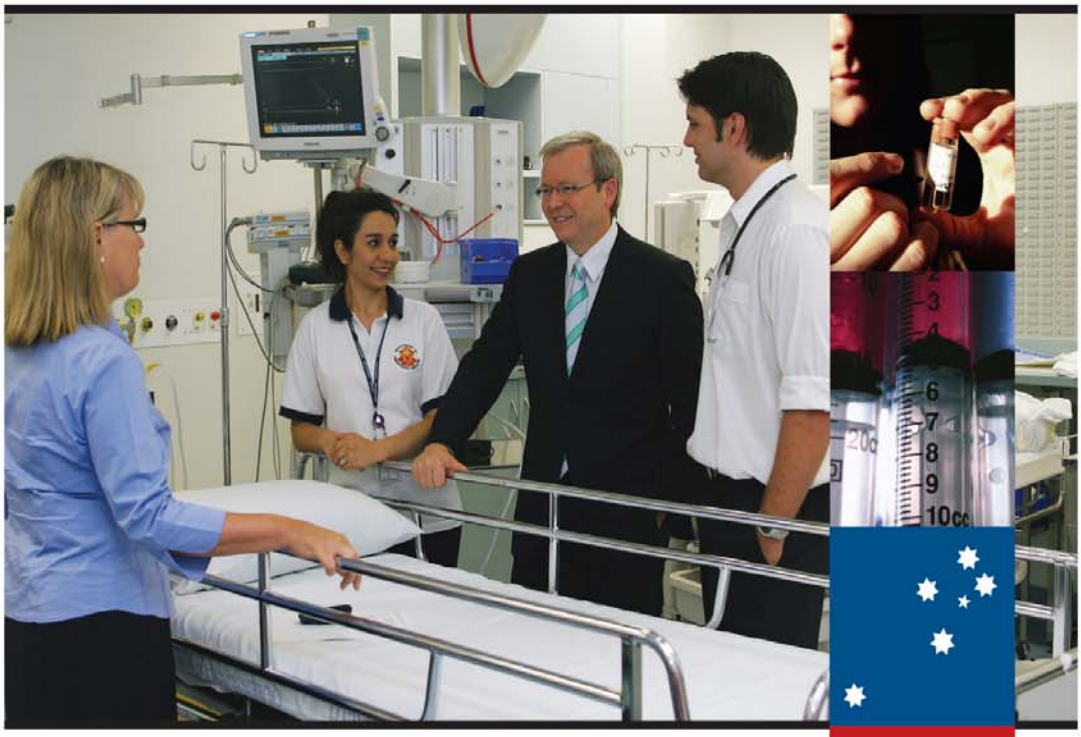
New Directions for Australian Health

Taking responsibility: Labor's plan for ending the blame game on health and hospital care



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August 2007

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Executive Summary

The need for reform

Australia's health system is in need of reform. Hospitals and health services are struggling to meet demand; our health workforce is overworked and under stress; and many Australians have problems accessing the care they need.

Poor health affects the quality of life of Australians and their families and can have significant economic effects by reducing their ability to participate in the workforce and through lost productivity and higher costs for business.

There are a constellation of challenges facing our health system:

- ***Long term trends*** such as population ageing, the increasing prevalence of chronic disease, labour costs and shortages, and the escalating cost of new health technologies including pharmaceuticals;
- The ***costs and inefficiencies generated by blame and cost shifting*** between levels of government over funding agreements that concentrate on inputs rather than health outcomes;
- ***Health care services that reflect these flawed funding arrangements*** rather than the needs of patients; and
- Health services which fail to intervene early or comprehensively to maximise people's ***productivity and workforce participation***.

Our health system is plagued with rising cost pressures and is increasingly unable to cope with the changing health needs of Australian families.

That is why Labor is proposing the single biggest health reform in a quarter of a century.

The importance of the health sector

Australia's health and hospital system accounts for total annual expenditure of $90 billion from both public and private sources. Commonwealth expenditure, which is currently $42 billion per year, represents about 45 per cent of these outlays.

Hospitals are a central part of our health system and are responsible for around onethird of all health expenditure.

Over $20 billion each year is spent on more than 700 public hospitals in Australia. Around 500 private hospitals are responsible for approximately $6 billion in expenditure, through private health insurance, Medicare payments and individual contributions.

Each year approximately 4.5 million Australians are admitted to public hospitals and around 4.8 million Australians visit a hospital emergency department.

One in four Australians rely on our public hospital system every year.

Our health system lies at the core of maintaining our well-being as individuals and families. But its sheer size and scope means that inefficiencies can weigh heavily on our economy and government budgets.

Challenges to the existing system

Our health system is ill-equipped to deal with the longer term pressures of:

- an ageing population,
- the increasing cost of pharmaceuticals and new technologies,
- the rise of chronic disease in our community, and
- the increasing expectations for access to high quality health services in the community.

These factors will see Commonwealth health spending as a proportion of GDP almost double from 3.8 per cent in 2006-07 to 7.3 per cent in 2046-47.

Over this timeframe the ageing of the population is expected to contribute just under one per cent to increased spending as a proportion of GDP, and the cost of pharmaceuticals as a proportion of GDP is expected to triple from 0.7 per cent in 2005-06 to 2.5 per cent in 2046-47.

Chronic diseases already account for almost $34 billion each year and nearly 70 per cent of allocated health expenditure. Left unchecked, this figure is expected to increase to 80 per cent of allocated health expenditure by 2020.

The impact on budgets of cost and blame shifting

Adding to these cost pressures are labour costs and workforce shortages. Our nursing population is ageing and turnover is high. Under-investment in medical places over the last decade has left many parts of the country struggling to find doctors. While additional funding has now been made available it will be several years before large numbers of new doctors become available to fill existing vacancies.

Notwithstanding these demand and supply pressures on our health system, a further source of pressure is generated by the way in which our health and hospital services are currently funded. In a report for the Business Council of Australia, Access Economics estimated that cost shifting, duplication and other inefficiencies in the Commonwealth-State funding arrangements cost some $9 billion per year. Of this, some $5 billion is related to spending inefficiencies, including around $1 billion in estimated health-related inefficiencies.

The recent House of Representatives Standing Committee Report into health funding, *The Blame Game,* noted 'there is significant scope for savings by reducing duplication of service provision and/or administration'.

The current Federal Health Minister has said that:

> *It would make sense to have one level of government in charge of the whole health system so that decisions can be made on the basis of health priorities rather than who pays.*[1]

The current Minister has also said that 'health is now such a dog's breakfast of divided responsibilities that sooner or later it will have to be sorted out'.

The impact on the Australian public – accident and emergency and acute care beds

Two examples illustrate well the costs imposed on both the health system and Australian families from the inefficiencies arising from blame-shifting and cost-shifting.

[1] Address to CEDA, 25 February 2005

First is the experience of too many families who cannot access a GP service and are as a result forced to attend a hospital emergency department. According to the Independent Pricing and Regulatory Tribunal of New South Wales, the use of emergency departments to provide GP-type services in New South Wales was estimated to cost an additional $110 million per annum. In comparison, delivering the same services through the Medicare Benefits Schedule would have cost approximately $30 million.

In other words, it costs the system almost four times as much when individuals who could see their GP are diverted to a hospital for non-urgent care.

In total, 12 per cent of all presentations to public hospital emergency departments are for non-urgent conditions and 500,000 admissions are for preventable illnesses that would have been better treated in the community.

Second is the experience of the estimated 2,300 older Australians who have been Aged Care Assessment Team (ACAT) assessed as requiring residential aged care beds but who are forced to wait in state-run hospitals because of shortages in the Commonwealth-funded aged care system.

The average cost per day of an acute public hospital bed is about $967, whereas the average cost for a residential aged care bed is just over $100 a day. This means the total cost to the system of having 2,300 people waiting in acute hospital beds for an aged care place is in excess of $700 million each year.

