

The Changing Demands on Australia's Health Policymakers: A Case Study on Intergovernmental Relations in Health over 40 years

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An overview of the Australian health system

Australia has a universal health insurance system funded primarily through taxation. All citizens are entitled to treatment as public patients in public hospitals at no additional cost, and to subsidies for a wide range of pharmaceuticals and medical services provided outside hospitals. In addition to universal public insurance, Australians can voluntarily purchase private health insurance, with tax-funded subsidies for premiums available to older people and some people on lower and middle-incomes. In some areas, private health insurance duplicates cover provided under the public insurance scheme (for example, hospital services), but in others it provides additional cover (for example, allied health and dental services).

In Australia's federation, responsibility for health is shared between the federal (the Commonwealth) and state and territory governments (the states). Total health expenditure in 2014-15 was \$162 billion, and this accounted for 10.0 per cent of Gross domestic Product (GDP).¹ Of this, \$108 billion was government expenditure; 41 per cent was funded by the Commonwealth and 26 per cent by the states. The remaining 33.1 per cent was funded through non-government sources, including individuals and private health insurers.²

Although both levels of government have some funding responsibilities, the Commonwealth's are larger because of its greater revenue raising capacity. The Commonwealth raises around 80 per cent of taxation revenue, mostly from individual and corporate income taxes, and taxes on goods and services.³

Because of the Commonwealth's greater revenue raising capacity, the states rely heavily (but not totally) on the Commonwealth to fund their activities in health. This imbalance between the revenue raising capacity and spending responsibilities of governments within a federation – known as the vertical fiscal imbalance – is greater in Australia than many other countries.⁴

¹ Australian Government, Australian Institute of Health and Welfare (AIHW), *Health expenditure Australia 2014-15*, 6 October 2016, Canberra, available at: <http://www.aihw.gov.au/publication-detail/?id=60129557170&tab=2>

² Ibid

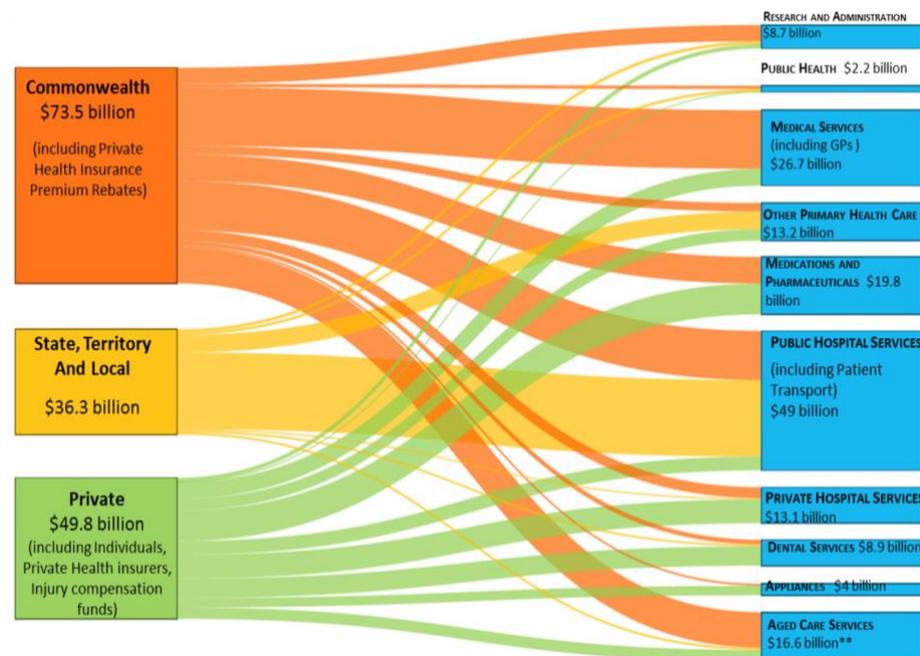
³ Australian Government, *Re:Think, Tax review Discussion paper*, March 2015, Canberra, available at: <http://bettertax.gov.au/publications/discussion-paper/>

⁴ Ibid

The Commonwealth has responsibility for funding public hospitals (it funds about 40 per cent of costs through intergovernmental agreements), pharmaceuticals (through the Pharmaceutical Benefits Scheme), medical services (through the Medical Benefits Scheme), private health insurance (through subsidies), aged care services, dental services for some people, and a range of prevention, population and mental health services.

