

The John Curtin Institute of Public Policy

**Australian Federalism and the Use of Tied Grants:
Case Studies of Public Hospitals and Schools**

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

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Abstract

Specific purpose payment or ‘tied grants’ are a highly contentious feature of the Australian federal system. The common view is that the Commonwealth's imposition of national goals through tied grants has reduced the efficiency, responsiveness, transparency, and innovativeness of State services. Considerably less known, however, is a contrasting scholarly view that the States are not completely powerless in the tied grant relationship, having ample capacity to resist the Commonwealth's policy intrusions. Neither of these positions is adequately supported by empirical research. The objective of this thesis is to evaluate these divergent propositions on tied grants and thereby identify the strengths and weaknesses of the grant as a policy making instrument. A longitudinal case study methodology is used to evaluate tied grant agreements for public hospitals. Additionally, comparative analysis is conducted on tied grants for public schools. The case study research draws on a labyrinth of evidence — around 5,700 pages of archival documents and interviews with senior bureaucrats.

The thesis finds that notwithstanding the Commonwealth's tenacious pursuit of national policy goals, neither the Commonwealth nor States consistently dominated policy formulation. Indeed, despite the Commonwealth's fiscal supremacy, the tied grant proves to be a highly imprecise policy making instrument. This trait is firmly rooted in Australia's constitutional make-up, which renders the Commonwealth incapable of complete policy ascendancy, with the acceptance and faithful implementation of national goals being entirely dependent on the States. The thesis also validates criticisms of the tied grant as an instrument encumbered with political, administrative and accountability inefficiencies. An important distinction identified however is that the severity of these inefficiencies is dependent on how the tied grant is used. In particular, the performance problems of tied grants are more evident when national goals are unilaterally and prescriptively applied by the Commonwealth. Under circumstances where national goals are derived from policy directions already being pursued by the States, the tied grant proves to be a powerful mechanism for invigorating policy agendas and implementation, offering critical leverage to States for overcoming local political barriers. By contrast with those who advocate return to a more ‘coordinate’ model of federalism, this historical analysis of tied grants finds that within the hospitals and schools area a cooperative model offers distinct policy-making advantages — provided the Commonwealth remains a refined and strategic player.

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List of Abbreviations

ABS	Australian Bureau of Statistics
ACT	The Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ALP	The Australian Labor Party
CGC	Commonwealth Grants Commission
COAG	Council of Australian Governments
CPI	Consumer Price Index
FAG	Financial Assistance Grant
GDP	Gross Domestic Product
GP	General Practitioner
MBS	Medicare Benefits Schedule
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MCEEDYA	Ministerial Council for Education, Early Childhood Development and Youth Affairs
NSW	The Government of New South Wales
NT	The Northern Territory
PBS	Pharmaceutical Benefits Scheme
Qld	The Government of Queensland
SA	The Government of South Australia
S & D	Scotton and Deeble
SPP	Specific Purpose Payment
States	The States and Territories of Australia
Vic	The Government of Victoria
WA	The Government of Western Australia

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INTRODUCTION

1 INTRODUCTION

1.1 Tied grants: potent but obscure

The specific purpose payment or tied grant is a core feature of Australian federalism. Authorised under section 96 of the Constitution,¹ the grant provides the Commonwealth with remarkably open-ended powers to intervene in State policy, financial and service delivery decision making. First applied in the 1920s, use of the grant was fairly constrained until the 1970s, when the Whitlam government radically and enduringly expanded the policy reach of the Commonwealth via a range of transfer programs. Close to four decades later, funding distributed through tied grants represents around 45 per cent of total Commonwealth grants to the States, estimated to total \$40.98 billion in 2012-13 (2012: 960-1). Playing a fundamental role in vital government services relied upon by everyday Australians — including hospital, school and vocational education, housing, disability and indigenous services — the significance of these grants is certainly without question.

In spite of forming an often controversial part of Australia's fiscal federal landscape, the tied grant has remained an under-researched area of Australian federalism. This state of affairs can be partly attributed to the grant's convoluted and obscure nature. Unravelling a tied grant arrangement reliably and meaningfully is by no means a simple concern. There is, first of all, an 'official' policy and fiscal settlement between the Commonwealth and States — documented through communiqués, formal agreements, parliamentary debates, legislation, and media dialogue. There can also be a 'closed door' settlement involving the special deals and compromises struck in order to reach agreement behind the scenes. Finally, there is the eventuating and comprehensive reality — the implementation side of the grant, during which Commonwealth and State 'policy actors', and other affected stakeholders, continue to haggle, this time over the interpretation of the official settlement. With significant policy making capacity and finances at stake for both levels of government, the journey to these different stages of policy consensus can involve in total, up to three to four years of sometimes fiery and shrewd negotiations and deliberation. Over this time, the shape of the 'policy consensus' can be both meandering and volatile, as the diverse 'policy actors' involved, aggressively and passively push and compete for policy space, including Ministers, Prime Ministers and Premiers, Parliaments, Commonwealth and State bureaucrats, 'street level' bureaucrats and external stakeholders. Additionally, although this extensive discourse results in voluminous archival evidence, much of the

¹ One of twenty five clauses of Chapter IV which outlines the division of trade and finance powers, section 96 allows the Commonwealth to "grant financial assistance to any State on such terms and conditions as the Parliament thinks fit".

crucial 'inside workings' of tied grants, the negotiation and implementation details, can remain submerged from public view for up to twenty to thirty years, being subject to strict public access restrictions.

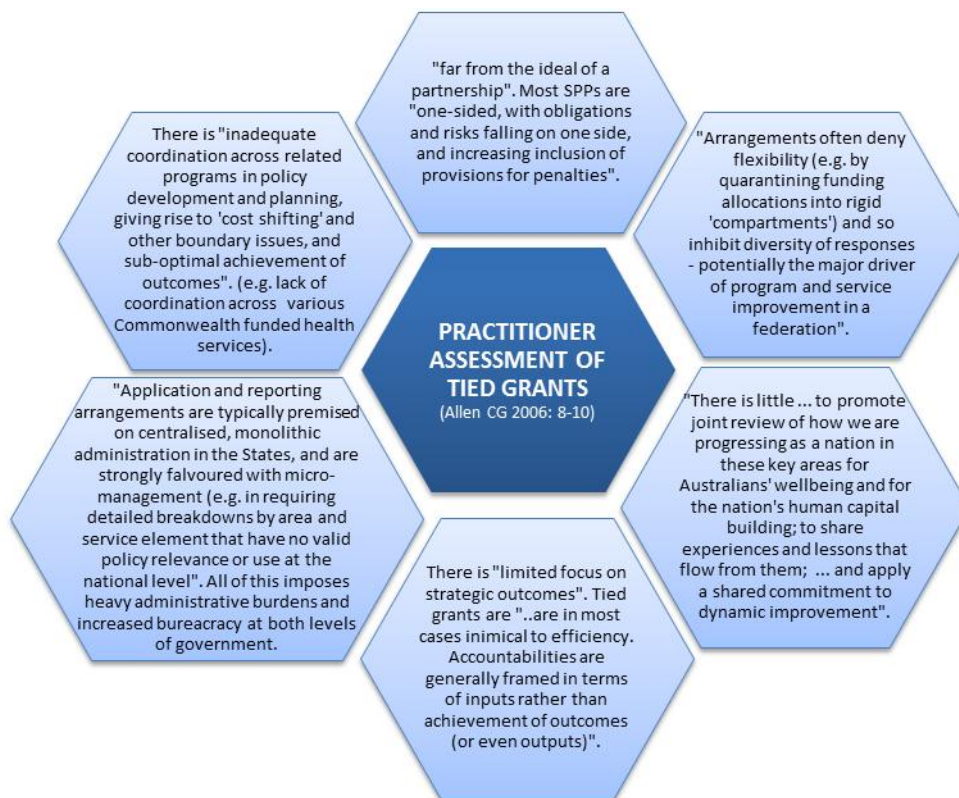
1.2 Literature on tied grants: two schools of thought

The literature that is available on tied grants can be grouped into two divergent schools of thought. One of these perspectives emanates from the literature generated by various practitioners, including parliamentary committees, State governments, business groups and audit offices. The other has more academic origins.

Debilities of tied grants

Practitioners have long protested the performance deficiencies and accountability 'blame-game' arising from the Commonwealth's attachment of prescriptive and onerous conditions to these grants.

Figure 1.1 Problems of tied grants



Commonwealth-imposed conditions generally fall into five categories: policy conditions; expenditure conditions; input control conditions (matching or maintenance of effort requirements); reporting conditions; and due recognition conditions (Koutsogeorgopoulou 2007: 125). Tied grant conditions have been justified as necessary for the 'national

interest', with the Commonwealth insistent it has a legitimate role in ensuring that State services: meet national standards and international obligations; enhance Australia's international competitiveness and economies of scale; and contain inter-jurisdictional spillovers. Yet, according to successive reviews by different practitioner groups, grant conditions create significant service delivery performance issues including: service duplication; cost-shifting and inefficiency; shortcomings in responsiveness and transparency; service coordination failures; and a lack of policy and program innovation — as indicated in Figure 1.1 above. Practitioners have also put forward a range of alternative grant designs, which they argue would allow for improved local policy and operational flexibility (Allen CG 2004, 2006; Commonwealth Parl. 2007; Department of Treasury and Finance and Cabinet 2002; Garnaut and Fitzgerald 2002; Parl Comm. 1995, 1998, 2006; Parl. of Victoria 1998; Treasury and Finance 2006; Twomey and Withers 2007).

A more sceptical view

Amidst these persistent and vocal criticisms of tied grants, there also exists another much less visible school of thought. This scholarly perspective casts doubt on practitioners' propositions that the Commonwealth is too intrusive in its use of tied grants, and that grant conditions have been a significant hindrance to the performance of State services. Parkin (2003) and Holmes and Sharman (1977) are some academic voices who have argued that State governments are not completely powerless in the tied grant relationship, and that they in fact possess sufficient policy making control to evade or resist Commonwealth policy intrusions. Holmes and Sharman (1977: 125) have argued, for example, that "state public servants are not likely to be hampered in the design and implementation of programs by any lack of jurisdiction...it is they who teach in schools, run hospitals and administer the vast majority of civil, criminal and administrative law....the conditional grant...is a blunt weapon". Parkin (2003: 103) asserts that while the federal government has sought to influence State delivered services, the day-to-day control and management of these policy areas has remained firmly in the hands of the States. Specifically, the States are described as "political actors with considerable capacity to secure their ends via successful bargaining and [remain] responsible for a large and significant area of public policy"(Parkin 2003: 103). Analysing the operations of the Commonwealth-State Housing Agreement, Parkin (in Galligan 1988: 249) concluded "rarely has the Commonwealth imposed unacceptable conditions on a reluctant state through housing grants. The grant conditions have tended to be so broad and flexible to permit wide variation in implementation and, arguably, even degrees of non-compliance".

In a historical examination of the Vocational Education and Training Agreement, Painter (1998: 62) observed that the sharing of policy powers regularly fluctuated between "collaborative, adversarial, [and] arm's length". After examining the evolution of the housing and disability agreements, Monro (2001: 376, 78-80, 82-4) also concluded it can be difficult for either Commonwealth or States to control policy making in a sustained manner. His study found that the sharing of powers wavered depending on the organisational, political and fiscal resources of both parties, with information asymmetries inhibiting Commonwealth control. Interestingly in terms of performance effects, Monro (2001: 381, 84-5) observed that "some degree of duplication" occurs under both coordinate and concurrent arrangements. Further, Monro argues that concurrent arrangements enhance political responsiveness and are more effective when the Commonwealth limited its "attempts to influence State actions" (Monro 2001: 384, 86).

These contrary normative and empirical assessments of the tied grant are vital signs that there are greater subtleties in the grant relationship than is currently apparent to policy makers and practitioners. Further investigation is necessary to achieve greater clarity around these nuances of the tied grant and its intrinsic strengths and limitations as a policy making and governance instrument from both Commonwealth and State perspectives.

1.3 Historical context: tied grants and intergovernmental relations

In embarking on a study of tied grants, it is important to firstly gain an appreciation of their historical context and of trends in Australian intergovernmental relations generally. The current prevalence of tied grants can be attributed to three main factors: the High Court's interpretation of the constitutional division of powers; vertical fiscal imbalance (VFI); and the ideological tendencies of the Australian Labor Party.

1.3.1 Constitutional interpretation and federal fiscal dominance

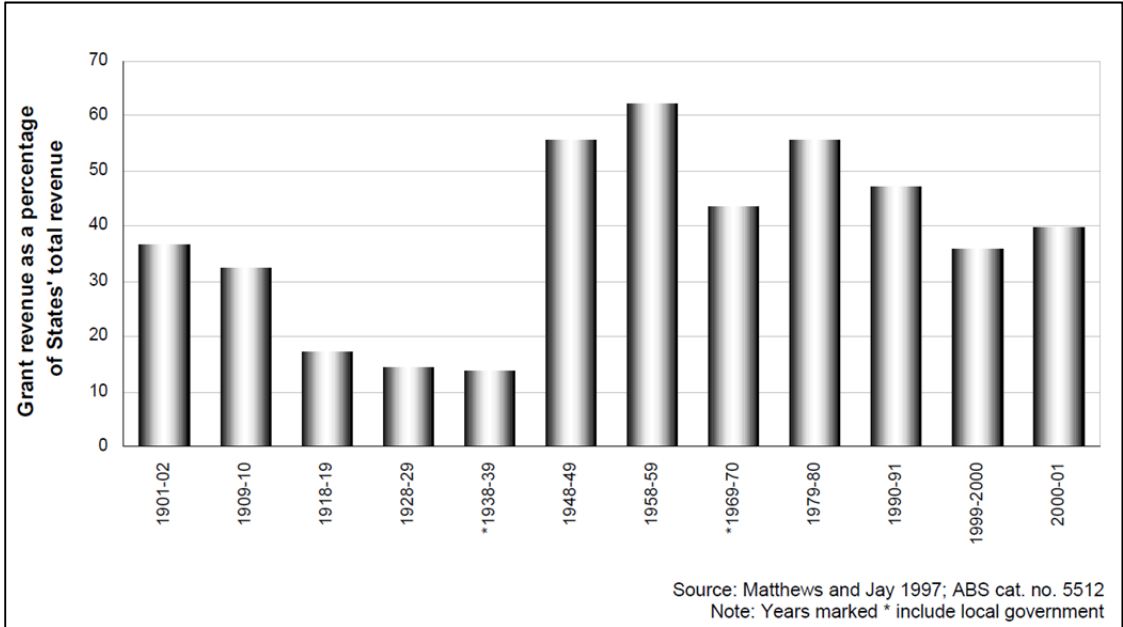
The division of legislative powers in Australia is articulated in Sections 51 and 107 of the Constitution. Section 51 assigns a range of specific powers to the Commonwealth, whilst Section 107 guarantees the plenary legislative powers of the States unless otherwise stipulated within the Constitution. Although the division of powers is predominantly a coordinate one, the reality has been a more integrated or concurrent state of affairs. A key driver for this has been the High Court and its very liberal interpretation of section 51. The Court's stance was first established in the 1920 *Engineers case*² where it determined that

² Amalgamated Society of Engineers v Adelaide Steamship Co (1920) 28 CLR 129.

the Commonwealth holds not only the legislative powers listed under section 51, but also “powers that are implied or incidental to those powers” (Parl. of Victoria 1998: Ch2; Warren 2006: 15-16; Wilkins 2005: 4). This broadened view of section 51 has given the Commonwealth an underlying legitimacy to expand its involvement into policy matters under State jurisdiction.

Further, the Commonwealth's relentless push for fiscal dominance has provided both the practical means for, and ensured the significance of, the Commonwealth's exercising of policy influence. "Vertical fiscal imbalance" (VFI), has been an integral part of the Australian fiscal landscape throughout its federal history, escalating dramatically from the 1940s (Garnaut and Fitzgerald 2002: 41):

Figure 1.2 Change in VFI over 100 years of Federation



While VFI is not an uncommon trait, levels in Australia are noticeably higher than other comparable federal systems (Warren 2006). VFI has its early roots in the colonies' agreement to a uniform tariff policy under which they relinquished their rights to levy customs and excise duties. Not surprisingly, rules around the redistribution of federal surpluses was a heatedly contested issue during the constitutional discussions, consuming “almost one third of the 2,500-odd pages of proceedings” (Saunders 1986: 151). The consensus reached was articulated in sections 87, 89, 93, 94 and 96. Of these five sections, four were short-lived such that from 1910 onwards, “the ubiquitous” and ‘eleventh hour safety net measure’ section 96, quite inadvertently, became the sole expression of the Commonwealth's revenue redistribution powers (Galligan 1995: 219, 21; Saunders 1993: 61).

The significance of section 96 is that it provides the Commonwealth with powerful capacity to not only *provide financial assistance* but also *regulate*, through the setting of terms and conditions (James 2000; C. Lloyd 2002; Saunders 1986: 171; 1987: 2-4, 7; Wood 1998; Wran 1981). The inadequacies of the financial provisions of the Constitutional Bill were acknowledged at the time, with Alfred Deakin declaring them to be "a testimony to the ability and shrewdness of its framers and also to the immaturity of their views" (Mathews and Jay 1972: 25). The scale of VFI increased dramatically in 1942 when the Commonwealth assumed the income taxing powers of the States under the Uniform Tax Scheme. The Scheme successfully survived High Court challenges in 1942 and 1957³ (Mathews and Jay 1972: 174-5; Saunders 1987: 16,28), with VFI further reinforced by the *Ha* and *Hammond* High Court judgements of 1997; the introduction of the Goods and Services tax and Intergovernmental Agreement on the Reform of Commonwealth-State Financial Relations in 1999; and the Intergovernmental Agreement on Federal Financial Relations in 2008 (Aust. Government 2008; Garnaut and Fitzgerald 2002: 38; Parl. of Victoria 1998: Ch5; Wood 1998: Ch10).

1.3.2 The Commonwealth's use of tied grants for policy intervention

Federations can use four mechanisms to compensate for VFI: "expenditure powers can be transferred; taxation powers can be transferred; intergovernmental transfers can be made; or a system of revenue sharing can be adopted" (Opeskin 2001: 132). Various typologies of intergovernmental transfers are cited in the literature (notably, Bahl 1986; Bergvall et al. 2006; Nathan 1983). At the most basic level, grants can take two forms. They can be conditional and impose a range of restrictions around use and access or they can be unconditional (lump sum) transfers to be used in any manner deemed fit by the recipient (W.E. Oates 1999: 1126-27). In Australia, VFI has been largely addressed through both conditional and unconditional grants to the States and Local Government authorities under the authority of section 96.

In terms of conditional grants, their considerable policy reach was ratified very early in a High Court challenge⁴ to the *Federal Roads Act 1926*⁵ (Bennett and Webb 2007; James 2000; Mathews and Jay 1972: 131). The case confirmed a number of operative aspects of

³ *South Australia v Commonwealth (Uniform Tax Case (No 1)) (1942) 65 CLR 373* and *Victoria v Commonwealth (Uniform Tax Case (No 2)) (1957) 99 CLR 575*.

⁴ [Victoria v Commonwealth \[1926\] HCA 48; \(1926\) 38 CLR 399](#).

⁵ The watershed legislation embodied the first use of section 96 for the payment of a tied grant. The Act gave the Commonwealth Minister considerable discretionary powers and permitted the Commonwealth to implement a grant agreement with prescriptive requirements on project approval, funding eligibility and State obligations.

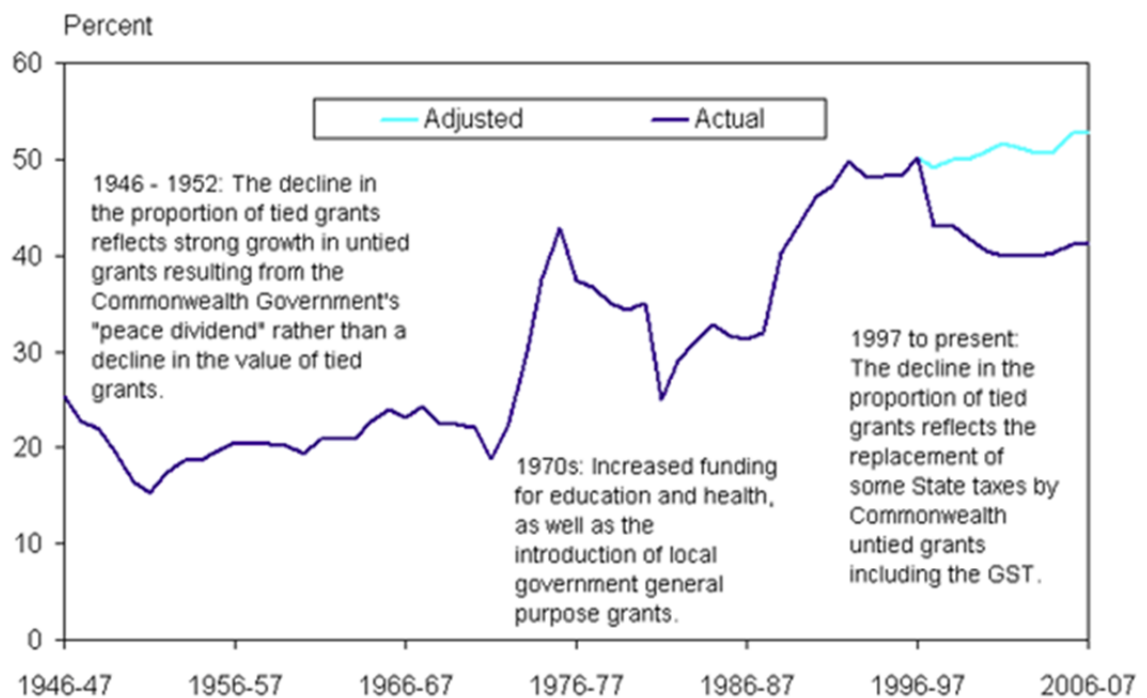
section 96: “1) that power (to set terms and conditions) can be delegated (by parliament)...to the executive under section 96; 2) that the section is satisfied if payments are left to the discretion of the Commonwealth Minister; 3) that a grant will constitute financial assistance within the meaning of the section if it is made for a purpose that is a State function; and 4) that all grants of financial assistance are unaffected by ... other constitutional provisions” (Saunders 1987: 29-30). Most importantly, the *Roads case* clarified that the Commonwealth could influence the “exercise of State legislative power in the expenditure not only of moneys received from the Commonwealth but of revenue raised by the State from its own sources” (Saunders 1987: 27). By validating that the prescriptive powers of tied grants could extend well beyond the financial contributions of the Commonwealth, the High Court increased the policy potential of section 96 to a new level.

Roads funding remained the only major tied grant arrangement to the Second World War. After 1942 however, there was much more rapid growth in the use of the grant (James 2000; Mathews and Jay 1972: 221). 1945 saw the first Commonwealth–State Housing Agreement under which the Commonwealth made capital advances to the States for housing projects while the States administered the provision of housing to the community (Mathews and Jay 1972: 207). The *Tuberculosis Act 1946* and *Mental Institutions Benefits Act 1948* authorised payment of Commonwealth grants for maintenance of special tuberculosis hospitals and mental institutions respectively, with the latter being subject to a condition that the States provided services free of charge to the community (Mathews and Jay 1972: 170-71). Other tied Commonwealth grants provided for: road safety programs and new immigrant hostels (1947); rural industry and water resources (1948); coal miner salaries and natural disasters (1949); housekeeper services (1951); and blood transfusion services (1953) (Mathews and Jay 1972: 223-29, 207). In the 1960’s, grants were introduced for teachers colleges (1967); science labs (1964); school libraries (1968); independent schools (1969) and school buildings (1971) (Mathews and Jay 1972: 223, 262-4).

With the inclusion of matching requirements and other spending conditions, tied grants from the 1920s to the 1960s are asserted to have undermined accountability and created the same type of resource allocation inefficiencies as claimed in the more contemporary practitioner reports. A notable difference, however, is that prior to the 1970s the overall quantum of tied grants was relatively minor. From the 1970s, under the Whitlam government, the Commonwealth began to harness the policy opportunities presented by section 96 in a much more expansive manner. Whitlam declared section 96 as “central to all

hopes for the people of Australia” (C. Lloyd 2002: 284), his government quadrupling their value from \$931 million (25.8 per cent of total grants) in 1972–73 to \$4,153 million (48.6 per cent of total grants) by 1975–76 (Mathews and Grewal 1995: 37). It is no accident that tied grants and the relevance of section 96 grew markedly under the Whitlam Labor government. Ideologically, the ALP had long held a difficult relationship with the Constitution. Frustrating its nationalistic objectives, in the late 1950s Whitlam declared that the Constitution “enshrines Liberal policy and bans Labor policy” (Evans 1977: 7).

Figure 1.3 Tied Grants as a Proportion of Total Payments to the States



Note: The “adjusted data from 1997-98 to 2006-07 enable comparison on a consistent basis with data prior to the introduction of Commonwealth revenue replacement payments for State business franchise fees in 1997-98 and the GST funding arrangements in 2000-01” (WA Department of Treasury).

The Curtin and Chifley governments of the 1940s had experienced varying degrees of success in expanding Commonwealth powers and programs. For example, the implementation of the Uniform Tax Scheme in 1942 and its continuation into peacetime, and the 1946 constitutional amendment⁶ were a boost to Labor’s ambitions to implement “Keynesian style management of the national economy ... and ... expand welfare state policies” (Galligan and Mardiste 1992: 75). On the other hand, bids to implement a voluntary transfer of a range of State social and economic powers to the Commonwealth for five years after the War; a government airline monopoly; and national health benefits

⁶ The new subsection S 51 (xxiiiA) allowed the Commonwealth to pay “maternity allowances, widows’ pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances”.

were unsuccessful. The most dramatic test for nationalisation came with the Chifley government's attempt to nationalise private banking. The legislation was struck down by the High Court in 1948⁷ as a violation of section 92⁸ of the Constitution. The upholding of section 92 by the High Court brought an undeniable end to any future policy aspirations for national regulation. Realising that the "commitment to nationalisation had become a sacred cow within the ALP", all references to nationalisation were removed from its policy platform (Whitlam 1985: 330,34-5).

Irving and Macintyre note that section 92 remained "the *bête noire* of the Labor Party" for at least half of the twenty three years it spent in Opposition before the Whitlam government (Irving and Macintyre 2001: 19). In the early 1960s however, Whitlam began to realise that the constraints of section 92 could be overcome with massive extension in the application of section 96 (Wran 1981). After serving on a joint Constitutional review committee, Whitlam concluded that "the Australian Government has as much constitutional freedom as any other national government to plan the public sector in Australia and to make arrangements with other countries" (Evans 1977: 308). Over the next decade, Labor framed a watershed policy platform that promised to provide "equality of services" and raise the "welfare and quality of life of Australians" in an unprecedented manner (Evans 1977: 5). By 1972, Whitlam was proclaiming: "My basic proposition is this: if section 92 is held up as the bulwark of private enterprise, then section 96 is the charter of public enterprise and section 51 the key to national responsibility and national regeneration" (Whitlam as quoted in Evans 1977: 17). Lloyd and Reid (1974: 285) appropriately claim: "metaphorically, s 96 was the constitutional link by which the ALP Government hitched the States to the star of the Commonwealth". The Whitlam era firmly embedded section 96 and tied grants into the Australian federal landscape, and according to Mathews and Jay (1972: 50), took the irrevocable step of rendering "section 51 meaningless".

1.3.3 Trends in Australian intergovernmental relations

Whilst the vagaries of the Constitution, High Court interpretations and federal fiscal dominance created the capacity for Commonwealth policy intervention through tied grants, shifting ideologies, political and policy setting circumstances have resulted in wavering patterns of intergovernmental policy making (Hollander and Patapan 2007). The post-war period of the 1950s and 1960s entailed a larger role for the Commonwealth, a necessary

⁷ *Bank of New South Wales v The Commonwealth* (1948) 76 CLR 1

⁸ Section 92 provides for "trade, commerce, intercourse among the States ... to be absolutely free".

shift for dealing with pressing social and economic challenges of the time. As discussed, the Whitlam government, recognising the “policy significance” of services under State jurisdiction, endeavoured to increase the Commonwealth’s influence substantially. In contrast, the Fraser government set out to reverse the centralist push and restore State policy space (Parkin 2003: 104-06).

The 1990s brought unprecedented advancements in Commonwealth–State collaboration under the Hawke and Keating governments, with the formation of the Council of Australian Governments (COAG) and policy cooperation on microeconomic reform (Braun 2006: 20; Carroll and Head 2010; Garnaut and Fitzgerald 2002: 185; Painter 1998; Parl. of Victoria 1998: Ch3). COAG arose primarily from the determination of the States to restore federal balance, after an extended period of intergovernmental tension. COAG enabled the integration of many different lines of intergovernmental decision making into a “new structure of federalism” (Castles and Uhr 2007: 114). This development was aided considerably by significant advances in State policy making capacities and the professionalism of public sector management from the early 1970s (Parkin 2003: 106). Under the Howard government, there was again a concerted centralist shift with Parkin and Anderson (2007) asserting that “the Howard government may be doing better than any previous Commonwealth administration in more tightly binding the States” to its policy objectives through tied grants and also bypassing the States completely in providing funding. These developments were partially offset by continuing collaboration on policy setting through COAG.

In the absence of greater constitutional prescription, a voluntary transfer of powers, or an extraordinary shift in High Court interpretation, the concurrent sharing of powers and the historic fluctuations observed in the policy roles of the Commonwealth and the States seem certain to continue. Braun (2006: 29) has appropriately described the distinct policy making relationship that exists between the Commonwealth and the Australian States as one that is “less binding and more flexible but also more contingent on actors’ interests and circumstances as it needs a joint willingness to overcome problems”. In an increasingly uncertain global economic context, this capacity and tendency for flexibility and ongoing adjustment in the allocation of policy powers appears to be a desirable attribute. Simeon (2001: 151) suggests for example that adaptation and the ongoing seeking of balance between “autonomy and independence, competition and consensus” can permit federal systems to maintain relevance and competitiveness in a rapidly moving global economy.

1.4 Purpose and Structure of Study

1.4.1 Research question

A number of propositions can be extracted from this historical account and the practitioner and scholarly literature on tied grants:

- a) as a result of constitutional drafting, High Court interpretation, VFI and Labor Party ideologies, section 96 grants have permitted a concurrent division of policy powers and the imposition of national policy priorities and designs in areas of State jurisdiction;
- b) the attachment of onerous conditions to tied grants has allowed the Commonwealth to assume dominant policy and fiscal control of the tied grant relationship, creating unnecessary administrative, program and political inefficiencies and problems of accountability; and
- c) the conditions attached to tied grants are by no means insurmountable, with State governments having ample capacity to frustrate or avoid tied grant obligations and thereby impede Commonwealth policy interventions through tied grants.

The primary objective of this study is to comprehend and evaluate the conflict that is apparent between propositions (b) and (c) on the balance of policy control and performance impacts of tied grants. In investigating these contrasting schools of thought, this study seeks to shed much needed light on the workings of tied grants and assist in resolving what has become a persistent and highly elusive question for policy makers and practitioners alike: *What role do tied grants play in Australian federalism and what are the impact of those grants on policy making and service delivery in the States?*

Additionally, by better illuminating the power sharing that takes place within tied grants, this study also seeks to improve understanding on power sharing within federal systems generally. At the crux of this study is a perpetual research query asked of federal systems of governance, namely, how does one optimally divide policy making responsibilities between the central and state governments, to facilitate effective policy making? Traditional 'coordinate' or 'dual' models of federalism provide for a discrete division of powers: central governments providing unity, exercising powers that concern the federation as a whole; and state governments providing diversity, exercising powers that impact on specific geographical areas (Saunders 2002: 1). The division of powers under concurrent models of federalism can more complicated to decipher and evaluate. Elazar (1964: 250) describes these interwoven modes of federal system governance as 'cooperative federalism'. He

argues such models are underpinned by four distinguishing features: “a federalist theory of government, a dual governmental structure, some specific cooperative programs, and some administrative techniques for intergovernmental collaboration”. Under cooperative federal system arrangements, there is both a formal and informal intermingling of central and state governments’ roles, responsibilities and structures; and ongoing negotiation and coordination, to establish what can typically be a fluctuating and adaptive sharing of powers (Agranoff 2001; Zimmerman 2001: 18-19). Within such power sharing arrangements, Braun (2006: 9) further differentiates between cooperative, collaborative and adversarial modes of intergovernmental coordination, observing that intergovernmental relations can waver between voluntary or compulsory bargaining and unilateral or mutual problem solving.

