Senate Standing Committee on Finance and Public Administration

Inquiry into the implementation of the National Health Reform Agreement.

Dr John Deeble, AO

Emeritus Fellow

The Australian National University

February 2013

The issue

In October 2012, the Commonwealth Treasurer made a determination under the 2011 Health Reform Agreement of the final amount to be paid to the States for public hospitals in the 2011-12 financial year, together with a Mid-Year Economic Outlook figure for the amount to be paid as advances in the 2112-13 financial year. Because of revisions in the factors on which the Indexation of payments is based the following changes were made.

- The 2011-12 figure was reduced by $150 million, or 1.2%, to $12,548 million.

- The 2012-13 advance was reduced by $253 million, or 2.0%, to $13,624 million, the larger proportionate reduction reflecting the compounded impact of the 2012 cut.

- The total cut of $403 million will be taken from the Commonwealth payment in 2012-13, an overall reduction of 3% this year, two thirds of which will be on-going.

The Victorian Government has passed this cut on to the hospitals. For the remainder of the financial year that raises some serious management problems. The other States have not publicly announced their intentions but the issue has been referred to by the Queensland minister in the context of LHN budgets and by South Australia in its budget preparation.

Impact

Objectively, the underlying reduction is not a major funding variation, although the addition of a retrospective year's adjustment exacerbates its current impact. A continuing 2% reduction in Commonwealth payments that approximate 40% of all government funding for public hospitals would shift the overall division by only 0.8%. Absorbing it would raise the State governments' outlays by only 1.3%, a figure much less than they have routinely accommodated in the past. And foregoing a 2% saving

would be an equally small adjustment for the Commonwealth in historical terms. Table 1 shows AIHW data of government funding for public hospitals from 2007-08 to 2010-11

Table 1 Government funding for public hospital services 2007-08 to 2010-11

	NSW	Vic	Qld	WA	SA	National
	$ mil	**$ mill**	**$ mill**	**S mill**	**$ mill**	**$ mill**
2007-08						
DOHA	3,690	2,678	2,111	1,080	903	11,081
State	5,407	3,633	3,383	1,643	1,410	16,537
% Cwth	**40.6**	**42.4**	**38.0**	**39.7**	**39.0**	**40.4**
2008-09						
DOHA	4,286	3,175	2,532	1,284	1.061	13,048
State	5,415	3,539	3,486	1,777	1.419	16,722
% Cwth	**44.2**	**47.2**	**42.1**	**46.9**	**42.8**	**43.8**
2009-10						
DOHA	4,203	3,027	2,507	1,287	1,038	12,818
State	6,213	4,546	4,086	1,865	1,621	19.522
% Cwth	**40.4**	**40.0**	**38.0**	**40.8**	**39.3**	**39.5**
2010-11						
DOHA	4,688	3,562	2,829	1,437	1,110	14,359
State	6,243	4,975	3,800	2,016	1,714	20,221
% Cwth	**42.9**	**41.7**	**42.7**	**41.6**	**39.3**	**41.5**
% increases						
2007-08 to 2008-09						
DOHA	16.1	18.6	19.9	18.9	17.5	17.8
State	0.1	-2.6	3.0	8.2	0.6	1.1
Total	**6.6**	**6.4**	**9.5**	**12.4**	**7.2**	**7.8**
2008-09 to 2009-10						
DOHA	-2.0	-4.7	-1.0	-	-2.2	-1.8
State	14.7	28.5	17.2	5.0	14.2	20.9
Total	**7.3**	**12.8**	**9.5**	**3.0**	**7.2**	**8.6**
2009-10 to 2010-11						
DOHA	11.5	17.6	11.2	11.2	6.9	12.0
State	0.5	9.4	-7.0	8.0	5.7	3.5
Total	**4.9**	**12.7**	**0.5**	**9.5**	**6.0**	**6.9**
2007-08 to 2010-11						
DOHA	27.0	33.0	34.0	33.0	22.9	29.6
State	15.5	36.9	12.3	22.7	21.6	22.3
Total	**20.2**	**35.3**	**20.7**	**27.7**	**22.1**	**25.2**

Sources: AIHW, Health Expenditure Australia, 2010-11, Appendixes A& B. National includes Tas, ACT and NT.

the last year for which official statistics are available. They do not exactly match funding under the Health Reform Agreement because they include some specific service payments under National Partnership arrangements. However the latter account for less than 10% of Commonwealth funding and will be phased out in 2014. Final figures for 2011-12 will be published in April.

As can be seen, the Commonwealth and State shares of government funding varied from year to year and between the States by much more than the adjustment proposed now.

- In 2008-09, as part of its GFC stimulus program, the Commonwealth and State shares of government funding increased hospital payments to the States considerably while State government spending virtually stood still.

- In 2009-10, the situation was reversed. Commonwealth funding actually fell, while the States spent the money they had saved in the preceding year, particularly Victoria.