The states are primarily responsible for delivering health services, but they also have substantial funding responsibilities. The states fund public hospitals (about 60 per cent of costs), some dental, prevention, population and mental health services. Funding allocations to various sectors of the health system from Commonwealth, state/territory and local governments, and private sources are illustrated in Figure 1 below. Funding amounts are approximates only.

Figure 1: Funding flows in the Australian health system



Source: Department of Health, 2015

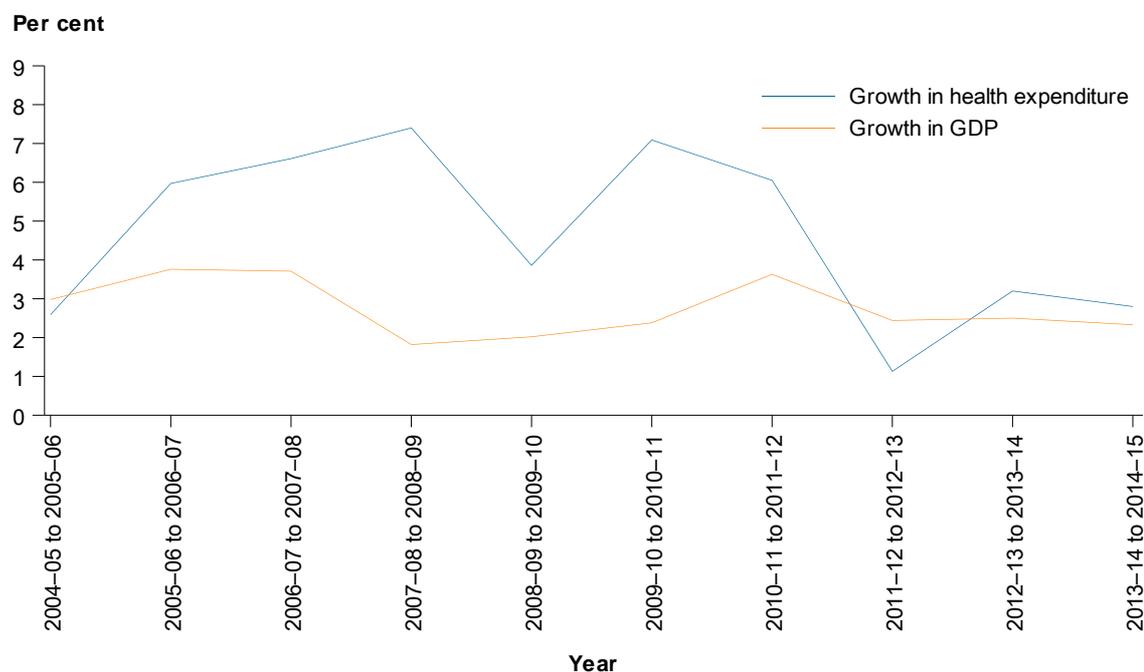
It is clear from this figure that there is considerable overlap in the roles of governments, and the private sector, in the Australian health system. Sustaining strong, co-operative relationships between governments is a requirement for the health system to function well. It is also an ongoing challenge for policymakers.

The fiscal sustainability challenge

Australian governments, like many around the world, are concerned about the fiscal sustainability of the health system because health expenditure continues to grow alongside demand for care. While the economy is growing, it is not growing as fast as health expenditure. The diagram below shows that health spending as a proportion of

GDP in Australia has grown at a faster rate than the annual growth in GDP for most of the last decade.