This is both distressing for older Australians and inefficient because other people requiring hospitalisation may be denied appropriate care.

People with mental illness and those with disabilities are also often forced to spend time in or revisit hospital due to the absence of appropriate accommodation, care and support in the community.

The impact on workforce participation

The current Government's failure to tackle both the long term health challenges – the rising prevalence of chronic diseases, preventable illnesses and preventable hospitalisation – and wholesale hospital reform will have a corresponding economic impact with workforce participation, productivity, and growth being lower than would otherwise be the case.

Recent studies have highlighted the economic costs of chronic disease, in addition to the personal suffering. For example the annual financial cost of chronic conditions such as cardiovascular disease in Australia are around $14.2 billion, or 1.7 per cent of GDP and include lost productivity costs of $3.6 billion. For obesity the annual productivity losses are approximately $1.7 billion.

The emerging literature on human capital demonstrates that investment and reform in the health care sector can have a measurable, and significant, impact on people's productivity and participation.

Participation rates are significantly affected for those with a chronic disease. They can reduce participation by between 12 and 40%.

As part of its analysis of the impact of reforms to improve human capital, improve workforce participation, and reduce inefficiencies, the Productivity Commission estimates that as many as 175,000 extra people could be in the workforce by 2030 and that implied expenditure savings could be around $2.8 billion. This represents an increase of around 0.6 of a per centage point in the workforce participation rate – a substantial increase at a time of significant skills shortages around the country.

Howard Government's response

Unfortunately, the Howard Government has failed to adopt health and hospital reforms which seek to shift agreement making and funding from a focus on ***inputs*** to the achievements of better health ***outcomes*** for the Australian people.

In fact, at the time the last hospitals funding agreement was signed in 2003, the Howard Government turned its back on widespread calls for major reforms to health funding which would have seen steps taken to end the blame and cost shifting.

At the same time, the Howard Government has reduced its funding commitment to our hospitals. Since 2000, more than $1 billion has been removed from Commonwealth-State funding to our hospitals which has seen the Commonwealth's share of hospital funding fall from 50 per cent to 45 per cent and to as low as 35 per cent in some states.

Having failed to take the opportunity to reform health and hospital funding during the decade it has been in power, the Howard Government is now, on the eve of a Federal election:

- cherry picking hospitals in marginal electorates for additional funding; and
- proposing an inadequate pool of capital funding that will not even begin to meet cost pressures facing our public hospitals.

Indeed, the Howard Government's Health and Medical Investment Fund is expected to return just $150 million per annum, or 0.2 per cent of the total Commonwealth health budget of $42 billion – barely enough to make any difference.

Australian families just want the health system fixed. Excuses by different levels of government and endless finger pointing does not help a family to get in to see a doctor or improve our hospitals in providing high quality care.

Federal Labor's response

This is why, in contrast to the Howard Government, Federal Labor has made explicit the urgent need for **systematic reform of health** and the need to bring to an end the blame game between the Commonwealth and State and Territory Governments.

This desire to achieve better health care for all Australians has already been illustrated by Federal Labor's commitment to an additional 2,000 transition care beds and other aged care reforms aimed at assisting older Australians currently waiting in acute hospital wards. This is a practical measure that will take pressure off our hospitals allowing them to put their savings back into providing better care for Australian families.

It is also why Labor has committed to incorporating preventative health care into a new Australian Health Care Agreement with the States and Territories.

This will help deal with the rising incidence of chronic diseases such as diabetes and cardiovascular diseases and so help prevent Australians from getting sick in the first place and reducing their need to end up in hospital.

Future directions

If we are to reform our hospital and health system, the Commonwealth faces four choices:

1. Maintain the status quo;

2. Maintain the status quo with random interventions into particular hospitals or areas of the health system without an overall health plan as the Howard Government has done;
3. Embark on a cooperative, systematic national reform process to improve services to the community, to reduce cost and blame shifting and to recoup by way of efficiencies the billion dollars currently lost by way of duplication and overlap; or
4. Assume Commonwealth funding of all our public hospitals (involving a parallel reduction in Commonwealth outlays to states at the point of transfer).

Federal Labor is committed to the third option – that is achieving national health care reform in partnership with State and Territory Governments.

However, if this fails, Federal Labor leaves open the option of proceeding to option four.

Labor's policy will occur in three steps.

First, a Rudd Labor Government will invest $2 billion in a National Health and Hospitals Reform Plan to provide assistance for immediate reforms to reduce blame and cost shifting and improve health services for Australians.

Labor's reform funding program will have three elements.

- **It will include additional funding to state and territory governments if they achieve agreed reform milestones – similar to the system of competition policy payments designed to reward those States that improve their performance. This will introduce a significant change and incentive to our health system – rewarding states and territories for reforms based on improved health outcomes not simply inputs.**

- **While the States and Territories should be rewarded on performance, a Rudd Labor Government will do its bit by also investing up-front in improving our health and hospital system to get the reform ball rolling. This will include investment in primary care where the Commonwealth has a clear responsibility.**

- **Third, given the importance of primary health care in reducing demand on our hospital system Labor will ensure funding is available to fund projects which strengthen our primary care system.**

Our aim must be to improve health outcomes and reduce the pressure on our hospitals by:

- **reducing avoidable hospitalisations and re-admissions to hospital;**
- **reducing non-urgent accident and emergency presentations;**
- **decreasing waiting times for those people who require essential hospital services such as elective surgery;**
- **providing more appropriate non-acute care for older Australians.**

Second, within the first one hundred days of its election, a Federal Labor Government, through COAG, will establish a National Health and Hospitals Reform Commission to develop a long-term health reform plan for the nation.

This Commission, headed by an eminent Australian, will, in co-operation with the States and Territories, and in consultation with health experts, professionals, and consumers, develop stringent performance benchmarks which the States and Territories will be required to meet. The Commission's work will form the framework for the development of the next Australian Health Care Agreements.

The objective is to eliminate cost shift and blame shift and to recoup (and reinvest in health services) at least the BCA's nominated $1 billion in efficiency savings across the principal categories of functional duplication and overlap:

- **Acute care beds and aged care places;**
- **Accident and emergency departments and GP services; and**
- **Other areas where funding responsibilities overlap, such as mental health and disability services.**

Third, if by the middle of 2009 the State and Territory have not begun implementing a national reform plan, a Rudd Labor Government will seek a mandate from the Australian people at the following election for the Commonwealth to assume full funding responsibility for the nation's public hospitals.

The assumption of Commonwealth funding for all public hospitals would require a parallel reduction in Commonwealth outlays to the States and Territories at the point of transfer. There would therefore be no windfall gain of any description to the states and territories.

If necessary, Federal Labor will also consider the possibility of conducting a national plebiscite or referendum at the following federal election on the question of any proposed Commonwealth takeover.

If a Commonwealth takeover of hospital funding received the support of the Australian people, a model would be devised that ensures the future of State, private and community-managed hospitals. There would be provision for the role of regional and local authorities to participate in the management of public hospitals and to ensure responsiveness of local hospitals to community needs. Under Labor's proposal, no public hospitals would be managed directly from Canberra.

The pursuit of this third part of Labor's reform plan may be necessary in the long term, given it may only be the national government that will be in a position to fund the long term needs of Australia's health and hospital system.

There is some support amongst State and Territory leaders for this more dramatic kind of reform.

The current New South Wales Premier Morris Iemma has suggested that 'if it leads to better healthcare for the people of Australia and the people of New South Wales, then New South Wales is prepared to cede power or jurisdiction'.

Similarly, Queensland Premier Peter Beattie has acknowledged:

> *I'm not sure giving health to the Commonwealth is the answer, but I think we need to have a look at it…the current system is broken – we need to fix it. It's costing people money and its bad service delivery. The trouble at the moment is the Commonwealth is terrified about cost-shifting, so nothing happens.*

Any reforms undertaken by a Rudd Labor Government would be underpinned by a continuing commitment to the maintenance and, where necessary, improvement of:

- Medicare;
- the PBS; and
- private health insurance rebates.

