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Recent developments in federal government funding for public hospitals: a quick guide

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Introduction

Public hospital services in Australia are jointly funded by the federal and state and territory governments under a national agreement, complemented by payments from non-government sources such as private health insurers. State and territory governments manage and operate public hospital services (a small number are operated by charitable organisations on behalf of state governments). Services are provided free to public patients, but waiting lists may apply. Patients can elect to be treated as either a public or private patient.

Until recently, the federal Government provided recurrent funding for public hospitals as specific purpose payments to the states and territories under a series of bilateral agreements, which were generally indexed to population growth and other factors. The signing of the National Health Reform Agreement (NHRA) in 2011 signalled a shift in how public hospitals were funded that was based on growth in activity levels, known as activity based funding (ABF)—'a way of funding hospitals whereby they get paid for the number and mix of patients they treat'.

A 2014–15 budget proposal to discard the ABF funding formula in favour of indexation was abandoned in 2016. The current national agreement for the funding of hospital services based on ABF principles is due to expire in mid-2020. A new agreement on hospital funding has been offered by the federal Government; all but two state governments have signed. This quick guide provides an historical overview of funding arrangements for public hospitals and recent developments. It does not address funding for capital and hospital infrastructure.

Historical overview

Prior to 2007

When Medicare was introduced in 1984, the federal government negotiated bilateral funding agreements with each of the states and territories for the provision of free public hospital services. This funding was meant to compensate the states for increased costs and loss of private patient revenue associated with the introduction of Medicare and free public hospital services. Prior to 1984, public hospitals were funded mainly through cost-sharing arrangements between the federal Government and the states and territories, based on a 50-50 split. Details of these early arrangements are provided in the Senate Community Affairs Committee's *First Report: Public Hospital Funding and Options for Reform* (2000), from which much of this section is drawn.

Section 24 of the *Health Insurance Act 1973* (now repealed) allowed for the Commonwealth and the states to make agreements with respect to 'public hospital services' and 'other health services', subject to certain standard 'heads of agreement' (listed in Schedule 2A of the Act). These bilateral agreements were initially known as the Medicare Agreements. Under the Howard Government these were renamed the Australian Health Care Agreements (AHCAs). These agreements included a commitment to the so-called 'Medicare principles' which,

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among other matters, guaranteed free public hospital treatment to public patients. In 1992, the Medicare principles and funding arrangements were enshrined in the *Medicare Agreements Act 1992* (repealed).

Commonwealth grants to the states and territories for public hospitals were in the form of specific purpose payments (SPPs). The Parliamentary Library paper *Specific purpose payments and the Australian federal system*, provides an historical overview. Health SPPs largely comprised a base funding level adjusted (at various times) for population growth, inflation, ageing, the veteran population, hospital output costs and private health insurance membership levels.

Changes under the Labor Government

With the expiration of the last AHCA agreement (2003–08), new federal financial arrangements were introduced. In March 2008, the Council of Australian Governments (COAG) agreed to implement a new framework for federal financial relations. These changes were outlined in the 2008–09 Budget and included reducing the number of SPPs from 90 to just five. These SPPs would cover healthcare, early childhood development and schools, vocational education and training, disability services and affordable housing. In November 2008, the *Intergovernmental Agreement on Federal Financial Relations* (IGA) was signed.

The National Healthcare Agreement (NHA) outlined financing for the health sector (Schedule F of the IGA), and set out the key principles for the provision of a range of health services. It established national objectives in prevention, primary and community care; hospitals; aged care; social inclusion and Indigenous health; sustainability; and the patient experience. Performance indicators and benchmarks for each reform area were specified. Significantly, following many years of debate, the NHA committed to the national implementation of ABF in order 'to provide a basis for more efficient use of taxpayer funding of hospitals, and for increased transparency in the use of those funds'. ABF uses a nationally consistent approach, where payments are based on the same price for the same service across hospitals. The NHA also sought to clarify the respective roles and responsibilities of the different tiers of government, which had frequently been a source of friction between the Commonwealth and the states and territories.