Figure 2: Annual growth rates of health expenditure and GDP, constant prices, 2004–05 to 2014–15



Source: AIHW, Health Expenditure 2014-15, Additional material, Figure 2.1

The ageing demographic of most advanced economies is a well-known pressure driving up health expenditure. Between 1960 and 2010, the proportion of people aged over 80 years in OECD countries increased from 1.3 per cent to 4.0 per cent. That proportion is projected to increase to 10.1 per cent by 2050. In Australia, the growth in the proportion of the population over 80 is also increasing, but at a rate slightly lower than the OECD average; it is projected to increase from 3.7 per cent in 2010 to 8.1 per cent by 2050.⁵

The implications for the health system of an ageing demographic are clear: as the population ages over time, demand for health and social services is likely to increase. One of the less frequently acknowledged consequences of an ageing population is the impact it has on the health workforce, which is also ageing. Over time, shortages in health workers and continued growth in demand are likely to drive up wages and professional fees, and cause health expenditure to increase further.

⁵ Organisation for Economic Cooperation and Development (OECD), *Health at a glance 2013*, 21 November 2013, Paris, available at: http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2013/trends-in-the-share-of-the-population-aged-over-80-years-1960-2050_health_glance-2013-graph168-en;jsessionid=2knqkmguh5ig8.x-oecd-live-03

Another major cause of the growth in health expenditure around the world is the growing burden of chronic diseases. In 2011, chronic diseases accounted for around two thirds of the total burden of disease in Australia.⁶

Although this trend has been evident for many decades in Australia, governments have had little success preventing chronic diseases. Trend data on the risk factors for developing chronic diseases – most of which are preventable – also show little sign of declining.⁷

Healthcare agreements in Australia: a brief overview

Australia first introduced a universal health care scheme in 1975. The scheme, called Medibank, guaranteed all Australians treatment as a public patient in a public hospital without charge. Medibank also subsidised the cost of out-of-hospital medical services by providing patients with benefits to cover the cost of services (either in part or in full). The scheme was financed through taxation originally with a levy on taxable income added subsequently.

Although the Commonwealth had been providing funds to the states for public hospitals since the 1940s, Medibank meant the Commonwealth had to make some changes to the way it provided these funds. Previously, the Commonwealth had funded access to public hospitals: as grants to the states based on the number of public hospital beds utilised, subsidies direct to patients, and subsidies direct to doctors.^{8,9} Introducing Medibank meant the Commonwealth had to negotiate public hospital funding agreements, known as Medibank hospital agreements, with state governments. These agreements determined the size of the grant the Commonwealth would make to each individual state for public hospital services over the period of the agreement. Direct subsidies to patients and doctors for public hospitals ended when Medibank began.

The original Medibank agreements lasted 5 years. By the time these agreements expired, the Commonwealth government had changed (the Australian Labor Party (Labor) lost power to the Liberal-National Coalition (the Coalition) at the end of 1975), and Medibank had been abolished. The Commonwealth government continued to pay block grants to the states for public hospital services using a variety of cost-sharing arrangements for several years.¹⁰

⁶ Australian Government, Australian Institute of Health and Welfare, *Australia's health 2016*, Australia's health series no. 15. Cat. no. AUS 199, 2016, Canberra, available at: <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555788>

⁷ Australian Government, AIHW, *Australia's health 2016*.

⁸ JA Gillespie, *The Price of Health: Australian Governments and Medical Politics*, Cambridge University Press, Cambridge, 1991 and 2000.

⁹ S Sax, *A strife of interests: Politics and policies in Australian health services*, 1984, Allen and Unwin, Sydney.

¹⁰ Ibid.

New health agreements were negotiated in 1983-84 when the Commonwealth government changed again (back to Labor), and Medibank was revived, this time it was called Medicare. The Medicare agreements also lasted for a 5-year period, and have been re-negotiated every 5 years or so since then. Table 1 below outlines the major intergovernmental health agreements made since 1975.

Table 1: Intergovernmental health agreements in Australia from 1975 onwards

Period	Intergovernmental agreement
1975-1980	Medibank hospital agreements
1980-1984	Various cost-sharing arrangements implemented
1984-1988	Medicare (Compensatory) Agreements
1988-1993	Medicare Agreements
1993-1998	Medicare Agreements
1998-2003	Australian Health Care Agreements
2003-2009	Australian Health Care Agreements
2009-2010	National Healthcare Special Purpose Payments
2010-2011	National Health and Hospitals Network Agreements
2011-2016	National Health Reform Agreements
2017-2020	Heads of Agreement between the Commonwealth and the states and territories on public hospital funding

The changing scope of intergovernmental health agreements

The original Medibank agreements focused almost entirely on funding public hospital services. At that time, the nation's main health policy priority was ensuring people had access to affordable hospital and medical services.¹¹ The Medibank agreements would address the problem of affordable access to hospitals because they required states to stop charging fees for public hospital services. Expanding access to medical services was achieved under Medibank by making changes to existing medical benefit arrangements. Because medical benefits are a Commonwealth responsibility, they were not covered in the Medibank agreements with the states.