This investment in health reform – in fixing our hospitals and improving health services in the community, providing incentives for the States and Territories to

improve their performance in delivering quality health services to Australian families, and in keeping Australians healthier and avoiding preventable diseases like Type II diabetes – will generate efficiencies within our health system by reducing duplication and overlap and ending the cost shifting that characterises our current system.

Investing in health reforms which reduce the incidence of preventable illnesses and reduces hospitalisations will not only improve the quality of life of our people but will generate a dividend to the economy through higher workforce participation, higher productivity, and reduced costs to business.

Unlike the Howard Government, Labor has been identifying savings – over $3 billion to date – to pay for our promises. This process is continuing and will underpin Labor's commitment to invest in this reform. This commitment to invest in our health system and our hospitals is fully costed and funded.

Introduction

Australia's health system is in need of reform. Hospitals and health services are struggling to meet demand, our health workforce is overworked and under stress and many Australians have problems accessing the care they need.

This imposes a high health, social and economic cost on our society. It impacts upon Australian families – consumers – who not do receive optimum care and also on health professionals who can become frustrated and disenchanted with the problems with the system. With the ageing of the population and the growing burden of chronic disease, this situation will only get worse unless solutions are found.

These solutions must include both additional funding and structural reforms. Under-investment in health over the last decade has left Australia poorly placed to meet this generation's health challenges. Significant inefficiencies arise from the way in which our hospitals and health care system is structured. In an environment where funding is not keeping pace with demand, the division of responsibility between Commonwealth and State and Territory Governments results not only in duplication and overlap but blame and cost-shifting.

If we are to prepare for the future we must invest in and reform our health system at every level. This includes both the hospital system and community-based care. We must also take action to get general practitioners and other primary care providers working more closely with hospitals, and improving the coordination of care provided by these two sectors.

The Reform Agenda

Providing better frontline care and reducing pressure on our hospitals should involve:

- **reducing avoidable hospitalisations** by investing in robust primary health services, focused on preventative health care and improved management of chronic disease;
- **working to reduce non-urgent accident and emergency presentations** by providing families with high quality after hours alternatives;
- **reducing readmissions** by providing proper discharge planning and post acute care;
- striving to **reduce waiting times** for services such as elective surgery; and
- ensuring that people who do need frequent care are **admitted less often for fewer days**, particularly older Australians once they have been assessed as requiring non-hospital care.

Improving preventive health services and chronic disease management will deliver better health outcomes for Australians and their families and help contain growth in demand for hospital services into the future. It will also promote greater workforce participation and productivity.

We need the hospital system working more closely with residential aged care services to ensure that people who need nursing home care can get it rather than being stuck, inappropriately, in hospital.

Increased efficiencies gained from hospital and health care reform, will enable a better allocation of scare health resources which can be used to improve services, reduce waiting times and waiting lists, and improve the quality of care people receive.

Barriers to Reform

A lack of national leadership and investment, and the complexity of existing funding arrangements, represent a major roadblock to the achievement of real health care reform.

The inability of State and Territory Governments to adequately raise their own revenue to finance their constitutional responsibilities has meant they are increasingly dependent on Commonwealth support to meet their growing health commitments.

For its part, the current Commonwealth Government has tightened both the funding conditions and funding envelope for hospitals and taken a hands-off role in planning for the growing demand in primary care. This lack of leadership has led to further pressure on the system, and in some cases reduced access to services for patients, and delivered poorer quality care.

Labor's Plan

Federal Labor is committed to investment and planning to achieve health reform – and to achieve the ultimate goal of improved health and health outcomes for individuals and the community.

A strategic, long-term approach is required to such investment – not a hospital by hospital patch up.

We are optimistic that a cooperative action plan for reform can be achieved with State and Territory Governments.

We know, however, that all Australians want the best health care services possible and a health system that delivers better health outcomes. Smooth operation of Commonwealth-State relations is not an end in itself. Therefore a Federal Labor Government would place a time limit on consensus-based health care reform.

Both levels of government must take responsibility for ensuring the good health of the Australian people, however the Commonwealth must be prepared to exercise leadership if required, to secure this outcome.

Federal Labor has already released four New Directions papers on health including:

- our plans for a *Healthy Kids Check* when children are starting school, the development of a *Healthy Habits for Life Guide* for parents, and the national roll-out of the Australian Early Development Index;
- *New Directions for Indigenous Children* – a $261 million down-payment on Federal Labor's commitment to closing the gap in Indigenous and non-Indigenous life expectancy at birth;
- *Fresh Ideas, Future Economy: Preventative Health Care for our Families and our Future Economy* – a blueprint for a greater focus on prevention in the health care system; and
- *New Directions for Older Australians* – a comprehensive plan for improving the transition from hospital to aged care.

This paper outlines additional commitments from a Rudd Labor Government to ensure our health system can meet the challenges of the future. These include:

- A $2 billion Health and Hospital Reform Plan, which will be used to reform hospital and health services to improve the delivery of services to all Australians. In addition to hospitals, a key focus of the Plan will be investment in bolstering primary care services provided in the community which help take pressure off hospitals.

- 2,000 additional fully-funded transition care places, funded by the Health and Hospitals Reform Plan. This will bring the capacity of the transition care system to 4,000 places which will assist up to 26,000 older Australians each year.
- within the first one hundred days of its election, the establishment of a National Health and Hospitals Reform Commission to develop a long-term health reform plan for the nation.
- A commitment to seek an electoral mandate for assuming financial control of public hospitals, if insufficient progress is being made on agreed reforms within a single term of government.

The Australian health system

The division of responsibilities for health care between the Commonwealth and states is complex: one commentator has described it as 'one of the more mixed, disintegrated and confusing systems on earth'.[2]

For the community, these divided responsibilities have often lead to worse health outcomes and services that are difficult and frustrating to navigate.

Roles and responsibilities

The Commonwealth's major contributions to the health system include:[3]

- Medicare, which subsidises payments for services provided by doctors and, in some circumstances, allied health professionals;
- the Pharmaceutical Benefits Scheme (PBS), which subsidises prescription medicines;
- shared responsibility – with the State and Territory Governments through the Australian Health Care Agreements – for funding public hospital services;
- subsidisation of private health insurance through rebates on the cost of private health insurance premiums;
- funding for a range of other health and health-related services, including public health programs, residential aged care, and programs targeted at specific populations;
- funding for training of the health workforce through funding of university places; and
- regulation of various aspects of the health system, including the safety and quality of pharmaceuticals and other therapeutic goods and the private health insurance industry.

The State and Territory Governments' major contributions to the health system include[4]:

- management of and shared responsibility for funding public hospitals;
- clinical training of doctors and nurses in public hospitals;
- funding for and management of a range of community health services;
- public health protection and surveillance;
- management of ambulance services; and
- regulation of various aspects of the health system, including licensing and registration of private hospitals, medical practitioners, and other health professionals.

For the Australian health system to be reformed to meet the challenges we face in an equitable and affordable manner, we will need to:

[2] S. Leeder, 'We have come to raise Medicare, not to bury it', *Australian Health Review*, vol. 21, no. 2, 1998, p. 30.
[3] Australian Institute of Health and Welfare (AIHW), *Australia's Health 2006,* AIHW, Canberra, 2006.
[4] AIHW, *Australia's Health 2006.*

i. define and clarify better lines of responsibility of both levels of government to remove overlap and duplication of effort;
ii. establish outcomes-based performance benchmarks – to improve health care and improve transparency and accountability on performance; and
iii. establish an incentive system that rewards reform achievements, and, upfront, invests in reform through improved hospital and community care infrastructure and service provision.

Health expenditure

Total annual expenditure in Australia from both public and private sources is around $90 billion. The Commonwealth's share of this is about 45 per cent at present.

