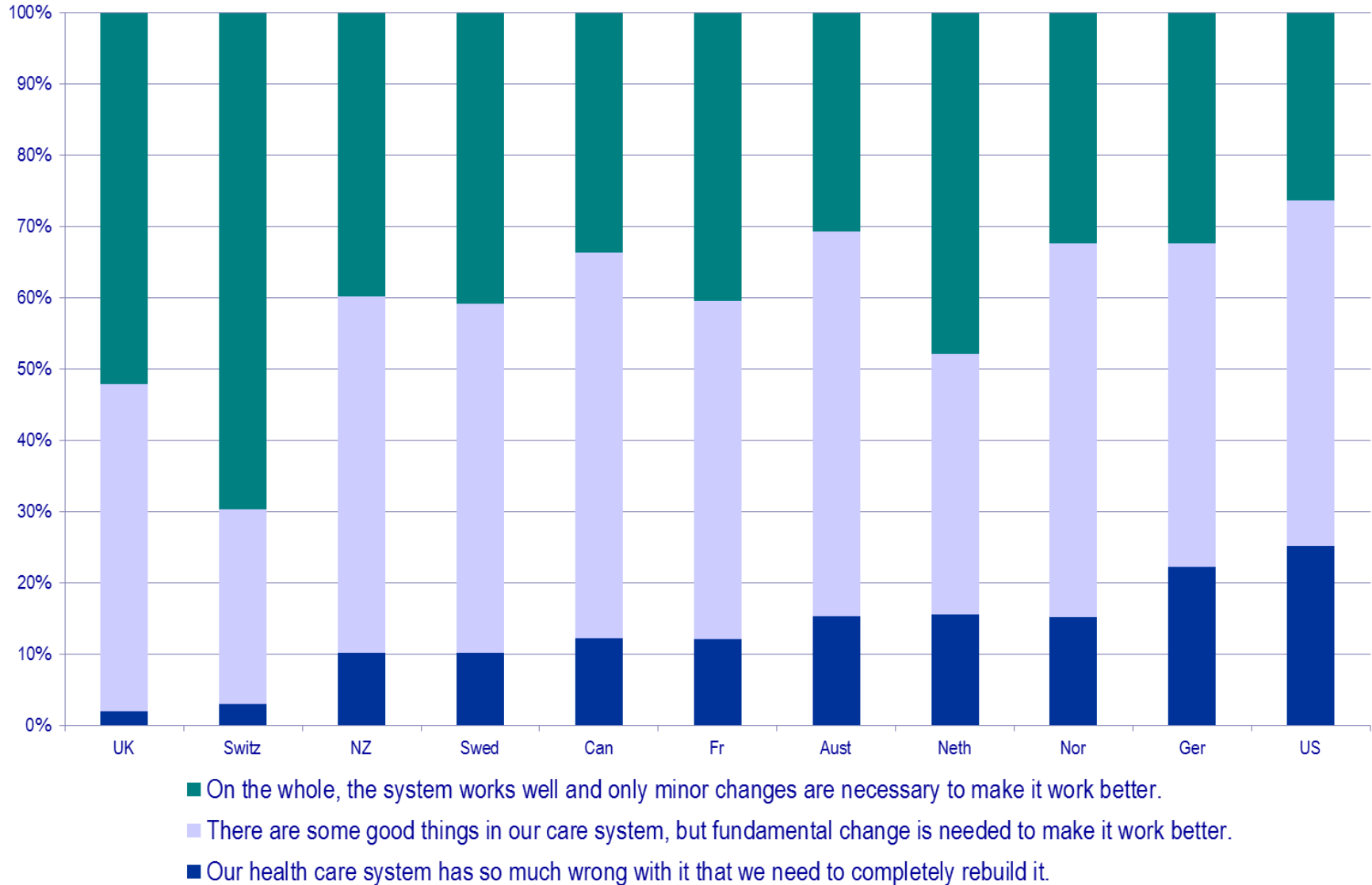
But first, a quick quiz

# How good is our health system?

Which of the following statements comes closest to expressing the citizens' view of the health care system?

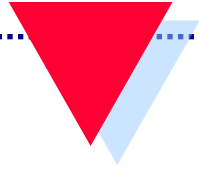
- A. On the whole, the system works pretty well and only minor changes are necessary to make it work better.
- B. There are some good things in our health care system, but fundamental changes are needed to make it work better.
- C. Our health care system has so much wrong with it that we need to completely rebuild it.

# Answer



Source: 2011 Commonwealth Fund International Health Policy Survey.

Data collection: Harris Interactive, Inc.



Is the health system in crisis?