Policymakers were aware of the problems stemming from the growing burden of chronic diseases in the 1970s, and broader reforms were being developed that sought to address the problem. The most significant of them was the national community health program, which would provide a wide range of health and social welfare services, tailored to local needs.¹² Although the community health program had some strong supporters at the time – including some of the Commonwealth government's ministers and many of the states^{13, 14} – it was not a major component of the agreement, and was seen only an adjunct to the flagship Medibank program.

¹¹ A Boxall and JA Gillespie, *Making Medicare: The politics of universal health care in Australia*, NewSouth Publishing, Sydney, 2013.

¹² J De Voe, A Policy Transformed by Politics: The Case of the 1973 Australian Community Health Program – a policy transformed, *Journal of Health Politics, Policy and Law*, 2003; 28(1): 77-107.

¹³ A Boxall and JA Gillespie, 2013.

¹⁴ VL Ramamurthy, Tied grants and policy reform in public hospitals and schools, in *Tomorrow's Federation: Reforming Australian Government*, P Kildea, A Lynch and G Williams (eds.), The Federation Press, Sydney, 2012.

Almost a decade later, awareness of the importance of preventing and managing chronic diseases was growing stronger in Australia. The scope of the Medicare agreements, however, did not change substantially at that time: they still remained largely focused on financing access to public hospitals. Funding for community health services was maintained in the Medicare agreements, but it still was only an adjunct to Medicare. Some additional funding was also made available in the Medicare agreements to support services delivered at the margins of hospital care, including day-only services, post-acute and palliative care.

The intergovernmental agreements made in 1993 reveal policymakers growing interest in preventing chronic diseases. For the first time, the Medicare agreements committed governments to developing national health goals and targets in areas such as chronic disease prevention, health literacy, healthy environments and the health system. Funding for mental health services outside hospitals was also provided, and funding for day-only, palliative care and post-acute care services was continued.

From 1993 onwards, funding for services and functions beyond public hospitals has gradually expanded in each successive intergovernmental agreement.

The most significant change in the scope of intergovernmental agreements came in 2010 and 2011 with the National Health and Hospitals Network Agreement and National Health Reform Agreement. While hospital funding remains a key component of these agreements, they also committed governments to implementing major reforms to the roles and responsibilities of governments, health system governance, and service delivery and performance monitoring arrangements.

Ultimately, some of the more ambitious reforms to governments' roles and responsibilities agreed in 2010 were not implemented, but many of the other reforms were. Intergovernmental relations in health fundamentally changed as a result these agreements. Whereas once agreements between governments were mostly confined to public hospitals and focused on funding, as a result of these recent agreements, governments are now committed to working together to ensure people can access a wide range of high-quality services in hospitals and the community.

It is also now accepted that the performance of the health system as a whole, its strategic direction, and outcomes are responsibilities shared between governments. The Commonwealth, despite its fiscal dominance, cannot achieve its desired outcomes in health system governance and performance without the support and co-operation of the states because the states have a much greater role than the Commonwealth in service delivery (they own and operate public hospitals and many primary and community health services, such as mental health, drug and alcohol, child and maternal health and community nursing services).

Likewise, the states remain reliant on the Commonwealth to fund health services and increasingly, they need to work with the Commonwealth (and the private sector) to deliver high-quality, well-coordinated health services. While there are many factors

that influence the outcomes of negotiations over intergovernmental health agreements (covered later), the states' capacity to influence policy development and negotiations has grown over time as the scope of agreements has expanded.

Developing policy for intergovernmental agreements

Over the forty years health agreements have been made between the Commonwealth and the states, policymakers have become more aware of the need to adopt a collaborative and inclusive approach to policy development.