Total Commonwealth expenditure on health is currently about $42 billion per year. The major components of this expenditure include:

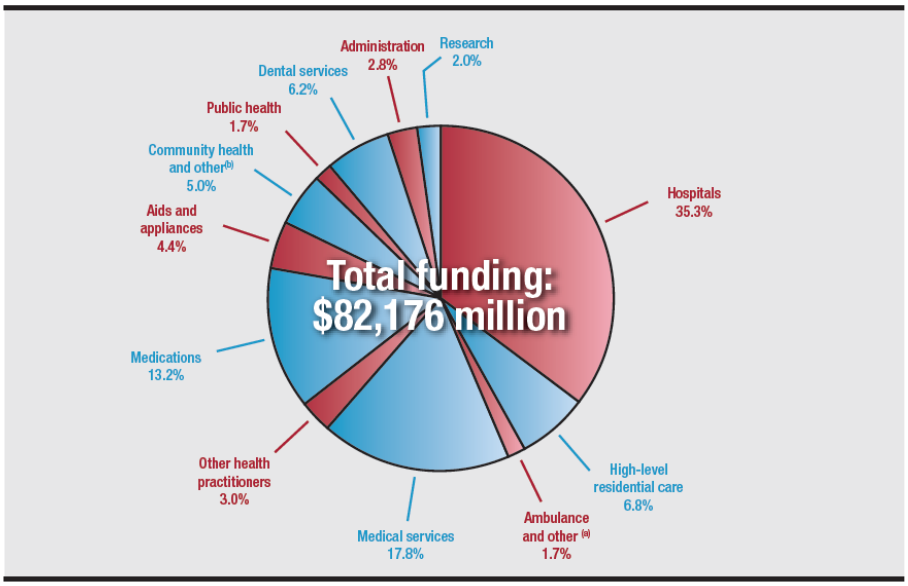
- Medicare (about $11 billion per year);
- the PBS (about $6 billion per year);
- funding to state and territory governments, including for more than 700 public hospitals (about $9 billion per year); and
- the private health insurance rebate (about $3 billion per year).

Total state and territory government expenditure is around $20 billion per year. The major components of this expenditure include:

- public hospitals (over $11 billion per year); and
- community health services, including public dental services (around $5 billion per year).

Individuals contribute almost 19 per cent of all health expenditure – a growing share under the Howard Government. Total expenditure on health by private sources (including out-of-pocket payments and private health insurance) is currently almost $28 billion per year.[5]

Chart 1: Recurrent expenditure on health goods and services, current prices, by broad area of expenditure, 2004-05[6]



[5] AIHW, *Health Expenditure Australia 2004-05,* AIHW, Canberra, 2006.
[6] AIHW, *Health Expenditure Australia 2004-05.*

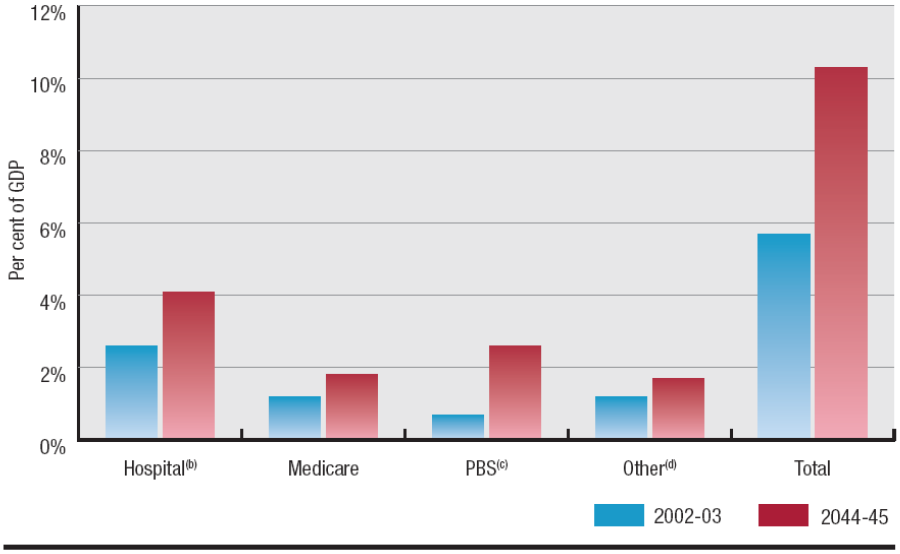
Health expenditure and the cost of providing health care, particularly in our hospitals, is rising.

The Intergenerational Report released in April this year foreshadows an increase in Commonwealth health spending as a proportion of GDP, from 3.8 per cent in 2006-07 to 7.3 per cent in 2046-47. In real dollars per person, this equates to an increase from $1,858 in 2006-07 to $6,458 in 2046-47.[7]

Hospitals and health services are projected to contribute significantly to this increased expenditure.[8]

In its 2005 report on the *Economic Implications of an Ageing Australia,* the Productivity Commission estimated that *total* government health expenditure (that is, both Commonwealth and state and territory government expenditure combined) is projected to increase from 5.7 per cent in 2002-03 to around 10.3 per cent of GDP in 2044–45.[9]

Chart 2: Projected Government Health Expenditure as a proportion of GDP, 2002-03 – 2044-45[10]



Our health services are under strain

Despite increasing expenditure across all areas of the health system, health services across Australia are under strain as a result of the ageing population, increasing cost of technology and the growing burden of chronic disease.

This is particularly the case for primary health care (especially GP) and public hospital services.

[7] The Treasury, *Intergenerational Report 2007,* April 2007.
[8] The Treasury, *Intergenerational Report 2007*.
[9] Productivity Commission, *Economic Implications of an Ageing Australia*, Productivity Commission Research Report, March 2005.
[10] Productivity Commission, *Economic Implications of an Ageing Australia.*

Primary health care

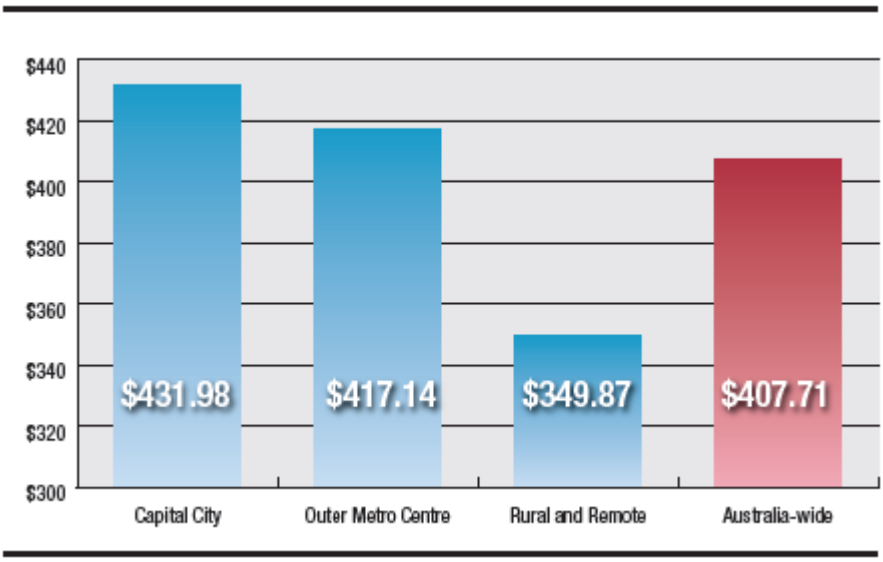
Primary care is 'first level' or frontline care, predominantly provided in Australia by general practitioners in private practice.

As the funder of GP services through Medicare, the Commonwealth is primarily responsible for the system of frontline primary care in Australia. Under Medicare, all Australians are entitled to free treatment at a public hospital, and a Medicare rebate for services provided by GPs, specialists (on referral from a GP), and allied health providers in some circumstances.