Fenna (2007b: 176; 2007a: 304; 2008: 509) observes that in Australia, the practise of cooperative federalism has brought advantages and disadvantages: enhancing capacity for national economic integration for example, but also creating potentially dysfunctional duplication and entanglement. He argues that the development of cooperative federalism has been impacted by the absence of constitutionally-prescribed mechanisms for intergovernmental relations. In fact, Fenna interprets the extensive use of tied grants to be an adaptive response to these constitutional gaps, an outcome that he argues has opened the door to ‘opportunistic’ Commonwealth policy intervention and fostered inadequacies in the “institutions and procedures (used) for joint decision making”. This study, in seeking to shed new light on the nuances and workings of tied grants, should also therefore provide valuable insights into the workings of cooperative federalism, an area requiring considerable further illumination at this time. As Hollander (2010) has argued, while successive governments have “sought to eliminate ... overlap and duplication” and “fix” Australian federalism by pursuit of more streamlined and coordinate models of policy making and governance — there are vital performance advantages with cooperative models that warrant better understanding and greater cultivation, particularly in the more complex areas of public policy.

1.4.2 Research design

This study adopts a case study research methodology incorporating case studies in the area of public hospitals and schools. The paucity of empirical evidence on Australian tied grants makes the case study a highly appealing investigative approach. On the selection of case study subjects, Stake (as quoted in Tellis 1997b; Tellis 1997a) proposes that case studies be chosen for “the opportunity to maximise what can be learned, knowing that time is

limited". In choosing cases, emphasis was given to the political, economic and community significance of the tied grant arrangement. In 2012/13, health and education grants are expected to account for around 70 per cent of total tied grants to the States in 2012/13 (Aust. Government 2012). These grants also feature heavily in the reform of tied grants driven by the Rudd and Gillard governments⁹ hence their significance is without question. A further factor considered in the selection of cases was the author's working knowledge of policy making as a state public servant of around two decades largely with the Western Australia Department of Health and Department of Treasury.

With regards to the case study timeframe, in view of the marked rise in the financial prominence of tied grants during the mid-1970s, this study begins from the Whitlam government and traces the development of the case study subjects through to the Howard government. The benefits of longitudinal studies are well documented in the intergovernmental grant literature. Rosenthal (1984: 475) for example confirms that the "evolutionary nature of intergovernmental programs" justifies the use of "in-depth longitudinal case studies" as a method of examination. The three-decade timeframe selected enables a rich evolutionary account to be constructed and a profound evaluation of the traits of tied grants. A further feature of the research design is the use of both *in-depth* and *high-level* case studies, which permits both a comprehensive and expansive investigation. In Chapters 4 to 6, four *in-depth* case studies are undertaken of public hospital tied grant arrangements signed under the Whitlam, Fraser and Hawke governments from 1975 to 1988 (the 1975, 1976, 1984 and 1985 Medibank and Medicare Agreements). In Chapter 6, the findings of these first four cases are further tested and calibrated, through three *high-level* case studies of public hospital tied grant arrangements signed under the Hawke–Keating and Howard governments from 1988 to 2003 (the 1988, 1993 and 1998 Medicare and Australian Health Care Agreements). Finally, the findings of the public hospitals cases, *as a whole*, are tested and examined through a *high-level, comparative* case study on tied grants for public schools 1975 to 2008 (Chapter 7).

As discussed further at section 1.4.4, the use of both *in-depth* and *high-level* case studies creates a rich longitudinal evidence base, enabling more robust and reliable conclusions to be drawn. From a comparative perspective, the *high-level* examination of the schools tied grants additionally demonstrates that the findings of the hospital case studies are highly

⁹ Since 2007, primarily in response to practitioner criticisms, the Commonwealth has been pursuing unprecedented reform of tied grants, including a scaling back of conditionality and the broad banding of separate grant arrangements (ALP Advisory Group 2007; COAG 2008b, 2008a). The reforms are ongoing, with early studies suggesting some promising elements, but mostly mixed outcomes at this time (COAG 2009; Fenna in Kildea et al. 2012; Fenna and Anderson in Appleby et al. 2012; McQuestin in Kildea et al. in 2012).

capable of being generalised. Further examination of the archival documentation underpinning all of the *high-level* case study grants, with reference to the case study analytical foci, would certainly allow the conclusions of this thesis to be further validated.

1.4.3 Data sources

This study relies predominantly on qualitative analysis of primary data: archival and interview records. Primary data is sourced from the Western Australia Government Archives, Western Australia Department of Treasury Archives, Commonwealth Department of Health and Ageing Archives, National Library and Commonwealth parliamentary records. In total, around 5,700 pages of archival documents were analysed on the negotiation and implementation of public hospital tied grants. The scope of archival evidence examined for this study includes formal and informal correspondence between the States; between the Commonwealth and the States; between WA Government and external policy making stakeholders; and between the central State health bureaucracy and provider hospitals. The types of documentation examined includes State Cabinet Papers; Ministerial papers; agendas and minutes of Commonwealth-State meetings; departmental briefing and file notes; media statements; Parliamentary Hansards; government reports; and Budget Papers.

Whilst the archives used in this study are predominantly located in Western Australia and do contain data unique to the WA context, it is important to recognise that archival records pertaining to intergovernmental grant negotiations are also inevitably rich in national content. This national content is mostly in primary form — for example as correspondence or other briefings prepared by other States — as opposed to second hand accounts written by WA government officials. The nature of tied grant negotiations is such that they are by and large, multi-lateral, with States frequently sharing information, both formally through meetings and conferences, and also informally as States collude and deliberate over Commonwealth offers. Even in the case of bilateral negotiations and covert one-on-one deals, the archival evidence confirmed that non-participating States do eventually gain knowledge of such bargaining outcomes, albeit with some initial uncertainty around the full details. It is highly likely that archival records in other jurisdictions also share these characteristics, containing extensive intelligence on the policy bargaining positions of the other States. Further investigation and analysis of other jurisdictional archives, including Commonwealth archives, would no doubt further clarify and validate the findings of this study and is strongly recommended for future research.

A further defining factor of this study is that the archival evidence used is sourced from both publicly available and closed access records. Cabinet and Ministerial archives in Western Australia remain in closed access status for periods ranging between twenty five to thirty years, after which they are generally made publicly available in the State Records Office. Departmental records also remain in closed access status for various periods depending on their nature and timing of release for public access.

The *in-depth* case studies of hospital grants to 1988 are based primarily on extensive public records that were found to be available. For the *high-level* hospital grant case studies extending beyond 1988, the key source of archival evidence analysed was closed access records, kindly made available by the Western Australia Treasury. Whilst understandably more sensitive, and not as extensive as the publicly available records, this more recent evidence was found to be comprehensive and amenable to detailed case study examination. Similar to inter-jurisdictional sharing of intelligence, these records contained considerable exchange and dialogue between States' line and central agencies during grant negotiations. Central agencies seek to have close involvement in hospital grant negotiations due to the significant implications of these grants on broader State finances. Hence for this study, whilst the closed access records used were located with a central agency, the content of the material was found to be diverse, including ministerial and central and line agency officer correspondence, at both Commonwealth and State levels.

To supplement and further validate the archival research, interview evidence was also collected from current and former State bureaucrats in the Western Australia Departments of Health, Education and Treasury (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008; WA Department of Health 2008b, 2008a; WA Department of Treasury and Finance 2011). In total, 13 interviewees including a former Executive Director (1), and current Directors (6), Managers (2) and Policy Officers (4) provided evidence. Coming from the intergovernmental relations areas of three different WA agencies, the interviews provided different perspectives on tied grants, which was useful in triangulating the archival evidence. As the interviewees continue to be actively involved, or were very recently involved, in intergovernmental negotiations, they agreed to participate in the research only if their confidentiality was respected. Whilst interview recollections can tend to focus more on recent events, this study was fortunate to have access to senior State bureaucrats who have worked for many years and are therefore very well versed in the changing dynamics of intergovernmental relations. Additionally, the study also makes reference to a wide range of relevant secondary literature. Drawing on

these multiple data sources – public archives, closed access archives, interviews and secondary literature, enabled case study findings and conclusions to be triangulated and thoroughly validated.

1.4.4 Methodology and Thesis Outline

The thesis begins by considering normative perspectives on federal system division of powers. The examined fiscal federalism literature offers highly insightful propositions on federal system design and performance (Chapter 2). From an analytical sense however, the literature does not readily lend itself to the operational-level investigation of tied grants sought for this study. An extensive literature review revealed the literature on policy implementation in federal systems to be much more compatible with the research question being considered. Underpinned by an array of analytical models and empirical studies, the policy implementation literature provides an expansive range of potential investigative frameworks. Common investigative themes extracted from this literature enabled the development of a comprehensive analytical framework. The framework outlined at Chapter 3, comprises nine separate analytic foci for assessing the balance of policy making powers within tied grants. The framework is applied in Chapters 4 to 6 to rigorously evaluate public hospital tied grants over 1975-1987. The framework also underpins the high-level case studies of tied grants for public hospitals and schools in Chapters 6 and 7.

In formulating conclusions, this study uses an iterative process. Firstly, the in-depth case studies of Chapters 4 to 6 are used to derive an exhaustive assessment of tied grants and establish a core set of findings on policy making traits and performance effects. Secondly, these findings are subject to further validity and veracity testing, and refinement, in the high-level case study examinations of Chapters 6 and 7. The combination of in-depth and high-level case studies proves very effective in that the study results in a detailed longitudinal 'story' on a vital tied grant arrangement for public hospitals, as well as providing a set of research findings which is comprehensively tested in two policy setting contexts, public hospitals and schools. The final empirical results of the study and normative implications for the future structuring of tied grant arrangements are discussed in the concluding Chapter 8.

With tied grant arrangements in Australia presently in an era of significant change, the outcomes of this study should provide valuable insights on the design and operation of tied grants and cooperative federalism for practising policy makers and scholars alike. Both expansive and comprehensive in its content, the study assists in alleviating the substantial

empirical gap that exists in this most important and intriguing area of Australian federalism. Additionally, the study is aimed at encouraging ongoing empirical investigation — for in an increasingly uncertain and competitive global fiscal environment, it is crucial that the performance of federal systems and intergovernmental arrangements is objectively evaluated and continually improved over time.

SECTION I

NORMATIVE PERSPECTIVES & CASE STUDY ANALYTICAL FRAMEWORK

Section I provides the normative and methodological basis for this study.

Chapter 2 draws on fiscal federalism literature to critically consider normative perspectives on: the division of federal powers; the performance consequences of centrally or locally inclined division; and the use of intergovernmental grants and intergovernmental relations as policy mechanisms.

Chapter 3 is draws on federal system policy implementation literature to develop an analytical framework, a fundamental part of case study methodology. According to Yin (2003: 109, 11-15), analytic strategies can be of three types, reliant on either: 1) the theoretical propositions underlying the research; 2) rival explanations; or 3) the achievement of a case description. The key purpose of an analytic strategy is to enhance the rigour and objectiveness of data analysis and ensure clear priorities are established for “what to analyse and why”. For this study, the primary focus of the analytical framework is to enable examination of the two research propositions or conflicting schools of thought on tied grants as discussed in Chapter 1. A key design factor is the need to analyse operational aspects of intergovernmental governance, described as “the ‘organic’ foundations upon which...unitary and federal structures are built” (Toonen in Hanf et al. 1983: 347, 51).

The normative perspectives and analytical framework are applied in Section II and the Conclusions at Chapter 8. Within Chapters 4 to 6, the analytical framework is used to: organise and analyse the voluminous primary and secondary data collected; categorise each tied grant arrangement as either central or state government controlled; and draw out the ensuing performance effects of each power-sharing arrangement.

2 NORMATIVE PERSPECTIVES ON FEDERAL DIVISION OF POWERS AND PERFORMANCE

2.1 OVERVIEW

The design of a federal system, in particular the division of policy powers between the central government and constituent units (in Australia, the States) creates diverse and competing performance effects. Understanding these effects is an important prelude to evaluating the efficiency and accountability impacts of tied grant arrangements, a primary objective of this study. Literature on fiscal federalism is rich in normative guidance on the economic, political, and administrative performance effects that can arise from centralised or decentralised federal systems. There are two generations of fiscal federalism theory (W.E. Oates 2005: 349). The first generation (F-G) theory focuses on performance from a fiscal and economic efficiency angle, while the second generation (S-G) theory gives greater emphasis to political, social and institutional factors which can have equal, if not arguably greater, influence on performance outcomes (Beer as quoted in W. E. Oates 1977: 21-3; Inman as quoted in W.E. Oates 1999: 1129). Applied together, both theories provide perspectives on “centralization and decentralization ... and draw implications for the structure of the public sector, fiscal institutions and policy making” (W.E. Oates 2005: 350).

2.2 FIRST GENERATION THEORY: AN ECONOMIC VIEW

2.2.1 Roles of government and division of responsibilities

F-G scholars have characterised the role of government into three distinct streams of responsibility: *allocation*; *redistribution*; and *macroeconomic stabilisation* (Musgrave 2000: 108-14). The theory stipulates that the *allocation* function is best shared between central and state governments, whilst *redistribution* and *macroeconomic stabilisation* is ideally performed by the central government. The entrustment of *macroeconomic stabilisation* responsibilities to the central government has a fairly pragmatic rationale, the theory proposing that state governments have “highly open local economies” and thus insufficient access to the fiscal and monetary instruments required to make significant impact on employment and prices (W.E. Oates 2005: 351). The rationale for assigning the *allocation and redistribution* functions is primarily performance-based. F-G scholars argue that the *redistribution* function is more effectively handled by the central government given its capacity to finance such initiatives through more efficient progressive taxes. Further, it is argued that central governments do not face the tax competitiveness and mobility risks attached to capital and high-income residents which can constrain state governments from

implementing more far-reaching redistributive policies (Musgrave 2000; W. E. Oates 1977; W.E. Oates 2005). On the *allocation* function, for public goods that are clearly national in nature, F-G scholars propose that these be provided solely by the central government, while for public goods that are local in nature, the theory advocates decentralised provision (W.E. Oates 2005: 352). The latter is known as the ‘decentralisation theorem’ (1977: 6).

2.2.2 Decentralisation theorem

The decentralisation theorem proposes that in an environment where community demands differ between jurisdictions, greater economic efficiency and enhanced welfare is achieved when the provision of local public goods and services is decentralised and thus more directly responsive to local demands and needs (W. E. Oates 1977: 6). The theorem embodies the principles of the Tiebout (or ‘voting with the feet’) model, which suggests that a federal system community is mobile, with decentralisation creating incentive for individuals to move to communities offering the “best combination of public service and local tax rate” (Thießen 2003: 240).

The decentralisation theorem is also consistent with the doctrine of ‘subsidiarity’ which stipulates that “public policy and its implementation should be assigned to the lowest level of government with the capacity to achieve objectives” (W.E. Oates 1999: 1134). State and local governments, being closer to the community and armed with more reliable and detailed information about local preferences and cost structures, are considered to be in a superior information position to make more efficient allocation decisions and identify new and improved service delivery methods (thus promoting ‘allocative’ and production or ‘technical’ efficiency respectively). Hurley *et al.* (1995: 8) point out that the quantum of technical efficiency gains available will depend on the extent to which production conditions varies between jurisdictions, whereas the quantum of allocative efficiency gains depends on the extent of heterogeneity of demand and values held by jurisdictional populations. Regardless of the quanta, however, decentralisation may be justifiable even where there is perfect homogeneity in the demand for goods and services across jurisdictions, simply because it facilitates *access* to these potential efficiency gains (Thießen 2003). The decentralisation theorem has also been justified from a political perspective, with Oates (2005: 353) arguing that the central government is likely to be constrained from pursuing non-uniform, Pareto optimal service outcomes within individual jurisdictions, as this is likely to involve openly endorsing more generous service levels in one jurisdiction as compared to another, creating potential community and intergovernmental conflict and bringing the risk of being construed as “pork barrel politics”.

2.2.3 Complexities in the application of the decentralisation theorem

While the simplicity of the decentralisation theorem is highly appealing, F-G scholars also acknowledge its limitations. The literature recognises two important qualifiers: the existence of 1) inter-jurisdictional spillover effects; and 2) economies of scale from centralised provision. Scholars assert that where spillovers or economies of scale are evident, decentralisation should be moderated, depending on the prevailing opportunity costs. This entails a weighing up of the efficiency and welfare gains available from a fully decentralised system, against the offsetting national benefits that may be available from the addressing of spillovers or the enabling of better economies of scale (Boadway 2001; Buchanan and Musgrave 1999: 157-8; Pestieau as quoted in W. E. Oates 1977: 177 and 10-11). Oates summarises the quite complex economic efficiency dynamics in play in the centralisation or decentralisation debate: “the (overall) loss of welfare from centralisation is a function of the variation in demand between local and centralised and the price elasticity of that demand” (Buchanan and Musgrave 1999: 157-8; W. E. Oates 1977: 10-11; W.E. Oates 1999: 1123).

Recognising the practical difficulties involved in delineating these competing effects, F-G scholars admit that achieving a perfect alignment between the financing, provision and benefits of public goods and services is likely to prove challenging, if not impossible, because the “market in which jurisdictions play is decidedly imperfect” (Musgrave 2000: 331). For example, in practice, there is likely to be no ready means of isolating and quantifying the spatial costs and benefits associated with specific services. Even the definitive classification of a public good as of a national or local nature can be highly problematic. For example, both health and education are locally-provided goods but can also be justified as having significant implications for national prosperity and social well-being (Musgrave 2000: 332; W. E. Oates 1977: 6). Other impediments to the theory’s application are: 1) potential weaknesses in the concept of full mobility since not all consumers may be capable of financing a move to another jurisdiction; and 2) imperfect information since consumers may not have full knowledge of the spatial costs and benefits associated with residing in one jurisdiction as opposed to another and may be unable to respond (Pestieau as quoted in W. E. Oates 1977: 177).

Notwithstanding these practicalities, the decentralisation theorem has stimulated useful debate on the competing efficiency, equity and economic trade-offs to be considered when designing or evaluating the performance of a federal system. One area of debate is that of the equity trade-offs associated with decisions to decentralise. Some scholars are most

disparaging of the equity losses from decentralisation, claiming that “federalism and equality of result cannot coexist” and the “very tolerance (even encouragement) of inequality facilitates the diversity that lies at the heart of federalism” (Wildavsky 1985: 48-9). Boadway (2001: 107) asserts that unfettered levels of diversity, or diversity that is “simply the result of competitive constraints or uncoordinated decisions” can create unacceptable jurisdictional inequities in access to basic services. In response to these assertions, F-G theorists acknowledge that governments not only have a role in securing the Pareto-efficient use of resources, but also in attaining “distributive justice and the balance of individual rights and obligations upon which a meaningful concept of liberty has to be built” (Buchanan and Musgrave 1999: 31-2). F-G theory therefore accepts there is a valid role for the central government in containing the scale of diversity across jurisdictions, such that the community has equal access to a minimum standard of goods and services, regardless of their place of residence.

A further area of debate centres on the economic trade-offs involved in decentralisation. In support of heavily decentralised systems, Deeg (1996) contends that State governments, through the control they possess over the local “production process”, have a more direct means of stimulating national economic interests, particularly within an increasingly globalised environment. In contrast, adopting a more centralist approach, Thießen (2003: 241-3) observes that pronounced inequities and differences in the supply of goods across jurisdictions can stifle national economic growth by preventing the “full use of production factors including human capital” — particularly in the case of public goods and services such as education, infrastructure and health with potentially large spillover effects. Further, the maintenance of minimum standards in literacy and numeracy by the central government is often advocated as a means of enhancing the national calibre of workforce and thus national economic prosperity (Boadway 2001: 109; W. E. Oates 1977: 14). Decentralisation has also been portrayed as a hindrance to macroeconomic stabilisation (Thießen 2003: 241-3). In supporting greater central involvement, scholars are nonetheless careful to qualify their arguments, stressing the need for central governments to behave in a cooperative manner. Oates (as quoted in Thießen 2003: 239-43) for example notes that centrally determined policies around infrastructure and education should be formulated in collaboration with State and local governments so that local allocative efficiency, an important driver of economic growth, can be optimised.

2.2.4 Verdict on division of the allocation function

The discussion so far confirms that there is no precise normative formula to achieving a performance optimal division of *allocation* responsibilities. While it may be more Pareto-efficient to decentralise the provision of local goods and services, F-G scholars concur that issues such as spillover effects; economies of scale; preserving of social equity; globalisation and national economic interests can warrant central government coordination and oversight. Decentralised federal systems may be better able to cope with the “fluidity of market forces and human behaviour” of a global marketplace, by encouraging innovation and experimentation, however globalisation is also “propelling economic integration”. It therefore appears that a variety of federal models (both centralised and decentralised) may be adopted, as each nation forges a tailored response to these competing performance pressures Kincaid (2001:87-8).

Overall, performance in federal systems is a matter of great complexity, with the equilibrium between “autonomy and interdependence” and “competition and consensus” requiring adjustment on an ongoing basis. Both “sides of the coin” — centralisation and decentralisation — have a legitimate role to play in positioning a federation to be responsive to changing international and national circumstances (Simeon 2001: 151). The balancing of these competing trade-offs requires the formation of “value judgements” (Boadway 2001: 105), on the weight to be attached to the various performance objectives (Bird et al. 2002: 72), with the end balance being dependent on the level of performance sought, and political and community ideology on the type of society desired. On this last point, Musgrave (2000: 332) comments that the sharing of responsibilities “may have less to do with what space is covered by a particular program than with the question...of how closely knit a nation the member jurisdictions of the federation wish to form”. Not surprisingly too, communities are often “less likely to be concerned with the niceties of federalism than they are in the seamless provision of publicly provided goods” (Simeon 2001: 146).

2.2.5 The role of intergovernmental grants in the allocation function

Given changing circumstances and the need for flexibility, governments require a mechanism to regulate the sharing of the *allocation* function and the performance effects created. F-G scholars advocate the intergovernmental grant as a versatile policy mechanism for this purpose. It is argued that through appropriate structuring of a grant arrangement, the performance advantages or disadvantages of either a centralised or decentralised approach can be harnessed or diluted respectively. For example, Oates (2005: 351)

proposes that losses in efficiency and welfare arising from inter-jurisdictional spillovers can be fully mitigated through the use of matching conditional grants, consistent with the “traditional Pigouvian theory of subsidies”. Intergovernmental grants are also considered the best policy mechanism from an equity perspective, with F-G theorists arguing that they provide more capacity to the central government to ensure distributive justice, in comparison to alternative mechanisms such as transfer payments to individuals, which mostly serve to “enhance the spending power of individuals” and are “contrary to federalism” (Buchanan and Musgrave 1999: 198).

In terms of grant structure, Gramlich (as quoted in W. E. Oates 1977: 220-22) identifies three types of grants, with varying performance effects. He proposes that **open ended matching grants** (“Case A grants”) are most appropriate for addressing benefit spillovers as they stimulate local service provision by subsidising the price of service provision; **unconditional or closed end lump sum grants** (“Case B grants”) are best suited for achieving re-distributional or macroeconomic stabilisation objectives as they increase the level of income available to the state, but do not affect relative local prices; and finally, **closed ended specific purpose grants** (“Case C grants”) are most appropriate for achieving greater uniformity in minimum service levels or standards as they allow the central government a fiscally-controlled means of increasing local spending, although local discretion is reduced. On the application of grants, a useful three-pronged typology is also put forward by Elazar (1972: 473-4). Elazar proposes that grants can be based on either: 1) “the federal government as servant theory” under which the central government is primarily a revenue raiser and re-distributor of revenues to the states with minimal input on allocation decisions; 2) “the national uniformity theory” whereby the main objective of intergovernmental grants is to establish uniformity and minimise state discretion and variations; or alternatively, 3) “the local right-national interest theory” under which grants allow for both local diversity and national standards.

While the structure and use of intergovernmental grants does vary across federations and over time, Courchene (2003: 2) has noted that “the nature of, and incentives within, these grants is anything but arbitrary...rather they tend to embody and indeed to reinforce the values and norms of the citizen-government and citizen-citizen relationships that underlie the societal and social/political contract. The importance of grant structure to performance outcomes is also highlighted by Reischauer (as quoted in W. E. Oates 1977: 126-7) who argues that excessive use of, or inappropriately structured, intergovernmental grants can create inefficient constraints around service delivery, increase local hostility, and at worst,

“render ... programs ineffective”. Reischauer observes that inadequately performing grant arrangements are often too quickly misinterpreted as shortcomings in State government performance, and unnecessarily abandoned in favour of more direct transfer payments to the community. He suggests that a more productive approach would be to undertake a rigorous review of grant structure and the performance effects created, with adjustments made to correct undesirable implementation behaviour or outcomes.

2.3 SECOND GENERATION THEORY: A POLITICAL AND ADMINISTRATIVE VIEW

Unlike the F-G theory of fiscal federalism which is centred on maximising economic efficiency and assumes that, by and large, elected officials serve in the public interest, second generation (S-G) theory introduces political and information considerations into the normative framework. S-G theorists view the *allocation* function to be undertaken in an environment of “imperfect information and control” and by “utility-maximising (community and official) participants” (W.E. Oates 2005: 356-7) both of which divert or distract individuals and institutions from the pursuit of optimal economic performance and the ‘common good’. There are a number of streams of S-G theory, these are briefly discussed below.

2.3.1 Public and Rational Choice theories

Advocating a decentralised approach, public choice theory begins with a fundamental premise that governments and bureaucrats possess “leviathan” tendencies, encouraging unnecessarily large public sectors and a propensity to maximise revenues (Buchanan and Musgrave 1999: 22-3). It is argued that decentralisation enables the containment of these tendencies, by enforcing horizontal and vertical competition and preventing oversupply of public goods and services, whilst stimulating higher policy creativity and innovation (Boadway 2001; Breton as quoted in Hamlin 1991: 202). Additionally, from a political perspective, the theory proposes that by reducing the concentration of political power, decentralisation serves to constrain the impact of vested interests and enhances democracy (Thießen 2003). The support of greater inter-jurisdictional competition or “competitive federalism” by S-G theorists is a distinct contrast to the F-G literature. F-G scholars warn that the pressure for tax competitiveness may lead to a reduction in the overall standard of services (a ‘race to the bottom’) and create undesirable distributional social inequities (Buchanan and Musgrave 1999: 181; W.E. Oates 1999: 1134). Further, F-G theorists maintain that inter-jurisdictional competition must be fostered with the support of central government coordination: either through fiscal equalisation or other “apparatus

that makes it possible to harmonise while maintaining differences” (Buchanan and Musgrave 1999: 188,202; Musgrave 2000: 334-6).

Notably, inter-jurisdictional competition is also not universally espoused in the public choice literature. Some scholars have suggested that the purported innovation gains could be hampered by the free-rider problem where jurisdictions are discouraged to invest in experimentation when the ensuing benefits would become openly available to other jurisdictions at no cost (Strumpf as quoted in W.E. Oates 1999: 1133). An interesting observation by Hamlin (1991: 202) is that inter-jurisdictional competition could very well lead to uniformity as a result of states “competing by copying”. Under such circumstances, he argues that any efficiency gain is likely to be price (production) based, rather than the traditionally anticipated allocative efficiencies. Bird et al (2002: 71-2) suggest that to harness the benefits of inter-jurisdictional competition, local communities require access to reliable inter-jurisdictional performance data (information accountability) and an ability to influence government decision making (democratic accountability). It is also noteworthy that the “leviathan restraint hypothesis” is a concept heatedly debated by first generation scholars. For example, a study conducted by Rodden (2003: 724) found that the hypothesis only holds true when decentralisation is associated with “autonomous local taxation”. When decentralised state governments are reliant upon intergovernmental grants that are financed by centrally regulated taxation, the loss of a direct link between taxation and public expenditure was found to encourage both levels of government to expand their expenditure base.

Similar to public choice theory, rational choice theory asserts that decisions are generally taken in an “individualistic” and “self-regarding” manner, with the objective of maximising “value (utility) given the constraints of the situation” as opposed to maximising economic efficiency and equity (Beer as quoted in W. E. Oates 1977: 25). The theory proposes for example that with regards to the *redistribution* function, central governments are more likely to be driven by political causes than by genuine economic justifications. On the division of powers, rational choice theory advocates for decentralisation arguing that this: 1) reduces internal conflict by encouraging mobility between states and thus grouping of community members with similar preferences; and 2) gives states greater flexibility and freedom to be more responsiveness to community needs.

Further, theorists suggest that performance is enhanced when a federal system is “not linked hierarchically by command but co-ordinately by exchange (Beer as quoted in W. E.

Oates 1977: 26-7). An administrative barrier noted in the literature is “technocracy or the rise of government by professionals”. It has been suggested that “strong vertical connections” formed between bureaucrats and professionals at the central and state government levels can result in administrators having an undue level of influence over *allocation* and *redistribution* decision making, reducing the scope for input from external participants (for example the community, interest groups and private sector parties) and reducing local community responsiveness (Beer as quoted in W. E. Oates 1977: 31).

2.3.2 Principal-Agent and Market Preserving Federalism theories

Oates (2005: 358) asserts there are two perspectives within principal-agent theory. The first designates the federal and state government as the principal and agent respectively, whilst the second view considers the electorate as the principal, and the “elected public official” as the agent. Literature on the first perspective illuminates the performance implications of overly centralised federal systems. Hurley and Oates (1995: 8; 2005: 359) for example claim that the information asymmetries of central governments reduce their capacity to drive local experimentation and innovation and increase information costs. Studies centred on the second perspective are useful in highlighting performance implications from a political accountability perspective. Literature in this area argues that a decentralised system gives the electorate (principal) more control over politicians (agents), and thus results in greater political accountability in the meeting of local needs (Bardhan 2002: 192).

Market preserving federalism (MPF) theorists strongly advocate decentralisation and the dispersion of policy making and political powers. Weingast (1995) argues that a decentralised federal system is more effective for fostering national economic growth. Additionally, he argues that politically decentralised policy making reduces the government’s “political responsiveness to interest groups”; stimulates competition between state governments; and reduces government’s ability to “confiscate wealth”. Qualifying these assertions, he also adds that for the model to be sustainable, “self-enforcing” mechanisms are essential, to ensure the role of government remains “limited”. The MPF theory is heatedly debated in the literature. For example, questioning the political arguments of MPF, Rodden and Rose-Ackerman (1997: 1523, 26, 35, 47, 51-2) propose that “local officials will not choose efficient policies unless they believe that their political survival is enhanced by good performance”. Additionally, they observe that an absence of strong central coordination leaves “neither fiscal nor regulatory carrots or sticks” to maintain a stable common market. They assert that the central government should not be

completely overlooked as it has a role in mitigating inefficiencies or inequities created by state governments operating in an uncoordinated manner and only their own self-interest.