The policy underpinning the original Medibank agreement was developed by two academics (both health economists) well before the Commonwealth government was elected in 1972.¹⁵ Although Medibank hospital agreements were not negotiated until 1975, little further policy development was needed because the agreements were primarily concerned with public hospital funding, and the policy settings had already been determined. As a result, there was little need or opportunity for others to be involved in policy development for the Medibank agreements.

The same is true for the Medicare agreements that followed. The policy was almost identical to Medibank, so it required little development.

Policymakers made considerable efforts to strengthen intergovernmental collaboration and broaden participation in health policymaking to support the 1993 healthcare agreements. For the first time, the 1993 agreement included a preamble that clearly outlined the rationale and need for collaboration between governments. It explained:

*'Essentially the need for a national approach in health results from three major areas – equity in access, standards of access and care and global management of expenditure. These broad national concerns are in the interests of both the Commonwealth and the states. They are best achieved by consultation and collaboration between the Commonwealth and the states.'*¹⁶

In the 1993 agreement, governments also committed to working with each other to develop new national health policy goals, targets and performance indicators. Much of this work was already underway following the establishment of the Better Health Commission in 1985.¹⁷ The Better Health Commission was a joint Commonwealth and state initiative, chaired by an eminent academic with a range of health experts

¹⁵ R Scotton and C Macdonald, *The Making of Medibank*, Australian Studies in Health Service Administration No. 76, University of New South Wales, School of Health Service Management, Sydney, 1993.

¹⁶ Agreement between the Commonwealth of Australia and the state of Victoria in relation to the provision of public hospital services and other health services from 1 July 1993 to 30 June 1998 under Section 24 of the Health Insurance Act 1973 (Commonwealth), Canberra, 1993, p. 12

¹⁷ SR Leeder, The contribution of epidemiology to the definition of health goals and targets for Australia, *International Journal of Epidemiology*, 1995; 24(suppl. 1): S109-12.

included as members.¹⁸ The 1993 healthcare agreement expanded opportunities for policymakers to engage with people outside the bureaucracy to develop and implement national health goals and targets. The agreement stipulated:

'It is agreed that successful implementation of the NHGT [National Health Goals and Targets] will require active engagement of all stakeholders: the Commonwealth and the states, medical and ancillary health professionals and educators, community representatives, local government, non-government organisations and the wider community'.¹⁹

In addition to this, the 1993 agreement also committed governments to working together to establish a public patient's hospital charter, and an intergovernmental planning group to help ensure a nationally co-ordinated approach strategic planning.

A decade later, in 2002-03, participation in policy development to support intergovernmental agreements had expanded further. Policymakers had not engaged substantively with clinicians and service providers on health policy issues covered in health care agreements previously. In the lead up to negotiations for the 2003-2008 agreement, the Australian Health Ministers Conference (membership included all Australian health ministers) established nine reference groups to provide advice on key issues. Reference group members were expecting their reports to feed into negotiations on the agreement and welcomed the opportunity to participate in policy development.^{20, 21} Ultimately, the reference groups' reports did not have much influence on the outcomes of the agreements, largely because negotiations between governments on the 2003 agreement were particularly acrimonious (see later). However, a precedent had been set by establishing these reference groups.²²

The most extensive consultations to date with the health sector were undertaken in the lead up to negotiations on 2010 health agreements. The Commonwealth government established the National Health and Hospitals Reform Commission in 2007 to provide advice on the framework for the upcoming health care agreements, and on short and long-term reform options.²³ Over the next two years, it commissioned numerous reports on key policy issues from academics, invited submissions from the health sector and the public (it received over 600), and consulted widely with the sector, including clinicians, service providers, consumers, state and territory governments, academics, community and non-government organisations. The Commission's final report outlined wide-ranging reforms to the health system, many of which were incorporated into the National Health and

¹⁸ D Nutbeam and E Harris, Creating supportive environments for health: a case study from Australia in developing national goals and targets for healthy environments, *Health Promotion International*, 1995; 10(1): 51-59.

¹⁹ 1993 Agreement, Schedule H, Clause 2.1, p 78

²⁰ SJ Duckett, The Australian Health Care Agreements 2003-2008, *Australia and New Zealand Health Policy*, 2004;1:5, doi:10.1186/1743-8462-1-5

²¹ M Cormack, The 2003-2008 Australian Health Care Agreements – an industry perspective, *Australian Health Review*, 2002; 25(6): 27-32.