The Commonwealth agreed to provide funding of $60.5 billion over five years to the states and territories to deliver their health services. This included an additional $4.8 billion in base funding over the forward estimates for public hospitals, and the introduction of a more generous indexation formula of 7.3 per cent per annum. The NHA was intended to be an interim arrangement until the new National Health Reform Agreement was agreed. The NHA framework was reflected in the 2009–10 Budget. Under this framework, the states continued to receive GST revenue.

National Partnership Payments

The IGA established National Partnership Payments (NPPs) to drive specific initiatives across sectors and improve outcomes. NPPs offered reward and incentive payments to jurisdictions for the delivery of outcomes in key areas. Each NPP was underpinned by an agreement (known as a National Partnership Agreement or NPA). In the health sector, NPPs initially covered Hospitals and Health Workforce Reform, Preventative Health, Taking Pressure off Public Hospitals and Indigenous Health. Several more NPPs were later developed for national priorities such as health infrastructure, Indigenous health, preventive health, mental health, public dental services, vaccines and other health services (such as bowel cancer screening, kids health checks and antimicrobial surveillance).

A National Health and Hospitals Network

The next major reform was the National Health and Hospitals Network Agreement (NHHNA) signed on 20 April 2010 by all heads of government (except Western Australia).The NHHNA committed the Commonwealth to become the majority funder of public hospital services and the sole funder of all primary health and aged care services. Specifically, it committed the Commonwealth to fund 60 per cent of the 'efficient price' of hospital services (based on the cost of the efficient delivery of public hospital services), in addition to a guarantee of no less than $15.6 billion in top-up funding over the period 2014–15 to 2019–20. Local Hospital Networks (LHNs) (to be established by the states and territories) would manage hospitals within a defined area, while responsibility for managing the hospital system as a whole would be retained by state governments. A new national funding body would be established to distribute pooled Commonwealth and state and territory contributions to hospitals, based on ABF arrangements. New primary health care organisations (later named Medicare Locals) would improve primary care and work with LHNs. The *National Health and Hospitals Network Act 2011* gave legislative basis to these reforms.

National Health Reform Agreement (NHRA)

The NHHNA arrangements were soon superseded due to political developments. Under the new Labor Prime Minister, Julia Gillard, the commitment for the Commonwealth to become the majority funder of public hospital services was modified. Under a Heads of Agreement on National Health Reform signed at the COAG meeting in February 2011, the Commonwealth promised to retain its base funding commitment as agreed; but from July 2014 funding would be limited to 45 per cent of the efficient growth in hospital services (based on an efficient price), rising to 50 per cent from 1 July 2017. Other elements of the NHHNA, such as the establishment of LHNs and new funding agencies, were retained.

In August 2011, the National Health Reform Agreement (NHRA) was signed formalising the Heads of Agreement and replacing the superseded NHHNA. The NHRA detailed the new framework for the future delivery of funding for health and aged care services. This included the establishment of Medicare Locals, as well as new independent bodies to administer key financial arrangements. The NHRA retained the commitment to national ABF arrangements for public hospital services.

Schedule B of the NHRA outlined the roles of new statutory bodies that would oversee particular aspects of the agreement:

- the Independent Hospital Pricing Authority (IHPA) to set a national efficient price (NEP) for hospital services
- the National Health Funding Pool, and the National Health Funding Body (NHFB) to administer pooled funding
- the National Health Performance Authority to measure health system performance
- the Australian Commission on Safety and Quality in Health Care to lead and coordinate improvements in safety and quality.

Clause A5 of the NHRA reiterated a Commonwealth guarantee to provide an additional $16.4 billion for hospitals between 2014–15 and 2019–20.

The *National Health Reform Act 2011* enacted these reforms, replacing the superseded *National Health and Hospitals Network Act 2011*. The first two years of the NHRA were transitional to allow for the establishment of new agencies.