Braun (2006:29-32) also queries an overly decentralised approach. His study of Australian intergovernmental policy making found that a highly centralised federal model can operate quite effectively if accompanied by “collaborative coordination”. Braun points out that “collaborative coordination” requires a strong central government to assume the role of agenda setter and broker in intergovernmental relationships. He does admit however that with no self-enforcing the long term sustainability of “collaborative coordination” in Australia is yet to be proven. Rubinfeld (1997: 1582, 84-5) attempts to strike a middle ground concluding that “an effective federalist system, with an active central authority that encourages economic efficiency and political participation and respects basic individual rights, can promote long term economic growth”. He also points out that unless there is true mobility across jurisdictions, it is unlikely that decentralisation and inter-jurisdictional competition can generate the anticipated economic efficiencies.

2.3.3 Verdict on division of the allocation function

Similar to the F-G literature, S-G scholars are also inconclusive about whether federal system performance is greater under a centralised or decentralised approach. There is strong support for a decentralised approach so as to: curb political opportunism by the central government and dominant interest groups; restrain inefficient public sector growth; enhance inter-jurisdictional competition and local production efficiency; foster innovation and local accountability; and reduce intergovernmental conflict. Nevertheless scholars are also supportive of a central government role in: containing political opportunism at the local level; stabilising national economic interests; correcting inequities and inefficiencies arising from too much disparity between jurisdictions or detrimental inter-jurisdictional competition; preserving individual rights; and acting in an overseer, agenda setter and broker role.

Second generation scholars acknowledge that even in a federation with “pronounced heterogeneous demand preferences”, it is preferable that decentralisation be accompanied by “adequate central government interventions” (Rubinfeld 1997; Thießen 2003). Additionally, it is recognised that while there may be significant efficiency gains available from decentralisation, these gains do plateau and beyond an optimum level, decentralisation can actually become disadvantageous for performance (2003: 252). Also evident is “a basic conflict inherent in fiscal decentralisation: the more one decentralises,

the more reasons may be generated for interventions at the national level” (Thießen 2003: 240).

2.3.4 The role of intergovernmental relations in the allocation function

A recurring theme in the S-G literature is that ongoing adjustment between a centralised and decentralised approach is a necessary part of managing overall federal system performance. In F-G theory, it is proposed that such adaptation occur through intergovernmental grants. S-G theory is not as explicit in defining a mechanism for dealing with the performance trade-off issues identified, a feature that has drawn criticism (W.E. Oates 2005). The literature does however discuss the importance of intergovernmental collaboration. Braun (2002) for example observes that it is not the division of the *allocation* function that in itself drives policy making, rather it is the extent of collaboration between the central and provincial government. He further suggests that a non-cooperative relationship is likely to give the central government a reduced scope for policy action; whilst a co-operative model enables policy action, but potentially weakens the impact of the policy instrument (depending on the results of distributive bargaining). He also notes that although collaboration is more feasible under a cooperative model of intergovernmental relations, efforts can be seriously compromised, and delayed, by the need to reach harmonious distributional outcomes (Braun et al. 2002:141). Referred to as the “joint decision trap”, too much intergovernmental cooperation can result in governments focussing on preserving harmony as opposed to servicing community need (Scharpf as quoted in Simeon 2001: 151).

2.4 SUMMARY

F-G and S-G literature highlights the diverse and competing economic, political and administrative effects, which can emanate from federal system design as shown below at Table 2.1. While advocating for a decentralised approach, the theories also point out the importance of central government coordination. In this regard, intergovernmental grants and intergovernmental relations are put forward as key mechanisms through which the performance advantages or disadvantages of centralised or decentralised governance can be moderated.

The normative perspectives examined in this chapter confirm that federal system performance is a complex and fluctuating affair, and careful consideration is required of all competing performance effects. De Villiers (1994: 22) describes the erroneous assessments that can be made of federal system designs not adequately evaluated and understood. He

observes that federal systems are regularly criticised for the complexities and inefficiencies purportedly created by “overlaps, duplications, conservatism and rigidities”, but argues there is a “counterview (this being) that the redundancies within federations provide fail-safe mechanisms and multiple safety valves enabling one subsystem within a federation to respond to needs when another fails to. In this sense, the very inefficiencies about which there are complaints may be the source of a longer-run basic effectiveness”.

Table 2.1 Summary - Normative Perspectives on Tied Grants

NORMATIVE PERSPECTIVES	
<i>Federal division of powers and performance effects</i>	
Centralised power sharing	Decentralised power sharing
<p>Equity Distributive justice (access to services) Equity in outcomes</p> <p>Political Intergovernmental conflict Restraint in local political opportunism Politically motivated redistribution</p> <p>Economic Improved macroeconomic stabilisation Economic Integration Economies of scale</p> <p>Administrative Undue technocrat influence Information costs</p>	<p>Equity Inequity and lower standard services due to unfettered competition/diversity</p> <p>Political Dispersion of interest group influence Greater political accountability</p> <p>Economic Smaller government Policy innovation and experimentation Local responsiveness Allocative efficiency Technical or production efficiency</p>
<i>Intergovernmental collaboration and performance effects</i>	
Cooperative intergovernmental relations	Non-cooperative intergovernmental relations
<p>Improved macroeconomic stabilisation</p> <p>Improved re-distributive justice</p> <p>Improved central government capacity for policy action <i>but subject to</i> distributive bargaining, compromised performance objectives and implementation delays</p> <p>Risk of cost shifting by states when budget constraints evident</p>	<p>Risks to macroeconomic stabilisation</p> <p>Risks to redistributive justice</p> <p>Reduced central government ability for policy action</p>

3 CASE STUDY ANALYTICAL FRAMEWORK FOR ASSESSING DIVISION OF POWERS

3.1 OVERVIEW

This chapter turns to policy implementation literature to develop a case study methodology for analysing the division of policy making powers in tied grant arrangements. Implementation studies have contributed a great deal both normatively and empirically, to the understanding of policy dynamics within a federal system (Fischer et al. 2007: 89-90, 101; Goggin et al. 1990: 14-15, 17-18). A fundamental premise in the literature that is of particular relevance to this study is that the distribution of power in intergovernmental policy implementation is neither centralised nor decentralised, but rather “a continuum located between central guidance and local autonomy” which over time, “resembles a swinging pendulum” (Fischer et al. 2007: 100; Van Horn 1979: 3). This dichotomised yet fluctuating representation of intergovernmental power-sharing, as depicted through the different conceptual models and empirical evidence underpinning the literature, offers a prolific basis from which to derive analytic foci for case study research of tied grants.

In choosing to work with this literature base, it is acknowledged that implementation literature remains characterised by “a multitude of potential explanatory variables” rather than a single unified theoretical framework. Scholars argue however that this should not be a deterrent for its application, or ongoing development (Fischer et al. 2007: 102-03). The lack of cohesiveness that is cited appears to come from the nature of public policy making itself: the complexities and uniqueness associated with different policies and the political and economic contexts within which they are implemented, rather than any weakness in theoretical rationale. Indeed, as shown later in this chapter, common themes are readily identifiable within the various analytical models put forward. A further trait of the literature to be noted is its predominantly U.S. basis. While there are significant variations between the U.S. and Australian federal system, this is not considered to hamper the relevance of the literature, given that it is being applied primarily in a methodological manner. This study essentially draws on analytic models and investigative approaches outlined in the literature, using these to identify suitable analytic foci for the case study research. In adopting the various analytic foci, there is no presumption made that the associated empirical findings of the literature will be directly applicable to the Australian federal system. Rather, the extensive empirical lessons in the literature are considered to provide useful propositions and reflections for consideration in this study of Australian tied grants.

3.2 Distribution of Policy Making Powers in an Intergovernmental Grant Program

It has long been recognised that the design and implementation of intergovernmental policy “that will both accomplish legitimate national goals and remain sensitive to legitimate local needs and priorities...[is]...a recurring and vexing problem” (Van Horn 1979: 5). Policy implementation literature offers three schools of thought to this dilemma: the top-down or principal–agent view of policy making and implementation; the bottom up or donor–recipient view; and hybrid views that synthesise aspects of the top-down and bottom-up schools of thought (Imperial 1998: 1-3). The *top-down* view advocates an arrangement where the central government has the more dominant policy setting role. The *bottom-up* view is supportive of arrangements in which policy setting is driven largely by state governments and local stakeholders. The *hybrid* view dismisses these polarised conceptions of shared governance, instead viewing the balance of power between “central steering and (state) local autonomy” as being determined by, and dependent on, a range of contextual factors, leading to a federal system that has elements of both top down and bottom up approaches (Fischer et al. 2007: 96-97; Van Horn 1979: 2).

3.3 Theoretical Perspectives

The top-down (TD) and bottom-up (BU) views of intergovernmental policy making offer a relevant theoretical basis for operational research into federal divisions of power, reflecting “different visions of how our federal system operates” with each “based, in part, on a normative and prescriptive argument about where power should lie” (Imperial 1998: 2).

3.3.1 Top Down or Principal–Agent View

The TD view has been described as a “governing elite phenomenon” (deLeon as quoted in Fischer et al. 2007: 91). TD approaches assume a direct causal relationship between central government policy making and community outcomes. Several principles underpin the TD approach, these being that: 1) federal systems should be managed as a single system; and 2) the interdependencies inherent within a federal system necessitate “the application of executive centred logic” (Sundquist and Davis as quoted in Agranoff and McGuire 2001: 673). The TD view considers the implementation process to be insignificant, portraying this to be a “problem of administration, not politics” (Imperial 1998: 2). Local actors are described as “impediments” and “agents” with “shirking behaviour” (Matland 1995: 148) — to be controlled and managed through financial incentives and sanctions, regulatory legislation and oversight, and prescriptive compliance regimes (at central government cost).

Strong central and hierarchical control is an assumed feature of the policy making process, and the best means of addressing duplication and overlapping responsibilities (Agranoff and McGuire 2001: 673; Fischer et al. 2007: 91-2; Van Horn 1979: 2). The TD approach originated in the post-war period during which federations experienced a surge in national programs and national minimum standards (White as quoted in Agranoff and McGuire 2001: 672). The approach was essentially a bureaucratic response to constitutional constraints and local political resistance which restricted central governments from expanding policy control.

The TD view has been criticised for its oversight of a number of practicalities. Toonen (as quoted in Hanf et al. 1983: 345-6) points out that central governments are themselves a “conglomerate of different organisations” competing for scarce resources and often characterised by issues of integration and overlap. In addition, he observes that the effectiveness of TD policy control is largely dependent on state governments providing supporting policy and implementation effort, adequate program delivery infrastructure and budgetary support. Critics also argue that in deeming implementation to be a largely administrative process, vital political factors, inherent to the policy making process are overlooked. Matland (1995: 147-8, 53) proposes that the pre-occupation with central actors ignores the considerable discretion available to local bureaucrats which makes it “simply unrealistic” to control all their implementation actions. It is also asserted that TD approaches can actually exacerbate state resistance by failing to recognise the experience and knowledge of local actors formulating policy.

A variation of the TD view is the principal–agent view which is derived from organisational theory and likens the grantor–grantee relationship to that of a superior–subordinate (Chubb 1985: 997-8). Three control issues are identified as typical of a such a relationship: 1) some extent of goal conflict between the goals of central government and state actors; 2) asymmetry of information, with states having more precise information about their performance and the central government having only an indirect knowledge; and 3) “shirking or non-performance by sub-ordinates when they can get away with it” (Bossert 1998: 1516; Chubb 1985: 998). The principal–agent view perceives federalism as a “hierarchical system of control”(Hedge et al. 1991), with emphasis on the specification of rules, ongoing monitoring and compensation or sanctions (Bossert 1998: 1516; Chubb 1985: 998; Hedge et al. 1991: 1055). Acknowledgement is given however to some of the complexities of unilateral central control. Scholars propose that there are two tiers of principal–agent relationships in federal systems: one between agencies of the central and

state governments and another between central government agencies and a host of central government principals including federal Ministers and Parliament who may place their own conflicting demands on central agencies (Chubb 1985: 1007; Hedge et al. 1991: 1059). It is recognised that the existence of competing and multiple policy actors at both national and state levels can severely undermine the ability of central governments to assume intergovernmental policy dominance. Hedge (1991: 1075-6) goes further to suggest that the multiplicity of actors is an intentional part of democratic system design, arguing that the use of TD or principal–agent approaches is feasible only in “comparatively simple policy milieu”.

3.3.2 Bottom Up or Donor Recipient View

In contrast to the centralised “chain of command” espoused in TD approaches, bottom-up or donor–recipient (BU) scholars put forward a more fluid and mutually dependent view of intergovernmental policy making. They propose that policy making is a continuous and flexible process, such that a policy initiated by the central government will continue to be decisively shaped by local implementation actors as they adapt the policy to local political settings and community need (Fischer et al. 2007: 92-94; Elmore as quoted in Hanf et al. 1983: 59-60). BU approaches do not view policy implementation as a simple linear execution of national policy goals, but as a process of political and administrative compromise: involving “negotiated settlements” with different stakeholder groups; “trading” between competing policy objectives; and navigation between “substantial conformity with national goals and some desired change at the bottom”. Viewed in this light, an intergovernmental grant becomes a vehicle of “bargaining between partly cooperative, partly antagonistic and mutually dependent sets of actors” (Agranoff and McGuire 2001: 673-4; Fischer et al. 2007: 92-4; Elmore; Sabatier as quoted in Hanf et al. 1983: 57-9, 304).

BU scholars argue that it is impossible for national goals to be formulated unequivocally, implying there is at least a residual capacity for local policy making. The notion that there is a direct causal relationship between national goals and community outcomes is rejected, with the BU view assuming that “contextual factors within the implementing environment can completely dominate rules created at the top”, or at least make central control “highly problematic” (Fischer et al. 2007: 94; Sabatier as quoted in Hanf et al. 1983: 304; Berman as quoted in Matland 1995: 148). Further, depending on how local discretion is applied, the BU view proposes that end outcomes can vary from site to site, to the extent that local actors can choose to ignore national standards altogether, either through inaction or open

non-compliance. Lower level governments are therefore perceived as separate jurisdictions, rather than “extensions of a single jurisdiction” (Fischer et al. 2007: 94; Elmore as quoted in Hanf et al. 1983: 66).

Unlike the TD approach where program success is measured by the extent of local compliance with national goals, BU scholars consider program success to be defined by the extent of policy making discretion and autonomy available to state actors, so that they are able to fulfil national goals whilst meeting local needs (Agranoff and McGuire 2001: 674). Some scholars take this point further, suggesting that unless there is adequate policy space allocated for local actors, the national program is likely to fail completely (Matland 1995: 148). A further factor cited is skills capacity in the local implementation structure, with program success argued to be very much dependent on this, particularly in the case of those at the coalface of service delivery, the “street level bureaucrats” (Sabatier as quoted in Hanf et al. 1983: 304; Weatherly and Lipsky; Hjern; as quoted in Matland 1995: 149). While TD scholars characterise implementation as apolitical and administrative in nature, the BU view considers the “implementation process is eminently political” with policy outcomes being heavily dependent on the decentralised political decision making of local actors. The BU school of thought also differs in its underlying style of democracy, using a “more participatory model of democracy” as opposed to the elitist approach of the top-down theorists (Fischer et al. 2007: 94-5).

The BU view has been criticised for exaggerating the extent of autonomy available to local actors. Critics assert that while local actors may possess significant influence over policy making at the delivery level, one should not overlook the power of the central government to limit the scope of that local autonomy, through its control of broader framework settings: for example, available resources; institutional structures; and policy boundaries. In addition, from a democratic and accountability perspective, some scholars argue that local autonomy and policy discretion may only be appropriate for circumstances when there is consensus over national goals between the central and state governments. They suggest that where there is significant goal conflict in the implementation of a national program, precedence should be given to the central government’s accountability to its constituency and that any “decentralisation should occur within a context of central control” (Fischer et al. 2007: 94; Matland 1995: 149-50).

3.3.3 Summary

The following table summarises key features of a top down or bottom up approach to policy making:

Table 3.1 Key Features of Top-down and Bottom-up Governance

Key characteristics	Top-down or Principal-agent view	Bottom-up or Donor-recipient view
Number of actors involved	Minimal	Multiple
Actors with dominant policy making influence	Central government	State government and local implementation actors
Policy goals	Clear and consistent	Flexible and open to bargaining
Focus of policy attention	National goals	National and local goals
Perception of intergovernmental policy implementation	Administrative	Political
Relationship between policy formulation and outcomes	Linear hierarchical relationship, policy formulation is separate from implementation	Complex relationship, national goals continue to be shaped at the state implementation level
Management style	Chain of command, less flexible, reliant on monitoring mechanisms and incentives, sanctions	Bargaining, compromising, reliant on allowing local actors adequate decision making space
Perception of implementers	Shirking agents	Policy making partners
Democratic basis	Elitist	Participatory
Policy outcomes	Mostly uniform	Varies according to site
Key measure of success	National goals successfully implemented	Local actors have sufficient autonomy to meet national goals and local needs

The divide between the two approaches is significant. Both schools of thought however serve an important purpose when conceiving of grant relationships as a continuum. By providing extreme views of central or state government influence, they effectively establish the boundaries for the case study analytical framework. As mentioned earlier, the hybrid view represents the scholarly thought between the TD and BU extremes. Hybrid approaches are derived by pragmatically combining various aspects of the TD and BU schools of thought (Fischer et al. 2007: 97). They are empirically based, with scholars putting forward a variety of models as part of their empirical implementation research. Hybrid approaches are therefore considered as part of the next section, together with other empirical evidence from the literature.

3.4 Empirical Perspectives

As mentioned, implementation literature is rich in analytical and investigative models. The aim of this section is to draw on the literature to identify analytical foci suitable for the case research objectives of this study. Further, the section also critically examines relevant empirical findings from the literature. These findings will serve as useful propositions for the case study research, forming a pertinent reference point both for the assessment of case study evidence and in forming conclusions on the division of powers in tied grants.

3.4.1 Development of a case study analytical framework

Yin notes that “unlike statistical analysis, there are few fixed formulas or cookbook recipes to guide [the design of an analytic strategy]...instead much depends on an investigator’s own style of rigorous thinking, along with the sufficient presentation of evidence and careful consideration of alternative explanations” (Yin 2003: 110).

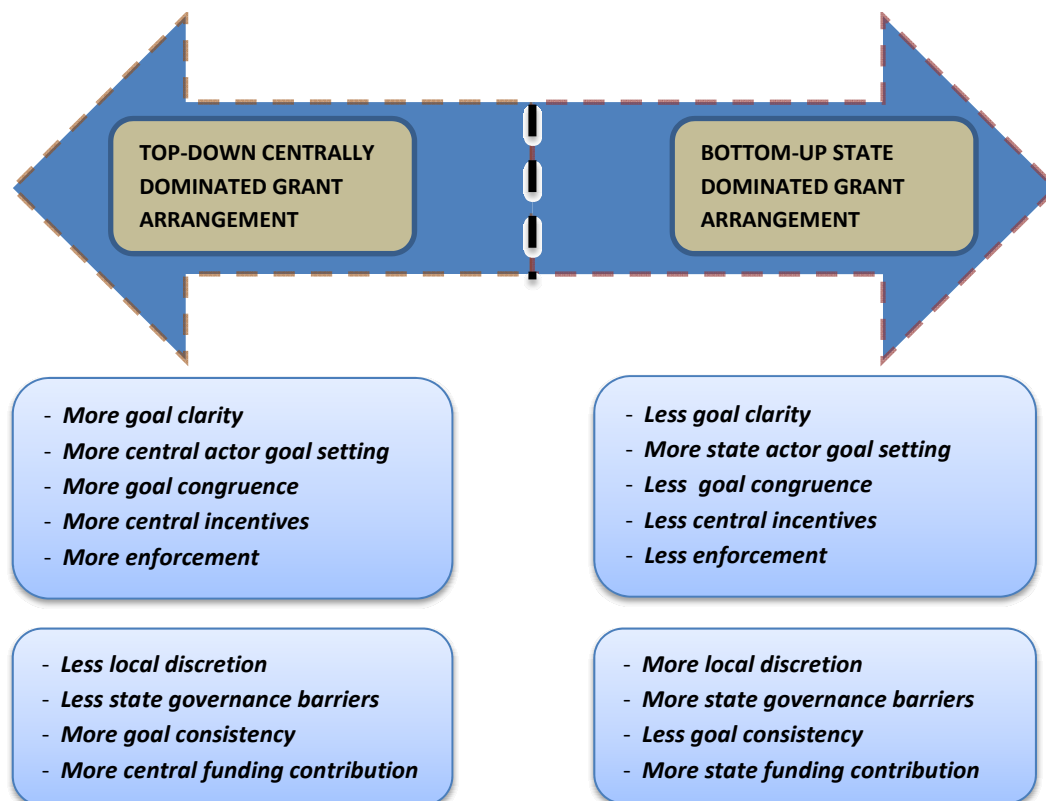
To identify relevant implementation studies and suitable analytical models, an extensive search was conducted of the literature. The search revealed a host of models, each serving unique research objectives, varying from a scholarly need to evaluate, describe or analyse – the design, implementation or outcomes of an intergovernmental program. Rather than identify a single “best-fit” model, it was decided to build the analytical framework from a collection of models, so as to derive a robust case study methodology. Drawing from multiple models also assists in overcoming the perceived weakness of the literature discussed earlier, this being the lack of scholarly agreement over the relative merits of different models and their applicability for specific types of investigations. From the field, suitable models were selected on the basis of their abilities to assist in the characterisation of tied grants. The selected models are summarised at Appendix 9.1.

As shown, while the selected models are diverse in their purpose and structure, it is possible to identify common themes, confirming that a degree of cohesiveness does exist within the literature. Nine common investigatory themes are evident in the analytical models examined:

- Goal clarity
- Goal setting
- Goal congruence
- Goal consistency
- Funding shares
- Incentives
- Enforcement
- Local discretion
- State governance barriers

Figure 3.1 shows how these common areas of investigation, depending on intensity, can be linked to the TD and BU normative perspectives discussed earlier:

Figure 3.1 Case Study Analytical Framework



3.4.2 Application of the analytical framework

In Section II, the above framework is applied in each of the tied grant case studies to: 1) facilitate the classification and analysis of the voluminous primary and secondary data collected; 2) formulate reliable assessments on the extent to which specific tied grant arrangements are centrally or state controlled; and 3) illuminate the varying performance

effects arising from this power sharing balance. It is unlikely that any grant arrangement will readily fall into a top down or bottom up classification, or remain of the same character over the entire case study timeframe. The more probable scenario is that there will be shifting and competing characteristics over time, with scholarly and professional judgement required to arrive at robust and reliable assessments across different policy spheres and timeframes. To assist with the application of the analytical framework, a range of potential explanatory factors were identified from the literature as outlined at Appendix 9.2. These factors should help facilitate consistent scholarly use of the analytical foci. The applicability of the various factors will however vary from case to case, depending on the type of primary and secondary data that is available.

3.4.3 Empirical reflections and propositions

Prior to moving to Section II and the case study analysis, it will be useful to conclude this examination of the policy implementation literature by considering some of its empirical observations. As discussed earlier, these empirical findings, organised by the analytical framework foci, provide insightful propositions and reflections for consideration against the findings on Australian tied grants.

The fallacy of central government dominance

Empirical studies of implementation have repeatedly shown that in spite of the existence of central government “statutory and budgetary” leverage, central dominance in the negotiation and implementation of intergovernmental grants is by no means a certainty. In their seminal study of intergovernmental grant implementation, Pressman and Wildavsky (1973) concluded that state governments and agencies, are able to “oppose, delay and reject federal initiatives” through either open defiance or quiet ignorance. In spite of an “exhilarating (federal) view” of national goals when a grant program is initiated, there are “innumerable steps” involved in grant implementation, each stage requiring careful “enforcement and persuasion” from central government actors, before a national goal can infiltrate State service delivery systems in the desired manner. At any stage of this grant implementation journey, both central and state actors can thwart, stall, re-shape and re-prioritise national goals (Manna 2006: 472; Pressman et al. 1973: 136-7, 47, 61).

Intergovernmental grants: goal clarity

One proposition in the literature for example is that the prescriptiveness of goals can change over the life of a grant program. Ingram (1977: 508) found that national policy objectives and standards can tend to be stated in vague terms when a grant program is first

being established so as to ensure State participation is attained. Ambiguous national goals have the benefit of reducing the risk of policy conflict and allowing the central government time to become more familiar with the policy problem and hence the appropriateness of the policy solution (Goggin et al. 1990: 86; Matland 1995: 158-61). From an implementation perspective however, unless supported by clarifying guidelines and procedures, policy ambiguity reduces central government capacity to monitor and enforce compliance and may also result in less uniformity in the implementation of goals, with outcomes being more dependent on local contextual factors (Goggin et al. 1990: 35; Matland 1995: 159).

Intergovernmental grants: goal setting

A further proposition in the literature is that policy making and implementation within federal systems is a form of bargaining, aimed at identifying a compromise between competing interests (Goggin et al. 1990: 115; Hedge et al. 1991: 1077; Ingram 1977: 524; Pressman et al. 1973: 134; Van Horn 1979: 8). Elmore (as quoted in Hanf et al. 1983: 38) describes four characteristics of such bargaining: “1) no actor controls sufficient resources to determine another’s actions with certainty”; 2) the interests of the actors are not identical, so that conflict over ends and means is, to some degree, inevitable; 3) the actors have something of value to gain from staying engaged with each other, so that to some degree, they depend on each other; hence 4) solutions to bargaining problems require the ‘formation of mutually consistent expectations among people with a stake in the outcome’.

Ingram (1977: 524) asserts that unless governments substantially share the same goals, an intergovernmental grant provides the central government with nothing more than a significant opportunity to bargain with the States, as opposed to a direct means of extracting compliance. Her vision of the intergovernmental bargaining process is an intriguing one: “instead of a federal master dangling a carrot in front of a state donkey ... the more apt image reveals a rich merchant haggling on equal terms with a sly, bargain hunting consumer. Further, Ingram (1977: 503, 25) observes that the bargaining power of the states may actually be greater than the central government in a number of ways: 1) states can benefit from applying collective bargaining pressure; 2) states control most of the ‘subtle’ operational details of programs, leaving the central government the less informed bargaining party; and 3) once an intergovernmental program has been in place for some time, states can be advantaged by “precedent and prevailing expectations” and become much more effective at resisting significant changes to policy goals or raising of performance standards. The latter advantage could of course equally apply to the central

government, should it choose to use community expectations around a program to pressure states into continuing a grant arrangement on its own terms and conditions.

Ingram (1977: 513) claims that the central government's bargaining position tends to be at its greatest when a grant program is first being established. Thereafter States become more adept at re-shaping national goals, depending on compliance costs and local benefit. The bargaining position of the central government can also be inhibited by the layers of policy bargaining involved in a federal system, requiring a policy bargain to be reached first between national politicians and central government agencies, even before bargaining commences with State governments and their agencies (Chubb as quoted in Hedge et al. 1991: 1055).

As a possible means of improving its bargaining stakes, Ingram (1977: 526) makes the suggestion that the central government may be better off targeting its grant funding on national goals "that are likely to be realised", and those States that are "likely to implement federal policy" as opposed to pursuing a "wholeheartedly a uniform policy". The advantages of a more targeted approach in national goal setting is also observed by Peterson et al (1986: 230-36) who found grant programs to be more effective when focussed on specific redistributive objectives for example, improved services for disadvantaged groups, the poor, elderly or children with special needs. These scholars argue that targeted national goals encourage better design of existing programs and also enhance cross-program coordination at the federal level. This view is further supported by scholarly observations that there is a greater level of conflict associated with redistributive policies (with clear winners and losers), hence justifying a top-down, hierarchical approach to their implementation (Ripley and Franklin; Windhoff-Heritier; as quoted in Fischer et al. 2007: 96; Goggin et al. 1990: 83). Derthick also makes a similar point noting that national policy makers are more likely to formulate high-principled goals, being far removed from political and administrative barriers at the local level which may discourage a State government from pursuing such policy directions (Derthick as quoted in Pressman et al. 1973: 142).

Intergovernmental grants: goal congruence

On the subject of goal congruence, empirical studies propose that policy bargaining does not cease at the grant negotiation or goal setting phase. Findings confirm that ensuring goal alignment between two levels of government at all stages of a grant arrangement is a continuing challenge. State government agencies are rarely single, cohesive organisations, it is more likely that they are fraught with "institutional (and actor) fragmentation, multiple

and confusing goals and inadequate funding” (Pressman et al. 1973: 93). This makes intergovernmental grant programs and thus the implementation of national goals, prone to conflict and setbacks. Four types of state responses to federal goals have been identified: 1) defiance; 2) delay; 3) strategic delay where the program is legitimately stalled; and 4) compliance (Goggin et al. 1990: 46).

The causes for compromised national goals are multi-fold. There is vigorous trading of objectives at the state level, whereby the emphasis placed on various policy goals regularly changes as a result of ongoing political and administrative (including budget) decisions, to address shifting local circumstances (Elmore as quoted in Hanf et al. 1983: 57-9). In addition, apart from this genuine need to balance competing policy agendas, national goals can also be set aside simply because of goal dissent. The larger the network of actors involved in implementing national goals, the greater likelihood for dissent with national goals, involving goal refusal or “surreptitious diversion and evasion”. Goal dissent can arise because of conflicts with personal or organisational values; self-interest of implementers; or incompatibility with organisational processes (Kronebusch 2004: 320; Manna 2006: 477; Van Meter and Van Horn 1975: 458-9, 73, 85). The behaviour of divergent implementing actors can be quite complex, affected by enforcement attached to a grant program and willingness of central government actors to act; interpretation and internal communication of national goals; political palatability; goal certainty and salience; professional norms; attitudes towards clients; public opinion; and general perceptions of the intergovernmental relationship and the credibility of central actors (Goggin et al. 1990: 38, 80, 93, 142-4; Hedge et al. 1991: 1061-3; Kronebusch 2004: 322). An interesting typology is put forward by Matland (1995: 160-8) with regards to the impact of policy conflict in the implementation of national goals. He suggests that national goals are: 1) more assured when there are clear goals and low conflict; 2) subject to the outcome of power struggles between the levels of government when there are clear goals and high conflict; 3) dependent on contextual factors when policy goals are vague and there is low conflict; and 4) subject to the outcome power struggles at the local level when policy goals are vague and conflict is high.

This is not to say that States do not accommodate national goals at all: concessions are regularly made by States in the interests of attracting monies, and over extended periods of time, there can be increasing alignment of State goals with national goals (Ingram 1977: 509-10). Goal congruence is more assured when grant programs are: compatible with existing State programs; tailored to the values and objectives of State agencies; and involve

incremental policy change. Ongoing commitment to national goals is also assisted if State agencies and other local implementers have participated in the goal setting process and the state is a willing collaborator (Goggin et al. 1990: 127; Ingram 1977: 514, 21; Van Meter and Van Horn 1975: 458-9). Goal congruence has also been shown to be more likely when grant objectives are focussed on a distinctive national goal as opposed to achieving reform or improvement state services (Ingram 1977: 458).

Additionally, scholars propose that goal congruence is unlikely to be achieved uniformly across jurisdictions. Central governments may seek to reduce variation between states, depending on their willingness to enforce compliance or institute tighter conditions to coerce compliance (Kronebusch 2004: 328-33). A further observation is that goal congruence changes as grant programs evolve: when a grant program is first introduced, goal congruence can be less certain as the central government takes a cautious approach, framing national goals in vague terms and allowing States freedom in the use of grant monies. This is followed by a period of greater coercion and conflict as the central government monitors implementation more closely and seeks more assurance over implementation of national goals. Finally, there is a period of maturity as national goals are modified and States become more accepting of the national program. Petersen et al (1986: 22, 114) also claim that goal congruence can be difficult in the case of national goals with a redistributive nature with States generally being less enthusiastic than the central government to implement programs that address national social inequities. On the other hand, there is greater likelihood of goal congruence when national goals involve the provision of universal services or regulation where policy winners and losers (benefits and costs) are not readily identifiable (Fischer et al. 2007: 109-10).