²² SJ Duckett, *Australia and New Zealand Health Policy*, 2004.

²³ Australian Government, Department of Health and Ageing, National Health and Hospitals Reform Commission, Terms of Reference, available at: <http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/terms-of-reference>

Hospitals Network Agreement (2010) and subsequent National Health Reform Agreement (2011).

The policy development process leading up to negotiations on the 2010 health care agreements were extensive, and the agreement itself was the broadest and most ambitious to date. Some of the most ambitious elements of the agreement relating to roles and responsibilities of governments and tax sharing arrangement were eventually scaled back (see later) because not all state governments would agree to them. However, many reforms relating to governance of the health system and health services, public hospital funding, and performance monitoring were adopted.

Ultimately, many factors influence the outcomes of negotiations on intergovernmental health agreements. Incorporating the views of the health sector and consumers into policy development helps build support for reform, but it does not guarantee that Commonwealth and state governments will agree on them. The failure, in 2010, to secure agreement on the controversial proposals to change governments' roles and responsibilities in health, and revenue sharing arrangements, illustrates this point.

Political factors affecting agreement negotiations

There are a wide range of political factors that influence the outcomes of intergovernmental negotiations on health; the partisan make-up of governments across the federation is an important one. Although it is not always the case, when the party in power at the Commonwealth level is also in power in the majority of states, negotiations between governments can go relatively smoothly. In 1983-84 for example, when the Medicare agreements were being negotiated, Labor was in power at the Commonwealth level and in most states.²⁴ The Commonwealth was able to negotiate the Medicare agreements reasonable quickly. Health ministers agreed to the Commonwealth's offer when they met at the Health Ministers' conference and the agreement was signed-off by first ministers at a Premiers' conference several weeks later.²⁵

In contrast, there are examples where the Commonwealth government has been negotiating with states held by another party (either all states or a majority of them), but still managed to secure an agreement, and sometimes even quickly.

In 1975, the Commonwealth Labor government was able to successfully negotiate Medibank hospital agreements with all states even though most were held by non-Labor governments. However, rapidly declining economic conditions, a series of political crises (including the sacking of the Treasurer), and the Commonwealth

²⁴ Although there was considerable controversy surrounding the Medicare agreements – it led to major conflict between governments and some medical specialist groups – relations between governments were reasonable amicable. At the time, Labor was in power at the Commonwealth level and in most states.

²⁵ A Boxall and JA Gillespie, 2013.

government's strong desire to implement Medibank all meant that the agreements it made were considered overly generous to the states.^{26,27}

A similar situation played out when the Coalition-led Commonwealth government was negotiating the 2003-2008 health care agreements. At that time, Labor held all the state governments. On this occasion, the Commonwealth had decided to make a non-negotiable offer to the states that slowed the growth in Commonwealth funding for public hospitals, increased accountability measures for the states, and introduced financial penalties for non-compliance with reporting requirements. The Commonwealth also imposed penalty clauses on the states if they refused to sign-up by a certain date, also determined by the Commonwealth.²⁸ State leaders met with the Prime Minister and attempted to secure concessions, but failed. They eventually signed the agreement, reluctantly, because the financial penalties they faced would only have made their situations worse.²⁹

Partisan politics will always have an impact on intergovernmental negotiations over health care in Australia, but its impact is not always easy to predict. This makes it difficult for policymakers, particularly within the bureaucracy, to respond or prepare themselves in any meaningful way because elected officials ultimately determine the high-level dynamics or 'tone' of intergovernmental relations.

The centralisation of negotiations

Over time, negotiations on intergovernmental health agreements have been centralised, with responsibility now resting primarily with central agencies and first ministers (state premiers and the prime minister). This shift of responsibility had been occurring gradually and has affected health policymakers' ability to influence the policy development underpinning intergovernmental health agreements, the negotiation process and outcomes.