SATURDAY, JUNE 29, 1957

## CRISIS IN THE HOSPITALS

The State Government has And the presumption of re-  
good reason to be dismayed curring debt, combined with  
by the huge debts incurred the belief that retailers will  
by our public hospitals, not, in the last resort, cut off  
though it can hardly be more supplies, has created a hand  
so than the unfortunate credi- to mouth attitude on the part  
tors who have been bearing of both hospital administra-  
the burden of unpaid bills tions and Government alike.  
with considerable forbear- The result is that the annual  
ance. That the hospitals have allocation of revenue has  
been living beyond their ceased to bear any serious  
means for years is common relation to actual needs.  
knowledge. But that they The fact must be faced  
should have been obliged, for that at present there is just  
whatever reasons, to conduct not enough money being  
their financial affairs on the spent to produce an efficient  
calculated assumption of a and solvent hospital service.  
And so long as the mechan-

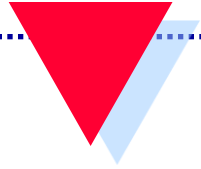
“The fact must be faced that at present there is just not enough money being spent to produce an efficient and solvent hospital service”

June 29, 1957

# But pressure on the health system is real

- ◆ ‘Unless alternatives are developed, it will be necessary to open at least 300 new beds in NSW each year to keep up with predicted growth in demand’. The implications are severe:
  - in 1971-72 health represented 15% of the total NSW budget
  - by 2007-08 this had increased to 28%
  - at this rate, funding for health will consume the entire State budget by 2033.”

*Ref: NSW Audit Office 2008, p.2*



# The Australian health care system

# The starting point for our western health care system

New South Wales became a (penal) colony in 1788,  
followed progressively by the other Australian States.

Australia didn't become a country until 1901

# A federation

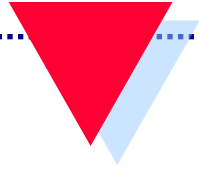
- ◆ Commonwealth (national) government
- ◆ 6 State (previously colony) and 2 Territory governments
- ◆ Constitution (1901) - health is the responsibility of the States
  - Except quarantine matters
- ◆ Amended in 1946
  - Commonwealth can provide health benefits for returned soldiers
  - More broadly - *“but not so as to authorise any form of civil conscription”*
- ◆ Commonwealth didn't have a formal role in health care until 1972 (Medibank)
  - Except for war veterans
- ◆ States and territories own all public health facilities and infrastructure

# Public hospital funding - 1

- ◆ Commonwealth agreed in 1972 to contribute 50% of public hospital funding (with inception of Medibank)
- ◆ 5 year Commonwealth-State agreements from 1983
  - Last agreement was 2008-2013 (ended 30 June 2013)
- ◆ 2003 agreement - Commonwealth effectively ended 30 year commitment to 50%
  - argued that private health insurance (PHI) tax rebate would take pressure off public hospitals
- ◆ PHI took no pressure off public hospitals and public hospitals perceived to be increasingly in 'crisis' since then

# Public hospital funding - 2

- ◆ Public hospital ‘crisis’ over the last decade largely due to Commonwealth decision to reduce it’s funding contribution in real terms
  - This began in last agreement under Howard government
- ◆ Rudd government elected in 2007
  - provided an injection of funds in 2008 and began planning for ‘national reform’
- ◆ The states and territories wanted a return to a 50% share by the Commonwealth
  - they got Labor Party style ‘national health reform’ instead



# A brief diversion to bigger issues

The constitution and beyond



# “Vertical fiscal imbalance”

- ◆ When one level of government (in Australia's case, the federal government) raises most of the revenue while another level (the States) provide most of the services but with limited ability to raise own revenue
- ◆ Options:
  - The government with the money takes over more and more services (Labor Party)
  - Force the states to raise more revenue ie, increase GST (Coalition)
  - Fix the vertical fiscal imbalance (states and territories)

# “Horizontal fiscal imbalance”

- ◆ When state and territory governments :
  - have different abilities to raise their own taxes and
  - differ in the cost of providing required public services
- ◆ Fixed by a “horizontal fiscal equalisation” policy
  - Commonwealth Grants Commission
  - Commonwealth funding to states according to population need adjusted for ability to raise own-revenue
  - Bigger, richer states cross-subsidise smaller ones - NT, Tasmania and South Australia

# Schools Chaplains Case

- ◆ Funding to the Scripture Union Queensland for chaplaincy services in State schools
- ◆ High Court ruled that this arrangement was not allowed under s 61 of the Constitution
- ◆ The executive power of the Commonwealth is limited to the execution and maintenance of the Constitution
  - payments to SUQ are invalid because they are beyond the executive power of the Commonwealth
- ◆ Much wider implications that are yet to be tested, especially in aged care

# National Health Reform Agreement (NHRA)

The Labor Party solution to the  
vertical fiscal imbalance

Signed by COAG 31 July 2011

- ◆ Health system splits into 5
  - Hospitals - State responsibility
    - ◆ Commonwealth to contribute its share on an activity basis
  - Private sector primary care - Commonwealth responsibility
  - “Aged care” including Home and Community Care (HACC) for people 65 years and over - Commonwealth
    - ◆ except Victoria and Western Australia
  - Disability services - State responsibility
    - ◆ All disability, HACC and residential care for people less than 65 years
  - Community health, population health and public health - State responsibility

## ◆ National

- Independent Hospital Pricing Authority (IHPA)
- National Health Performance Authority (NHPA)
- National Health Funding Pool
  - ◆ Reserve bank accounts (one for each state and territory) with an independent administrator

## ◆ State

- Ongoing reorganisations of most departments

## ◆ Local

- Local Hospital Networks (LHN)
  - ◆ Local Health Districts in NSW, Hospitals and Health Services in Qld etc
- ‘Medicare Locals’

# Commonwealth Premise

- ◆ Hospitals - big white buildings surrounded by a fence
- ◆ Everything outside the fence is either 'primary care' or 'aged care' or a 'disability service'
  - no terms defined
- ◆ Specialist services outside the fence (public and private) not adequately recognised in original agreement
  - but IHPA has gone some way to addressing this since

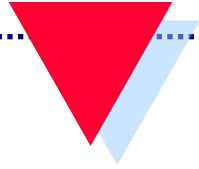
# Hospitals

- The centre of the health reform
- creating perverse incentives for some very regressive thinking!