Intergovernmental grants: goal consistency

A further proposition in the literature is that the acceptance and implementation of national goals can be dependent on the extent to which the central government itself is certain about its policy settings. Implementation studies show that conflicting and inconsistent messages can create confusion, reduce credibility and foster evasion or resistance to national goals at the State level. Of course there may be genuine reasons for goal change. National goals may be adjusted over time to incorporate the benefit of implementation experiences; political pressures; or machinery of government changes level (Goggin et al. 1990: 75, 87; Van Meter and Van Horn 1975: 466). National goals may also be modified as part of the ongoing bargaining that occurs with states over the life of a grant program (Manna 2006: 487). Sabatier (as quoted in Matland 1995: 151) suggests that goal

consistency needs to be assessed over a period of ten years or more as national goals evolve in a cyclical manner.

Intergovernmental grants: funding shares

While the promise of federal funding by no means guarantees State embracement of a national goal (Ingram 1977: 524), this factor cannot be totally discounted from an analysis of grant implementation. Studies show that central government influence tends to be greater when it makes a larger funding contribution to a grant program. National funding can also be an indication of national goal consistency: grant cutbacks may be interpreted as a sign of falling support for a policy goal; while withholding of funding as a sanction for non-compliance sends a strong message of policy commitment. The choice of funding model can also have significant impact on State adoption of national goals, with output-based or input-cost approaches; and the extent to which States have participated in the development of funding models; both prompting different implementation patterns. Finally, State fiscal capacity may dictate the extent to which it can contribute to a grant program and thus remain committed to a national goal (Goggin et al. 1990; Van Meter and Van Horn 1975: 468).

Intergovernmental grants: incentives

Implementation studies confirm that adverse responses to national goals and grant programs can be averted to some degree through the inclusion of appropriate incentive systems. Elmore suggests that incentive systems can assist the central government to achieve better control over policy trade-off decisions at the state level. Incentives thereby provide the central government with greater leverage over national goals and, by “cutting across multiple (policy) implements and implementing organisations” also extend its lateral control over the State policy setting and service delivery environment (Elmore as quoted in Hanf et al. 1983: 67). For example, incentives can involve the provision of quarantined grant funding, with accessibility criteria designed to encourage policy choices consistent with national goals, over other competing policy goals existing at the local level.

Another technique used by central governments to advance the acceptance of national goals is the “socialisation, persuasion and co-optation of state and local actors”. Building professional allies at the local level can enhance the prospect of successful implementation. Other techniques include “conciliatory talk” and providing “political cover”. Incentives can also be used to influence the bargaining associated with grant programs, for example financial and non-financial “sweeteners” can be provided to entice a State to sign up to a

grant arrangement and also to remain committed to national goals throughout the life of the grant (Bossert 1998: 1522-3; Ingram 1977: 507; Manna 2006: 489; Van Meter and Van Horn 1975: 468). Naturally if the State government is financially dependent on a grant, the central government is likely to be less inclined to pursue incentives with rigour. States can, and do, reject grants that are not cost-beneficial, so although the central government can pursue hard bargaining process, ultimately it has an interest to ensure grant offers are structured appropriately (Ingram 1977: 506).

Intergovernmental grants: enforcement

One means of achieving greater assurance over the implementation of national goals is the inclusion of enforcement measures in grant arrangements. Chubb (1985: 1010-11) proposes that enforcement measures can be an indicator of the extent of “penetration” of state and local government by the central government. The design and selection of enforcement measures is a complex undertaking, requiring an understanding of State agency: goals; structures; motivations; power relationships; communication systems; and responsiveness to national goals. For example, Etzoni (as quoted in Van Meter and Van Horn 1975: 454-5) suggests that the effectiveness of enforcement measures varies according to intergovernmental settings: states with a propensity for goal dissent will warrant the use of more coercive forms of enforcement; while more normative enforcement (“symbolic rewards and deprivations”) would be sufficient for States where there is greater commitment to national goals; and finally, remunerative enforcement is likely to be most effective in situations where states concur with national goals but their acceptance is subject to cost-benefit uncertainty.

Enforcement measures can be of financial or non-financial form, and at varying expense to the central government. Measures can include the specification of procedures, guidelines and elaborate reporting systems; ‘tough talk’; requiring of detailed implementation plans for endorsement by central government actors; frequent communications about national goals; matching funding requirements site inspections; or management audits. Two forms of enforcement are purportedly the most effective: the provision of technical assistance and advice on the interpretation and application of grant rules; and positive and negative sanctions. More coercive forms of enforcement involve the withholding or delay of grant funding and the establishment of national management entities to become more directly involved in local issues.

With regards to withdrawal of grant funding, studies show that this is rarely used. Central governments are generally reluctant to damage political and intergovernmental relationships and potentially lose broad support for grant programs. On this note, it is apparent that both national and state actors generally seek to avoid open conflict, hence often just the threat of enforcement can be sufficient to achieve the desired effect. Politically and ideologically, it seems that governments prefer to avoid the grant program being labelled, at least in the public eye, as a federal intrusion; or from the state perspective, an erosion of state rights. A further deterrent for funding withdrawal is that it compromises the national uniformity usually sought by the central government, with the punished State not being able to pursue the national goals. The central government may also have insufficient credibility to act on enforcement measures when there are no established public expectations around program performance; the program is untested; or securing state participation in first place required considerable persuasion and concessions. Further, the central government can lack adequate local knowledge to form a reliable judgement about goal dissent or resistance (Chubb 1985: 998-1011; Goggin et al. 1990: 90; Ingram 1977: 502, 08, 10, 25; Kronebusch 2004: 328; Manna 2006: 487; Van Meter and Van Horn 1975: 467-8).

Selective enforcement appears to be the most effective, with heavy-handed measures shown to create “perverse consequences” in the administration of grants by overly emphasising compliance, at the expense of end outcomes and service delivery performance (Elmore as quoted in Hanf et al. 1983: 66). Determining an appropriate level of enforcement is thus a significant design issue, with the ensuing perceptions and impact, affecting both the attractiveness of the grant program to potential State participants, and overall federal system performance once the grant is in place. Toonen (as quoted in Hanf et al. 1983: 347) has claimed for example that much of the inefficiencies and “wasted energy” associated with intergovernmental grant programs arises not from institutional settings (constitutional, financial and legal) but from “consistently overestimating the degree of control that policy makers can or should exercise”. Additionally, enforcement measures by no means ensure goal compliance. Central governments are dependent on the accuracy and completeness of state provided information and the time invested by central overseers, these dependencies generally giving state actors the upper hand. Enforcement uncertainty is also greater when reporting requirements are outcomes based, hence federal agencies tend to prefer monitoring staffing, funding and other inputs, as opposed to

program outcomes which are more difficult to quantify and assess (Ingram 1977: 504,25; Kronebusch 2004: 320).

In framing enforcement measures, studies show that consideration is required not only of the potential behaviour of State implementers, but also that of agents in the central government itself. Actors responsible for monitoring compliance are often not the ready users of compliance information that one would expect (Van Meter and Van Horn 1975: 456). Hence the design of enforcement systems should not overlook the inclusion of appropriate resourcing capacity and incentives, to ensure that central government authorities make use of the feedback information collected. This may be more relevant for older, more settled grant programs where there can tend to be diminished oversight as central government authorities become more secure with the grant arrangement (Bossert 1998: 1523; Ingram 1977: 510).

Intergovernmental grants: local discretion

The acceptance of national goals at the State agency and grassroots service delivery level is the largest determinant of whether goals are eventually translated into end outcomes. Pressman and Wildavsky (1973: xvi) make a vital observation that “the longer the chain of causality, the more numerous the reciprocal relationships among the links and the more complex implementation becomes”. Although the central government may hold the purse strings, Ingram (1977: 503,22) argues that central government agents are merely “peripheral” participants, and it is the states who have the greater advantage of controlling “the context in which the federal government acts”.

The challenge for the central government is not just how to mobilise state governments and state agencies to act on its national goals, but more importantly, how to coordinate and obtain the ‘buy-in’, of a whole network of organisations and actors, each wanting input into shaping those goals at the local level. A ‘one size fits all approach’ is unlikely to be appropriate, given that social, political and economic circumstances vary between States, affecting their responses to intergovernmental grants and national goals. Nor would the central government want to stifle local discretion completely, as States are known for being ‘laboratories’ of policy and program innovation. Numerous studies show that there are “very substantial limits” on the extent of control or influence that a central government is able to exert on decentralised ‘street level bureaucrats’ These include teachers, social workers, doctors and other professionals who are directly responsible for service delivery to the community and making the program work. Some scholars argue that it is futile for

the central government to seek to exert control over these actors; instead they should be providing grant funding and allowing local management without meddling. Others assert that the bargaining and policy making decisions of local bureaucrats are within the influential reach of the central government and thus should be factored into the design of its grant arrangements (Lipsky as quoted in Fischer et al. 2007: 92-3; Goggin et al. 1990: 38, 98; Elmore; Sabatier as quoted in Hanf et al. 1983: 60-5; 304-5; Hedge et al. 1991: 1056-7, 76; Ingram 1977: 522; Van Meter and Van Horn 1975: 455-6).

The extent of local discretion can have an impact on the timeliness of national goals and end outcomes, as States opt for different budget mixes, access rules and implementation approaches to suit local policy preferences, political culture, community needs and operating circumstances. Local discretion can also thwart central government ambitions for uniformity in national policy outcomes, with studies showing that the interpretation and application of national goals, and thus end outcomes, can vary widely from State to State (Goggin et al. 1990: 39,52,76,100; Berman as quoted in Matland 1995: 148).

Intergovernmental grants: state governance

A final factor impacting on the extent to which national goals are faithfully implemented is state governance capacity, including political, economic, fiscal, and workforce capacity. Implementation studies confirm that capacity weaknesses at state level, for example in winning public support; overcoming interest group pressures; and administering programs – can become “liabilities for the federal government as well” (Derthick as quoted in Pressman et al. 1973: 142). Features of State governance such as bureaucratic structures; centralised or devolved management style; expertise of administrators; innovative drive; leadership style; budget adequacy; communications networks; and political support have been known to either aid or impede the development and implementation of national goals in line with central government ambitions (Goggin et al. 1990: 121,30,41-2; Hjern as quoted in Matland 1995: 149; Peterson et al. 1986: 74; Van Meter and Van Horn 1975: 476-77). Naturally state institutional settings are geared towards local priorities and circumstances. Thus to be successful, central government grant programs must successfully navigate through the unique political and administrative territory that is associated with different states.

3.5 Conclusions – Section I

Chapters 2 and 3 confirm the complexities involved in choosing between a decentralised or centralised model of intergovernmental governance. The examination of normative and empirical literature in fiscal federalism and policy implementation in federal systems confirms a number of pertinent propositions:

- a) there is no simple normative formula that prescribes a performance-optimal balance of policy powers in a federal system;
- b) choices around the centralisation or decentralisation of the allocation function must account for a wide range of legitimate, competing performance trade-offs of an efficiency, equity, economic and political nature;
- c) federal systems tend to deviate between centralised (top-down) and decentralised (bottom-up) governance as the weight given to competing performance objectives varies, and local and national needs and priorities change;
- d) intergovernmental grants and intergovernmental relations are mechanisms through which federal systems attain the flexibility needed to be responsive to changing needs;
- e) end community outcomes depend not only on the stipulated division of powers and its intrinsic effectiveness but also on the manner in which intergovernmental grants and relations, the facilitating policy mechanisms, are structured and operated; and
- f) an intergovernmental grant program involves a complex chain of administrative and programmatic links that are continually being adjusted, with the result that grant arrangements are rarely consistently federally or state dominated.

In the following Section II, the nine analytical foci identified in this chapter is applied to primary and secondary evidence collected on tied grant agreements for public hospitals and schools. Later, in Section III, the normative and empirical findings of Chapters 2 and 3 are considered, as part of the formulation of conclusions on the division of powers and performance effects of tied grants and the practise of cooperative federalism in Australia.

SECTION II

CASE STUDIES OF

AUSTRALIAN TIED GRANTS

Section II presents a case study analysis of selected Commonwealth-State tied grant agreements.

Chapters 4, 5 and 6 present primary case studies centred on public hospital tied grants drawing on the nine analytical foci defined in Chapter 3. As discussed at Sections 1.4.2 and 1.4.4, *in-depth* and longitudinal analysis is conducted on the negotiation and implementation of four hospital funding agreements signed under the Whitlam, Fraser and Hawke governments (1975–76 Agreement, 1976 Agreement, 1984–88 Agreement and 1985 Agreement). Findings from this detailed examination are further validated and evaluated in Chapter 6 through three *high-level* case studies of hospital grant arrangements signed under the Keating and Howard governments (1988–93 Agreement, 1993–98 Agreement and 1998–2003 Agreement). The empirical data source for these case studies includes the original signed grant agreements; archived correspondence of the WA Government (Departments of Health, Treasury and Finance and Premier and Cabinet) documenting the negotiation and implementation of the grant; government-commissioned reports; statistical publications and interview evidence from the WA Department of Health. .

Finally, the findings of all seven public hospital case studies, are further tested and refined through a high-level, comparative case study of public school tied grants at Chapter 7. The Chapter firstly considers the policy-making dynamics evident in the negotiation and implementation of school tied grants. The findings of both the schools and hospital case studies are then contrasted and discussed. The empirical data source for this case study is interview evidence from the WA Department of Education and a former senior bureaucrat of the Department. A range of secondary literature is also considered.

*The farther backward you can look ...
the farther forward you are likely to see ...*

(Winston Churchill)

CASE STUDIES ON TIED GRANTS FOR PUBLIC HOSPITAL SERVICES

Chapters 4, 5 and 6 present a longitudinal examination of tied grants for public hospitals. Each chapter considers the negotiation and implementation of specific tied grant agreements with a view to critically evaluating the distribution of policy making powers as top-down (centrally inclined), bottom-up (locally inclined) or of a hybrid (more balanced) nature.

The chapters begin with a contextual overview and follow with an in-depth analysis of negotiation and implementation evidence, structured according to the analytical foci identified in Chapter 3. In addition to the three *in-depth* case studies of Chapters 4, 5 and 6, Chapter 6 also incorporates findings from a *high-level* examination of three further hospital tied grant agreements.

In terms of framework application, seven of the analytical foci are examined at a case study level, whilst the consideration of Funding Shares and Goal Consistency is conducted at an overall level at Chapter 6, covering all six hospital case studies. The approach adopted for Goal Consistency is consistent with the empirical literature which suggests that this variable is best examined over a longer timeframe. For Funding Shares, a consolidated time-series analysis offered more effective analysis of this variable.

Each chapter concludes with a resolution on the balance of policy making powers and a case-specific discussion on tied grant performance. These findings and conclusions are further evaluated and discussed at Chapters 7 and 8.

4 THE WHITLAM ERA — CARROTS AND COMPROMISES

4.1 OVERVIEW

The Whitlam era saw the signing of the first contemporary public hospital tied grant agreements for the provision of universal public hospital services. Although this era is often portrayed as one of Commonwealth supremacy and coercive policy intrusions, this case study analysis reveals that the 1975 Hospital Cost Sharing Agreement was secured by the Commonwealth only after an extensive and heated period of negotiations, with the terms and conditions of the Agreement dominated by significant financial concessions; policy compromises on both sides; and sustained resistance from the Senate, States and the medical profession. Certainly the Commonwealth did ultimately achieve its desired end of universal hospital care, however the States and medical profession were by no means subdued bystanders, but shrewd and aggressive in their policy bargaining approaches.

4.1.1 The 1972 Policy Platform

Heading into the 1972 election, the ALP announced specific national goals in relation to hospitals and health care. These included: a publicly funded universal health insurance scheme; the establishment of an Australian Hospitals Commission to promote the modernisation and regionalisation of hospitals; and the introduction of a free school dental program (Whitlam 1972). Labor's policy platform was driven by both ideology and growing electoral dissatisfaction over inequities in community access to health care. Ideologically, the addressing of health service access inequities was consistent with Labor's philosophy that the role of a central government was to enhance positive equality (equal opportunity) and the social wage (public goods), and encourage a viable market economy that would operate first and foremost in the public interest (Emy et al. 1993: 20-2). From an electoral perspective, the platform offered a distinct alternative to the Liberal Party's voluntary health insurance scheme established in the 1950s by the Menzies government. Criticism of this scheme, which had firmly entrenched fee-for-service and private health insurance as the primary source of health financing, had been steadily mounting. By the 1968 election, the scheme, and health care access inequities were a high profile community issue (Gray 1991: 96-101; G.R. Palmer 1979: 105-6; Whitlam 1985: 336-7).¹⁰

¹⁰ According to (Whitlam 1985: 336-7), by the 1960s 17% of people had no medical insurance cover, 15% no hospital insurance cover, and medical bad debts were common. Access to health care was dependent on individual capacity to either self-finance medical costs or alternatively afford private health insurance. Adding to the inequities was the availability of tax deductions to people who subscribed to private health insurance, further favouring those on higher and middle incomes who could afford health insurance. There were also the inefficiencies of the private health insurance industry, not being subject to price-competition, literally hundreds of funds had developed, duplication and diseconomies of scale were

In Labor's view significant policy shortcomings existed in:

- **regulation** – a lack of national regulation over private health insurance premiums and doctor remuneration;
- **management** – inefficient practices at the hospital service delivery level; and
- **supply** – States' failure to maintain the hospital infrastructure development in line with urban and population expansion, especially in NSW and Victoria.

Specifically, a range of systemic deficiencies were considered to warrant national policy attention: 1) inadequate monitoring of hospital standards; 2) over-servicing by doctors; 3) lack of readily available specialist care for accident and emergency cases, surgery and outpatient treatment due to the predominantly honorary workforce; 4) lack of proper hospital coordination and planning causing an over-supply of public hospital beds and duplication and competition between hospital facilities; 5) lack of centralised control over public hospital administration, with control divided between Boards, doctors and nurses; 6) other inefficiencies created by the honorary medical workforce including wastage in travel time and discharge practices that suited the interests of the medical practitioner and the hospital, rather than the patient; and 7) the excessive number (close to 200) of private health funds which collected significantly more contributions than benefits dispersed (Whitlam 1965).

4.1.2 Biases Evident in Labor's Policy Making Approach

Labor's frustrations with health and hospital services were long-held. As early as 1957, Whitlam (1985: 332-6) proclaimed:

The present constitutional position is quite unsatisfactory in that the Commonwealth has to pay more and more for the running of hospitals and still has no say in running them, patients are unable to afford medical and hospital treatment and the medical profession participates in any scheme only on its terms.

Whitlam justified that as the Commonwealth and State governments jointly financed 90 per cent of drug costs, 72 per cent of hospital revenues and 40 to 50 per cent of doctors' incomes (through private health insurance subsidies and taxation deductions), the central government had a legitimate role in ensuring the expenditure was efficient and equitably distributed. Although publicly by the election 1972, Labor had stepped well away from its traditional anti-federal, anti-Constitution stance, internally, its deep-rooted convictions for strong Commonwealth policy input and control remained a powerful undercurrent in policy

apparent, contribution rates rapidly escalated, with significant reserves accumulated, around 74% higher than normal operational requirements.

making processes. The fervent desire to expand Commonwealth policy reach, and the associated distrust and underestimation or complete overlooking of State governments' capacities brought undue partiality and haste into Labor's policy making. This is probably most evident in its selection of the universal hospital care goal.

Whitlam was undoubtedly the principal actor in the formulation of Labor's health policy goals. The journey to the 1972 election platform was however a highly deliberated one, with the Party intensely divided over Whitlam's preference for a publicly-funded universal health insurance scheme. Confirmed as the centrepiece of Labor's platform in 1968, this policy goal was derived from the work of two Melbourne economists, Richard Scotton and John Deeble. The Scotton and Deeble (S & D) proposal offered an immensely appealing alternative to the voluntary health insurance scheme and the dominance of fee-for-service, considered to be one of the crucial barriers to more equitable access to medical and hospital services. Most importantly, the proposal embodied a service delivery structure that focused on existing infrastructure: individual private practice and public hospitals, the latter institution being of considerable attraction to Whitlam who viewed public hospitals as central to any national public health service system. Scotton (1978: 107) recounts that this was "partly due to an unrealistically close identification of high-technology institutional medicine with levels of health".

Whitlam's passionate disposition towards the S&D proposal was overwhelming, and suppressed prospects for alternative policy initiatives. A competing policy concept circulating in the Party at the time was the establishment of a national health service through federally-funded community health centres, staffed by doctors on salaried or sessional payment arrangements. The concept of community health centres had been gaining policy momentum during the 1960s in New South Wales and other States, with "health department leaders in NSW... [beginning]...to embrace community health concepts" (DeVoe 2003: 90)¹¹. Whitlam's commitment to the S&D proposal is claimed to have been rooted in his apprehensions around the conflict and confrontation that had marred the Chifley government's pursuit of a national health service in the 1940s. DeVoe (2003: 93,101) has compiled an intriguing case study using textual analysis and interviews with key Commonwealth policy actors of that time. She argues that Whitlam made a very

¹¹ Palmer and Short (2000: 122) describe the community health centre concept as "the use of multidisciplinary teams of health workers, including medical personnel, to provide primary care, with an emphasis on disease prevention and health promotion, at the one geographical location. It is based on the recognition of the limitations of general-practitioner-based primary care, especially when this is provided using fee for service. The most important limitation ... is the constraints on the employment of non-medically qualified staff ... to perform more cheaply and possibly more effectively some of the tasks currently performed by doctors".

shrewd choice to place the universal health insurance scheme (and public hospital grants) at the forefront of Labor's health policy platform for the 1969 and 1972 elections, deliberately allowing community health to play only a secondary role:

The Deeble/Scotton insurance proposal was an enticing alternative that differed from Labor's attempts to establish a national health service in the 1940s, providing an option to circumvent the anticonscription addendum in the 1946 constitutional amendment. Aware of historical barriers that had set a distinct path for future health policy reform, politicians were eager to craft Medibank in a way that avoided major legal challenges from individual States and from the medical profession. Proposals for federally funded community health centres, however, contained elements that challenged both of these significant historic barriers to health care reform – federalism and medical pressure group opposition.

Her proposition is that Medibank (a model of "indirect remuneration") as opposed to the Community Health Program (a model of "direct service delivery") offered a much more politically assured approach for Labor to introduce its national health service (DeVoe 2003: 98). Given historical context and Labor's extended time in Opposition, it is quite reasonable that Whitlam would have strategised around potential constitutional, High Court and medical profession challenges, as well as potential electoral sensitivities on an intrusive central government.

From both an electoral and implementation perspective, it is not difficult to see how the universal health insurance scheme offered greater security than the federally-funded community health centre concept. Electorally, health insurance was a high profile issue at both the 1969 and 1972 election, with only 77 per cent of the population covered for basic hospital treatment (Last as quoted in DeVoe 2003: 87; PHIAC 2009). Whitlam was no doubt acutely aware that a publicly provided insurance scheme would capture the attention of the under-insured electorate whilst also serving to reduce the medical profession's stronghold over the fee-for-service system. Additionally, from a practicality point of view, in infiltrating the States with federally-funded and staffed community health centres, the Commonwealth would no doubt have faced ardent resistance from an AMA seeking to preserve its members' private practice and fee-for-service revenues. Further, the State governments, who had only just begun conceiving of community health alternatives, are not likely to have received such a proposal favourably, construing it to be very prescriptive intrusion into their constitutional policy space. One cannot also overlook the fact that neither the community health sector nor the associated policy framework was well developed. The establishment of new infrastructure, policy settings and recruitment of workforce (whilst dealing with an irate medical profession and resistant States) therefore embodied considerable political risks.

In comparison, the universal health insurance scheme offered a much more discrete and electorally acceptable approach to bringing about Labor's desired regulation of medical fees. Further, the provision of public hospital grants was a less publicly intrusive means of establishing improved access to services, a more cost-effective salaried or sessional hospital workforce and Commonwealth 'buy-in' to State hospital management. All in all, the proposition that the universal health scheme and public hospital grants represented a much more politically expedient pathway to achieve Labor's national goals is very convincing. Labor member Cass confirms (as quoted in DeVoe 2003: 94) "the Caucus members eventually recognised that the health insurance proposal was going to contribute to a Labor victory in the next election, so we had to just shut up and do it, but it wasn't what we had wanted".

It is noteworthy that although public hospitals were central to the national health aspirations of both the Chifley and Whitlam governments, Whitlam's longer term intentions were much more bold and far-reaching. Whereas the Chifley government had sought to provide free treatment to patients in public wards, Whitlam did not mask his more considerable ambitions for Commonwealth-directed and operated hospitals. Scotton and Macdonald (1993: 154-5) reveal that even as late as 1973, it took considerable argument from Bill Hayden, Sidney Sax and other Commonwealth policy actors to convince Whitlam to abandon his plans to build Commonwealth hospitals to operate alongside the State public hospital systems, and attach significant conditions into State hospital grants that would effectively have the Commonwealth controlling the administration of State hospital activities in a comprehensive manner.

In spite of the dominating emphasis on universal health insurance and hospital care, the Community Health Program was factored into Labor's health policy platform — perhaps to appease "its own left wing" (Milio as quoted in DeVoe 2003: 95,101). After the election, the Whitlam government established a grants program which included payments both to the States and direct to community organisations. Sax (as quoted in DeVoe 2003: 99) suggests the retention of the Community Health Program could have been part of "back door" strategy to effect structural change across the health system through "incremental steps":

From the beginning, we started funding a lot of services that weren't comprehensive, and we always had an excuse for doing it, and the excuse was that you had to begin to have some services, and then maybe in later years, you could pull them all together. But if there was no service, there was no point talking about a comprehensive service.

Whether or not this was the case, the often extolled community health initiatives¹² of the Whitlam government did not evolve into a comprehensive community health sector that would co-exist in an equivalent way to the hospital sector. The Whitlam government's bias towards public hospitals, brought primarily about by constitutional and political constraints, thus resulted in the minimisation of the community health agenda. As discussed later at section 4.12, the emphasis placed on public hospital services curtailed State government flexibility around the structure of the health care system, creating considerable long term imposts on system performance. One can only wonder what sort of cutting-edge health system might have evolved in Australia if community health had been placed at the centre of Labor's policy framework at that critical time of health policy formulation.

4.2 GOAL CLARITY

4.2.1 Goal clarity — Analysis

In forming an assessment of goal clarity under the Whitlam government, it is most important to separate 'facts' from 'perceptions' and 'actual outcomes' from 'original intentions'. There is no shortage of literature arguing the top-down tendencies of the Whitlam government. The *prima facie* evidence is quite convincing. Certainly, Whitlam made some very dramatic statements about his government's aspirations for a larger policy setting role. For example he declared to the State Premiers in 1973:

From now on we expect to be involved in the planning of the future in which we are financially involved...We believe it would be irresponsible for the national government to content itself with simply providing funds without being involved in the process by which priorities are set up and by which expenditures are planned and by which standards are met (C. Lloyd 2002: 285)

This is also supported by the expenditure evidence, with total tied grant grants quadrupling in value from \$931 million (25.8 per cent of total grants) in 1972–73 to \$4,153 million (48.6 per cent of total grants) in 1975–76 (Mathews and Grewal 1995: 37). The *intention* for increased Commonwealth policy control was most definitely there, but how much clarity did Labor *actually achieve* in terms of public hospital policy settings? The logical starting point for this examination is the 1972 election speech (Whitlam 1972) which articulated Labor's health policy goals:

- Introduction of a universal health insurance scheme to be administered by a "single Health Fund" with contributions "paid according to taxable income ... The Fund will pay the full cost of medical treatment if doctors choose to bill the Fund directly, or refund 85% of fees if the patient pays those fees himself";

¹² According to Scotton (1978: 105-06, 08, 12), "the innovation of the Labor government which promised to have the most direct impact on the health service delivery system was the community health program ... some 727 projects were funded ... to the end of 1975". The funding contrast between community health and the hospital Medibank programs are a telling indication of the relative priority attached to these two policies. An estimated \$105 million of community health grants were provided between 1973-74 and 1975-76, compared to \$139.8 million provided for hospital capital grants over the same period, and an estimated annual cost of \$830 million for the hospital grants in 1975-76.

- Establishment of an “Australian Hospitals Commission to promote the modernisation and regionalisation of hospitals. The Commission will be concerned with more than just hospital services. Its concern and financial support will extend to the development of community-based health services and the sponsoring of preventative health programs. We will sponsor public nursing homes. We will develop community health clinics. These services will call for the employment of increasing numbers of salaried doctors”; and
- Introduction of a 5 year program to provide free dental services to all Australian school children.

While these are specific goals that signal intrusion into State policy settings, they are fairly broadly stated. Given that Labor’s hospital policy was derived from the work of S&D, it is also relevant to refer to their original design which provided for (R. B. Scotton and Macdonald 1993: 61):

- guaranteed access to free standard ward treatment on request, including medical services by doctors paid by hospitals;
- benefit payments to be made direct to the hospitals or hospital authorities except perhaps for patients hospitalised overseas;
- payment of doctors to be predominantly by sessional fees or salaries rather than by fee for service;
- grants to compensate public hospital authorities for loss of revenue through the abolition of standard ward fees and means tests.

The S&D proposal entailed the replacement of all Commonwealth benefits payable at the time with conditional grants requiring state hospitals to: abolish means testing; provide adequate beds for public patients; and contract with doctors for medical services. The grant payment formula specified involved the payment of uniform bed-day subsidies (commencing at \$7 per day and rising to \$13 per day in the first full year of operation), together with additional grants to cover medical service costs. Other relevant design features were the imposition of a 1.25 per cent levy on taxable incomes as a financing mechanism and the abolition of tax deductions for “insurance contributions and net medical expenses”. This evidence offers a greater level of goal clarity and indicates a more significant loss of state policy making space than is first apparent from Whitlam’s election speech. In return for Commonwealth grant funding states were required to forgo their discretion over: 1) which patients were granted access to public hospitals; 2) the mix of private or public patients admitted at any time; 3) the charging of private and public patients; and 4) payment arrangements for medical staff (1993: 61, 26-7) .

As discussed at Chapters 2 and 3, policy making can be a highly iterative process with numerous deliberations and obstacles to overcome before *policy intentions* are translated into final *policy settings*. Scotton’s own admissions reveal the considerable policy formulation gap that existed immediately post-election:

the first task...was to translate the Labor party’s policy into a formal government program, capable of being expressed in legislation and implemented in practice. Initial discussions with senior departmental officers showed how much ground had to be covered. Despite the fact that the policy appeared to be well developed, it consisted of little more than the original Scotton-Deeble papers and a number of

speeches, letters and articles by Whitlam and Hayden which had variously alluded to or amended the original proposals. Apart from clarifying the policy as it existed, it was necessary to take account of changes which had occurred in health care systems at Commonwealth and State levels, and to explore a mass of administrative and legislative details, many of which had not even been thought about (R. B. Scotton and Macdonald 1993: 54).