- In 2010-11, Commonwealth spending grew by 12% but all of the States cut back. The growth in total government funding hardly changed – 7.8% in the first year, 8.6% in the second and 6.9% between 2009-10 and 2010-11 – but its composition varied. Nationally, Commonwealth funding grew by just under 30%, State government funding by 22.3%. The Commonwealth share therefore rose in all states except Victoria – the jurisdiction most actively opposing the current change – where State government spending rose considerably, largely in 2009-10. However Victoria still received the national average in 2011. In a whole-of-government context all of the differences were minor and they were managed with without conflict.

Comment

If these were long term trends in a stable environment, some adjustment to the Commonwealth / State balance might be necessary. However, this was a short and atypical period and the present financing structure will only last another year. From July 2014, Commonwealth funding will move from a population base to one based almost entirely on the volume of public hospital activity at the 'nationally efficient price' determined by the Independent Hospital Pricing Authority. The IHPA has already set the NEPs for 2011-12 and 2012-13 and funds are flowing under that arrangement, subject to a guarantee that total payments will be no less than the Commonwealth had previously committed. The Commonwealth share will be 40% of the NEP, with a slowly increasing proportion of post-2014 activity growth over a number of years. To minimise transition problems, it is therefore important that the Commonwealth share in 2013-14 is as close to 40% as possible. The present changes are commonly viewed in the context of the 2012-13 budget outcome and that is probably true. However there may be some longer term considerations as well.

But that is not the present issue. The current reductions rely on the indexation factors included in the 2011 Reform agreement. The question is whether those factors have been correctly calculated and properly used. Some of them have not. The component measures are:

- A five year average of changes in the AIHW Health Price Index (+2.27% in 2012-13)
- A technology factor estimated by the Productivity Commission (a constant 1.2% cost rise)
- Population growth from the ABS (+1.55% plus 0.55% for ageing = 2.13% in 2012-13)

The three factors are multiplied, applied to the national payment in the preceding year to give a new national figure which is then distributed to the States by population. Based

on both population growth and cost factors, the national indexation rate for 2012-13 is 5.71%.

Population growth is the only factor that varies by State. It is also the most contentious because the Commonwealth has, quite extraordinarily, treated a reduction in the ABS population figures based on estimated over-enumeration over a number of censuses as if it all occurred this year. The Australian Statistician has clearly stated that the effects should be spread over a quite lengthy period and intends to complete the distribution by June 2013. That might reduce some of the inter-state anomalies. But it will be too late to change the present process. There are also issues about inconsistency in the calculation of growth rates from adjusted and un-adjusted population estimates and the Commonwealth refusal to acknowledge the Statistician's advice and imminent review. Other submissions will no doubt refer to them. It is not my area of expertise.

The other factors relate to different components of expenditure change per person - the AIHW Health Price Index, a so-called technology factor from a Productivity Commission inquiry some years ago, and a hospital utilisation factor intended to capture some of the effects of an ageing population. The Health Price Index published by the AIHW measures changes in input prices, not product cost. The total index is actually a combination of nine separate indexes covering different health services, weighted for their importance in national health expenditure. Though compiled by the AIHW, most of the data come from the ABS. In its publications AIHW refers to the total health price index as the best broad indicator of health care cost movements generally, but <u>not</u> for any component service for which a separate measure is available. Hospitals are one such group and in its own publications it uses a hospital-specific index in adjusting for input price change. For agreement purposes, the technology factor is then as added as a constant to the selected index to move from price adjusted figures to final product costs.

Table 2 shows movements in the total health price index and its components over the six years to 2010-11. The Health Reform Agreement relates entirely to hospitals. The only relevant indicators are therefore the second one – government final consumption expenditure on hospitals and nursing homes – and, for comparison, professional health workers wage rates. Nearly three quarters of hospital costs are wages and until 2010-11 the two sub-indexes moved almost identically.

Table 2 Changes in health price indexes, 2004-04 to 2010-11

Years	**05 to 06**	**06 to 07**	**07 to 08**	**08 to 09**	**09 to 10**	**10 to 11**
Total health price index	**4.0**	**3.5**	**2.3**	**2.3**	**2.4**	**0.9**
Govt exp hospitals & nursing homes	**4.4**	**4.1**	**3.0**	**3.2**	**3.7**	**1.4**
Medicare fees charged	5.6	3.1	2.7	1.5	2.4	1.5
Dental services	4.1	5.5	4.0	3.5	2.5	0.9
Other heath practitioners	4.8	2.0	-0.1	4.2	2.6	3.2
Professional health worker wages	**4.5**	**4.6**	**3.7**	**3.8**	**4.1**	**3.6**
PBS pharmaceuticals	0.2	0.2	0.2	0.5	0.2	0.3
Chemist goods	1.3	2.3	0.6	-1.4	-0.3	0.4
Aids and appliances	2.7	2. 1	2.8	-1.7	-4.8	-5.6
Commonwealth capital	0.7	1.6	-0.1	2.2	-0.8	0.2
State capital	3.0	3.3	2.4	3.9	-2.0	0.5
Private capital	3.0	2.2	5.0	2.4	-0.6	0.3