Since Medicare was established, cracks have started to appear in the Medicare system. Structural barriers mean that Medicare services which are a universal entitlement are not always universally accessible. For example, workforce shortages in many areas mean that it is not always possible to access Medicare funded GP services in some communities.

Analysis of expenditure on Medicare in different geographical areas reveals vast disparities in benefits paid per capita. People in many outer metropolitan, regional, and rural areas are missing out. Chart 5 highlights the differences between Medicare benefits per capita by geographic region in 2002-03 (the most recent year for which this data is available).

Chart 3: Medicare benefits per capita in metropolitan, rural and remote areas, 2002-03[11]



Another barrier to accessing Medicare services for many people is cost. Under-investment in Medicare over the long-term has led to record high out-of-pocket costs for Medicare services.

Labor has committed to a reform process to modernise and simplify Medicare. Labor's review of Medicare will focus on ways of providing incentives to GPs to practice quality preventative health care, through longer consultations when appropriate, and through facilitating multi-disciplinary care through primary health care teams.

Boosting primary care services in local communities also requires boosting infrastructure through which these services can be delivered.

[11] Source: Department of Health and Ageing, *Annual Report 2002-03.*

Bolstering primary care services will mean better health care for local communities, but will also help take pressure off public hospitals.

Bolstering primary care requires ensuring adequate infrastructure to deliver primary care services in local communities, as well as making general practice an attractive career option for young, newly graduating doctors.

Labor is committed to investing in reforms to primary care which will address these needs and help equip the primary care system to deal with the challenges of the future.

Public hospitals

Over the last decade, too many Australians' experiences of our hospital system has been characterised by queues for emergency care, waiting lists for surgical procedures, and inadequate follow up care.

Poor access to frontline GP and primary care services in local communities means many people can't or don't tackle their health problems early. Attending to them after the problems have got worse often makes their experience of the health system more traumatic and inevitably puts pressure on other parts of the health system, particularly public hospital emergency departments.[12]

According to the recently released *State of Our Public Hospitals* report, 12 per cent of presentations to public hospital emergency departments were for non-urgent conditions (that is, conditions that may be better managed by a GP).[13]

The hospital system is under strain more generally. A recent AIHW report revealed that over 500,000 hospital admissions per year were the result of mostly preventable conditions that would have been better treated in the community.[14]

The *State of Our Public Hospitals* report showed that the most common reason for admission to a public hospital in 2005-06 was the need for renal dialysis. Renal dialysis is used to treat end-stage kidney disease, the most common cause of which is Type 2 diabetes – a largely preventable chronic disease.

If these kinds of conditions were better managed in the community, and more hospital admissions prevented, a significant amount of public hospital capacity for things like elective surgery could be freed up. In other words, this would mean fewer public hospital resources spent treating people who shouldn't be in hospital and more resources available to treat people who should.

The pressure on public hospitals from population ageing, new technologies and chronic disease has been exacerbated by the Commonwealth's failure to adequately fund public hospital services.

While demand on public services is increasing, the Commonwealth's share of funding for public hospitals has been in decline.

Funding for public hospitals is provided through the Australian Health Care Agreements (AHCAs). Before the last Health Care Agreements, the Commonwealth took $1 billion out of funding for public hospitals. The Commonwealth's share of funding for public hospitals fell from 50 per cent in 2000 to 45 per cent in 2005 as a result, and is now as low as 35 per cent in some states.

[12] Productivity Commission, *Report on Government Services 2007,* 2007, p. 10.2.
[13] Department of Health and Ageing, *The State of Our Public Hospitals – June 2007 report,* p. 49.
[14] AIHW, *Atlas of Avoidable Hospitalisations in Australia: ambulatory care-sensitive conditions*, 2007.

The 2003–08 Agreements require each State and Territory to increase funding for public hospitals to at least match the rate of growth of Australian Government funding. The States and Territories exceeded this commitment in 2005–06.

While the nature of Australia's health challenges are changing, with the ageing of the population and the growing incidence of chronic disease, the AHCAs are narrowly focused on hospitals and hospital funding. At present the AHCA is developed largely in isolation to other health programs such as Medicare, the PBS, and the subsidisation of private health insurance.[15]

Yet the adequacy and direction of these other programs will have an impact on the outcomes that can be achieved under the AHCAs, for which the States are held accountable. Primary care is the most obvious area where this is the case – poor integration between primary care and hospital care inevitably results in pressure on the hospital system.

Another significant weakness of the AHCAs are the degree to which they place state and territory governments in a funding straightjacket. In seeking to over prescribe the inputs, the Commonwealth hinders state and territory governments' ability to achieve good outcomes for individuals.

For example, the requirement on states and territories to provide the same range of services as were provided at 1 July 1998 reduces their flexibility to introduce new models of care that may achieve better outcomes for patients.

The difficulties imposed by such restrictive conditions has been exacerbated by less generous Commonwealth funding indexation arrangements.

The adequacy of the funding provided under AHCA is contingent on the level of Commonwealth provision of substitutable primary care and other services to which the States have little or no input. And the impact of the lack of such services has dramatically increased as the burden of disease is changing.

Yet the States are solely responsible for providing any additional public hospital funding, that is, they carry the full risk of demand or cost increases which are not foreseen or not provided for, and must report to the Commonwealth on waiting times, which in turn are published by the Commonwealth in the 'State of our Public Hospitals' report.

Narrowly structured and under-funded ACHAs mean that the health system, in general, and the hospital system, specifically, are subject to considerable cost and blame shifting. For example people who require hospital treatment may be discharged with a prescription but no medication because it is cheaper for the State or Territory hospital system for them to access a private pharmacist where the Commonwealth picks up the cost through the PBS.

The recent *Standing Committee Blame Game Report into Health Funding* cited numerous examples of alleged cost shifting between both levels of government including:

- States shifting costs to consumers and the Commonwealth through public hospitals 'encouraging' patients to elect to be private patients;
- cost shifting to the States by diverting after-hours patients from general practice to emergency departments;
- cost shifting to the States when nursing home type patients occupy public hospital beds rather than being accommodated in a residential aged care setting; and

[15] Allen Consulting Group, *Governments Working Together? Assessing Specific Purpose Payments*, June 2006.

- States shifting costs to the Commonwealth and patients when public hospital patients are sent to have pathology and radiology undertaken either in private practice clinics co-located with the public hospital or sent to GPs to have the request ordered privately by the GP.[16]

Health care for people with chronic conditions such as cancer and kidney disease could be improved if the States had sufficient capacity to invest in providing more services in community settings. Specialist consultations, chemotherapy and renal dialysis are examples of services which can safely be provided in non-in-patient settings. Providing more care in community settings outside of hospital would be better for patients, but it would also free up valuable public hospital resources for other patients.

The greatest costs of current funding arrangements which encourage cost shifting and blame shifting come in the form of less than optimal care for patients.

Too many people, who, with coordinated and thorough preventative health care, need not be admitted to hospital, end up there. Too many older Australians who have been admitted but assessed as requiring aged care or transition care, remain in an acute hospital ward waiting for a more appropriate bed and denying another person in need a place.

For the health system to be equipped to meet the challenges of the future – most notably the ageing population and the growing burden of chronic disease – the AHCAs need to include much more than a narrow focus on hospital funding.

Labor has already committed to broadening the AHCAs to include primary care and a greater focus on prevention, and to making the transition between hospital and aged care a key focus of the next round of negotiations.

Equipping the health system to deal with the challenges of the future will require a long-term, comprehensive, strategic plan for overcoming waste, duplication, and poor integration of services that results from the current division of responsibility between different levels of government for health services in Australia.

The blame game

There are innumerable reports which document the difficulty in delivering health outcomes for Australians in a Commonwealth where responsibility for the various elements of the system are shared between State and Federal Governments.

Vertical Fiscal Imbalance

Vertical fiscal imbalance refers to the mismatch between the revenue-raising capacity and spending responsibilities of the States and the Commonwealth.