A more revealing test of the extent to which the intended goal clarity was achieved should be identifiable from the agreements signed. Examination of the 1975 Health Agreement (Aust. Government 1975) signed between the Commonwealth and WA Government on 31 July 1975, against the design, shows that the Commonwealth was successful in incorporating most of its intended policy objectives as well as a number of other objectives not originally specified:

Table 4.1 Terms and Conditions 1975 Hospital Cost Sharing Agreement (WA)

<p><u>Universal hospital care</u></p> <ul style="list-style-type: none"> · Clause 7.4 required discretion for public or private status to rest with the patient; · Clauses 6.3, 7.1 and 7.3 confirmed that Western Australia must provide hospital in-patient and outpatient treatment free of charge and not means tested, with the costs to be covered including accommodation and meals, medical services, nursing, diagnostic services, drugs, operating and other facilities, surgical supplies and ancillary services; <p><u>Patient revenue restrictions</u></p> <ul style="list-style-type: none"> · Clauses 8.1 to 8.3 set out bed day charges for private patients and an agreement that they will be set jointly between the Commonwealth and the State; <p><u>Commonwealth grant formula</u></p> <ul style="list-style-type: none"> · Clause 4.1 confirmed that the Commonwealth shall pay to the State an amount equivalent to the lesser of either 50% of the net operating costs of all recognised hospitals or the State's funding of all recognised hospitals; <p><u>State reporting</u></p> <ul style="list-style-type: none"> · Clauses 10.1 to 10.4; 13.1 and 14.1 set out reporting obligations for the State which comprise mainly of monthly projections of estimated revenues and costs; audit certificates and other statistics as requested. Clause 11.2 provides for a joint Commonwealth-State investigation where there actual costs are in significant variance to the original budget; · Clause 15.1 dealt with the scope of operations and requires Commonwealth authorisation for changes to hospital operations with significant impact on net operating costs; <p><u>Medical staffing payment arrangements</u></p> <ul style="list-style-type: none"> · Clause 6.4 acknowledged that staffing levels and appointments are a State responsibility; · Clause 16.1 to 16.3 required the State to employ medical staff on a salaried or sessional basis, or other contract basis that must first be discussed with the Commonwealth. Salaried or sessional arrangements are required for medical staff in teaching hospitals and the State must also preserve any salaried arrangements currently existing in non-teaching hospitals. Clause 16.5 also seeks an undertaking from the States that salaried arrangements will be introduced for all medical staff in non-teaching hospitals and for general practitioners (presumably those operating in country hospitals); · Clause 16.6 to 16.7 required the State to keep fee for service arrangements to a minimum and where they do exist, ensure that fees are no higher than the medical benefit rate. Clause 16.8 recognises that salary or sessional rates will be determinable by the appropriate State authority;

· Clause 16.10 required periodic Commonwealth participation in discussions with medical workforce over payment terms and conditions “with a view to achieving uniformity between States and Territories and ultimately to establishing national machinery for the determination and review of payment for and conditions of service of medical staff in hospitals. Clause 16.11 allows the State to hold independent discussions with the medical workforce in addition to those held jointly with the Commonwealth.

The Commonwealth additionally prescribed that “free standard ward treatment” included not just inpatient medical and accommodation fees, but also the costs of diagnostics, drugs and ancillary services. Further, the Agreement provided for free services to both hospital inpatients and outpatients, this being a policy detail that is not immediately evident from either the election policy platform or the D & S design. The Commonwealth also included clauses for State reporting — the early beginnings of ‘enforcement’ which over the next three decades would evolve into more detailed requirements. The reporting clauses appear to be directed at enabling calculation of the Commonwealth’s share of monthly funding; nonetheless, the open-ended wording creates capacity for more involved Commonwealth enforcement. In fact, the Fraser government made considerable use of these reporting requirements compared to the Whitlam government.

Clauses 16.1 to 16.10 are especially noteworthy for the controls they place on State employment of medical staff. In particular, the State government is required to *consult* with the Commonwealth when contractual (non-salaried or sessional) arrangements are agreed with medical staff, in spite of staffing levels and appointments being declared to be a state responsibility under Clause 6.4. In addition, the Agreement required the Commonwealth to be an active participant in prospective wage setting negotiations with medical staff. The wording of Clause 16.10 in particular suggests that the Commonwealth desired the implementation of uniform wages across States, determined through “national (industrial relations) machinery”. So, although Clause 16.8 clarified that the setting of remuneration rates are a state responsibility, Clause 16.10 opened the door to Commonwealth involvement in or dominance over, medical wage setting.

Two important exceptions where the State managed to secure a more favourable outcome than the Commonwealth intended was in the composition of the grant formula and in the flexibility gained on salaried and sessional arrangements in non-teaching hospitals. These two policy departures from the S&D design are highly significant, in view of the initially obstinate stance adopted by Commonwealth actors when Agreement negotiations first commenced.

4.2.2 Goal clarity — Overall evaluation

According to the case study analytical framework of Chapter 3, a higher level of goal clarity indicates enhanced Commonwealth policy making powers over the States. The preceding analysis of goal clarity shows that the Commonwealth was successful in securing the WA Government's agreement to two fundamental national goals: 1) universal access to inpatient and outpatient hospital care; and 2) the implementation of salaried or sessional remuneration arrangements for medical staff in teaching hospitals. Additionally, the Commonwealth managed to confirm its participation in: 1) the determination of public hospital accommodation fees for private patients; 2) wage setting negotiations conducted with public hospital medical staff and; 3) decisions around any proposed new hospital services with significant impact on recurrent costs. Finally, the Commonwealth was also able to establish a requirement for the State to provide regular reports on its finances and other statistics. The last four requirements could be considered as 'enforcement measures' as well as policy setting intrusions, as their inclusion gave the Commonwealth a capacity to monitor and regulate its national goals over time.

From the State's point of view, the national goals committed to in the Agreement very clearly removed its ability to independently determine: 1) which patients were granted access to public hospitals; 2) the mix of private or public patients admitted at any time; 3) the charging of private and public inpatients and outpatients; 4) payment arrangements for medical staff; and 5) major reconfigurations of hospital services. There is no doubt that these were significant policy trade-offs: the State's local discretion sacrificed in return for a generous injection of Commonwealth funding and a degree of freedom to negotiate modified fee-for-service contracts with doctors in the non-teaching hospitals.

Despite the initial impression of a considerable loss of policy making space for the State, a distinguishing characteristic of goal clarity under Whitlam is the fairly broad manner in which national goals and Commonwealth participation requirements are stated. Given Labor's awareness of the weaknesses of State hospital systems, it is noteworthy that the Agreement made no attempt to impose more specific requirements onto the States in terms of operational detail such as bed numbers, hospital planning and location, and discharge practices. These types of operational controls became much more prevalent in subsequent iterations of the Agreement. The prescriptive restraint is most likely due to this being a first Agreement. The Commonwealth's main objective would have been to secure its initial entry into State policy setting processes. One must not forget the tremendous nationalisation hurdles the Labor Party had faced in the preceding forty years. Just having

the opportunity to put the national goals in place would have been viewed by the Commonwealth as a momentous achievement in itself. At this program inception stage it was necessary for the Commonwealth to engage in fair and reasonable bargaining with the States if the program was to be implemented at all.

The Whitlam government was restricted in both its time and bargaining space, to assume bargaining supremacy and impose any more specific conditionality over States' use of the grant funds. It also had little concern of the macroeconomic impact of the program.¹³ Economic impacts became a much more significant issue for every federal government that followed, causing a considerably greater emphasis to be placed on goal clarity. Notably, while the reduced focus on goal clarity at this stage may have worked favourably for the Commonwealth in facilitating State acceptance of national goals, this short-term gain came with a hefty price attached: national inflationary pressures and a detrimental impact to the long term efficiency and effectiveness of the public hospital system and its interaction with the wider health system. The sudden and massive injection of funding and the policy vacuum arising from broadly-stated national goals had far-reaching implications for hospital system governance and performance, as discussed at section 4.12.

In conclusion, this examination of goal clarity indicates neither a top-down or bottom-up policy making approach. Whilst top-down coercion from the Commonwealth is likely to have played a role in State acceptance of the hospital Medibank goals, the generous policy concessions on grant formula and payment arrangements for doctors in non-teaching hospitals are ample evidence that the States and medical profession were by no means passive participants. Closer examination of the goal setting process is necessary to appreciate more fully how these goal outcomes came about and what circumstances led to the Commonwealth or the State conceding its bargaining position. Were there other policy gains achieved by the State apart of the two areas of concession identified? To what extent were these national goals desired by the States themselves? These issues are further considered in sections 4.2 and 4.3.

4.3 GOAL SETTING

This section considers the goal setting process and policy compromises made by both the Commonwealth and the States, both prior and subsequent to, the signing of the

¹³ Although it must be noted that Hayden carried concerns over the viability of the hospital Medibank program during both its conceptualisation and subsequent implementation (Murphy as quoted in R. B. Scotton and Macdonald 1993: 41).

Agreements. The objective is to achieve a greater insight into the relative bargaining positions of the Commonwealth and State over time.

The Whitlam government's pathway to hospital Medibank was no less dramatic than the Chifley government's nationalisation experiences. A most telling indication of this is that the last of the Agreements were signed just months before the Whitlam government's dismissal. Thus, most of its three years in office were consumed in formulating and negotiating the tied grant arrangement, a process which triggered a highly public and fierce bargaining process between Commonwealth actors, State actors and the medical profession, and threatened the core stability of the federal government. Both antagonistic and subtle bargaining manoeuvres were applied by the various policy players engaged in the negotiations, before goal clarity was finally settled. During these deliberations, the Whitlam government was not only compelled to adjust its policy goals but also accept a bargaining timeframe that was predominantly controlled by the Senate, State governments and the medical profession. This is in spite of the States facing the threat of Commonwealth revenue losses. Goal clarity also continued to be adjusted after the Agreement was signed off, as the Commonwealth and State governments, public hospitals and the medical profession negotiated the translation of the Agreement into practice.

It is important to confirm the main sources of data used for this analysis. The Commonwealth perspective on the negotiation of the Agreements is described in considerable detail by Scotton and Macdonald (1993). Scotton was one of the architects of the S&D model, with Macdonald an independent observer. This account is assumed to provide a reliable source of knowledge in terms of the approach taken by the Commonwealth to negotiate Agreements with the States. The State perspective of the negotiations has been gathered from a review of Medibank policy files from WA Government archives for the 1972 to 1976 period. As discussed in Chapter 1, archival evidence is considered to provide a highly reliable insight into the inside workings of tied grant negotiations. Analysing both the primary and secondary sources together enabled both the Commonwealth and State viewpoints to be brought into the analysis, and also allowed for triangulation between the two datasets.

4.3.1 Goal setting — pre 1975 federal election

Goal setting compromises on Labor's hospital policy framework began well before the 1972 election. Scotton and Macdonald (1993: 33,55) describe three specific compromises Labor was forced to concede on in order to alleviate significant stakeholder resistance during the

1969 election campaign. First, to assuage the AMA, Whitlam agreed to abandon a plan to deduct utilisation charges from medical benefits payments to general practitioners and un-referred specialist attendances. Both Whitlam and Hayden also committed to a changed formula for the taxpayer levy which involved providing a ceiling of \$100 per family and a waiver for all families below the poverty line. This policy change was intended to appease the concerns of working wives and also counter the Liberal government's recent introduction of a subsidised health benefits plan. Finally, to mollify the Private Hospitals Association, Whitlam committed to retaining the income tax deductibility of net medical expenses and health insurance contributions. This commitment was contrary to the S&D design which proposed that the tax deductions to be abolished to improve distributional equity in Commonwealth health funding. While each of these pre-election compromises did not affect the 1975 Agreement directly, they are very likely to have curtailed the Commonwealth's financial capacity. These early compromises were the first round of a range of costly policy concessions that would be made during the policy making process.

4.3.2 Goal setting — pre 1975 Hospital Agreements

Formulation of goals — Commonwealth (December 1972 – August 1975)

A number of critical observations can be made from the account of Scotton and Macdonald (R. B. Scotton and Macdonald 1993). The Commonwealth's goal setting process was:

- *time-pressured* due to the multiple sources of policy resistance which restricted the time available for considered policy deliberation and analysis (an inappropriate policy setting environment for such a significant policy area);
- *highly dramatic*, involving a double dissolution of Parliament and a federal election, a risky tactic adopted by Whitlam to try and overcome the Senate's resistance to the Medibank legislative bills which were ultimately defeated three times before being passed in Australia's first and only joint sitting of Parliament;
- *highly contentious*, involving persistent and aggressive combat from a militant medical profession determined to 'sink' the proposal;
- *oblivious to long term economic or performance effects*, the authors aptly refer to "Whitlam's 'crash through or crash' style of leadership" (1993: 27). It would appear that the Commonwealth single-mindedly pursued its Medibank goals with little apparent consideration for long term affordability or State governance capacities. Senate resistance also did not assist, its two-time rejection of the Levy bills severed

a crucial accountability link which the S&D design had incorporated between program spending and taxation revenues; and

lacking in policy detail, although considerable emphasis was placed on defining strategic policy, there was inadequate development of policy impact at an operational level. The outcome was a distinct policy vacuum, which left hospital administrators and clinicians as the default policy setters, an issue discussed further at section 4.9. Additionally, the Commonwealth's lack of focus on operational detail resulted in significant governance shortcomings within the public hospital systems, being overlooked as outlined at section 4.9.

The key Commonwealth actors driving negotiations were the Prime Minister and the Minister for Social Security, Whitlam and Hayden¹⁴ (1993: 41). Hayden had a very limited group of Commonwealth actors to rely on during the bargaining process, with the Commonwealth bureaucracy being either inexperienced (having had minimal interaction with State hospital systems) or resistant (disbelieving that the program would ultimately be implemented) (R. B. Scotton and Macdonald 1993: 56, 117, 90, 220). Hayden's first step was to form a Health Insurance Planning Committee (HIPC) that was tasked with developing a Green Paper for consultation. The Green Paper process is claimed to have been conducted with "limited external consultation and without invited submissions other than from the AMA". This appears to be mainly for expediency, with Hayden aiming for a 1 July 1974 commencement date, "realising it was ambitious but probably not how ambitious it really was" (R. B. Scotton and Macdonald 1993: 54, 65) Greater inclusion of the States at this stage may have allowed the Commonwealth to develop a more astute awareness of the governance and performance weaknesses that existed within the State systems.

Between the issuing of the Green Paper in May 1973 and the parliamentary tabling of the White Paper in November 1973, the Commonwealth consented to two key policy compromises. The first was on doctors' remuneration arrangements. Initially Hayden was unwavering in his endeavour for universal implementation of salaried or sessional arrangements in public hospitals. Drawing from the Queensland experience, where the

¹⁴ The two are described by Scotton and Macdonald (1993) as having contrasting approaches to policy formulation, Whitlam somewhat obstinate in his commitment to the hospital Medibank ideology, Hayden more pragmatic and open minded to the canvassing of possible alternatives as far as possible. Unfortunately Hayden's style of "due process" policy making would not be sustained through the hospital Medibank journey, as ongoing Senate, medical profession and State government delays, together with pressure from Whitlam and political instability severely tainted the negotiations and deals he agreed with the States. Hayden was particularly pressured following his transfer to the Treasury portfolio in June 1975, in the last few months of negotiations he was highly anxious to finalise the signing of the agreements partly to be rid of them and partly because he wanted to have the program implemented before supply issues forced otherwise.

honorary system and rights of private practice had been abolished in most hospitals since 1944 (Butler 1989: 305), Hayden was determined to expand this model to all States.¹⁵ However, through his negotiating team, particularly Deeble and Sax, Hayden found that national extension of the Queensland model was not easily attainable. The Commonwealth's intended bargaining position was to offer salaried or sessional rates to compensate doctors not only for losses in private fees income but also for services previously provided on an honorary basis. The first objections to the goal came from non-teaching hospitals where levels of honorary work were low, thus making the proposed salaried or sessional payments considerably less attractive. At first Hayden would only consent to an alternative involving "creative methods of distributing a sessional quantum among treating doctors", but by the time the White Paper came to be issued, Hayden had reluctantly agreed to allowing "greater flexibility if found necessary in the future in methods of paying doctors in standard wards" (R. B. Scotton and Macdonald 1993: 62-3, 87). It is notable that whilst this policy concession assisted the Commonwealth to secure the acceptance of the states, the adjusted policy goal remained "an empty gesture" from an implementation perspective, as in most States, bargaining with the medical profession only began after the signing of the Agreements (R. B. Scotton and Macdonald 1993: 222).

The other key policy compromise was on the grant formula which in fact underwent a number of iterations. Initially there was the S&D formula which involved the payment of bed day subsidies and top-up grants. As part of developing the Green Paper, the HIPC discarded the S&D formula on efficiency grounds, arguing that uniform bed day subsidies would encourage States to hold and utilise a larger bed stock; did not sufficiently account for the fixed and variable costs associated with bed provision; and would not appropriately distinguish between private and public patients, in particular the additional services provided to public patients (R. B. Scotton and Macdonald 1993: 61). Ultimately the HIPC put forward a somewhat intellectual formula that promised a fair and precise grant allocation, but was extremely difficult to understand and hence discuss with the States. The recommended formula involved a fixed and variable component: a facility payment based on bed numbers (50 per cent of the grant) and a bed day payment of \$6.50 per bed day. In addition, in order to "diminish incentives to over-provision of beds the levels of facility

¹⁵ While this it may have appeared a deserving reform to pursue, particularly given Queensland's apparent record of achieving a cost per hospital case that ranged between 0.82 and 0.67 of the average cost in other States, Hayden's proposal seemingly overlooked the unique circumstances of the Queensland hospital system. Due to a range of economic and political factors, the evolution of public hospitals in Queensland had allowed the State government to possess a high level of centralised administrative control over its public hospitals, a feature which is likely to have assisted in sustaining the salaried arrangements over a thirty year period (Butler 1989: 305).

payment were to be inversely related to average bed to population ratios in each State" (R. B. Scotton and Macdonald 1993: 62).

Not only was the formula complex, but it also resulted in a totally different distribution of Commonwealth funding amongst the States, in comparison to the Commonwealth benefits being paid at the time. SA was one jurisdiction which stood to lose considerably from the formula recommended by the Committee. Not surprisingly, the SA government, being one of only two Labor States, sought to strike a deal with Hayden who by that time "badly needed to give substance to the hospital program by securing an agreement in principle with at least one State" (R. B. Scotton and Macdonald 1993: 87). Being fully aware that three of the most populous States were at ideological odds with the Whitlam government's policies, the SA government shrewdly and successfully convinced Hayden in October 1973 to adopt a 50–50 cost sharing grant formula, on the basis of its simplicity and practicality. With little regard to the damaging inflationary pressures that would be created, Hayden conceded to SA's request, inserting the new formula in the White Paper.

A further costly policy compromise forced onto the Commonwealth was in the area of medical fees. While it was the Commonwealth, as the provider of medical benefits, who felt the immediate financial impact, there would also have been a flow-on impact to hospital costs, particularly in those hospitals where modified fee-for-service arrangements were permitted. In addition, the significant growth in medical fees, just prior to the implementation of Medibank, would no doubt have influenced the wage setting determinations for salaried and sessional arrangements. The AMA was able to institute a number of significant medical fee increases from 1973 to 1975. The first of these was a 39.1 per cent increase in the AMA fees index from May 1973. Unfortunately for the Commonwealth, the 1973 Medical Fees Tribunal largely supported the fee rise, and hence the increase was reluctantly added to the baseline fees schedule (R. B. Scotton and Macdonald 1993: 79). The second fee increase of 32 per cent was announced in January 1975 and again the Commonwealth was embarrassed by a private arbitrator declaring this a valid fee rise. Finally, a third fee increase of 12.5 per cent was announced to apply from 1 July 1975, the proposed start date for Medibank. This time a private arbitrator found the Commonwealth's case favourable and declared only 4.2 per cent of the fee rise to be justified. These fee rises proved to be a substantial blow for the cost of the overall program. Scotton and Macdonald (1993: 181-2) assert that the driving factor for growth in Commonwealth health spending post-Medibank was not growth in service utilisation (cited as 12 per cent between 1972 and 1976) but the significant hike in medical fees.

The medical fee rises, carefully orchestrated by the medical profession, are claimed to be part of the necessary financial price of having Medibank successfully implemented.

Finally, a most detrimental goal setting compromise made by the Whitlam government was its failure to conduct an integrated policy making process. Very early on, Whitlam decided to hand responsibility for the Medibank program (comprising the health insurance and Hospital Agreement streams) to Hayden, Minister for Social Security. Responsibility for other health policy goals such as the Hospital and Health Services Commission (HHSC), and the proposed community health and dental health programs, was assigned to the Minister for Health. The HHSC was itself divided into a Social Welfare Commission and a Hospitals and Health Services Commission, apparently to appease the interests of “social welfare professionals” (Milio 1984: 20). These politically and administratively expedient decisions led to damaging program segregation, compromising Commonwealth and State capacity to ensure a coordinated health system planning approach. In spite of the considerable rhetoric attached to the HHSC being a vehicle for achieving an integrated health service system, the end outcomes were much different. Sax (1984: 107) chairman of the Commission lamented:

Many of the problems associated with fragmented sources of funds administered by different levels of government could have been overcome. But that was not to be. Government was anxious to implement its policies quickly, and long before it had any formal indication that national plans were being developed, even though the report ‘A Community Health Program for Australia’ was submitted only 53 days after the HHSC first met, the Labor administration had already added to the list of special purpose health and welfare grants.

Milio (1984: 20-21) further observes that the administrative and program segregation led to three separate policy making processes being established. Medibank became the higher profile policy, developed under formalised policymaking process involving legislation and parliamentary oversight. In comparison, she asserts that policy making around the Community Health Program lacked clear objectives and legislative backing, and was “left to develop outside cabinet circles”.

Formulation of goals — State (August 1974 - June 1975)

The granting of policy compromises did not cease at the Commonwealth level with goal adjustment continuing during the negotiations between the Commonwealth and the States, and between the States and the medical profession.

Archival evidence (WA Govt 1974-75: 1, 57, 66, 77-8) indicates that negotiations for the WA Hospital Cost Sharing Agreement took place between August 1974 and June 1975. In spite of the significant Commonwealth funding involved, the WA Government was initially strongly opposed: “we have rejected the scheme put forward, all we are asking of

reasonable people is for the Commonwealth to sit down with us and discuss something which is fair and reasonable and logical” (Premier of Western Australia, March 1975). The State managed to control the bargaining process for around ten months, putting forward a range of counter proposals (refer Table 4.2) and conferring with the other non-Labor States. The ‘strategic delay’ tactics appear to have persisted as late as mid-May when the State advised the Commonwealth it was still pondering the hospital Medibank scheme.

Table 4.2 Counter proposals submitted to Commonwealth December 1974

1)	<u>Offsetting</u> – “No amount received by the State on a 50/50 cost sharing basis to be offset against reimbursement of general revenue to the State”.
2)	<u>Payment arrangements</u> – “Payment to doctors in peripheral, country and Goldfields hospitals would be on a contractual basis as against sessional or salaried payment”.
3)	<u>Scope</u> – “Consideration should be given to the inclusion of psychiatric and mental hospital patients to be covered for the first 84 days of hospitalisation in any 12 month period. These patients had been excluded under the Act”.
4)	<u>Exclusivity</u> - The Commonwealth not to develop a separate civilian hospital system nor increase beds and/or repatriation facilities for the purpose of treating civilian patients without the agreement of the State.
5)	<u>Timeframe</u> – “The term of agreement to be for 5 years, with a mutual arrangement for renewal for a further 5 years, as against the original proposed term of agreement for 2 years which would have been entirely satisfactory”.
6)	<u>Funding</u> - An assurance be given by Mr Hayden that the Commonwealth Government would not unreasonably exclude from “operating expenditure” items which the State currently defines as operating costs and finances from Consolidated Revenue and patients’ fees.
7)	<u>Private patient fees (setting)</u> – “The State to reserve the right to fix accommodation fees for private patients when deemed necessary”.
8)	<u>Private patient fees (daily rates)</u> – “Uniform conditions in relation to insurance and payment for private patients, i.e. Bed for other than a single room \$20 per day; Bed in a single room \$30 per day; as against the suggested terms of the Commonwealth to provide for the differences in charges where a hospital patient could demand a bed at \$8 and \$15 per day as against a private patient bed of \$15 to \$22 per day.”
9)	<u>Private health insurance</u> – “The Commonwealth Government and Minister for Social Security to encourage the continuity of the private health insurance organisations to provide benefits for private patients in public hospitals, private hospitals and for ancillary services”.
10)	<u>Operational (beds)</u> – “So far as practicable, public hospitals would make beds available in sufficient numbers, as against the Commonwealth’s proposal for a specified number of beds to be available in approved hospitals”.
11)	<u>Operational (hospital configuration)</u> – “The State to reserve the right to determine the level of treatment and services in individual hospitals. “Highly sophisticated medical equipment cannot be provided in smaller hospitals”.

The momentum shifted from late June 1975. By 25 June, the State had confirmed its intention to sign for a 1 July start, with the Commonwealth responding it could only commit to a 1 August commencement date. In late July, the State’s Crown Solicitor recommended a number of clarifying amendments to the draft Agreement including the insertion of an

“arbitration clause”. The Crown Solicitor also advised the State government that section 18(2) of the State’s *Hospitals and Health Services Act 1927* might be deficient in allowing the Minister to direct hospital boards in the manner required by the Agreement (WA Govt 1974-75: 82-4). This advice was certainly significant, raising a potential operational obstacle to grant implementation. In this regard, it is apparent that legislative structures existing at the time did not allow the State government full and direct control over its hospital operations.¹⁶ Although the legal advice received could have very well been utilised as an opportunity to bargain further, the State government, after holding out for close to a year, instead lapsed into a passive stance, accepting the Commonwealth’s suggestion that any additional changes to signing the Agreement would jeopardise the 1 August commencement date.

There are some obvious reasons as to why WA ultimately agreed to the Agreement. First, there was the benefit of potentially a one-time opportunity to secure significant additional funding from the Commonwealth. Papers from the 1971 Health Ministers Conference (WA Govt 1971-72: 7) indicate that States were suffering from serious funding deficiencies and had warned that hospitals would face bankruptcy if Commonwealth funding contributions did not increase. Victorian data suggests a Commonwealth funding contribution of 12.2 per cent, compared to 54.7 per cent from the State government and 31 per cent from patient co-payments¹⁷. The States had discussed a proposal to seek an increased Commonwealth contribution of 33 per cent, with the preference for this to occur through increased pensioner benefits¹⁸. Thus the prospect of a 50 per cent funding contribution from the Commonwealth no doubt appeared an offer too good to refuse, particularly given the five or ten years terms being offered. The Premier justified to the AMA in August 1975 that the “State could not afford to remain aloof from the Medibank scheme because of the financial assistance from the Commonwealth which would be lost by such an attitude” (WA Govt 1974-75: 43). Fiscal reasons also appear to have been played a part in Queensland, a non-Labor State already providing a universal hospital insurance scheme. Having agreed to forgo a \$10 million claim for back payments, the Premier’s announcement of Queensland’s participation clearly reveals fiscal pressures driving his State’s signing:

¹⁶ According to the Hospitals and Health Services Commission (1974: 163) report *A Report on Hospitals in Australia*, WA’s Medical Department controlled “nine metropolitan and thirty eight country hospitals..(and supervised) the administration of a further forty one country hospital boards ... in addition ... five teaching hospitals (are) controlled by boards of management”.

¹⁷ Whitlam’s justification for greater Commonwealth involvement in the delivery of hospital services as noted earlier certainly appears deflated when considering the federal government’s meagre 12.2% funding contribution at the time.

¹⁸ The States considered this to be a most reasonable request when considering their Canadian counterparts which received a 50 per cent funding contribution from the federal government whilst having wider taxing powers than Australian states.

In compliance with requests from the Treasurer Mr Hayden we will sign the document operative from September 1 ... Mr Hayden has demanded that we do this and he is in a position to say whether or not we get the money (The Australian, 15 August 1975).

Adding to funding temptation was the veiled Commonwealth threat of being excluded from the program altogether. Scotton and Macdonald (1993: 170-1) describe Hayden's "medical plus three States strategy" which by early 1975, had the Commonwealth focused on securing agreements with just SA, Tasmania and Queensland. From Hayden's viewpoint, with the instability of the Levy Bill, this strategy addressed his growing concerns over the cost of the program and its burden on an already pressured Commonwealth budget. Scotton and Macdonald (1993: 190) note that a delay in signing up NSW, Victoria and WA was worth "\$285 million in a full year" to the Commonwealth, a handy financial buffer at the time. From Whitlam's perspective, the strategy was designed to break down the non-Labor States resistance. Implementing the program in only three States would create State variations in benefit payments and contribution rates, generating enormous political pressure as "the difference between participating and non-participating States (became) very obvious" (R. B. Scotton and Macdonald 1993: 171). Apart from the fear of exclusion by the Commonwealth, there was also an element of mistrust between the States. Scotton and Macdonald (1993: 187-8) point out that the "united front was never all that it seemed" with the non-Labor States apprehensive that their 'allies' would weaken to separate deals with the Commonwealth. Certainly it appears the Commonwealth made the best of the situation in this regard, holding separate discussions with State governments and their bureaucracies.

While it did not have an immediate impact on State resistance, the election of Fraser as Liberal Party leader in March 1975 and his announcement of bipartisan support for Medibank (no doubt cognisant of the electoral impact of this) must surely have influenced the WA government, in terms of the long term continuity of the program. Scotton and Macdonald (1993: 174, 88) also mention the growing public support for Medibank which would have been a pragmatic electoral issue difficult for States to ignore. Certainly a turning point for the Victorian government in its negotiations was the realisation that hospital Medibank was "the law of the land" and non-participation would mean that Victorians would be paying taxes for services they could not utilise (R. B. Scotton and Macdonald 1993: 192). At this early stage of the grant program, the States were effectively cornered. Political expediency and fiscal constraint necessitated Western Australia signing up to deliver a national goal that was acknowledged "would bring about a higher rate of increases in costs" and threaten the State government's preferred policy of encouraging

private health insurance cover. A comment from the Premier in August 1975 is a good indication of the extent of forfeiture of State policy making space: “it is impossible at this stage to be certain of the [cost] ... effect ... the State will be keeping a close watch on movements in the costs of conducting hospitals and will be pressing the Commonwealth government to take appropriate action as necessary”. Essentially, without the benefit of knowing what the potential demand, costs and benefits would be, or having access to an opting out or review clause, the State placed itself at the mercy of the Commonwealth by tying itself to a national goal that gave the community unlimited access to its public hospital system but would never be backed with funding certainty. A medical practitioner aptly noted (WA Govt 1975-76b: 168):

If history repeats itself...the Commonwealth will start off with a flourish, and when the bills begin to roll in, will blame the State for maladministration and waste and will shove more and more of the cost of the health maintenance initiated under their policies back onto the States (Letter to State Minister for Federal Affairs 18/09/75).

By mid-September 1975, the State had already begun to approach the Commonwealth for amendments to the Agreement. Not surprisingly, with the ball now firmly in its court, the Commonwealth resisted the request, telling the State it preferred to defer consideration until the Agreement had settled in, and also raising doubts as to the merit of some of the suggested amendments that could potentially reduce consistency across the States.

This analysis confirms that the WA government was compelled to sign the Agreement out of fiscal and political pressure. Was there any gain, however, from the ten months of bargaining and strategic delays? Examination of the signed Agreement (Aust. Government 1975) against the counter proposals put forward by the State government indicates that seven of the State’s counter proposals were accepted by the Commonwealth. Proposals on offsetting, five-year grant timeframe, daily bed-day rates for private patients, flexible payment arrangements for doctors in non-teaching and rural hospitals and the preservation of local discretion (at least at a detailed level) over hospital beds and configuration were accepted in their entirety. The policy win on “no offset’ is discussed by Scotton and Macdonald (1993: 157-9). They note that the States were able to argue successfully that the Agreements entailed new responsibilities that would be significant and ongoing, thus distinguishing the grant from other tied grants.¹⁹ It was categorically indicated to Hayden as early as 1973 that the States would resist the grant outright if any offsetting was involved. The Commonwealth’s pathway to allowing this policy concession was not a smooth one however, as Hayden faced conflict from the Commonwealth Treasury who believed the

¹⁹ Tied grants recently negotiated for housing and education had been offset against general purpose grants.