Originally, negotiations between governments on health care agreements were led by health ministers (or their equivalent) and endorsed by first ministers.³⁰ During 1974 and 1975, for example, Bill Hayden, the minister responsible for implementing Medibank, conducted ongoing negotiations with states in an effort to secure their agreement on the Medibank hospital agreements.³¹ However, over time there has been a subtle shift of responsibility, with central agencies and first ministers gradually taking on a more substantive role. Negotiations on the 2003-2008 agreements were a

²⁶ RB Scotton and C Macdonald, 1993.

²⁷ S Sax, *A strife of interests: Politics and policies in Australian health services*, 1984.

²⁸ SJ Duckett, 2004

²⁹ L Dubecki and O Guerrera, Irate, but leaders sign health deal, *The Age*, 1 September 2003; L Allen and M Mellish, Ministers slam health talks boycott, *The Australian Financial Review*, 20 February 2003.

³⁰ A Boxall and JA Gillespie, 2013.

³¹ Bill Hayden was Minister for Social Security from 1972 to 1975 and had responsible for implementing Medibank, including negotiating the hospital agreements. Hayden, however, was appointed as Treasurer in 1975 but the Prime Minister at the time, Gough Whitlam, asked that he retain responsibility for Medibank and negotiating the hospital agreements.

key turning point because on this occasion, central agency bureaucrats assumed the lead for making policy decisions related to the agreements.³²

When the 2003-2008 agreements expired (they were extended by a year to 2009), the centralisation process was advanced further. In 2009, the Australian Healthcare Agreements were replaced by National Healthcare Special Purpose Payments; the Special Purpose Payments were part of a broader Intergovernmental Agreement on Federal Financial Relations administered by the Commonwealth Treasury. These new payments gave the Commonwealth more control over the quantum and distribution of funds to the states, and gave the Treasurer more control over expenditure in a range of portfolios, including health.³³ Another consequence of adopting the Special Purpose Payments was that it gave policymakers from Treasury and other central agencies a greater role in developing policy for the 2010 intergovernmental health agreement.

There was also a centralisation of power within executive government during this period (2007-2010) that further strengthened central agency policymakers' role. During this period, key decisions across portfolio areas, including health, were often made by a sub-committee of cabinet, the Strategic Priorities and Budget Committee; its only members were the Prime Minister, Deputy Prime Minister, Finance Minister and Treasurer.³⁴ These changes in the way the executive made decisions had a flow-on effect within the Commonwealth bureaucracy, with central agency bureaucrats playing a substantial role in developing policy to support the 2010 and 2011 intergovernmental health agreements.³⁵

As a consequence of this centralisation trend, both the 2010 and 2011 health agreements were negotiated at the Council of Australian Governments by first ministers. The most recent Heads of Agreement (an interim one) was also negotiated by first ministers at a Council of Australian Government meeting.³⁶

There are many reasons for the centralisation of decision-making on health agreements: some unique to Australia and some experienced in comparable countries around the world. However, in Australia, health expenditure (all health, not just programs administered through healthcare agreements) now accounts for 16 per cent of the Commonwealth's total expenditure, and fiscal environments are consistently tight.³⁷ As a result, central agencies need to scrutinise health agreements closely.

The challenge of improving health policymaking

³² Personal communication, Commonwealth public servant, 10/10/2016

³³ VL Ramamurthy, 2012.

³⁴ G Kefford, The Presidentialisation of Australian Politics? Kevin Rudd's Leadership of the Australian Labor Party, *Australian Journal of Political Science*, 2013; 48(2);135-146, doi:10.1080/10361146.2013.786676

³⁵ Personal diaries

³⁶ Heads of Agreement between the Commonwealth and states and territories on public hospital funding, 1 April 2016, available at: <http://www.coag.gov.au/node/538>

³⁷ Australian Government, Budget paper no.1, statement 5, Table 2, available at: http://budget.gov.au/2016-17/content/bp1/html/bp1_bs5-01.htm

The pressure on policymakers to manage rising health expenditure within tighter budgets while the prevalence of chronic diseases continues to grow has had a major impact on intergovernmental relations on health in Australia. This case study has examined health care agreements between the Commonwealth and state governments over a 40-year period. It shows that over this time there have been substantive changes in the scope, policy development processes and negotiating approaches for health care agreements. Where once health care agreements focused primarily on public hospitals funding arrangements, they have progressively expanded to cover a wide range of primary care, preventive and community-based services, as well as performance monitoring, accountability and health system governance arrangements. As a result of these changes, the states now have more influence over policy development and both level of governments' ability to achieve objectives set out in the agreements.