State governments have access to only a small number of taxes which constrains their revenue raising capacity relative to their expenditure responsibilities.

In contrast, the Commonwealth Government collects more revenue than it needs for its own purposes. As a result state and territory governments rely on grants from the Commonwealth to fund their expenditure responsibilities.

The introduction of the GST has further tilted this fiscal imbalance because State and Territory Governments have been required to abolish a number of their own taxes in return for this new one. The Commonwealth collects around 82 per cent of total

[16] House Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding,* December 2006.

national taxation revenue (including the GST), but is responsible for only around 54 per cent of own-purpose expenses.

A study by Professor Neil Warren for the New South Wales Treasury which included a comparison between different federations across the world found that expenditure responsibilities are generally allocated between the different levels of government in a relatively consistent fashion.

However he found the main points of difference between Australia and the other federations are in health and education. Whereas health and education funding is shared almost evenly between the Commonwealth and the States in Australia, in most other federations those responsibilities are allocated almost exclusively to one level of government.

This division of expenditure responsibilities in Australia can result in inefficiency and avoidance of accountability by blaming the involvement of the other level of government.

The high degree of vertical fiscal imbalance in Australia also means that the States are dependent on the Commonwealth for fiscal transfers and must take whatever they can get. The negotiations over the current Health Care Agreements in 2003 demonstrated this. High vertical fiscal imbalance can also lead to reduced public accountability and can hinder the pursuit of economic efficiency.

The cost of inefficiency

Cost-shifting, duplication and inefficiencies cause great frustration for our health professionals who must work within some peculiar boundaries due to the division of responsibilities between states and territories and the Commonwealth.

And although it is difficult to quantify the precise cost of current inefficiencies, some estimates put it as high as $4 billion annually.[17] The recent House of Representatives *Standing Committee Blame Game Report into Health Funding* noted in relation to these estimated savings that:

> *Although the committee has not tested the reliability of these estimates, their order of magnitude suggest that there may be significant resources that can be saved within the existing health budget and be directed to more appropriate areas. With over $87 billion in health expenditure in 2004-05, including $2.3 billion in administration costs, there is significant scope for savings by reducing duplication of service provision and/or administration. A 10 per cent reduction in administrative cost, for example, would save $230 million.*[18]

In fact a range of studies have sought to estimate the financial costs of the current inefficient system.

In 2002, Mark Drummond calculated that as much as $20 billion per annum is lost through the inefficiencies of the current Commonwealth-State system across all portfolio areas.

More recently Access Economics, in a paper for the Business Council of Australia, estimated that the total costs of various Commonwealth-State inefficiencies, including health, totalled some $9 billion per annum.

[17] House Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding,* December 2006.
[18] House Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding,* December 2006.

According to the Independent Pricing and Regulatory Tribunal of New South Wales,[19] the use of emergency departments to provide GP-type services in New South Wales was estimated to cost an additional $110 million per annum, compared with $30 million for the provision of these services under the Medicare Benefits Schedule.

The net cost to the community ($80 million) from providing the services in emergency departments rather than in a general practice setting represented 1.5 per cent of New South Wales public hospital costs in 2002-03.

There are many estimates of the likely efficiencies that can be derived from providing a timelier and appropriate transition from hospital to aged care for older Australians.

There are currently approximately 2,300 older Australians in public hospitals who should been in residential aged care, as recommended by an Aged Care Assessment Team.[20] The situation has deteriorated since 2004 when it was estimated that on any one night in Australia there were 1,684 people in public hospital beds waiting for aged care.[21]

While older Australians are well cared for in hospital, acute care facilities are not equipped to provide the social interactions and personal environment that contributes to their quality of life. Acute hospital beds are also a very expensive and therefore an inefficient place for people to wait for an aged care pace.

The average cost per day of an acute public hospital bed is about $967, whereas the average cost for a residential aged care bed is just over $100 a day.[22] The total cost of having 2,300 people waiting in acute hospital beds for an aged care place is therefore in excess of $700 million each year.[23]

Therefore, improving 'allocative efficiency' through changes to the composition of services across the health sector could reasonably be expected to improve overall productivity. For example:

- where residential care is more appropriate and cost-effective than hospital acute care for elderly people;
- where primary care services (such as GPs) are more appropriate and cost effective than hospital emergency departments; and
- where preventative care and early intervention is more appropriate and cost effective than hospitalisation.

[19] Independent Pricing and Regulatory Tribunal of New South Wales, *NSW Health: Focusing on Patient Care,* August 2003.
[20] *Caring for our health?* A Report by State and Territory Health Ministers, June 2007.
[21] *From hospital to home: Improving care outcomes for older people*. AHMAC Care of Older Australians Working Group, July 2004.
[22] Productivity Commission. *Report on Government Services 2007*. The pensioner supplement and other supplements will add another $8 per bed per day.
[23] This is based on the data provided in reference 12, released after Labor's media statement of 8 June which used 2000 as the figure for the number of older Australians in hospital beds on any given night.

Chart 4: Assumed potential health sector productivity gains under NRA-consistent reforms[24]

	Subsector productivity %	Subsector shares[a] %	Contribution to productivity gain of sector[b] %	Implied expenditure savings[bc] $m (2005-06)
Subsectoral productivity				
All hospitals (public and private)	4	48	1.9	1,170
Other, including medical services	2	52	1.0	634
Change in composition of services across sector			1.7	1,036
Total Sector		**100**	**4.6**	**2,840**

The Productivity Commission makes clear that reforms must proceed on the basis of robust cost–benefit analyses but suggests that changing the composition of health services, while maintaining the overall health outcomes of the population, could increase sectoral efficiency by a further 1.7 per cent.

The Productivity Commission estimates that in aggregate, the productivity gain as a result of National Reform Agenda-consistent reform could be in the order of 4.6 per cent.

This, according to the Commission, would represent a cost saving of around $2.8 billion of the estimated 2005-06 total health sector costs and be achievable within a decade.[25]

While some of the savings outlined in these studies and reports are hypothetical in nature and may overstate gains, they demonstrate the potential for significant efficiencies from Commonwealth-State reform which could be reinvested in improved health services for patients.

Assessing the impact of health reforms aimed at lifting productivity and participation

While overlap, duplication and cost shifting have long been recognised as a source of inefficiency and cost to the system, more recently a range of studies have focused on the human and economic costs of the system failing to provide strong preventative health care and support for managing chronic disease. The more recent studies sought to assess the productivity and participation effects of the current health funding priorities.

Access Economics has undertaken a number of studies which seek to quantify the cost of individual diseases and conditions. These studies are significant in that most are chronic, preventable diseases which carry a substantial health cost and having an increasing impact on productivity and participation.

What these studies demonstrate is that the costs of not addressing the pressure on the health system caused by the growing burden of chronic disease extend well beyond the health system itself – because the burden of chronic disease takes a huge toll on our economy and national productivity.

For example Access Economics has estimated that:

- the annual financial cost of cardiovascular disease in Australia at $14.2 billion, or 1.7 per cent of GDP. This figure includes lost productivity costs of $3.6 billion, caused by lower employment rates and premature mortality. In addition to the

[24] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[25] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.

financial costs, Access Economics estimates the value of suffering and premature death from cardiovascular disease at a staggering *$94 billion*.[26]

- the total cost of obesity in Australia in 2005 was $21 billion. This includes productivity losses of $1.7 billion, as a result of absenteeism, lost management productivity, long-term lower employment rates, and premature death; as well as the cost to the health system of obesity-related illness, and a range of indirect costs such as lost wellbeing.[27]

- the total cost of diabetes is around $21 billion. This figure includes lost productivity, health and carer costs, taxation revenue foregone and welfare and other payments. People with Type 2 diabetes have significantly lower productivity in the workplace; lower workforce participation rates; and are more likely to suffer from heart disease.[28]

Recent work undertaken by the Productivity Commission also highlights the impact of chronic conditions on labour force participation rates.