Hospital Agreements did not deserve special treatment. The argument between Hayden and Treasury persisted all through 1974 and was resolved only in February 1975 when Whitlam “suddenly cracked the whip ... he declared that Medibank was a vital program which must be pushed through, and that Hayden must line up three States within a week ... there would be no offsets”.

Two of the other counter proposals — exclusivity and funding — were not specifically addressed in the Agreement, but there are no qualifiers in the Agreement to suggest they were rejected by the Whitlam government. The funding counter proposal was in fact one of the first policy deals to be tested by the Fraser government when it assumed office. With regards to the private health insurance counter proposal, here too the Commonwealth appears to have yielded some ground, albeit symbolic. Whilst the Agreement makes no specific references to private insurance, an opening Statement in the Agreement states that the arrangement should act “in such a way as will not place any impediment in the way of persons being able to seek private treatment in public hospitals if they so wish”. In addition, following a contentious public declaration by Hayden that: “Tasmanians would not need to continue contributions to private medical insurance funds after July 1”, the WA government sought and received assurance that the Commonwealth would not make similar statements in WA.

On top of these more transparent gains, evidence from the Fraser era reveals that WA managed to secure some gains that may not have been common to the Agreements negotiated with other States. The "most significant gains" of this category as described by a hospital administrator are as follows (WA Govt 1977d: 13-14):

- The inclusion of the Perth Dental Hospital and all its fixed clinics...as a recognised hospital. (In contrast it is noted that the Sydney Dental Hospital) which does not provide as wide a service ... is not cost shared;
- The inclusion under...Central Services...: 1) (the) Northwest and Remote Areas Medical Service; 2) Remote Area Transport (of patients to Perth) Scheme (excluding Royal Flying Doctor Scheme); 3) Visiting specialists (salary and travelling costs); and 4) Computer Services;
- (The inclusion of) outpatient services...provided free of charge to all patients except those attending the Perth Dental Hospital or its clinics.

The abovementioned negotiating gains were a considerable bargaining coup. Some further inadvertent gains mentioned were the cost sharing benefits accruing from: "the high proportion of... (indigenous people) treated" in the WA public hospital system; and the "known higher costs of providing services in the North West and other remote areas". In fact, the Commonwealth later claimed (and the State accepted) that WA "does better than any other State per capita under the Hospital Agreement (WA Govt 1977d: 13-14).

Counteracting all of these policy ‘wins’ was the Commonwealth’s refusal to concede to the inclusion of an arbitration clause and psychiatric hospitals in the policy scope, and its insistence that private patient accommodation fees be determined jointly. This latter condition would have been viewed by the Commonwealth as an important enforcement measure, to regulate fee consistency across the States and also protect its own interests from a budget perspective. Archival evidence (WA Govt 1979b: 74) confirms that while WA may have been sympathetic to the need for greater uniformity in fees across States, its preference was for this to be achieved through inter-State cooperation and consultation. Direct Commonwealth participation in the setting of fees was considered to place what would otherwise be an operational issue, “into the political arena”. Further, the Commonwealth wasted no time in executing its new powers to become involved in remuneration negotiations with the medical workforce, confirming on 31 July that all contractual arrangements between the state government and medical staff were required to be jointly agreed by the Commonwealth Director-General of Social Security and the State Director-General of Medical Services.

The overall impression gained is that while the Commonwealth was able to secure a firm foothold in the State’s policy making arena through the signing of the Hospital Agreements, this was preceded by a period of sustained State resistance and bargaining in which the State did manage to restrain or re-shape the Commonwealth’s goals. The WA Government’s resistance resulted in some very beneficial Commonwealth policy concessions. The State was not unique in this regard with the other States also successful in negotiating similar policy concessions (R. B. Scotton and Macdonald 1993: 161-70, 219-25).

4.3.3 Goal setting — post-1975 Hospital Agreements

General observations on doctors’ remuneration goal setting

As mentioned earlier, policy compromises made on doctor remuneration arrangements were fairly hollow, as the deliberations with the medical profession had not been completed at the time the Agreements were signed. Early in the negotiating process, during deliberations with the ACT, SA and Tasmania for example, the bargaining had a greater level of integrity, involving more realistic remuneration arrangements being negotiated, with genuine policy concessions. Later in the bargaining process, however — particularly with Victoria and NSW — the Commonwealth allowed policy compromises that were known to have no reasonable chance of being accepted by the medical profession. The Victorian government actually committed itself to the Agreement without even beginning

negotiations with doctors. It sought, unsuccessfully, an amended Agreement just three days after both parties had signed off. In terms of the NSW agreement, which was not signed until September 1975, two months before the Commonwealth's downfall, both the Commonwealth and NSW government sought frantically to stitch up the deal, NSW appeared to be willing to "agree to anything...[because] there would be an election soon" (R. B. Scotton and Macdonald 1993: 219-23).

The deferral of the doctor remuneration negotiations to the post-Agreement period was certainly a feature of the goal setting process that worked considerably in the Commonwealth's favour, although this seems to have been more of an inadvertent outcome from a politically expedient approach as opposed to a deliberate strategy. The shifting of the confrontation with the medical profession to a State level effectively enabled the Commonwealth to prevent a unified and powerful retaliation from the AMA. Gray (as quoted in R. B. Scotton and Macdonald 1993: 266) asserts: "if the implementation of Medibank had depended upon the federal government reaching an agreement with the AMA, as in the 1940s, it would almost certainly have failed". The anticipated confrontation was diffused into a series of separate battles, against different State governments and numerous individual hospital administrators. The bargaining power of the medical profession was thereby considerably diluted, and the effectiveness of its opposition campaigns gradually diminished as the number of individual settlements between hospitals and doctors grew, and divisions began appearing within its own membership.

Shifting the medical profession battle to the State level also created another important policy outcome. Prior to the signing of the Agreements — certainly in WA and SA where the voluntary health insurance scheme had worked well — state governments appear to have passively accepted the fee for service model preferred by the medical profession. Once the Agreement had been signed, however, the government and bureaucracy could no longer uphold such a congenial stance with the medical profession. Attempts were made to justify the Agreement as a necessary political compromise — one hospital administrator explained: "the new ground rules have been made for us in the political arena and (we must) administer them faithfully". However, the act of signing the Agreement automatically placed the State government in an adversarial standoff against the profession, leading to a significant re-alignment of its policy setting position (WA Govt 1974-75: 25). Scotton and Macdonald (1993: 223) describe how the States "ceased to be allies of the AMA and reverted to the pursuit of their own interests. They had to steer a delicate course between the dictates of the Commonwealth paymasters and the demands of their doctors, on whom

they depended for the provision of services which they had undertaken to provide.” By making the State governments a party to its national goals, the Commonwealth had drawn a clear line between these two policy actors.

Formulation of goals — Medical Profession (July – September 1975)

Similar to the goal setting process between the Commonwealth and the State, policy bargaining between the State government and the medical profession commenced with a period (around five months in this case) where the negotiations were firmly controlled by the medical profession. However, unlike the Commonwealth–State bargaining which had involved measured deliberations, proposals and counter proposals, and strategic but subdued resistance, the State-medical profession policy bargaining was much more impulsive, public and riotous.

The State government wrote to individual doctors confirming that from 1 August, a default salaried or sessional payment arrangement would apply, unless the doctor expressly preferred a modified fee-for-service contractual arrangement. This letter triggered what would become months of heated confusion and service disruptions within the non-teaching hospitals, generating much media attention and antagonism²⁰. The AMA made clear its intention that any benefits gained from the signing of the Agreement would be short-lived:

We believe the facts indicate that Medibank will be a passing advantage, financially speaking, solely for the State Budget. We believe it will set in train a chain of events precipitating major deficits wiping out all previous transitory advantages. We believe that a counter attack against Medibank in hospitals is not only desirable but feasible and we will soon be meeting with the private funds and the private hospitals to discuss ...in greater depth (Letter to Premier, July 1975, WA Govt 1974-75: 69).

Counter action from the medical profession began just three days after the signing of the Agreement with obstetricians at the Woodside Hospital and doctors in Busselton refusing to treat patients on anything other than a fee-for-service basis. An AMA brochure from September 1975 clearly indicates the combative style adopted: “only by sticking together and not negotiating separately can doctors effectively handle the pressure of the system”. While obstetricians at the Osborne Park Hospital ultimately accepted the change to salaried arrangements, they too argued that “haste at this stage (and) loose wording (could lead) to bitter confusion in later years”.

By mid-August the WA Government was battling its pathologist workforce who objected to a salaried arrangement, forcing the government to bar private pathologists from public hospital duties and relying on its own pathology workforce. Angered, the private

²⁰ Gray (1991: 135) points out that the universal hospital care policy was viewed by the medical profession, private insurance industry and private hospitals as a long term threat to the private medical care market; professional autonomy around medical fees; and the viability of the private health insurance and private hospital industries.

pathologists claimed “the State government though liberal and committed to free enterprise, preferred to call sessional work what was frank conscription” (The West Australian 18 August 1975). In mid-September, most of the 70 or so general practitioners providing weekend radiography services at the Osborne Park Hospital confirmed they would not be prepared to continue on a salaried basis. Doctors in Geraldton were also refusing to treat non-private patients which on a number of occasions resulted in patients being moved to Perth (WA Govt 1974-75).

Amongst the resistance, there were also doctors that agreed to the salaried or modified fee for service arrangements. The State’s thoracic surgeons for example put forward what was a genuine case for supplementation to salaried arrangements to address workforce shortages apparent in their field. Gradually, the remuneration arrangements settled down and by the end of September all contracts for teaching and non-teaching hospitals had been formalised and endorsed by the Commonwealth (WA Govt 1974-75). These incidents were not dissimilar to events in other States. While the WA battleground mainly involved the non-teaching and non-metropolitan hospitals, in NSW, doctors from the major teaching hospitals refused salaried or modified fee-for-service contracts, the stalemate leading the NSW Government to request Commonwealth intervention, either in the negotiations or through modification of the Agreement conditions (*The Australian* 21 August 1975).²¹

Did the medical profession gain any policy ground from its revolt against the Agreement? The profession was obviously not able to stifle the Hospital Agreement completely. Nevertheless, the AMA’s intense opposition is likely to have yielded some gains in terms of constraining or delaying the number of salaried arrangements settled. Also in terms of operational policy setting, there was significant detailed negotiation between individual doctors and hospital administrators, over issues such as the: scope of services; hospital

²¹ The resistance of the medical workforce represented much more than a demonstration of their distaste for the remuneration arrangements required by the new Agreement. First, hospital Medibank severed the one-to-one traditional relationship that had existed between private practitioners and their hospital patients, replacing this with a systemised model of health care, whereby treatment for a patient came from a transiting pool of salaried doctors. The Agreement was therefore perceived as a major intrusion into the mode of delivery of medical services, an AMA brochure of September 1975 declares: “only the doctor and patient have the right to determine the doctor patient relationship in or out of hospital ... the system has no right to meddle with this relationship ... as if medicine can be delivered impersonally like a bag of groceries”. Secondly, hospital Medibank brought about substantial changes in the way that private practitioners interacted with the public hospital system.

Prior to the Agreement, there were long standing arrangements between individual practitioners and public hospitals whereby the practitioner’s access to private practice and either free or heavily subsidised hospital facilities was counter balanced with their honorary provision of services for eligible public patients. The implementation of hospital Medibank completely over-turned the mutually cooperative systems that had developed over time, ceasing honorary arrangements and restricting private practice in public hospitals to the salaried or contractual terms authorised by the Commonwealth and State governments. The cessation of private practice in public hospital outpatient clinics was particularly contentious. This made the situation irrefutable, by preventing doctors from being able to manipulate their public-private balance as claimed to have been possible with the first Hospital Agreements under the Chifley administration (Gillespie as quoted in R. B. Scotton and Macdonald 1993: 8).

facilities to be made available and leasing rates; salary rates and travelling allowances; general practitioner access to the hospital; and the continuity of a range of long standing service arrangements for example periodic rounds of rural hospitals and weekend rostering. Given the public and media pressures, again it is more than likely there were policy and remuneration gains for the profession from these deliberations around operational terms and conditions.

There also appears to have instances of more subtle resistance from the profession. A letter from a Northam Regional Hospital administrator in August 1975 points out the frustrations of admissions staff as a result of doctors not openly disclosing their remuneration status as either a salaried or modified fee for service professional and also choosing to quietly disregard patient elections to be treated as a public patient. There was also considerable confusion and deliberation around the design of patient election forms. Due to the independence of the board run hospitals, the WA Government faced difficulties in implementing a common patient election form across the system and at one stage there were five different versions in use. Adding to the chaos, the AMA issued its own patient election form, recommending it to members and suggesting that patients continue to be advised of the desirability of opting for a doctor of choice and maintaining private health insurance. Further the AMA also requested its members to monitor their hospital administrators to ensure that patient election forms were not illicitly amended (WA Govt 1974-75: 29).²²

4.3.4 Goal setting — Overall evaluation

The discussion on goal clarity confirmed that the Commonwealth was able to secure the upper hand in a number of strategic policy bargaining areas: 1) which patients were granted access to public hospitals; 2) the mix of private or public patients admitted at any time; 3) the charging of private and public patients; and 4) payment arrangements for medical staff. These policy gains were offset by some significant compromises conceded on the grant formula and doctor remuneration arrangements in non-teaching hospitals, thus it appeared that policy making was fairly evenly balanced between the Commonwealth and the States.

The preceding goal setting analysis reveals that the WA government was able to secure several additional policy concessions around offsetting, grant timeframe, daily bed-day

²² Subtle resistance also took the form of medical fee manipulation whereby practitioners charged an ancillary fee, for example a 'booking' or 'accounting fee' on top of the benefits schedule fee, or offered discounts for cash. In September 1975, the Commonwealth publicly warned such practitioners would be prosecuted; however, it is unclear whether the Whitlam government was able to enforce compliance.

rates for private patients, and the preservation of local discretion (at least at a detailed level) over hospital beds and configuration. Counter proposals regarding exclusivity and funding also seem to have been successful. In addition to the gains jointly gained with other States, WA appears to have secured some very generous individual gains: the inclusion of the Perth Dental Hospital and its clinics; a wider definition of Central Services; cost sharing of the high rate of treatment for indigenous people and remote area communities unique to WA; and finally, the inclusion of free outpatient services (with the exception of dental services) in the scope of universal hospital care. The inclusion of outpatient services was especially significant. As further discussed at Chapter 5, this led to a substantial increase in outpatient services during the Fraser era (WA Govt 1977d: 13-15).

Offsetting these policy bargaining gains was the loss sustained by the State with regards to its requests for the inclusion of psychiatric hospitals and an arbitration mechanism. The State also assumed an obligation to the Commonwealth for regular financial reports and other statistics. Further, while the Commonwealth made some symbolic compromises on private health insurance, this was a major loss of policy making sovereignty for the State, in that the WA Government had to commit to a universal health insurance scheme when in fact its policy preference was for the existing voluntary scheme. The largest area of policy discretion left untouched at this stage was the operation of the hospitals themselves. The Commonwealth did not impose any specific conditionality around policy setting parameters such as bed numbers, location and configuration of hospitals and numbers of workforce. Although bed numbers featured in the Commonwealth–State discussions and the Agreement made the Commonwealth a party to any future wage setting deliberations with doctors, at the time of the Whitlam government’s dismissal neither of these potential policy levers had been utilised in any significant manner. The generous grant formula was also a substantial policy gain for the State (R. B. Scotton and Macdonald 1993: 160, 266).

The WA Premier claimed in September 1975 that WA had secured the “most favourable (terms) so far obtained by any State” (WA Govt 1974-75: 1), this being in spite of WA not managing to secure the ten year grant timeframes of the Tasmanian or SA Agreements. Under considerable political and fiscal pressures to conform, WA did hold out successfully for a considerable range of policy concessions. This assessment of goal setting during the Whitlam government strongly indicates a bottom-up policy making approach, particularly given the massive financial injections and the broadly stated national goals. An open-ended financial deal of this nature was never repeated in future iterations of the Agreement. There was also considerable policy discretion left with the States, as further discussed at

section 4.9. The consideration of goal congruence that follows should allow the proposition of a bottom-up policy making approach to be further tested.

4.4 GOAL CONGRUENCE

4.4.1 Goal congruence — Commonwealth level

Goal congruence at the Commonwealth level during the Whitlam era was by no means stable or assured. The Commonwealth's policy goals were blocked by the Senate three times, and required astute political strategising to eventually be legislated. There was also persistent pressure from other portfolios over the substantial budgetary burden being created by the Hospital Agreements, with Treasury officials and other Commonwealth agencies at one stage seeking (unsuccessfully) to be present at the negotiations. It was discussed earlier that the Commonwealth Treasury's objections to the offsetting of the cost sharing grants stalled state negotiations for more than twelve months. Within the bureaucracy, there was passive resistance, with many quite senior officers disbelieving the program would be finalised, and conflict evident between the different Commonwealth agencies and the specialist policy advisers recruited by Hayden to assist with negotiations (R. B. Scotton and Macdonald 1993: 117, 57, 225).

It is often argued that the Whitlam government used its considerable fiscal powers to *compel* tied grants onto the States. These claims appear to overlook the considerable battles the Commonwealth faced within its own jurisdiction before negotiations even began with the states. The emergent picture is that the Hospital Agreements were not a clean policy 'takeover' as such, but involved a hefty financial price that was not only significant in size but also not offset against existing Commonwealth grants. The ongoing antagonism of the medical profession and the Senate-driven threats to supply actually placed the Commonwealth in a highly vulnerable position, in comparison to the dominating picture so often described. At all stages, there was tremendous risk that the program would not be implemented, for example the double dissolution triggered election that worked in Labor's favour and the bi-partisan support from Fraser (which generated conflict within his own Party) were all external factors beyond the Commonwealth's direct control. So too was the hidden inflationary impact of the program which did not become apparent to the public until months after the implementation began. In late 1975, the national Arbitration Commission had just started experimenting with the cost of living indexation of wages and the ABS had not yet determined the treatment of Medibank in its calculation of the Consumer Price Index (The Australian Financial Review 23/09/75 as quoted in WA Govt

1975-76b: 157). Had the ensuing wage and inflationary impacts been known much earlier, electoral support for the program may not have been as high. Regardless of the confidence and centralising arrogance that may be evident from statements by Whitlam, the implementation of Labor's policy goals were not a neatly executed outcome, with Scotton and Macdonald (1993: 266) professing that the entire process "benefited from a certain measure of luck".

4.4.2 Goal congruence — State level

Universal hospital care

Were the States aspiring to, or perhaps were even in the process of, implementing the two goals that of the Hospital Agreements? As discussed earlier, some States had been pondering the expansion of community health orientated initiatives during the late 1960s and early 1970s. In fact, States had put considerable thought into health service access issues and were of the view that a complete re-evaluation of health service provision was needed. A NSW government paper called for a national committee of inquiry similar to the 1964 Canadian Royal Commission. The paper highlights the complexities and budgetary burden of health services, with expenditure in Australia at the time growing at 8.6 per cent per annum compared to 7.5 per cent annual growth in GNP. Importantly the paper stressed "if a system were being designed afresh, it would not take the form of our present structure" (WA Govt 1971-72: 9). A supporting paper by the University of Queensland's Dean of Medicine (Saint 1970) points out the extent of fragmentation evident in health service provision:

the bewildering degree of fragmentation of the health service and ... the impediments which exist to the continuity of medical care ... responsibilities for preventative care rest between the private sector, government departments and hospitals, with poor lines of communication between the points of the triangle ... In the management of chronic illness ... the lines of communication between the personal physician, the hospital specialist and the rehabilitative services are not clearly defined, and often actually cross ... Capital investment in hospital-based facilities is heavy; investment in domiciliary services is slight in comparison. It is truly a confusing and probably wasteful situation. The bold and politically imaginative step would be to transfer all those aspects of health care which, for reasons long forgotten, have been tacked on to non-health orientated ministries to health departments – to effect a fusion, a centralization, a rationalization of health administration in one ministry at Federal and State level.

The NSW Government was acutely aware of structural shortcomings: "institutional care accounts for 45 per cent of total spending" but "it is clear that the mass of poor health which afflicts the population is not be found in the hospitals but in the community's homes, schools and industries". The State resolved that the institutional-centric health system persisted because there were no alternative health care facilities to encourage greater emphasis on preventative and community services. The government called for the

development of a blueprint to address the “massive subsidisation of medical services in hospital but little to help keep people out”. Further, the government recommended an inquiry be established to identify: “ways and means of providing an organisation for comprehensive care outside the hospitals which is endowed proportionately at least as well as is the complex organisation inside the hospitals” (WA Govt 1971-72: 10-11). Clearly, the NSW government’s policy preference was to transition the health system from a hospital to community-centred one, in contrast to greater emphasis on the public hospital system as proposed by the Commonwealth. These policy aspirations had also translated into early actions with Milio (1984: 19) noting that “health centre pilot projects had begun in New South Wales around 1970”.

The enthusiasm for de-institutionalisation in health care was not restricted to NSW with the SA, WA and Queensland governments also expressing support for the community health centre concept. Although admitting that significant new Commonwealth funding was required, a paper by SA government acknowledged:

There is growing realisation that many patients currently being accommodated in hospitals and nursing homes could be cared for in the community, if adequate facilities were available ... In the long run, by shifting emphasis on health care from ‘institutions’ to more broadly based community services, public monies ... are likely to be better spent, a higher quality and more personalised service made available, and at the same time, savings effected (WA Govt 1973: 3).

The SA government also highlighted another systemic issue not addressed by the Commonwealth’s universal hospital care policy. Arguing for increased Commonwealth funding for nursing home beds, the government confirmed: “[there are] ... many long-term patients who could be adequately cared for in nursing home beds ... [who] ... are occupying standard ward beds in public hospitals, which are already insufficient to meet the anticipated demand which would arise from the provision of free standard ward accommodation in public hospitals” (WA Govt 1973: 14). The WA branch of the AMA also separately noted this issue, pointing out that aged care demands would add to system pressures once public beds were provided universally free of charge (Press Statement 1/07/75, WA Govt 1975-76b: 170). The Commonwealth’s decision to overlook the interdependencies between the aged care and hospital sectors is similar to its decision to omit psychiatric hospitals from the scope of the universal hospital care policy. Interestingly, in an early paper arguing the case for compulsory health insurance, S&D (1968: 11) confirm that the scope of the universal hospital care policy was in fact intended to be flexible. Their choice to restrict the universal policy to medical and general ward hospital services was justified simply as being the same scope of services covered by the existing policy framework.

In a subsequent evaluation of the policy, Scotton (1978: 130) argued that:

universal coverage does not imply that services should be free, nor that limitations cannot be imposed on the range of covered services or the conditions under which benefits are available ... one may well question, for example, why all services now listed in the medical benefits schedule should be covered under a public program, and why they should be subsidised on similar conditions for all patients, regardless of the condition of the patients or the therapeutic effectiveness of the services.

Perhaps if the Commonwealth had discussed the scope and definition of 'universal care' in a more pragmatic manner with the Australian community and the implementing State governments and their agencies, as appears to have been the intention of the policy architects, a more holistic and pragmatic policy making approach may have eventuated.

It is clear therefore that the Commonwealth's universal hospital care goal was not a policy priority for the States. Why did they not put up a firmer policy resistance against such a vague and open-ended national hospital goal? The earlier analysis of goal setting indicated the States held considerable bargaining power. However, that power was *within the details of the national goals* tabled for negotiation, they appear to have been much weaker in terms of debating the *goals themselves*. The best opportunity for States to have raised their policy preferences was at the time of development of the Green Paper or during the Hospital and Health Services Commission (HHSC) review. It has already been noted that the States were not heavily consulted during the preparation of the Green Paper, and that the HHSC did not manage to realise its broad ranging potential. Due to its ideologies and political expediency, the Commonwealth adopted a highly coercive and unilateral approach in identifying policy solutions to the health service access issues that existed. The Commonwealth's approach appears to be a classic case of a non-cooperative model of intergovernmental relations, whereby governments tend to avoid the use of policies that "demand ... collaboration because efficient coordination devices are lacking and distributive bargaining is expensive", despite this not necessarily leading to "welfare-efficient" outcomes Braun (2002: 140).

What about those States with a higher level of goal congruence? Queensland already provided universal hospital care and held the largest financial incentive of any State, yet it still opposed the cost-sharing agreements. This curious opposition appears to have been rooted in unique political and ideological circumstances with the then Liberal-National Party Premier intent on using his rejection of the Hospital Agreements as a means of confronting political differences within his own Party, and to demonstrate his disregard for Labor Party involvement in State affairs. Goal congruence was not at all the issue here. Ultimately it was the Commonwealth's fiscal pressures and some careful political strategising within the Queensland Liberal Party that resulted in the Agreement being

signed (R. B. Scotton and Macdonald 1993: 193-5). The case of Queensland highlights that even where there is complete goal alignment, a top-down approach may not always be successful. States can, and do, resist a national policy goal — not because they disagree with the policy ends being pursued, but simply because it carries the risk of greater Commonwealth involvement in their affairs.

Salaried and sessional arrangements

In comparison to the universal hospital care goal, there was a much greater level of goal congruence for the national goal of salaried doctor remuneration in public hospitals. The Commonwealth's push for universal salaried and sessional payments came at a time when State governments had been voicing concerns around the uncertain future of honorary medical services in public hospitals. Momentum had been gradually building for a suitable replacement of the honorary system (R. B. Scotton and Macdonald 1993: 62). However given the numerous and different arrangements that had propagated across hospitals over time, there was no consensus as to its design.

Evidence from the 1972 Health Ministers Conference (WA Govt 1971-72: 7-8) confirms that Commonwealth and State representatives had actually settled on three possible options to finance the replacement of the honorary system. These were (in order of preference): 1) "direct grants from the Commonwealth to the States outside of the insurance scheme...; or 2) a sharing grant from the Commonwealth to the States for this specific purpose ... the proportions to be agreed upon after negotiations between the Commonwealth and State governments; or 3) that the 'all inclusive hospital fee system' should be adjusted to underwrite the cost of eliminating the honorary system in so far as medical services concerned are provided for patients other than pensioners". Hence the States had been drifting towards the concept of a Commonwealth grant, specific purpose or otherwise, for the replacement of the honorary system even before the Whitlam government assumed office.

When Hayden presented the goal of universal salaried and sessional arrangements, the main qualifier sought and successfully received by the States was that the 'universality' of the goal be restricted to the teaching hospitals, with State flexibility retained around the non-teaching and country hospitals. The States were quite willing to adopt the Commonwealth's goal, and accept its financial and logistical support in negotiating with the profession. It was noted earlier that the Commonwealth's diffusion of the conflict with the profession was a key feature of the goal setting process that enabled the Hospital

Agreements to be put in place. It is doubtful whether the States would have pursued their battles with the profession without the financial and political sway that came through the top-down approach from the Commonwealth.

In addition to the immediate negotiations, the Agreements provided for ongoing Commonwealth involvement in medical wage setting deliberations. The ready acceptance of this conditionality by the States was also not viewed so much as a loss of policy making space, but as a means of contracting in Commonwealth powers when deliberations with the profession necessitated this. In fact, at the 1976 Health Ministers Conference (subsequent to the Whitlam government's dismissal), the States concluded that:

the Commonwealth government and all State governments are most anxious to secure some form of national machinery for solving... major impediments to the smooth running of hospital services, clearly indicated by the inclusion...[of such clauses]...in the Hospital Agreements (WA Govt 1975-76a: 2-19).

Quite fascinating is the State governments' search for bonafide pathways to national wage setting machinery for hospital medical personnel, to overcome potential technical barriers presented by the Constitution. States supported the formation of a working party to assess industrial relations issues pertaining to medical officers, with the WA government stating: "there is considerable merit in conferring with the other States and the Commonwealth with a view to obtaining a more consistent and uniform approach to fixation of salaries and conditions of service for medical practitioners providing services in hospitals" (WA Govt 1975-76a: 19).

4.4.3 Goal congruence — Overall evaluation

The preceding analysis shows that considerable goal congruence was evident in the Whitlam government's national goal around doctors' remuneration. Barring Queensland and Tasmania, no State government had been able to introduce salaried and sessional arrangements in a wholesale manner (R. B. Scotton and Macdonald 1993: 62), hence they are likely to have seen the Commonwealth's push as one that also served their own purposes. In terms of this particular national goal then, the policy making approach seems to be neither top-down nor bottom-up, with the Commonwealth securing its policy goal but the States also desiring, and successfully negotiating refinement of this goal.

As for the national goal of universal hospital care, the overall impression appears to be that there was little goal congruence at the Commonwealth level, with open and passive resistance by Commonwealth actors and astute political strategizing involved in ensuring the goal's survival through the federal Parliament. In terms of goal congruence between the Commonwealth and the States, NSW, Queensland and SA supported the pursuit of a more

community health oriented system; and whilst there was relatively higher electoral support for the goal in Victoria, that State, similar to the Queensland government was ideologically and politically opposed. Hence the Commonwealth appears to have driven a heavily top down approach, suppressing a more open and considered examination of viable policy alternatives such as community health, aged care and even private health. Certainly in terms of the latter alternative, aspects of the WA and SA private system that may actually have been working well, do not appear to have been given an opportunity to be considered as part of the policy setting process because the Hospital Agreements were preoccupied with a totally public system (The AMA 21/07/75 as quoted in the West Australian; WA Govt 1975-76b: 165). In addition, in its haste to secure agreement for the goal, the Commonwealth completely overlooked governance weaknesses inside the public hospital systems as discussed further at section 4.9.

The earlier evaluations of goal clarity and goal setting indicated a Commonwealth that was not totally dominating, with the States able to secure a highly favourable financial deal, and managing to retain considerable discretion around hospital operation. The analysis of goal congruence now confirms that while the States secured policy discretion and open-ended funding, *this policy making capacity was in fact restricted in scope to the public hospital system*. As noted before, it was the Commonwealth's desire to overcome potential constitutional, political, ideological and electoral barriers that drove its decision to focus on the policy of universal hospital care, as opposed to a broader system of health care (DeVoe 2003). The fact that Whitlam engaged in goal setting with the States only when the universal hospital goal was being implemented, rather than at the initial goal formulation stage, thwarted potential State cooperation and opportunity to negotiate a more holistic national health service with the significant new funding involved.²³ Interestingly, the HHSC (1974: 37) found that public hospitals were being used as intensively as they were primarily because it was the *only major type of health facility available to the Australian community at the time*. The Commission asserted: "at present there is a demand by the community for facilities off the hospital campus, closer to their homes, less insulated from the people, smaller, less bureaucratic, but just as available, just as comprehensive, and efficient". While the non-hospital side of Medibank increased access to medical care in the

²³ The inability of the States to pursue more comprehensive health service planning was not a new phenomenon. Gray (1991: 102) points out from her analysis of health services between 1950 and 1970: "State policy makers were aware that many gaps existed in the services available under a system of predominantly private practice, but the extent to which supplementary services could be provided was limited by financial dependence on the federal government. This situation was exacerbated by Commonwealth policy which forced the states to meet an increasing share of the operating costs of general hospitals, the most expensive sector of health services. The federal government was able to control by indirect means the provision of medical services in hospitals and the rate at which the states were able to expand on other health services".

community, it did little to restructure the primary care sector to serve as a comprehensive and organised alternative to the public hospital system.

4.5 INCENTIVES

According to the case study analytical framework, the offering of incentives can suggest a top-down approach. The earlier discussion confirms that the States successfully coerced the Commonwealth into offering an open-ended 50/50 cost sharing agreement that would not be offset, in order to secure their participation in the grant arrangement. While the financial incentives did entice the States to sign up, the evidence confirms it was the States who brought about the highly generous 50-50 funding deal, through their shrewd bargaining. This contribution was well ahead of the 33 per cent share they originally discussed. Thus a bottom-up governance approach is indicated.