# Commonwealth role

- ◆ Pay a 'national efficient price' for every public hospital activity (patient care, teaching, training and research)
  - Using 'activity based funding' model
  - Funding at historic levels (around 38%) until 1 July 2014
  - 2014-2017 - fund 45% of **efficient growth** in public hospitals
  - 2017 on - fund 50% of **efficient growth** in public hospitals
  
- ◆ Agreement has detailed arrangements for defining a 'hospital' service that the Commonwealth will partly fund
  
- ◆ Postscript: 2014 Coalition budget commits to fund 45% of growth 2014-2017 only. Just CPI increase after that



Primary care

“Medicare Locals”

## ◆ **Service delivery**

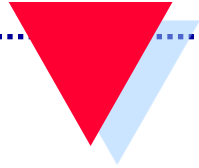
- Health promotion and prevention programs

## ◆ **Networking and coordination**

- Facilitate allied health care and support for people with chronic conditions as identified in personalised care plans prepared by GPs
- Work with LHNs to identify pathways for services, transitions out of hospital and into aged care

## ◆ **Population level planning and selective commissioning**

- Identify groups of people missing out on primary health care or services that local areas need, and better target services to respond to these gaps
- “Act as fund-holder and purchaser of services in areas of market failure and where patient needs are not being met”



# 2014 federal budget included big changes

Bye bye IHPA, NHPA, Medicare Locals etc.  
Hello Primary Care Organisations and (maybe)  
National Productivity and Performance Authority

# ‘Price signals’

- ◆ Economics 101 – you can change behaviour by price signals (incentives and penalties)
- ◆ \$7 co-payments, not just for GPs but also for every diagnostic test
  - The worse health policy possible
- ◆ Expect more and more use of ‘price signals’ in both health and aged care, not just to save government expenditure but also to change behaviour and expectations

# A few 2014 budget headlines

- ◆ White paper on the future of the federation:
  - Hospitals and schools are a state, not a federal, responsibility
  - Implications for aged care and disability?
- ◆ National Health Reform Agreement in place till 2017, won't be renewed. From July 2017:
  - Commonwealth reverts to block payments
  - Commonwealth growth funding reduces from 9% pa to 6.5%.
- ◆ Medicare Locals cease 30 June 2015, being replaced by Primary Health Organisations
  - 20-24 for Australia or 15 for NSW?

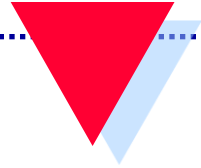
# Interface between health, aged care and disability services

- ◆ Commonwealth Home Support Programme
  - commences 1 July 2015.
  - “the basic tier of the end-to-end aged care system envisaged by the reforms”.
  - replaces existing Commonwealth aged care programs
    - ◆ HACC, Respite for Carers, Day Therapy Centre and potentially the Assistance with Care and Housing for the Aged Program
- ◆ But policy vacuum in relation to the interface between health, aged care and disability care
  - How to make it all fit together for consumers?

## The challenge for the Illawarra

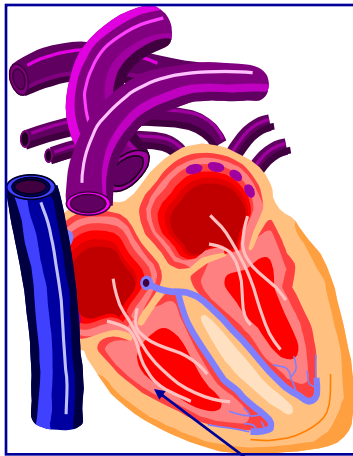
- ◆ How does the Illawarra make it all fit together?
  - Illawarra Shoalhaven Local Health District
  - Whatever replaces Illawarra Shoalhaven Medicare Local
  - Aged care reform on the ground
    - ◆ Community and residential aged care
    - ◆ One stop shop regional assessment
    - ◆ Consumer directed care
    - ◆ Advanced care planning etc
  - University of Wollongong – teaching and research
  - GPs, NGOs, community health services etc etc etc





Once we've sorted that out, the next  
big challenge

# WHEN TREASURY RESTRUCTURES THE HUMAN HEART



Tam Scott

We consider the relationship between the left and right ventricles is far too cosy... - our proposal would separate the heart into 4 isolated chambers located in different parts of the chest. They would then tender independently for the right to pump blood to particular parts of the body.

Competition should improve the overall cost efficiency of the blood vascular system