Source AIHW, Health Expenditure, Australia, 2010-11, Table C3

One feature is clear. The total health price index is obviously the wrong measure for the agreement's purposes. It is too influenced by conditions in other parts of the health care industry. However the Commonwealth has interpreted the agreement's reference to 'The AIHW Health Price Index' to mean the total index and relies on the Premiers' signatures to insist on that, although it is doubtful if either they or their officials understood the differences. The total price index has consistently shown lower increases than the hospital-specific one, almost nothing in the final year - a very implausible result - and only 2.3% a year over the five-year averaging period. Use of the correct, hospital-specific, measure would add about 0.8% to that figure but even that is understated. In the five years to 2009-10, the hospital index rose by 3.7% a year on average. A one-year fall to 1.4% is quite extraordinary.

It is hard to say what the right figure might be. However an alternative and broader approach may give some indication. Table 3 combines hospital expenditure data with those from another AIHW publication (Australian Hospital Statistics) to estimate the separate contributions of cost increase and service volumes to total expenditure growth over the two years to 2010-11. The activity measures are weighted by their contribution to total hospital expenditure - 70% to admitted patients, 30% to others. The difference between expenditure growth and weighted activity growth is then the growth in cost per output unit, including that covered by the Productivity Commission constant..It is a

Table 3 Public hospital activity and cost, 2009-10 and 2010-11

	2009-10	**2010-11**
Expenditure ($mill)	**36,238**	**38,937**
% increase	8.3	7.4
Activity		
Admitted patients (mill seps)	5.07	5.28
% increase	3.6	4.1
Non admitted (mill services)	49.5	50.2
% increase	0.6	1.4
% increase, cost weighted	5.8	3.3
Expenditure components		
Cost increase		**4.0**
Service volume		**3.3**

Source AIHW, Australian Hospital Statistics, 2010-11, Tables 2,6 and 2.7 .Health Expenditures, Australia, 2010-11. Tables A1, A2, A3,

less complex and more understandable process that does not assume that the results of one Productivity Commission study can be applied at the same rate for ever. The estimated cost increase of 4.0% in 2010-11 is much more consistent with the long term trend and if the technology constant of 1.2% a year continued to be deducted for agreement purposes, the implied inflation rate would still be 2.8%, well down from the 2009-10 figure but twice the reported level. Over the five-year averaging period, the total health price index would rise from 2.27% per annum to 2.47% and the hospital-specific one by a similar proportion from 3.09% to 3.36% respectively. The differences between the measures are significant. If the correct one was used about half of the Commonwealth cuts would disappear.

Compiling the health care price indexes is therefore relatively unimportant compared with determining the indicator to be used. In principle, the only valid one is the hospital-specific component which is unaffected by changes in other branches of health care. The Commonwealth's inclusion of the lower-cost Total Health Cost Index in the 20i1 agreement and its current reliance on that cannot be defended on other than short term grounds. And that period will be very short, because as outlined earlier, the present funding system will only last another year. Payment will then be based on public hospital activity only and the body responsible for setting the unit prices paid - IHPA - has already made two determinations of the 'efficient' prices for 2011-12 and 2012-13. The indexation of cost per case was 5.1% a year. The comparable component of the Treasury's 2012-13 determination was only 3.5%. That disparity cannot continue.

Summary

***** In October 2012, the Commonwealth Treasurer announced a 3.0% reduction in the Commonwealth's 2012-13 payments to the States under the 2011 Health Reform Agreement. One third of that came from a retrospective reduction in payments for 2011-12, the remainder to be on-going. Revisions to the indexation factors included in the Agreement were cited as the reason. .

***** Historically, the change is relatively small and less than has been routinely managed in the past. However, Victoria has passed the reductions on to the hospitals, a potentially difficult management problem for them. The position elsewhere is unclear

***** The indexation factors in the Health Reform Agreement relate to, firstly, the population numbers on which a component of both total hospital payments and their distribution between States is based, and to a combination of indicators relating to cost and service volume changes, including inflation.

* There are serious questions about how both of these aspects have been handled, on the population side because of the Commonwealth's decision to treat the Statistician's downward revision of population growth over a number of census periods as if it all occurred this year; and on the cost side because of a confusion between total

cost change and input price inflation for which the Agreement mandates the wrong measure. Using the correct index would effectively cut the Commonwealth savings in half.

* Though important for another year, all of these issues will change from July 2014, when the whole payment system shifts to Activity Based Funding.