4.6 ENFORCEMENT

The earlier discussion on goal clarity confirmed that the Hospital Agreement required Commonwealth involvement in three areas of State decision making, these being three potential areas for future Commonwealth enforcement: 1) private patient accommodation fee setting; 2) medical wage setting; and 3) significant additions to the scope of hospital services. The Agreement also provided for regular State financial and statistical reporting. Being dismissed just months after the Hospital Agreements were signed, however, the Whitlam government did not have the opportunity to enforce or potentially exploit the policy making space it had gained through these conditions. The considerable leverage made available was certainly utilised to great effect by the Fraser government that followed. The absence of enforcement at this stage suggests a bottom-up governance approach.

4.7 LOCAL DISCRETION

As discussed earlier, the Hospital Agreements left the States with considerable policy autonomy over operational matters such as bed numbers, hospital planning and location, and discharge practices. This section explores this autonomy in greater depth, to better understand the effect of the Hospital Agreement on day-to-day service delivery. The primary sources used for this analysis are: 1) a national inquiry conducted into the Efficiency and Administration of Hospitals²⁴ (Jamison 1981) commissioned by the

²⁴ The Inquiry was aimed at identifying strategies for cost constraint and improvement of efficiency in public hospitals. The Terms of Reference for the Inquiry included: "factors behind the costs and escalation of costs of hospitals and associated or related institutions and services"; and the "effectiveness of machinery for determining objectives, policy and resource allocation in hospitals and associated or related institutions and services".

subsequent Fraser government, in conjunction with the State governments; and 2) a State inquiry conducted into the Financial Management of the SA Hospitals Department²⁵ (Parliament of South Australia 1979). Given their timing, the two Inquiries provide a reliable insight into the local governance environment that prevailed during the implementation of the Agreements. Key findings are discussed thematically below.

4.7.1 Strategic policy setting

An important observation made by the Jamison Inquiry (1981: 33-34) is that it was the public hospitals, rather than the State governments, that absorbed the strategic policy making discretion left by the Commonwealth in this first iteration of the Hospital Agreements. According to the Inquiry, due to the vague and incomplete policy setting by both Commonwealth and State governments, policy setting powers came to be dominated by the public hospital system (local level bureaucrats and professionals) by default:

It has been argued that the pursuit of objectives at the services delivery level, particularly by administrators and doctors, and the ever-rising expectations of the public, have led to inaction by governments and their departments in setting clear objectives and policy.

A key reason for the State government policy vacuum appears to have been information asymmetry and under-developed analytical capacity. While the State governments are acknowledged to have “substantial administrative and financial control ... [over the] size and range of services provided by public hospitals including the control of beds and equipment”, the Inquiry found them to be ill-equipped in policy making: “because of a lack of appropriate information on which to base policy advice and decisions or to evaluate them ... unfortunately analysis of the relative costs and benefits of policy decisions is not well developed in the health area”. A further barrier for some State governments was the heavily decentralised governance structures that made it difficult to reconcile competing policy objectives. For example the SA Health Commission (as cited in Jamison 1981: 64) confirmed its struggle to “stand between Governments and those providing services (to) attempt to define service objectives for a State; at the same time as recognising professional and public constraints and expectations”. The choice between centralised or decentralised management structures inherently involves performance trade-offs. While decentralisation has been pursued as a more efficient operational structure (Parliament of South Australia 1979: 110), the ‘let the managers manage’ approach appears to have stifled policy coordination capacity.

²⁵ The Inquiry was conducted between 1975 and 1979, with the aim of investigating causes for “repeated criticisms appearing in the Auditor-General’s Annual Report to Parliament” (Parliament of South Australia 1979: 172).

The most effective policy lever seems to have been State governments' control over the public purse. Through the budget process, the States could potentially contain the operational autonomy of hospital bureaucrats and professionals by limiting the availability of, and enhancing the competitiveness of, public funding. The Inquiry (1981: 45) noted that "at the State level, the administrative machinery for allocating funding available lies with State Treasuries. The final amount allocated...is influenced partly ... by the State health authorities' capacity to negotiate with State Treasuries for untied funds from State resources". Hence the policy making discretion of local hospital bureaucrats and professionals was subject to the ability of the State Health Minister to bargain with, and navigate through, State level opposition from Cabinet colleagues, central agencies and parliamentary scrutiny. In this regard, 'political influence' seems to have been highly important, particularly in the absence of objective evidence on the costs and benefits of particular funding initiatives. Queensland, for example, confirmed that policy decisions mostly depended on "the competing levels of influence of administrators, medical and nursing staff over their 'political masters'" (1981: 375-6).

While the State governments had capacity to constrain their health budgets, rigorous tightening of health budgets came only during the subsequent Fraser era, after the Commonwealth imposed its own funding caps. During the Whitlam government, the Inquiry (1981: 24-5) notes that both hospital boards and administrators "took little positive action to exercise control" with the generous funding arrangements offering "the hospital sector substantial protection against inflation and largely (overcoming) the problem of financing ... increases in salaries". In fact, the Inquiry (1981: 112) asserts that the open-ended nature of the Hospital Agreement funding formula led to the State governments substituting Commonwealth funding for their own.

4.7.2 Operational policy setting

Similar to the experience with strategic policy setting, the Jamison Inquiry (1981: 28, 57) found that it was the public hospitals and not the State governments, that dominated decision-making around operational policy. The Inquiry observed that public hospitals held "considerable authority" over growth in numbers of staff, adoption of new medical technologies, and expansion of facilities, to the extent that with the significant injection of new funding²⁶, "some hospitals were out of control". Further the Inquiry (Jamison 1981: 347) noted significant variations between States in: "the objectives and scope of legislative

²⁶ For example, the annual operating costs of public hospitals in South Australia increased from \$58.2 million in 1973 to \$226.9 million in 1978 – a rise of "290 per cent over five years" (Parliament of South Australia 1979: 15).

control” and regulations; governance structures and “centralised or decentralised decision making”; and “costs, bed provision and utilisation”. Significant variations were observed in SA hospitals’ policies on the issuing of drugs upon discharge or in outpatient services (Parliament of South Australia 1979: 19). In terms of the rationalisation of medical technologies, the Inquiry (1981: 246) observed that while the State governments had the power to control the adoption and expansion of medical technology, “unfortunately political and community pressures, through such means as fund raising appeals for special units, often override bureaucratic controls”. This evidence suggests a significant level of local autonomy over the use of the Hospital Agreement funding.

In terms of medical practice, the Inquiry’s findings again confirm substantial local policy discretion. One policy area investigated was the average length of patient stay. The Inquiry observed marked differences in length of stays between hospitals and between doctors treating the same patient mix and conditions. Some of these variations were attributed to differences in the availability of post-hospital care, but much variation was also dependent on the extent of discharge planning and performance monitoring of doctors that hospitals chose to undertake, these being matters of operation that remained inaccessible to both State and Commonwealth governments (1981: 546). The Inquiry also found that public hospitals were able to use their extensive discretion to circumvent specific policy controls established by the Hospital Agreements. A study of hospital admissions in Western Australia (Opit and Hobbs as quoted in 1981: 478-82, 542) reveals that hospital doctors adapted their practices to overcome operational constraints arising from the Commonwealth’s policy conditions. The study observed a marked increase in short stays between 1972 and 1977, a trend also apparent in NSW, a tactic adopted it would appear to supplement private revenues:

Although the patient may spend less than 24 hours in hospital, the claim on the health fund is for an overnight stay. Along with the provisions in the hospital cost sharing agreement which do not allow practitioners to charge patients for services received in outpatient departments, this is believed to have contributed to the increased frequency (50 per cent) in short stay admissions.

Additionally, the Inquiry found that in terms of hospital configuration and role delineation, local hospital bureaucrats and professionals were the primary policy setters. The Inquiry (Jamison 1981: 533-4) noted it could not:

obtain an adequate explanation for the emerging concentration and utilisation of resources in teaching hospitals...the excellence of these institutions is not in question rather the validity of utilising the most expensive facilities on patients who may well be treated elsewhere is a matter of concern ... some 50 teaching hospitals out of a total of 790..public hospitals consumed 49 per cent of expenditures in 1978/79 while providing 37 per cent of occupied bed days.

For example, WA data between 1970 and 1979 shows there to have been a consistently higher than national average concentration of expenditure in teaching hospitals and a

lower than national average concentration of expenditure in the non-teaching hospitals (Jamison 1981: 118). In addition to these unexplained disparities in resource allocation between teaching and non-teaching hospitals, the Inquiry (1981: 118) also observed marked inequities in the geographical distribution of hospital funding, bearing no relationship with population or demographic variations between regions.

The Commonwealth's universal health care goal, established in an opportunistic manner to bring the States on board, coupled with States' own inability to prescribe more detailed policy guidelines, fostered a governance environment that was dominated by the public hospitals. This was no doubt a most undesirable implementation context particularly when considering the significant funding injected at the time and the hospital system's propensity to grow. Considerable cost variations between the States (after allowing for structural and demographic differences) were observed by the Inquiry (1981: 535) This is further substantiation that the Commonwealth had little or no real influence or control over the degree of State efficiency in utilising Hospital Agreement funding.

4.7.3 Service mix

One area where the Commonwealth did hold the upper hand was in determining the overall mix of health services available. The Jamison Inquiry (1981: 45) observed the diminished flexibility of states to "allocate funds between different types of health services and to different areas". This is asserted to be the result of the "extensive involvement of the Commonwealth, not only in providing the money but also in regulating the way it is spent". This finding confirms the earlier discussions under Goal Setting and Goal Congruence that while the Hospital Agreements allowed for considerable bottom-up policy making by the States, the scope of State freedom was in fact mainly limited to the public hospital sector. The Commonwealth, because of its fiscal supremacy and extensive use of S 51(xxiii) powers, came to dominate policy decision making over the *overall* mix of health services available in any State, including the quantum of hospital, aged care and community health services.

4.7.4 Staffing

It was established earlier that the Hospital Agreements provided the Commonwealth with a capacity to exert policy influence over doctor wage setting negotiations. At that point in time, however, policy decisions over hospital staffing configuration and workforce size seem to have rested firmly with the public hospitals. The Jamison Inquiry (1981: 52) cited evidence that "there is no general agreement in Australia over optimal staffing patterns,

mixes and organisation in hospitals. For the most part, these have developed on the basis of local experience, and hence vary widely, even between hospitals of similar size and service". A study of manpower changes between 1971 and 1977 in WA (similar to trends in other States) revealed a 27.8 per cent increase in hospital workforce, including 51.6 per cent growth in administrative and clerical staff; 79.3 per cent growth in salaried medical staff; and 125 per cent growth in sessional medical staff (Schapper and Hobbs as quoted in Jamison 1981: 378).

In SA, an increase of 6,336 full time equivalents or 159 per cent was observed in metropolitan general hospitals between 1967 and 1978, during which time there was a 28 per cent increase in average daily in-patients (Parliament of South Australia 1979: 6). The Inquiry noted there was no transparency around the drivers for staff growth, for example, no clear evidence on the extent to which the growth was attributable to greater case complexity or whether the rise in hospital staff had been accompanied by productivity increases. It was noted that while the interstate variations on staffing mix may not be inappropriate in itself, "there appears to be no real understanding as to why they exist. They appear to be historical rather than the result of conscious implementation of policy" (1981: 214-15). Apart from the capacity to cap the budgets of public hospitals, the minimal influence of the Commonwealth and State governments in policy making around workforce mix, is plainly evident. The impression gained is that staffing policy was more the outcome of a series of potentially *ad hoc* and disjointed operational decisions, as opposed to a strategic policy and planning process.

Even in terms of the policy capacity gained through the doctor remuneration goal of the Hospital Agreements, it seems the Commonwealth stood on shaky ground, the Inquiry finding that there was little monitoring or uniformity in doctor remuneration arrangements following the implementation of the Agreements (1981: 420). It was noted that: "within the public hospitals about half are treated by private practitioners, although this varies across States and across hospitals of different size and function". In SA, it would appear that rights of private practice "were not being enforced, did not provide control over the extent of such practice and could result in the provision of additional resources above needs" (Parliament of South Australia 1979: 10). With a large part of the medical wage negotiations taking place only after the Agreements were signed, and its premature removal from office, the Whitlam government had little opportunity to influence the remuneration and working conditions of the Visiting Medical Officer (VMO) workforce which replaced the honorary system. The Inquiry (1981: 427-30) noted that VMO contracts varied from State to State,

constituting around one third of all medical officer payments in Australia by 1979–80 (Jamison 1981: 28). One must acknowledge, however, that as discussed earlier at Goal Congruence, the States had expressed interest in establishing national wage setting machinery to gain greater control over medical wages growth; however, this appears to have dropped from the policy agenda once the Fraser government took office.

The absence of Commonwealth enforcement or monitoring of doctors' remuneration arrangements immediately following implementation of the Agreements also had another unexpected flow on impact. The Inquiry observed that often remuneration arrangements negotiated with medical staff provided for the partial retention of private patient revenues in a 'private practice trust fund'. Over time, these funds evolved into an important means for public hospitals and doctors to circumvent budgetary or policy constraints imposed by both Commonwealth and State governments. For example the Inquiry (1981: 454-5) observed in respect to claimed shortfalls in Commonwealth and State funding of hospital infrastructure:

Many hospitals have been using money ... from the private practice trust funds ... the major equipment problem is being overcome in a somewhat backhand way by using funds that are not provided and not controlled by the State health authorities. Hospitals which utilise this system have expressed great concern over the continuing provision of funds should private practice trust funds be stopped ... nonetheless under the present arrangement, a substantial transfer of costs is taking place, with a net increase in the Commonwealth contribution, through medical benefits, and a net reduction, through revenue obtained, of State payment. There is no evidence that the transfer has either reduced overall costs or that it has the potential for doing so. On the contrary, it may well have increased costs in the past and may do so in the future.

The Whitlam government's apparent 'control' over remuneration policy settings was most definitely not water tight. These findings confirm there was ample room available for the hospitals to manoeuvre their way around the policy barriers — particularly with the Commonwealth's information asymmetries and there being no formal post-implementation follow-up by the Fraser government.

4.7.5 Bed numbers

Bed numbers were another policy matter predominantly determined by the public hospitals. The Inquiry noted (1981: 226) significant variations between the State governments in terms of their legislative control over bed numbers. Other than NSW and Victoria, states had no legislative levers to control bed numbers and equipment on the basis of 'need'. Further, the Commonwealth Department of Health confirmed (1981: 225):

States have considerable discretion about the level and distribution of beds and services. Much of the health facilities in the States has developed in response to ad hoc initiatives taken by semi-independent boards of management, voluntary organisations and private entrepreneurs 'rather than as a means of achieving explicit objectives about the appropriate size and configuration of the health care delivery system.

Victoria confirmed that historically, its bed numbers and distribution were shaped by electoral and political pressures (Jamison 1981: 236). The Inquiry recognised that bed numbers were in need of further rationalisation (1981: 227). The over-supply of hospital beds in Australia was also noted by the Commonwealth's HHSC (1974: 34-5), however the Whitlam government did not secure any major foothold in this policy matter.²⁷

4.7.6 Local discretion — Overall evaluation

According to the case study analytical framework, a greater level of local discretion is indicative of a bottom-up governance approach. The overarching impression gained from the preceding analysis is one of significant local discretion, in particular at the public hospital level. The only exception to this is in the area of service mix, where the Commonwealth's emphasis on universal hospital care restrained State flexibility in terms of expanding community access to other lower-cost forms of health care. Apart from this broader health system constraint, within the public hospitals, in spite of the imposition of national goals by the Commonwealth, ultimately it was the hospital administrators and professionals who were the key decision makers over resource allocation and service rationing.

With no public transparency or accountability behind such decision making, Commonwealth 'policing' of compliance with national goals was highly challenging, if not impossible. Within a governance environment of this nature, it is not unreasonable that the channelling of significant new funding in an open-ended manner as provided for by the Hospital Agreements increased the potential for unjustifiable growth in the hospital system and unchecked inefficiencies. Notwithstanding the merits of the universal hospital care and salaried and sessional doctor remuneration goals, the Commonwealth simply did not have sufficient understanding of, or the capacity to control, the potential operational 'loopholes' the public hospitals would find. The intimate level of operational knowledge that was required was held by the State governments either; however, their superior access to the hospital systems, legislatively and physically, did place them in a more influential position than the Commonwealth.

²⁷ The Commission reported that Australia's beds per 1,000 population ratio of 6.1 in 1971 as being "relatively high" compared to other countries, although noting that "perhaps the increased provision (was) originally considered necessary for a country with low population densities and long travel time". The Commission additionally pointed out the need for improvement in bed occupancy rates, cited as 71 per cent in 1973 compared to the close to 80 per cent rates being achieved by many countries.

4.8 STATE GOVERNANCE BARRIERS

The case study framework suggests that the presence of significant state governance barriers can prevent or stall Commonwealth influence and effective implementation of national goals.

The implementation of the Hospital Agreements took place within a State delivery context that was burdened with a range of systemic flaws in — planning and evaluation; financial management; and other operational machinery. The Jamison Inquiry confirmed that “much of what it saw” in terms of governance, efficiency and accountability “in hospitals of all sizes in all States was unimpressive”. It is also suggested that “responsibility for this sorry state of affairs is not due solely to the individual hospital administrators in as much as the Commonwealth and State health departments are woefully lax in their controls to ensure efficiency in the disbursement of taxpayer monies” (Jamison 1981: 69).²⁸ Key findings on state governance barriers are outlined below — as in section 4.9, the analysis is organised thematically and based on evidence from the Jamison Inquiry and South Australia Public Accounts Committee (1981; 1979). It is worth noting that the HHSC (1974) highlighted many of these governance barriers in its early assessment of State systems, hence the Commonwealth was well aware of them prior to commencing negotiations.

4.8.1 Policy setting machinery

Given that the Hospital Agreements were a funding and policy partnership between the State and Commonwealth governments, any weakness on the part of the States in terms of their capacity to coordinate and direct the implementation process represents a major barrier to top-down policy control. We have already established that the public hospitals (as opposed to the State governments) assumed primary policy setting control of the implementation of Hospital Agreement goals.²⁹ At the time, hospital policy making was a complicated affair, involving a hierarchy of structures, approval processes and competing interests between — hospital staff and executive; the Board and hospital executive; the Board and the central office; and finally the central office and State government central agencies (Jamison 1981: 64). The end design and outcomes of the 1975 Hospital Agreement were ultimately dependent on a multitude of every-day choices made over resource

²⁸ The Inquiry did recognise that some of the managerial shortcomings in planning, information systems, financial management and performance monitoring were not unique to Australia they were in fact an evolving discipline in public health systems across the world at that time (Jamison 1981: 242). The SA Public Accounts Committee also noted that some of the shortcomings were a common trend throughout the public service at the time (Parliament of South Australia 1979: 13).

²⁹ The Inquiry commented that “objectives in the health services have most often been determined at hospital or service level, often by default, rather than deliberately or explicitly...this has permitted costs to increase without appropriate responses from governments (Jamison 1981: 33).

allocation and service prioritisation by hospital administrators and clinical professionals. The lack of uniformity in State hospitals' legislative and regulatory framework also created wide variations in operations, a further barrier to the consistent implementation of Commonwealth policy goals (Jamison 1981: 45).

4.8.2 Planning and evaluation machinery

The Jamison Inquiry observed that:

- States lacked a robust strategic planning framework to facilitate the development and communication of objectives, policies and activities, and the regular monitoring and public reporting of results. It was noted that States actually undertook very little detailed planning of hospital services. In addition, there was a dearth of data on health needs and no planning guidelines or service standards issued. The Inquiry was advised that “political reasons” were often the reason for “many facilities (being) located where they were” and the number of speciality units (Jamison 1981: 34, 56, 61; Parliament of South Australia 1979: 5).
- Commonwealth–State machinery for the rationalisation and evaluation of medical equipment was in its “infancy”, this governance shortcoming permitting “remarkable growth in technology and equipment”. The duplication and overprovision of technology is asserted to have compounded cost pressures and reduced productivity. Evidence is cited on one particular medical technology first adopted in 1968, with clinical tests growing from 320,000 in 1968 to 1,750,000 in 1977. It appears that clinicians had little information on the costs of these tests, with one teaching hospital declaring “because we can do more tests, we find no reason not to do them” (Jamison 1981: 28, 57).
- Little medical and nursing workforce planning occurred with quality workforce data also scarce. The Inquiry noted an apparent “oversupply of doctors in Australia” which in turn brought the risk of supplier-induced demand “with no guarantee of improvements in health status”. It is asserted that between 1972 and 1980, medical training posts grew by 75.4 per cent, staff positions increased by 97 per cent and staff specialists by 196.3 per cent. On the issue of staffing generally, the Inquiry was surprised to find that despite salary costs consuming around 70 per cent of hospital budgets, “little attention” was given to the size and distribution of health workforce, staff productivity, staffing configuration variations between facilities, and ongoing training needs. There were no “regular reviews of total staff establishments in hospitals” and no monitoring and control of the rights of medical private practice (Jamison 1981: 52, 75, 79, 120; Parliament of South Australia 1979: 9). Additionally it was noted that the health

workforce had diversified considerably in the preceding thirty years, increasing the different types of workforce from 12 or so to more than 100. This phenomena had created diseconomies of scale and a highly fragmented workforce (Jamison 1981: 374). Such fragmentation and siloed work practices existed too between hospital professionals and administrators, making it very difficult to coordinate and plan hospital workforce needs (Jamison 1981: 356, 74).

- Little regular monitoring of hospital utilisation, predominantly due to inadequate information systems and management expertise, which stifled State capacity to reduce the “unnecessary use of services ... and lengths of stay” (Jamison 1981: 62-3, 83-4). The States seem to have been well aware of these shortcomings. A NSW government paper from the 1973 Health Ministers’ Conference called for the establishment of “an Australian system of hospital utilisation review”, to contain “the insatiable demands from hospitals” that threatened the allocation of resources for “preventative, ambulatory and domiciliary care” (WA Govt 1973: 13). Even the Commonwealth’s HHSC (1974: 79) noted the risks of over-utilisation from open-ended availability of hospital services:

In the absence of a deliberate system of utilisation reviews...where hospital care is as completely insured as other services, the pattern of provision may be distorted towards the use of expensive in-patient care even when less expensive ambulatory services would be as effective...because specialist care may be as well insured as that provided by general practitioners, the use of services can be distorted towards specialists ... people are now willing to pay higher prices for the same levels of service, and are able and eager to obtain the more expensive medical and hospital services. Hospitals are responding to increasing demands and the willingness to pay for sophisticated services by supplying them.

4.8.3 Financial management and operational machinery

The Inquiry observed that:

- Resource allocation processes used by the States were driven by historical patterns of expenditure, and were therefore unresponsive to changing health needs across regions. While the Commonwealth’s primary objective with the Hospital Agreements had been to enhance equity in access to hospital services, the Inquiry observed that the outcome was such that “inequities are still obvious in the uneven geographical distribution of health services ... which cannot be fully explained by differences in the characteristics of the population and the pattern of service provision (Jamison 1981: 44-5). It would appear that inadequacies in State financial and performance management systems as well as a lack of information on health needs, prevented the effective allocation of Hospital Agreement funding, and stifled subsequent monitoring of results.

- Hospital budgeting processes were “cumbersome and time-consuming”, inflexible, cash-based and serving more as a vehicle to request or allocate finance, as opposed to facilitating efficiencies and cost control. Hospital administrators were chided for “poor managerial control” with evidence of “ridiculous and unsubstantiated demands for additional staff, inefficient allocation of staff ... rosters deliberately organised to ensure certain employees had a guaranteed overtime component in their wages ... and reluctance to introduce measures with proven cost savings”. It was also observed that the use of historical budgeting “tends to penalise the efficient and reward the inefficient” (Jamison 1981: 63-4, 71-2). The rudimentary budgeting practices were also chastised by the SA Public Accounts Committee (Parliament of South Australia 1979: 9, 20-1).
- Hospitals were fundamentally lacking in cost accountability. The Inquiry noted “there are no agreed ways of measuring hospital output” and no comparative data to enable the benchmarking of efficiency across hospital facilities either nationally or at a State level. In addition, hospital management structures fail to provide a link between “clinical accountability ... [and] ... cost accountability ... despite the fact that clinicians play the dominant role in the provision and utilisation of health services”. It was suggested that hospital autonomy be restricted until there was sufficient cost management information to enable central offices to monitor and assure that funds were expended in an accountable and cost conscious manner. Some hospital boards were reprimanded for their “irresponsible behaviour” in allowing hospitals to overspend. The Inquiry observed that “financial efficiency has taken second place to spending in many hospitals” (Jamison 1981: 63-4, 70-1). It would seem that apart from hospital boards or administrators failing to understand hospital costs adequately, there was also resistance to such advancements within some of the hospitals. It was put to the Inquiry for example that “a true assessment and attribution of costs is the last thing anyone working in the hospital system at present wants to know. Its introduction would introduce a revolution in the present balance of power sharing in the hospital. This would have incalculable consequences” (Jamison 1981: 411-2)³⁰.
- Hospital middle management skills were considerably lacking, this being a primary cause of “communication failures between the central authority and the institutions”.

³⁰ A survey of 100 hospitals over a three year period revealed that only: 8 per cent had cost containment committees; 33 per cent assessed staff productivity; 39 per cent had financial procedure manuals; 46 per cent provided regular performance reports to departmental heads; 65 per cent involved departmental heads in budget preparation. The Inquiry found these results and the absence of basic financial controls such as asset registers and inventory records “disquieting” and an “unimpressive picture of the influence of modern management techniques on this important, and costly, area of public expenditure (Jamison 1981: 401-3).

Criticism was also directed at personnel in central offices and their “inability to understand the complexity of hospital problems”. It was further noted that often hospital board members were selected for their “political affiliation” as opposed to their “personal qualities” (Jamison 1981: 66, 69-70, 91).

- There were lengthy delays in receiving approval for capital funding and other proposed initiatives. Some purchasing systems were rated as “overly centralised”. “Control of day to day activities by central public service bodies appears to be incompatible with initiative, innovation and efficiency by hospitals and their capacity to respond to changing needs”. It would appear that central offices at the State level had a tendency to micro-manage hospital services delivery as opposed to playing a more strategic role in planning and management (Jamison 1981: 62, 72; Parliament of South Australia 1979: 5, 8, 110).

4.8.4 State governance barriers — overall evaluation

The preceding analysis clearly confirms that there were substantial governance weaknesses at the State level — particularly within the public hospitals where a predominant part of the policy making occurred. These governance shortfalls are significant and fundamental to policy implementation, and undoubtedly reduced the efficiency and effectiveness of the Commonwealth’s policy goals. The shortcomings strongly point to a bottom-up governance approach, dominated by public hospital administrators and clinical professionals.

4.9 CONCLUSIONS: BALANCE OF POWERS

The following table summarises the assessment formed against each of the analytical foci. As shown, governance of the 1975 Hospital Agreement under the Whitlam government was overwhelmingly of a bottom-up nature.

Table 4.3 Balance of Powers – Whitlam Era

Analytical Foci	Indicative Shared Governance Approach
Goal clarity	Neither top-down or bottom-up
Goal setting	Bottom-up
Goal congruence	Top-down
Incentives	Bottom-up
Enforcement	Bottom-up
Local discretion	Bottom-up
State governance barriers	Bottom-up
OVERALL ASSESSMENT	BOTTOM-UP

On goal clarity, the Commonwealth was prescriptively attached to its universal hospital care goal and inhibited the fostering of a more community based health policy agenda. Nonetheless, due to information asymmetries and resistance from both Commonwealth and State policy actors, the Commonwealth was forced to accept a broad policy goal which provided considerable policy space for State level policy setters. Similarly, with the doctors' remuneration goal, the Commonwealth attempted, but did not achieve a uniform level of policy prescription across all hospitals, with the States successfully negotiating for flexibility in remuneration contracts at non-teaching and rural hospital sites. Hence goal clarity is rated as neither top-down or bottom-up dominated.

The analysis of goal setting revealed that the Commonwealth was compelled to make a range of costly policy concessions at both federal and State levels, before its national goals were accepted. This was primarily due to the Agreements being a first iteration, and the Commonwealth's haste in wanting to ensure its long-held idealistic ambitions for a national health scheme could be realised. The enormous financial concessions granted, and the unprecedented level of risk the Commonwealth faced within its own jurisdiction in order to overcome obstacles from the Senate and the bureaucracy, heavily sways the assessment of goal setting towards a bottom-up approach. On goal congruence, while there was policy alignment on the doctors' remuneration goal, in view of the long-term structural effects of the Commonwealth's unilateral approach on universal hospital care, the assessment was of a top-down approach.

Finally, as the Agreements were implemented, the policy and governance control increasingly swung towards the States. The extremely generous funding base extracted by the States' firm bargaining stance; the lack of federal enforcement and monitoring of national goals; and the massive scope allowed for local policy making and discretion placed policy control firmly in the hands of the States. Policy control was in fact held at the lowest level of the system, by the public hospitals and administrators, with information asymmetries and under-developed analytical capacity preventing state central offices from prescribing policy in any great detail. Further, the fundamental shortcomings that existed in the State hospital systems at the time, served to compromise the efficiency and effectiveness of goal implementation. Bottom-up governance is thus the dominating theme apparent — from an incentives; local discretion; enforcement; and state governance barriers perspective.

In conclusion, the Commonwealth managed to dominate only the ‘policy setting’ around the universal hospital care goal, with the States dominating when it came to ‘policy implementation’. On the doctors’ remuneration goal, as this was a goal equally desired by the Commonwealth and the States, control over policy setting and policy implementation was weighed towards the States and the medical profession. The proposition of a bottom-up governance arrangement does stand in marked contrast to the more prevalent view of the Whitlam government as heavily centralising. The nuances revealed by this case study show that as open-ended as the section 96 power may be, the policy reach of Commonwealth can be inherently constrained by both constitutional and practical realities. The Whitlam government simply could not negotiate a position that would allow it to intervene directly in State service delivery activities.

The Whitlam government’s pathway to the Hospital Agreements was fraught with challenges at both the federal and State levels. Whilst the Commonwealth managed to secure State government participation, this did not automatically lead to top-down policy control as hospital policy making was heavily fragmented and decentralised at State level. The fragmentation of policy making powers worked favourably in allowing the Commonwealth and State governments to overcome political resistance to their jointly shared doctors’ remuneration goal. However, in terms of the universal hospital policy goal, the combination of fragmented policy making, State governance weaknesses, and the failure of the Commonwealth to foster a more integrated and holistic health service policy approach, brought substantial inefficiency and ineffectiveness into the implementation process, ultimately compromising the end outcomes of the Commonwealth’s policy initiative. Importantly, the Commonwealth was also unable to monitor or influence the extensive policy making that occurred post-Agreement, due to its removal from office shortly after the last Agreements were signed.

4.10 REFLECTIONS ON TIED GRANT PERFORMANCE

A number of vital reflections on the performance of tied grants can be drawn from this case study analysis. These reflections are outlined below and will be further discussed and refined in the case studies that follow, and consolidated in Chapter 8.

4.10.1 Performance advantages of tied grants

This case study confirms that the tied grant can enhance managerial efficiency where a grant goal is congruent with State policy preferences and by nature is subject to political resistance. Shared and collaborative governance was a critical factor in enabling both

Commonwealth and State policy makers to overcome professional interest group opposition to the salaried and sessional doctor remuneration goal. The Commonwealth, with its fiscal superiority, can thus play a crucial role through tied grants, in assisting States to overcome local political barriers that impede worthy policy reforms. This is particularly relevant in the health sector and other policy areas characterised by considerable interest group pressures.