There is also evidence that policymakers have become more aware that the success of intergovernmental health agreements depends in part on their ability to broaden participation in policy development and maintain effective collaboration across governments. While governments have not consistently translated this awareness in action, there are some examples, particularly in recent years, of strong, collaborative and inclusive policymaking in the lead up to negotiations over healthcare agreements. This has helped build support for more wide-ranging reforms to the health system.

Over time, the process for negotiating health care agreements has also changed. Health policymakers – health bureaucrats and government ministers – were once primarily responsible for developing and negotiating health care agreements. In many ways, the policy development for earlier healthcare agreements was a technical exercise. It involved developing and agreeing complex funding formulae for public hospitals, and later, performance indicators and monitoring requirements. While central agencies bureaucrats and first ministers were always interested in the quantum of funding, they did not have special technical expertise to contribute to the policy development process.

In recent years, as healthcare agreements have broadened in scope, expenditure has increased, and budgets have been scrutinised more closely, bureaucrats from central agencies (especially finance and treasury) and first ministers have taken the lead in policy development and agreement negotiations. This shift in responsibility poses a challenge for policymakers as they now have to navigate a path between two vastly different world views: that of fiscal and health policymakers.

The Organisation for Economic Cooperation and Development (OECD) explores this challenge in a recent publication.³⁸ It outlines some of the unique challenges facing health policymakers:

³⁸ Organisation for Economic Cooperation and Development (OECD), *Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives*, 24 September 2015, Paris, available at: http://www.oecd-ilibrary.org/social-issues-migration-health/fiscal-sustainability-of-health-systems_9789264233386-en

- citizens perceive health to be a very high priority
- there are many stakeholders intervening in processes between government financing and delivery of health care (for example, state governments, social security/welfare institutions, private insurers)
- there are a wide range of service providers and clinicians operating in highly diverse contexts, and
- arrangements and institutions vary considerably across and within countries.

These factors make health policy analysis particularly challenging. Unlike the disciplines of economics and finance, there are no grand, over-arching explanatory theories in health policy, no widely accepted or uncontested methods of policy analysis: not even any dominant schools of thought. The sector is too diverse and complex to enable this to happen. Because health systems vary so much, it is often even difficult to draw lessons from other countries.

The complexities and uncertainties of health policy analysis – let alone the politics of health – can sometime be frustrating to economic and finance policymakers. Finding a way to bridge the gap between the diverse worlds of health and fiscal policymakers is one of the most pressing issues facing contemporary governments, but it is vital if they are to constrain health expenditure growth without undermining access, quality or equity.

There are many possible ways of bridging the gap between the health and fiscal policy views. One potential strategy in Australia is to help policymakers work together to identify and address the political and institutional risks threatening the sustainability of the health system, but to do this over the medium to long-term. According to the OECD, this may require governments to discuss and agree the extent to which:

- health expenditure needs to be contained, even agreeing specific growth targets, if necessary;
- health governance and administration should be decentralised to the states (the states, for example, could be given set budgets and responsibility for providing the full range of health services); and
- the public and private sectors, including health insurance, should overlap.³⁹

Policymakers should also expand the range of policy levers used to address health expenditure and the sustainability of the health system. Economic and finance policymakers often rely on demand-side policy levers in health such as individual contributions/co-payments, gatekeeping policies and eligibility rules. These play a vital role, but the tool-kit could be expanded with a greater use of supply-side levers (for example, changes to provider payment methods and competition and regulatory levers (for example stronger controls on pharmaceutical pricing and health technology assessment)). In many of these areas, input from health policy experts is essential because it requires policymakers to have an understanding of health service delivery,

³⁹ OECD, *Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives*, 2015.

health workforce dynamics and the politics of health. And finally, and perhaps most controversially, bridging the gap between health and fiscal policymakers will require governments to re-open discussions on the role revenue policy has in the sustainability of the health system.⁴⁰

⁴⁰ Ibid