

Final report of the National Health and Hospitals Reform Commission: will we get the health care governance reform we need?

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The recommendations on governance from the final report of the National Health and Hospitals Reform Commission (NHHRC) may be its most important. Governance, in this context, refers to the “leadership and stewardship of the health system”;¹ in other words, who manages the health system, and how.

The problems of the current governance arrangements are well known. They were instrumental in establishing the NHHRC in the first place, following the political brouhaha in the last federal election over the state of the nation’s public hospitals. The central issue is the historical split in governance between the federal government and those of the states and territories. This has led to fragmentation of service delivery, cost-shifting and a lack of unified health policy. The resulting “blame game” is, however, only the immediate problem. Of greater concern is our capacity to meet the challenges ahead to sustain a universal health scheme. These include financial sustainability, with the growth of spending per person on health care outstripping inflation by some 3% per year, and out-of-pocket payments, which are inequitably distributed, increasing faster than other sources of funding.² Perhaps more important is its political sustainability — the capacity of our political and bureaucratic structures and processes to deal with the distortions inherent in any tax-funded scheme in which consumers and providers face no (or little) responsibility for costs. This creates incentives for stakeholder groups to manufacture the political storms necessary to protect and increase their share of the tax pie, while the general tax-paying public has no engagement in the difficult task of deciding how much we want to spend on public health care versus other priorities.

In dealing with this challenge, the NHHRC has had to consider not only recommendations about what should be changed, but

ABSTRACT

- The National Health and Hospitals Reform Commission (NHHRC) has recommended that Australia develop a “single health system”, governed by the federal government. Steps to achieving this include: a “Healthy Australia Accord” to agree on the reform framework; the progressive takeover of funding of public hospitals by the federal government; and the possible implementation of a consumer-choice health funding model, called “Medicare Select”.
- These proposals face significant implementation issues, and the final solution needs to deal with both financial and political sustainability.
- If the federal and state governments cannot agree on a reform plan, the Prime Minister may need to go to the electorate for a mandate, which may be shaped by other economic issues such as tax reform and intergenerational challenges.

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also how, or by what pathway change should be implemented. This is no easy task.

First the NHHRC has identified that Australia needs “one health system” and has opted for governance by the federal government. It has then suggested three stages, listed below, that can be considered a pathway to such a solution.¹

- The Council of Australian Governments (COAG) should meet to agree on a “Healthy Australia Accord” on implementing the NHHRC’s recommendations, including future governance.

- The federal government should progressively take over funding responsibilities for Medicare, starting with public hospital out-patient and community health services as part of the primary care strategy, clinical education and training and partial funding of public hospital inpatient and emergency department services. The NHHRC sees this funding responsibility increasing to 100% over time as the federal government builds its capacity to “purchase” these services.
- Subject to a successful period of research and development, a funding model called “Medicare Select” should be implemented, under which public and private health plans compete, allowing consumers to exercise choice and preference.

Will these recommendations be implemented? The Prime Minister has committed the government to “leave each of these three options on the table for the next six months or so, as we engage in a detailed, direct consultation with the health sector and with communities around the nation . . .”³ A special COAG meeting to consider the reforms is to be scheduled for late 2009, and the federal government will put its plan to a COAG meeting in early 2010. It is hard to be optimistic that the heads of governments will reach a Healthy Australia Accord without significant financial incentives. The NHHRC’s recommendations themselves could already cost over \$5 billion. The Prime Minister has said, however, that if agreement is not reached with the states, “the Commonwealth will proceed to seek a mandate from the Australian people for the proper reform of our health system for the future”.³

Assuming an Accord is agreed, will the federal government takeover of funding public hospital services solve the governance problems? It is possible that it will make them worse. Hospital cost inflation will be under pressure, as the federal government will have uncapped exposure to its 40% share of inpatient and emergency department cost escalation. The states will be under more pressure to increase their spending in these areas, as they will only have to pay 60%, rather than the current full cost. The political burden of public hospital governance will then be added to the federal government agenda without any initial mechanisms for responding, other than with more funding. It is this dynamic that the NHHRC presumably feels will lead to the federal government becoming an effective purchaser. It will require more than activity-based funding, especially as it moves to the desired 100% funding, and there is a real risk it will respond in bureaucratic style, establishing the very regional health authority structure rejected by the NHHRC.

This leaves us with the prospects for the third recommendation, Medicare Select. Elsewhere, we have argued the merits of using consumer choice among competing health plans as a model for the

future sustainability of Medicare.⁴ Unfortunately, the NHHRC has turned away from a social insurance model in favour of the current tax-funded system. The benefit of the former is that it makes funding for health care transparent, and thus enables the public to engage in the governance issue of how to respond to excessive cost escalation. It also makes it possible to link growth in health spending prospectively to an indicator of economic growth. A substantial direct payment to the chosen health plan allows for price competition between funds, with an income-related rebate maintaining equity. This price competition is needed to improve health plan purchasing. A tax-based model does not address political sustainability.

While the NHHRC is to be congratulated on having gone further than might have been expected with its proposed governance reforms, it might not have gone far enough to maintain our universal health scheme into the 21st century. We now await the federal government’s response which, as the Prime Minister noted, will be influenced by the Henry Report on tax reform and the next Intergenerational Report,³ both due by year’s end. This reminds us that the need to reform health care governance will also be driven by these economic challenges.

Competing interests

Johannes U Stoelwinder is a member of the Board of Medibank Private.

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References

- 1 National Health and Hospitals Reform Commission. A healthier future for all Australians: final report June 2009. <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report> (accessed Aug 2009).
- 2 Australian Institute of Health and Welfare. Australia’s health 2008. Canberra: AIHW, 2008: 404. (AIHW Cat. No. AUS99.) <http://www.aihw.gov.au/publications/aus/ah08/ah08.pdf> (accessed Aug 2009).
- 3 Rudd K. Reforming Australian health care. Address at the John Curtin School of Medical Research, Australian National University, 2009; 27 Jul. <http://www.pm.gov.au/node/6069> (accessed Aug 2009).
- 4 Stoelwinder JU, Paolucci F. Sustaining Medicare through consumer choice of health funds: lessons from the Netherlands. *Med J Aust* 2009; 191: 30-32.

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