Chart 5: Labor force participation rates by health condition: 2001-04[29]

Condition	Cancer	Cardio-vascular	Mental/ nervous	Major injury	Diabetes	Arthritis
Total population	%	%	%	%	%	%
Does not have condition	80.3	82.0	80.7	80.2	80.7	82.6
Has condition	68.6	64.0	39.3	60.1	56.6	63.1
Males						
Does not have condition	89.0	90.8	89.0	88.6	89.1	91.2
Has condition	67.8	70.6	37.5	67.1	64.6	68.0
Females						
Does not have condition	72.3	74.1	73.0	72.5	72.8	74.5
Has condition	69.4	56.7	40.8	52.1	46.0	59.3

Participation rates are significantly affected for those with a chronic disease. This is especially the case for people with a mental illness or nervous condition.[30]

In relation to mental illness, the Productivity Commission notes that:

> *Australian studies suggest that the early application of optimal evidence based treatments has the potential, on average, to reduce the burden of the disease by 50 per cent.[31] For depression, however, the estimated increase in the disease burden averted is close to 75 per cent,[32] while for schizophrenia, it is around 45 per cent.[33]*

[26] Access Economics, *The shifting burden of cardiovascular disease in Australia,* 2005.
[27] Access Economics, *The shifting burden of cardiovascular disease in Australia,* 2005.
[28] Access Economics, *The Economic Costs of Obesity,* October 2006.
[29] Productivity Commission, *Effects of Health and Education on Labour force participation*, Staff Working Paper, 2007.
[30] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[31] Hickie, I., Groom G, Davenport T, (2004). *Investing in Australia 's future: the personal, social and economic benefits of good mental health*. Canberra: Mental Health Council of Australia.
[32] Andrews, G., Sanderson, K., Corry, J., and Lapsley, H.M. 2000, 'Using epidemiological data to model efficiency in reducing the burden of depression', *The Journal of Mental Health Policy and Economics*, vol. 3, no. 4, pp. 175–186; Issakidis, C., Sanderson, K., Corry, J., Andrews, G. and Lapsley, H. 2004, 'Modelling the population cost-effectiveness of current and evidence-based optimal treatments for anxiety disorders', *Psychological Medicine*, vol. 34, pp. 19–35; Vos, T., Haby, M., Barendregt, J.J., Kruijshaar, M., Corry, J. and Andrews, G. 2004b, 'The burden of major depression avoidable by longer-term treatment strategies', *Archive of General Psychiatry*, vol. 61, pp. 1097–1103.
[33] Andrews, G., Sanderson, K., Corry, J., Issakidis, C. and Lapsley, H. 2003, 'Cost-effectiveness of current and optimal treatment for schizophrenia', *British Journal of Psychiatry*, vol. 183, pp. 427–435.

This represents a significant opportunity for both individuals and the economy more generally.

Chart 6: Estimated average direct health cost savings[34]

Chronic disease	Average cost per patient[a] $	Cases avoided no.	Gross avoided costs $ million
Mental health	2,064	—	—
Cardiovascular	1 720	1,578,000	2,714
Type 2 diabetes	1 465	508,000	745
Injury (serious)	11,757	26,000	303
Cancer	9 374	15,000	142
Musculoskeletal	765	25,000	19

Poor health is also associated with lower productivity: people in poor health tend to be less productive when they are at work, because, their condition negatively affects their ability to perform on the job.

For example, mental health problems such as depression can not only cause absenteeism but also impair motivation and work performance.[35]

But the Productivity Commission points out that the reverse is also true: 'healthy workers can expect higher returns from work and, as a result, have a greater incentive to be in the labour force'.[36]

Subsequently, the cost of inaction on prevention and early intervention is significant.

In the case of mental health, for example, early intervention can lead to improved management of risk factors, help prevent some problems developing or reduce their impact on an individual's life including their ability to maintain employment.[37]

The Productivity Commission has estimated that modest investments in health promotion and prevention will deliver improvements in workforce participation and national productivity. For example, it is estimated around 100,000 deaths could be avoided by 2030 through improved health promotion and disease prevention.[38]

The Productivity Commission also estimates that improved health promotion and prevention could result in as many as 175,000 extra people in the workforce by 2030, due to reduced mortality and incapacity, as well as an associated reduction in the need for carers (Chart 7).

These extra workers would represent an increase of around 0.6 of a per centage point in the workforce participation rate – a substantial increase at a time of significant skills shortages around the country. The biggest gains stand to be made by improved prevention and management of mental health, cardiovascular disease, and Type 2 diabetes, as the following chart shows.[39]

[34] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[35] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[36] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[37] The Allen Consulting Group, *Governments Working Together: A better future for all Australians*, November 2004.
[38] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[39] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.

Chart 7: Estimated potential workforce effects from improved health outcomes: 2030[40]

Chronic disease	Increased participation		Relative productivity
	Number	% points	%
Mental health	101,000	0.46	70
Cardiovascular	30,000	0.01	100
Type 2 diabetes	31,000	0.07	100
Injury (serious)	8,000	0.03	100
Cancer	6,000	-0.01	100
Musculoskeletal	1,000	0.00	100
Less double up	2,000	0.01	100
Total	**175,000**	**0.55**	**83**

Options for reform

The seemingly intractable nature of Commonwealth-State health funding agreement making has led experts to propose a range of reforms that seek to rebalance responsibilities in an effort to improve health outcomes.

According to the former Secretary of the Department of Health and Ageing, Andrew Podger, our health system has the following structural problems:

- a lack of patient-oriented care that crosses service boundaries easily with funds following patients, particularly those with chronic diseases, the frail aged and Indigenous people;
- allocative inefficiency with the allocation between different types of care not always achieving the best health outcomes possible, and with obstacles to shifting resources for individuals or communities to allow different mixes reflecting different needs;
- poor use of information technology, where better investments and usage could not only reduce administrative costs but also support more continuity of care, better identification of patients at risk, greater safety and more patient control; and
- poor use of competition, with an uneven playing field in the acute care area, a reluctance to use competition to ensure best access to medical services at reasonable cost, and less choice than should be possible (in aged care in particular).[41]

In response, Podger proposes a single funder model which would seek to overcome problems in the current system by streamlining lines of responsibility and accountability. Under Podger's model, the Commonwealth would become the single funder of health services, including hospitals, and set broad policy objectives and principles, and regional health organisations would have responsibility for purchasing health services for their region.[42]

Others such as Scotton advocate a ‘managed competition’ model, under which both Commonwealth and state funds are channelled through private health insurance funds using vouchers equal to each individual’s risk-rated premium which the

[40] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[41] A. Podger, A Model Health System for Australia - Inaugural Menzies Health Policy Lecture : 3 March 2006.
[42] A. Podger, A Model Health System for Australia - Inaugural Menzies Health Policy Lecture : 3 March 2006.

individual may pass to the fund of their choice, the fund then having full responsibility as funder/purchaser of all their health and aged care services.[43]

While the general community may support greater Commonwealth involvement in the funding and management of hospitals in the hope that this achieves improved outcomes, such an approach should be second rather than a first step in reforming current health funding arrangements.

Any alternative hospital funding approach would also need to be evaluated thoroughly to ensure that consumers existing access to programs such as Medicare, the Pharmaceutical Benefits Scheme and private health insurance rebates are not in any way eroded.

If history is any guide, it is likely State and Territory governments would embrace further health reform on a cooperative basis. This is evidenced by their approach to previous AHCA negotiations.

Despite initial agreement between the Commonwealth and State and Territory Governments on the need for reform focused on improved health outcomes during the AHCA negotiations in 2002 and 2003, the Federal Health Minister abruptly terminated negotiations to impose an offer devoid of any innovation or incentives for serious, long-term reform.[44]

The positive discussions held prior to the Howard Government's imposition of their 'take it or leave it' offer in 2003 suggests that serious health reform *is* possible through collaboration between the Commonwealth and the States and Territories, if the Commonwealth is prepared to show sufficient leadership.