Changes under the Coalition Government

The 2014–15 Budget included an announcement that the ABF formula agreed to under the NHRA would be abolished from 2017. From July 2017, Commonwealth contributions would be based on a new formula, comprising population growth and changes to the consumer price index (CPI). In addition, from 2014–15, the funding guarantees agreed to under the NHRA ceased. During the period July 2014 to July 2017, funding for public hospitals would be calculated using the ABF model agreed to in the NHRA—that is, committing to funding 45 per cent in 'efficient growth'. From July 2017, however, the Commonwealth's contribution would use the indexation formula.

This revised approach to hospital funding was expected to generate considerable savings, which the Parliamentary Budget Office estimated would total $56.2 billion to 2024–25.

These proposed reforms proved to be controversial, with key stakeholders—including state governments—voicing their opposition. A Senate Select Committee was established to examine the impact of these changes.

Shortly after becoming Prime Minister, Malcom Turnbull indicated that the Government was reconsidering public hospital funding arrangements, including retaining ABF and the NEP from 2017 onwards.

Funding for 2017–20

At the April 2016 COAG meeting, the Commonwealth and the states and territories signed a Heads of Agreement specifying that 2017–20 funding for public hospitals would retain ABF principles and the NEP—thus confirming the reversal of the controversial 2014–15 Budget decision to apply a new indexation formula. The Commonwealth agreed to fund 45 per cent of the efficient growth in activity levels over the three years (an estimated additional $2.9 billion in funding for public hospital services), with growth in funding to be capped at 6.5 per cent a year according to the Communiqué.

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An addendum to the NHRA, signed in March 2017, formalised these revised arrangements. It committed all parties to implement reforms designed to improve health outcomes for patients and decrease avoidable public hospital admissions; and to support trialling new funding models, such as Health Care Homes.

Proposed funding 2020–25

The current public hospital agreement is due to expire in mid-2020. In February 2018 at COAG, the Commonwealth presented an offer of $130.2 billion from 2020–21 to June 2025 for public hospitals. Consistent with current arrangements, the Commonwealth is offering to fund 45 per cent of the efficient growth of activity based services, capped at 6.5 per cent per annum. So far, six states have signed a Heads of Agreement with only Victoria and Queensland yet to agree. Key features of the agreement include:

- implementing 'new long-term system wide reforms' (including 'paying for value', 'joint planning', 'nationally cohesive technology assessment', 'health literacy empowerment', ' prevention and wellbeing' and 'enhanced health data') and
- enacting My Health Record implementation and the Australian Health Performance Framework.

The federal government is providing $100 million towards a Health Innovation Fund to support trials of health prevention projects. States and territories that sign up to the Heads of Agreement will obtain early access to 50 per cent of the Fund.

In addition, all parties agreed 'to ensure the information and process for patients electing to use private health insurance in public hospital emergency departments is appropriate, robust and best supports consumer choice'. This followed on from concerns that increasing numbers of private patients in public hospitals were leading to longer wait times for public patients. The IHPA, in its *Private Patient Public Hospital Service Utilisation: Final report* (March 2017), found that the number of public hospital separations funded by private health insurers had increased substantially over the period from 2008–09 to 2014–15. It suggested that agreements between LHNs and state and territory governments appeared to create incentives to increase the number of privately insured patients because this increased revenues.

A 2017 report from the Australian Institute of Health and Welfare (AIHW), *Private health insurance use in Australian hospitals, 2006–07 to 2015–16*, confirmed that public hospital admissions funded by private health insurers had increased, from 8.2 per cent of hospitalisations in 2006–07 to 13.9 per cent in 2015–16. The AIHW report also found that public patients experienced longer median wait times for elective surgery than private patients in public hospitals.

Federal Health Minister Greg Hunt expressed concern that these practices may be driving up private health insurance premiums and increasing public hospital waiting lists. At the time, the Minister flagged that the issue would be considered in the context of negotiating the next health funding agreement.

The Heads of Agreement includes a Commonwealth offer to provide $100 million for a Health Innovation Fund to fund trials that support health prevention and the better use of health data.

Notably, the Heads of Agreement no longer commits the parties to the Medicare principles, which have been enshrined in previous agreements. Instead, the parties are to 'note' Medicare principles and agree 'to examine historic changes to the original Medicare principles and ensure the final agreement supports access to public hospital services by all patients on the basis of clinical need'.

While all states are yet to sign the agreement and further negotiations may become complicated due to looming elections, it would seem that ABF is now firmly entrenched as the basis for public hospital funding. As the Productivity Commission found, '[the ABF] has significantly slowed national growth in the average cost of providing hospital services'.

Recent and current funding levels for public hospitals are shown in a table on the Department of Health's website.

Activity based funding pricing arrangements

National efficient price

Under ABF arrangements, hospital activities or services are priced according to their complexity and the resources required. Under current arrangements, each year the IHPA determines the NEP for public hospital services, which covers admitted acute care, admitted subacute care, non-admitted (that is, outpatient) care and emergency department care. The NEP forms the basis for the federal government's NHRA funding for public

hospitals and is based on the average cost of an admitted episode of care provided in public hospitals in a financial year—known as a National Weighted Activity Unit (NWAU). The 'average' hospital service is worth one NWAU. More complex, more expensive activities are worth more NWAUs, while simpler, less expensive activities are worth a fraction of an NWAU. The NEP is adjusted for special types of care (such as paediatric or intensive care) and for other factors (such as remoteness or Indigenous status).

Based on the advice of the IHPA each financial year, the federal Health Minister determines the total amount and the manner in which NHRA payments are distributed between the states and territories, via legislative instrument. According to the 2018–19 NEP determination issued in March 2018, the NEP for 2018–19 is $5,012 per NWAU.

The IHPA also determines a 'National Efficient Cost' (NEC) for smaller rural hospitals not deemed suitable for ABF funding. Instead, these hospitals receive block funding based on the NEC. The NEC for 2018–19 is $5.171 million, which represents the average operational cost of a block-funded small rural hospital.

The IHPA noted that:

> The release of the seventh NEP continues to demonstrate the impact that ABF is having in reducing the rate of growth in public hospital costs; since the first NEP in 2011–12, there has been an average growth rate of 1.3 per cent per annum.

Pooled funding

A key component of the NHRA is that the Commonwealth and the states and territories pool funding for public hospitals through the National Health Funding Pool (the Pool). The Pool is administered by the National Health Funding Pool Administrator (NHFPA), assisted by the National Health Funding Body (NHFB).

The Pool comprises eight state and territory bank accounts. Commonwealth payments into the Pool are made monthly, while state and territory payments are made either weekly or monthly. The NHFPA administers the funds contributed to the Pool; and oversees distribution of payments to public hospital networks (LHNs as described above), third parties on behalf of LHNs, state health departments and other providers. Payments are not made direct to individual hospitals. Payments from the pool are known as NHR payments.

Two main types of payments for public hospitals are distributed from the Pool: ABF payments based on activity levels; and block funding, which is for smaller regional hospitals (and which also supports teaching and research). The Pool does not include funds for capital expenditure. The flow of current NHR payments to and from the Pool is explained in a graphic from the NHFB, 'Payment and funding flows'.

Further, the NHFPA administers:

- cross-border funding contributions (when a resident from one state or territory receives treatment in another state or territory, the resident's home state compensates the provider state) and
- a public health component paid by the Commonwealth into the Pool for disbursement to state and territory governments for public health activities (such as vaccinations).

The NHFPA publishes monthly and annual reports on NHR payments made by the Commonwealth and state and territory governments to LHNs. These reports are accessible on the public hospital funding website. Details of funding for individual hospitals are not included in these reports.

Note that NHR payments to the states and territories are taken into account by the Commonwealth Grants Commission when calculating the distribution of GST revenue.

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