A Rudd Labor Government will first seek to improve health and hospital services through a collaborative approach with the States and Territories. However, if improved outcomes cannot be delivered within a certain period of time through this approach, Federal Labor will consider more extensive reforms to the health system.

Labor's Health and Hospitals Reform Plan

A Rudd Labor Government will work with the State and Territory Governments to reform our health and hospital services to improve health outcomes for all Australians.

This plan sets out our strategy to drive both sets of reforms for lasting benefit to the community – and an action strategy if improved health outcomes cannot be achieved in a short timeframe.

Labor's Health and Hospitals Reform Plan

Federal Labor will invest $2 billion in a Health and Hospitals Reform Plan, to improve the delivery of health and hospital services to all Australians.

The focus of the Plan will be ensuring communities across the country have access to strong local health services and well supported public hospitals.

This investment will be used for initiatives that address one of four key outcome areas:

[43] House Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding,* December 2006.
[44] S. Duckett, 'The Australian Health Care Agreements 2003-08', *Australia and New Zealand Health Policy,* 2004.

1. **A reduction in preventable hospitalisations and non-urgent accident and emergency presentations.** Funding would be available for new or enhanced primary care services, stronger preventative health care and improved chronic disease management.

   Examples of projects that may be funded against this outcome would include projects aimed at strengthening the role of GPs as coordinators of patients with chronic disease, dental care or the establishment of primary health care centres or clinics which focus on improving chronic disease prevention and management and take pressure off public hospitals.

2. **A reduction in waiting times for essential hospital services such as elective surgery.**

   An example of a project that may be funded against this outcome include upgrades to elective surgery facilities to increase capacity and throughput.

3. **Fewer and shorter hospital stays for frequent hospital visitors, particularly older Australians once they have been assessed as requiring non-hospital care.**

   Examples of projects funded against this outcome would include improved facilities for transition care, and specific projects designed to reduce re-admission rates (for example, through better discharge planning or management of medication).

4. **Increased access to medical and specialist services in the community.**

   Examples of projects funded against this outcome would include outreach renal dialysis and chemotherapy and oncology services or clinics.

Funding provided under Federal Labor's **Health and Hospitals Reform Plan** will have three components:

- Up front Commonwealth funding for mutually agreed ***immediate health reforms and investment needs*** which will improve the health system and seek to overcome cost shifting and the blame game between Commonwealth, State and Territory Governments;
- ***Incentive funding*** that will be paid upon achievement by State and Territory Governments of agreed outcomes
- Funding dedicated to strengthening the provision of ***primary care*** services and reduce pressure on public hospitals.

Funding will be provided on the basis of need. Areas where services, particularly Medicare services, are currently under-utilised because of workforce shortages and lack of adequate health care infrastructure will be prioritised.

Transition Care Beds and Aged Care reforms

A Rudd Labor Government will provide 2,000 additional fully-funded transition care places. This will bring the capacity of the transition care system to 4,000 places which will assist up to 26,000 older Australians each year.

Labor's commitment to provide 2,000 new Commonwealth-funded transition care places will not only help up to 13,000 older patients move from hospital to more appropriate care and recovery each year, but will benefit an equal number of public hospital patients who are waiting for a bed. There is also a major financial benefit to the States and Territories.

A Rudd Labor Government will also provide $300 million in zero real interest loans to build or expand residential and respite facilities in areas of need.

These loans will be available to aged care providers to build or expand facilities in areas where there is a shortage of beds for permanent and respite care as assessed by the provision ratio of beds against the benchmark.

Federal Labor will fast track these loans to those providers who can begin building or redeveloping facilities immediately to bring new places online as swiftly as possible.

This initiative is expected to release an additional 2,500 residential aged care beds.

Implementing Federal Labor's health reforms

If we are to reform our hospital and health system, the Commonwealth faces four choices:

1. Maintain the status quo;
2. Maintain the status quo with random interventions into particular hospitals or areas of the health system without an overall health plan as the Howard Government has done;
3. Embark on a cooperative, systematic national reform process to reduce cost and blame shifting and to recoup by way of efficiencies the billion dollars currently lost by way of duplication and overlap; or
4. Assume Commonwealth funding of all our public hospitals (involving a parallel reduction in Commonwealth outlays to states at the point of transfer).

Federal Labor is committed to the third option – that is achieving national health care reform in partnership with the State and Territory Governments. However, if this approach fails, Federal Labor leaves open the option of proceeding to option four.

Labor's policy reforms will occur in three stages.

First, a Rudd Labor Government will invest $2 billion in a National Health and Hospitals Reform Plan as described above.

Second, within the first one hundred days of its election, a Federal Labor Government, through COAG, will establish a National Health and Hospitals Reform Commission to develop a long-term health reform plan for the nation.

This Commission, headed by an eminent Australian, will, in co-operation with the States and Territories, and in consultation with health experts, professionals, and consumers, develop stringent performance benchmarks which State and Territory Governments will be required to meet. The Commission's work will form the framework for the development of the next Australian Health Care Agreements.

The objective is to eliminate cost shift and blame shift and to recoup (and reinvest in health services) at least the BCA's nominated $1 billion in efficiency savings across the principal categories of functional duplication and overlap:

- Acute care beds and aged care places;
- Accident and emergency departments and GP services; and
- Other areas where funding responsibilities overlap, such as mental health and disability services.

Third, if by the middle of 2009 the State and Territory have not begun implementing a national reform plan, a Rudd Labor Government will seek a mandate from the Australian people at the following election for the Commonwealth to assume full funding responsibility for the nation's public hospitals.

The assumption of Commonwealth funding for all public hospitals would require a parallel reduction in Commonwealth outlays to State and Territory Governments at the time of transfer.

If necessary, Federal Labor will also consider the possibility of conducting a national plebiscite or referendum on the question of any proposed Commonwealth takeover.

If a Commonwealth takeover of hospital funding received the support of the Australian people, a model would be devised that ensures the future of State, private and community-managed hospitals.

There would also be provision for the role of regional and local authorities to participate in the management of public hospitals to ensure responsiveness of hospitals to local community needs. Under Labor's proposal, no public hospitals would be managed directly from Canberra.

While State and Territory failure to meet agreed benchmarks would provide an initial trigger for Commonwealth assumption of financial responsibility for public hospitals, in the long term such a step may become necessary for other reasons. For example, it may only be the national government that will be in a financial position to fund the long term needs of Australia's health and hospital system.

There is some support amongst State and Territory leaders for this more dramatic kind of reform.

The current New South Wales Premier Morris Iemma has suggested that 'if it leads to better healthcare for the people of Australia and the people of New South Wales, then New South Wales is prepared to cede power or jurisdiction'.

Similarly, Queensland Premier Peter Beattie has acknowledged:

> *I'm not sure giving health to the Commonwealth is the answer, but I think we need to have a look at it…the current system is broken – we need to fix it. It's costing people money and its bad service delivery. The trouble at the moment is the Commonwealth is terrified about cost-shifting, so nothing happens.*

Any reforms undertaken by a Rudd Labor Government would be underpinned by a continuing commitment to the maintenance and improvement of:

- Medicare;
- the PBS; and
- private health insurance rebates.

This investment in health reform – in fixing our hospitals and improving health services in the community, providing incentives for the States and Territories to improve their performance in delivering quality health services to Australian families, and in keeping Australians healthier and avoiding preventable diseases like Type II diabetes – will generate efficiencies within our health system by reducing duplication and overlap and in ending the cost-shifting that characterises our current system.

Investing in health reforms which reduce the incidence of preventable illnesses and reduces hospitalisations will not only improve the quality of life of our people but will generate a dividend to the economy through higher workforce participation and reduced costs to business.

Unlike the Howard Government, Labor has been identifying savings – over $3 billion to date – to pay for our promises. This commitment to invest in our health system and our hospitals is fully costed and funded.