4.10.2 Performance deficiencies of tied grants

Two performance deficiencies are apparent when the Commonwealth adopts a coercive and unilateral approach to the establishment of tied grant goals.

Policy bias towards the larger states

In its aggressive pursuit of universal hospital care, the Commonwealth appears to have been predominantly driven by health access issues in the more populous States of NSW and Victoria. According to Sax (1984: 102), Whitlam “representing a [health facility] deprived electorate, was ... aware of the grass-roots pressure for change in the outer suburbs of both Sydney and Melbourne. If the Labor Party was to succeed at the 1972 general election, these areas had to be won and policies were designed to remedy the obvious deficiencies”. A sweeping national approach can thus lead to the prioritisation of the needs of the more populous States at the expense of needs and nuances of smaller States.

Tendency for sub-optimal policy solutions

As discussed earlier in this chapter, De Voe (2003) argues that the Whitlam government’s focus on the universal hospital care goal led to the marginalisation of an alternative community health-based policy solution. She further suggests that the tied grant’s policy bias was a deliberate and strategic choice by the Commonwealth, aimed at increasing implementation certainty in the face of anticipated goal resistance from the medical profession and States. In seeking to understand the performance effects of tied grant, these propositions are worthy of further examination.

Certainly, there is clear evidence of the professional and State resistance foreseen by the Commonwealth. The politics around community health is observed to be a complex affair (Milio 1984, 1986), with implementation resistance varying across jurisdictions. Palmer (1979: 121) claims that compared to other States, implementation barriers were lower in Victoria and SA: “by 30 June 1975 ... [of the] ... 48 main community health centres providing primary medical care (that) had been established in Australia ... 20 were in Victoria and 12 were in South Australia”. Interestingly, he also notes that the progress made in Victoria was

little due to State efforts, with the “majority of centres ... established by community groups” (G.R. Palmer 1979: 121).

In terms of State resistance, despite their firm interest in community health based solutions it is noteworthy that there was no automatic embracement of the Whitlam government’s community health initiatives. Scotton and Macdonald (1993: 188) recall the introduction of a Bill by the Victorian government that allowed the State government to dismiss “State employed doctors and hospital administrators if they took part in Commonwealth programs not approved by the Victorian government”. The NSW and Queensland governments are also suggested to have obstructed payment of community health grants or hampered the establishment of comprehensive community health services (Galligan et al. 1991: 344).

Notwithstanding professional and state resistance however, one cannot overlook the significant opportunity available to the Commonwealth at the time, to facilitate a more integrated and efficient health system, particularly with the massive amount of new funding that was injected. Duckett (1984: 960-1) recalls that:

The community health program had great potential and could have become a major instrument to change the organisation and orientation of the health delivery system. [Citing two successful implementation examples in Victoria and NSW, he notes] that the potential for a more responsive, more egalitarian and, indeed, more efficient health system was present.

Rather than opting to dominate the policy setting process, the Commonwealth could have chosen to work more cooperatively with the States to foster their preferences for community health solutions. Undoubtedly the community health pathway would have been fraught with more political difficulties and a lengthier implementation timeframe, given the policy was at an embryonic stage and, just like the hospital policy, open to vigorous interest group resistance from the AMA (Milio 1986). However, a collaborative and more paced Commonwealth role that was supportive, rather than overstepping, of State policy setting processes would have enabled a more sustainable community health policy framework to be cultivated.

Palmer and Short (2000: 121-7, 337) assert that community health services differ markedly between States — these variations arising largely “from the “administrative arrangements and political relationships that existed at the time the program was introduced in the early 1970s” (G. R. Palmer and Short 2000: 337). Additionally, they argue that the Commonwealth has played an inadequate role in enabling States to overcome the funding, administrative and political barriers that have prevented the community health concept from evolving. Their finding of stalled and deformed development, three decades on, vindicates the proposition that Whitlam’s public hospital-centred policy goal, carried on by

subsequent federal governments, brought sustained structural damage to health policy and planning processes. The Jamison Inquiry (1981: 39, 112) confirmed that the public hospital tied grant “perpetuated rather than solved” structural problems evident in the Australian health care system, such that the “dominance of the hospital sector was increased and has been maintained ever since”. Use of a tied grant to secure a dominating Commonwealth policy influence, against State goal preferences, can thus lead to the implementation of sub-optimal policy solutions and reduced managerial efficiency and innovation.

Convoluting policy compromises

As discussed at section 4.9, the Whitlam government was compelled to offer generous financial and policy concessions in order to have its universal hospital care goal accepted. These concessions brought long lasting and detrimental effects to local managerial efficiency.

Having examined the initial establishment of this tied grant arrangement, the next Chapter moves to the Fraser era to assess how the grant evolved after the dismissal of the Whitlam government, and further validate the policy and performance findings of this case study.

5 THE FRASER ERA — ASCENDANCY AND INTRUSION

5.1 OVERVIEW

The Fraser era was characterised by unilateral goal shifts and aggressive intervention into hospital operations. Following the tumultuous years of the Whitlam government, which saw the implementation of universal hospital care, the Fraser government embarked on a progressive downsizing of this national goal, a journey that concluded with complete abandonment of the goal by 1982. Between 1976 and 1981, there was also considerable tightening of goal clarity and enforcement, as the Commonwealth's policy focus shifted from national equity and expansion of public goods (access to hospital care) to macroeconomic stabilisation. Under the Whitlam government, the Commonwealth's time and energy had been devoted to winning the acceptance of policy stakeholders at federal and State levels. The States' resistance to the Commonwealth's goals allowed them to gain significant financial concessions and retain considerable local discretion. During the Fraser era, these negotiated gains were systematically clawed back by the Commonwealth, with the open ended 50–50 cost sharing evolving into capped funding by 30 June 1981. The Commonwealth also used its tied grant levers to intrude more deeply into hospital policy setting decisions; define the scope of services in greater detail; and attempt to overcome the governance shortcomings that the Whitlam government had ignored in its haste to get all the States on board.

5.2 GOAL CLARITY

5.2.1 Goal clarity — Analysis

Unlike its predecessor, the Fraser government entered office facing a bleak economic outlook, including a federal budget deficit and inflationary pressures. With Commonwealth eyes firmly focussed on scaling back public sector expenditure, the revamping of the Medibank program became a crucial element of economic and fiscal policy. The Fraser government's preference was to discard the universal hospital goal altogether, however the electoral backlash would have been too great. Uncertainty over the future of Medibank sparked by wayward comments from Shadow Minister Chipp in September 1975 whilst the Liberal Party was in Opposition, were quickly repudiated by Mr Fraser who, unlike his predecessor Mr Sneddon, had come to acknowledge "that Medibank was a reality" which had to be dealt with (WA Govt 1975-76b: 162-4). Politically unable to abandon the universal hospital goal in the short term, the Fraser government resorted to implementing

phased adjustments to the Medibank program, including an increasing of goal clarity in its dealings with the States, as mechanisms to bring the Commonwealth's funding contribution under better control. The desired tightening of goal clarity was facilitated both by the nebulous nature of the universal hospital goal, and the policy intervention capacity that had been agreed to during the negotiation of the 1975 Hospital Agreement (but largely unused by the Whitlam government).

In January 1976, two months after assuming office, a value-for-money review of Medibank was announced by the Fraser government, with the terms of reference firmly centred on the assessment of "cost and efficiency factors" (WA Govt 1975-76b: 108, 12-3). Acutely aware of electoral sensitivity, the Commonwealth went about carefully building an argument that universal coverage was being provided at an exorbitant price. Justifying the first of a series of modifications to Medibank, the Health Minister argued that Commonwealth share of health funding had grown from:

55 per cent in 1972/73 to an estimated 73 per cent in 1975/76. Not only had the Commonwealth share grown quickly, but the actual amounts of expenditure had risen, by about 1000 per cent, from \$260 million in 1963/64 to an estimated \$2500 million in 1975/76 (the Medibank share being approximately \$1400 million in this latter year). At the same time, State expenditure has risen from \$201 million to \$950 million, and private expenditure from \$418 million to \$1200 million...The largest proportion of total expenditure...54 per cent ... goes on public and private institutional care (WA Govt 1975-76b: 82-92).

The statistics are certainly staggering and no doubt offered a convincing basis for the desired policy re-think on universal care. However, the cited state of affairs was in fact due to a much more complex range of causes — some simply the result of the tumultuous bargaining of the 1975 Agreement and others unavoidable or circumstantial:

- inflationary pressures sweeping not just health services, but the entire economy, flowing on from global events of the time;
- the cost of transitioning from an honorary to fully paid medical workforce;
- industrial relations changes in the 1970s which gave greater wage parity to female workers and workers aged 18 years, affecting in particular the cost of the nursing workforce;
- the generous fee schedule changes negotiated by the medical profession around the time of Medibank implementation;
- the expansive scope of hospital costs being shared by the Commonwealth such as the inclusion of ambulance costs into the 50-50 cost sharing arrangements;
- increases in the size of the public hospital medical workforce; and
- weaknesses in hospital governance as discussed in Chapter 4.

The first three of these factors, are likely to have affected health service expenditures in some manner, regardless of Medibank, whilst (4) and (5) could be viewed as part of the negotiating 'price' paid for the introduction of Medibank. In particular, rises in medical fees were not at all a new phenomenon with the Commonwealth struggling to attain control over professional fees long before the Medibank program. The sixth factor was a supply issue influenced by the Commonwealth, with the growth in workforce no doubt partly or wholly stimulated by the Commonwealth's expansionary policies. Finally, on the seventh factor, the expenditure rises accruing from this were as much attributable to the Commonwealth as to the States — given the failure of the Commonwealth to pay serious attention to these shortcomings during the introduction of the highly open ended 50–50 cost sharing arrangement. As discussed in Chapter 4, in its determination to secure State government acceptance, the Commonwealth left considerable local operational discretion in the hands of the hospital systems, doing very little to encourage more effective governance of hospital budgets and resources. Additionally, the Commonwealth's own policy bias towards expanding hospital services no doubt played a role in adding to the higher concentration of expenditure in the institutional care sector.

Acutely aware that any change to the financially generous 1975 Hospital Agreements would attract the wrath of the States, the Commonwealth adopted a veiled, but heavy-handed, approach. Whilst insisting both publicly and internally in its dealings with the States that the commitment to the universal care goal remained unchanged, little time was wasted in instigating policy changes to match the Commonwealth's realigned priorities. In mid-May 1976, as part of wider reforms to the Medibank program, the Commonwealth announced it would "seek discussions" with the States on a number of key policy changes:

- the replacement of cost sharing arrangements "with a system of block grants";
- the doubling of charges for intermediate and private ward treatment, justifying that this would bring the charges "closer into line with charges in private hospitals" and "add something to the revenue of the States";³¹
- the introduction of charges for medical services for privately insured inpatients and outpatients; and,
- replacement of daily bed payments to recognised hospitals with payments directly to the States.

³¹ Additionally, the Commonwealth argued that greater fees parity between public and private hospitals would encourage greater use of bed capacity in the private sector, thus easing pressure on the public sector.

Whilst the Commonwealth attempted to downplay the significance of the proposals, claiming it was "of course, open to any State Government to accept or reject", anxious States took a more astute view of the announcement, interpreting it as a deliberate move to reduce federal funding of universal hospital care. The NSW, Victoria, SA and Queensland governments adamantly opposed any change to the 1975 Hospital Agreements, with the Queensland government additionally objecting the Commonwealth's proposal for a 2.5 per cent Medibank levy, on the grounds that its own 'free' hospitals" had operated well before Medibank commenced (WA Govt 1975: 40-41; 1975-76b: 30-2, 72, 77-9).

No doubt the obstinate standoff by the States left the Commonwealth in a difficult predicament. The response was both swift and potent. By the end of that month, on the basis of advice from the Attorney-General that was "so clear and firm it is suggested that nobody would bother taking the matter to the High Court", the Commonwealth dramatically declared the 1975 Hospital Agreements to be legally invalid, whilst also somewhat dubiously suggesting that this new development had nothing to do with its earlier attempts to amend the cost sharing arrangements in discussion with the States. To further reinforce its position, the Commonwealth hurriedly introduced into Parliament, a *States Grants (Hospital Operating Costs) Bill 1976*, designed to provide interim cash flow payments to the States whilst the legal uncertainty was resolved. The Bill very clearly signalled the Commonwealth's intent to move away from the cost-sharing arrangements, with the Second Reading Speech confirming that payments would be made "as block grants to the States on such terms and conditions as the Treasurer determines after consultation with the Minister for Health". The Commonwealth's stance was naturally rigorously disputed by the States who had received contradicting advice from their own Crown Solicitors, and vowed to take the battle to the High Court. An irate Labor Opposition added that it had been fully aware of the "heavily qualified" legal opinion, but insisted that the legal weakness was not of such a substantial nature as to warrant the Commonwealth's present actions (WA Govt 1975-76b: 14, 30-2, 41-2, 66-8, 77-9).

A dramatic showdown between the Commonwealth and the States appeared to loom at the June 1976 Premiers Conference. The Commonwealth had publicly confirmed its view that the present basis of cost sharing "is open-ended and does not provide in the Government's view, adequate incentive for cost efficiency". The States on the other hand tenaciously defended their position that the signed Agreements were valid, with the WA Premier challenging that "it was up to the Commonwealth to demonstrate - if it could - that the State's advice was incorrect". It certainly appeared as if an enthralling and drawn-

out brawl lay ahead. Ultimately however, the outcome of the Premiers Conference was astonishingly subdued. The Commonwealth very simply announced that the Premiers had "agreed to set aside differences about the validity of the agreement ... [concurring] with the Commonwealth's calls for increases in fees ... [and] ... to proposals that would stop the open-ended nature of the present agreement". It was contended at the time that the States had somehow succumbed to the "financial lure" of additional revenues of \$75 million a year, made feasible through the Fraser government's push for a doubling of private patient fees³² and the exclusion of privately insured patients from universal care. It was also suggested that the higher patient fees would "make private hospitals more competitive, thus easing pressure on State hospital bed space". Additionally, the Commonwealth had budgeted somewhat on the future basis for funding — the Fraser government had initially pressed for payments to the States to be based on 50 per cent of a *fixed* budget for hospital costs, leaving States to carry the full risk of price fluctuations that might occur during the year. The States were, however, able to negotiate some additional flexibility, with the Commonwealth paying 50 per cent of hospital costs established on an '*agreed basis*' to be determined between Commonwealth and State officials. Although the States were aware that this compromise would necessitate the Commonwealth having a larger "say in deciding what net operating costs amount to", they gained some satisfaction in managing to leave the door open for further bargaining and discourse on the funding base (WA Govt 1975-76b: 1, 14, 27).

Negotiations between Commonwealth and State officers continued over the next few months with a view to implementing a new Agreement by October 1976. During a Health Ministers Conference in July, it was agreed that Commonwealth–State Standing Committees would be established (comprising equal numbers of Commonwealth and State officials) to meet twice-yearly. Additionally, detailed processes were developed for the formulation and review of hospital budgets as evident in a letter from the Prime Minister to all State Premiers (WA Govt 1975: 14-15):

The March meetings would aim to establish budget proposals for each State for the following financial year and would in addition consider the provision of additional requirements for substantial adjustments that have to be met during the current financial year. In addition the March meetings consider and bring forward recommendations on hospital charges ... The procedure (for determining yearly budgets) would be for the following year's budget to be based on actual net operating costs during the first half of the current year adjusted to a full year basis and further adjusted for: 1) the effects of actual and anticipated wage and price changes and fee rates during the second half of the current financial year; 2) seasonal and irregular receipts and payments; 3) actual and anticipated variations in services through the opening or closure of hospitals or units in hospitals or other extensions or contractions of services within hospitals during the second half of the current financial

³² A policy lever brought under joint Commonwealth-State control through the 1975 Hospital Agreements.

year; and 4) anticipated variations in services and changes in wage, price and fee rates during the coming financial year.

The November meetings would have two principal activities. They would review budget performances for the previous financial year and, secondly consider variations from the yearly budgets developed in March for which additional provision would need to be made in supplementary estimates.

The Commonwealth sees a need for a national standing committee to discuss broad policy issues related to the Joint Commonwealth/State examinations of hospital expenditure, including proposals to improve efficiencies and the equitable provision and rationalisation of services throughout Australia.

The above machinery represents a considerable increase in clarity in joint Commonwealth–State budget setting, in marked contrast to the "extraordinarily vaguely worded" 1975 Hospital Agreement (Aust. Government 1975; WA Govt 1975-76b: 123) which stipulated:

for the purposes of joint participation of the Governments in budget preparation, Western Australia will, from time to time as appropriate, provide to Australia, in an agreed form, estimates of operating receipts and payments for each recognised hospital and central service in the State". Clause 11.2 additionally provided that "If the actual gross operating costs of a recognised hospital exceed substantially that hospital's approved annual budget in respect of such costs, the parties may jointly authorise such investigations as are necessary to establish how the situation may be corrected (Clause 10.2).

Naturally, the States treaded cautiously in enabling closer involvement by the Commonwealth. The WA Minister for Health commented, for example: "whilst recognising that all requests from the Commonwealth for available information should be met, this State's officers endeavoured to avoid meeting possible future unreasonable Commonwealth demands for unnecessary detailed information which would be time consuming, expensive and unproductive" (WA Govt 1975: 13).

By early August, negotiations appeared to be on track, with the Commonwealth and States proceeding amicably towards a new Agreement. The WA Government was satisfied to have secured an in-principle settlement on 50–50 cost sharing, albeit with some additional Commonwealth–State machinery. In early September, however, the Commonwealth appeared to renege on its policy commitment to cost-sharing yet again when it decided to insert a "last minute" clause into the Heads of Agreement of its Health Insurance Amendment Bill (1976). The proposed amendment served to "limit the obligation of the Commonwealth to an approved budget or an approved variation of that budget". The WA Minister for Health observed that this amendment, if passed, would provide the Commonwealth with discretion to "refuse to pay any portion of ... excess expenditure which the ... [federal] Minister considers is not justified".

The wording, particularly the inclusion of a "limit", and the assignment of discretionary powers to the Commonwealth Minister (rather than the joint Commonwealth-State Standing Committee), not surprisingly raised the suspicion of the States. The Commonwealth for all intent and purposes appeared to be retreating from its more liberal

assurances at the June Premiers Conference that it "would meet 50 per cent of the cost of established (budget) variations and of the costs of escalation". An agitated WA Government requested that the "limiting clause" be withdrawn to remove any doubt that "inescapable wage and salary rises (and) increases in prices and costs" would continue to be cost-shared. The Commonwealth was immediately pacifying, however, denying there was any "question about the Commonwealth continuing to meet 50 per cent of the approved net operating costs ... [and insisting that] ... Medibank funding for hospitals ... [would not] ... be subject to arbitrary limits imposed by the Commonwealth" (WA Govt 1975: 4-5, 6-8, 14). By year end, such cajoling had resulted in all States being signed up, with Victoria being the last to commit to the new Commonwealth–State Agreement on the Provision of Hospital Services as it was known (WA Govt 1976a: 1, 7-8).

Examination of the 1976 Agreement (WA Govt 1976b: 57-96) reveals a mixed outcome for the States. The most significant features in comparison to the 1975 Agreement (Aust. Government 1975) were:

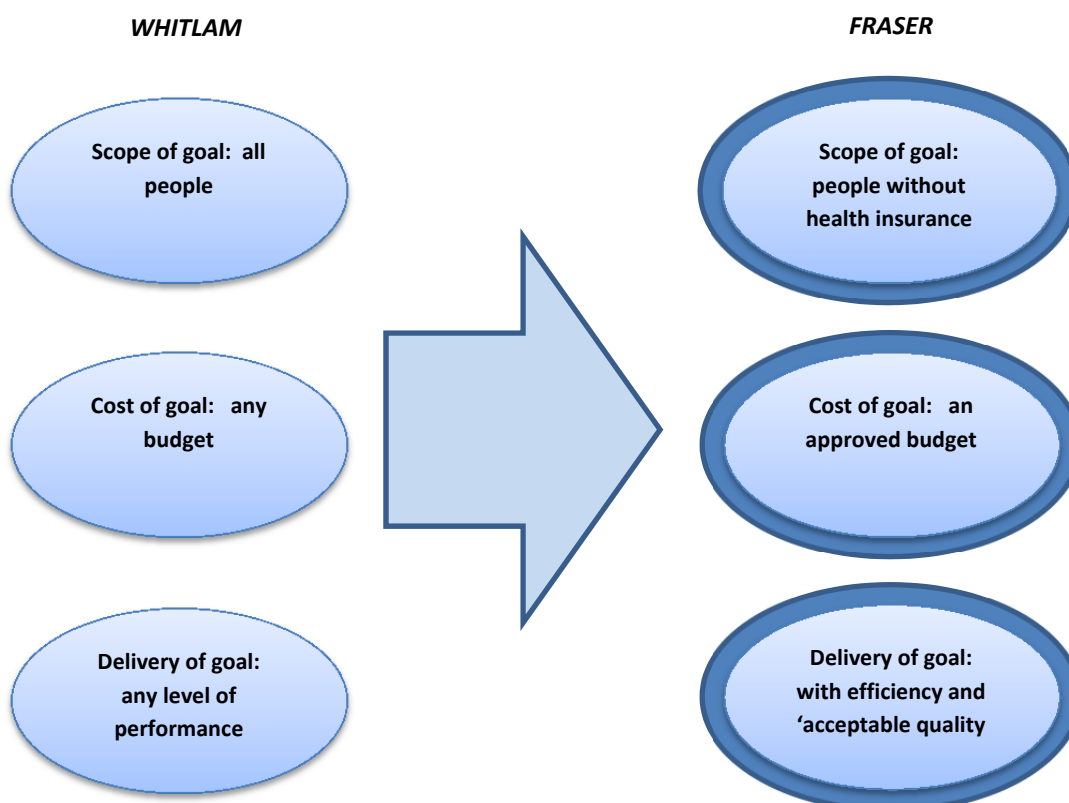
- 1) a tightening of the concept of 'universal hospital care': in particular a restriction of the provision of inpatient services to eligible people *with no private health insurance*. Additionally, the 1976 Agreement required WA to consider "patient demand" and "degree of need" in making beds available, in contrast to the more open-ended requirement of the 1975 Agreement to make services available to all "eligible persons...who wish to receive them". The 1976 Agreement also placed somewhat of a qualifier on the quality of services, specifying that they be of an "acceptably high standard".
- 2) increased budget setting and revision machinery: the Agreement formalised the establishment of Commonwealth–State Standing Committees for each jurisdiction. The new Committees were responsible for formulating and revising budgets, in contrast to the 1975 Agreement which left hospitals budgets predominantly in State hands. In addition, the new Agreement placed greater onus on the States to explain budget variations, as opposed to the original accord which took a more collaborative and flexible approach to budget revisions. The increased machinery was also accompanied by increased information requirements; for example, the States were required to detail the price and activity assumptions underlying budget estimates, and provide more frequent reports on actual outcomes.
- 3) increased focus on operational efficiency: the 1976 Agreement placed greater policy emphasis on *operational efficiency*. Efficiency was to be a key consideration in budget

formulation and new machinery was also specified to allow the Commonwealth to become more involved in the identification of efficiency improvements and hospital service rationalisation.

- 3) increased machinery for setting of private patient charges: the 1976 Agreement assigned responsibility for the determination of private patient charges to the State Standing Committees. Further, the Agreement included a policy objective to achieve national uniformity in patient charges. Whilst this goal may have been discussed during the Whitlam government negotiations, it did not form a part of the 1975 Agreement.
- 4) continued policy emphasis on salaried and sessional doctor remuneration: policy goals relating to doctor remuneration, including the requirement for Commonwealth participation in wage setting for medical staff, were largely carried over from the 1975 Agreement. The main variation was the omission, in the 1976 Agreement, for annual joint implementation reviews. This indicates a stepping back by the Commonwealth, in contrast to the more 'hands-on' implementation role in the original Agreement.
- 5) retention of the "no offsets" clause: the 1976 Agreement upheld this financial concession secured by the States through their negotiations with the Whitlam government and unique to this tied grant arrangement.

Appendix B.1 outlines the significant variations in more detail. Figure 5.1 summarises the additional goal clarity established by the Fraser government's hospital funding agreement:

Figure 5.1 Goal clarity – Fraser era



The above refinement of the universal hospital goal could be construed as typical of a public policy making cycle. However in the case of the Fraser government, it is evident that goal refinement was not driven by implementation evidence and policy learning (particularly occurring so early in the implementation phase) but by a pressing need to address budget pressures and ideologies. Thus the States, having accepted increased Commonwealth financing and involvement in the provision of hospital services under the Whitlam government, were now obliged to allow the Commonwealth greater say over how those services were delivered, as the Commonwealth focussed on reducing the cost of the hospital Medibank program.

The increasing of goal clarity did not cease with the signing of the new hospital funding agreements. As the new Agreement was implemented, the Commonwealth continued its push for increased involvement in policy and budget setting decisions at the State level. The first WA Government budget presented to Commonwealth officers in November 1976 was accepted without question. However, by the end of 1976 it was obvious that the Commonwealth had some very specific ideas on the role and functioning of the State Standing Committees and the information it would require from the States. A letter from the Commonwealth in December 1976 provided standard forms for capturing quarterly State data on gross operating costs, revenue and net operating costs, by hospitals and central services. Additionally, the Commonwealth confirmed that the policy scope of the Standing Committees would extend not just to the Hospital Medibank program but also the Hospitals Development Program and Community Health program. More detailed processes for the annual March and November meetings were also proposed (WA Govt 1976a: 4-6):

At the March meeting, the Committee will: 1) formulate the budget for the ensuing year; 2) review the budget for the current year; 3) formulate any variations to the budget for the current year; and 4) review hospital charges and make recommendations to the National Standing Committee.

At the November meeting the Committee will: 1) review the budget for the previous year; 2) determine the extent to which the actual payments and receipts are in conformity with the basis, factors and considerations upon which the budget of the previous year was formulated; 3) formulate retrospective variations of the budget of the previous year consistent with 2); 4) report to Ministers on matters of dissent in 5) and provide information for Ministers consideration; 5) formulate and submit to Ministers recommendations as to future action on reviewed budget or current or succeeding budgets; 6) review the budget for the current year; and 7) formulate any variations to the budget for the current year.

Each State would provide each of the Divisional Offices with completed documentation as necessary for consideration of formulation of budgets, with provisions of and for variations, for material related to budget performance, for consideration of up-dating of charges etc. Extensive and detailed work on these papers will be conducted by officers in the State capitals with contact with a central office Director. These detailed papers would need to be with Divisional Offices some weeks before the time set down for the actual Committee meeting in a particular State and a minimum of three weeks will be required.

Through the State Standing Committees, the Commonwealth progressively increased its reach into a wide range of hospital policy issues. At a Standing Committee meeting in April

1977 for example, the Commonwealth sought to discuss: "head office salaries and wages"; "financial assistance to country people for travel for medical and hospital treatment"; "approval of intensive care facilities for newly born babies"; "interpreter services in hospitals"; and "state government plans and policies concerning future development in the public hospital area" (WA Govt 1977d: 37). Furthermore, notes from Standing Committee meetings in November 1977, May 1978 and March 1979 show exhaustive deliberations with State officers and the Commonwealth pursuing detailed information on controls over: hospital staffing levels and budgets; infrastructure and other capital expenditure in hospitals; charging of private patients for radiological services; clinical loadings paid to academic clinicians; the appropriateness of bed and staffing numbers within individual hospitals; financial data of individual hospitals; employment of indigenous people; escalation rates used for formulating expense budget estimates; and explanations for specific expense budget variations (WA Govt 1977d: 1-12, 16-21, 23-32).

To standardise the flow of information coming from the States, in 1978, the Commonwealth added greater prescription to the forms and procedures used for capturing data on budget variations. The WA Government was required to explain actual and anticipated budget variations arising from wages, fees and prices; service volumes and one-off events such as the upsizing or downsizing of a hospital. The revised forms also sought additional detail on revenue estimates, including private patient collections in a single room and collections in other rooms; professional service fee collections; and outpatient fee collections in respect of privately insured patients. Further, the Commonwealth sought State preparation of three year forward estimates, although this seems to have been resisted (WA Govt 1978c: 1-29). The rapid increase in policy intrusion from the Commonwealth is quite remarkable to observe. While we cannot be sure whether the Whitlam government would have ventured down this path, the vagueness of the 1975 Agreement presumably provided the States with more scope to argue or act against such intrusiveness. By incorporating a 'committee' approach, the Fraser government was able to force the States into an ongoing and comprehensive dialogue on an unlimited range of service delivery matters. Policy influence or control by the Commonwealth became easier to initiate.

Certainly from a budget process perspective, the Commonwealth held the upper hand. Standing Committee notes from November 1977 reveal the Commonwealth's preference for line-item budgeting, which precluded the States from realigning their budget allocations to respond to changing needs. "Following [State objections] and legal advice on the

matter", the Commonwealth eventually consented to allowing the State greater budget flexibility — nonetheless still insisted on being "advised [of every line-item change] and [having] the right to agree or disagree" (WA Govt 1977d: 26). On the other hand, notes from a March 1979 meeting show the Commonwealth refusing to provide a 'ball park' estimate of its likely funding contribution, thus preventing the State from confirming budget allocations for its hospitals. Delays caused by Standing Committee deliberations and the Commonwealth's own budget process resulted in hospital budget allocations being conveyed three months into the financial year, presumably reducing the capacity of all parties to pro-actively manage budget outcomes.

Admittedly, some of the Commonwealth's actions can be attributed to the state of public financial management at the time. Reforms such as one line budgeting; rolling budgets; and early presentation of budgets were still a decade away, appearing during the mid-1980s. Nevertheless the more complex intergovernmental machinery impeded State decision making. Indeed the Commonwealth commented in October 1978 that its updated procedures were intended to avoid "repeated draft revisions (of budgets)", implying that earlier Standing Committee discussions had consumed considerable administrative time of senior officers from both levels of government (WA Govt 1977d: 2; 1978c: 8). The hands-on involvement of the Commonwealth could perhaps be justified as necessary for overcoming the known weaknesses in State hospital governance. Surely however, the more strategic approach would have been for the Commonwealth to encourage and incentivise longer term structural improvements in State governance systems, as opposed to the micro-level analysis and questioning of annual State budgets that was resorted to. While the Commonwealth may have satisfied its immediate need to constrain health expenditure, there was little fostering of more meaningful reforms for improved efficiency and effectiveness over the medium and longer term. These matters are further discussed at section 5.12.

In addition to having greater input into operational and budgeting decisions, the Commonwealth also continued to push for further tightening of the scope of universal hospital care. In May 1978, the Commonwealth Health Minister announced he would engage with the States to curb the "rising costs of hospitals" through a range of measures targeting bed numbers, out-of-pocket payments, and service delivery performance:

- Make the best use of public and private hospitals without wasteful over-provision or duplication;
- Restrict the beds approved for hospital cost-sharing to no more than is essential for good care;
- Require long stay patients in recognised hospitals to contribute towards their accommodation and care as they would do in nursing homes;

- Require hospitals to satisfy prescribed standards of accommodation and service as a condition of hospital cost-sharing;
- Classify different types of hospitals with a view to applying varying levels of charges to different groups of hospitals;
- Require the standards for hospital cost-sharing to cover the efficiency of management, methods of assessing the quality of care, estimates of the appropriateness of the technology used and arrangements for sharing expensive resources in a rational manner; and
- Incorporate some out-of-pocket payment, for example through a system of utilisation review in which out-of-pocket payments would be required for unauthorised stays in hospital.

Insistent that "we cannot escape the bill ... there is no such thing as free health care", the Commonwealth moved rapidly on the rationalisation of hospital activity (WA Govt 1978b: 49). At a Standing Committee meeting in March 1979, the Commonwealth tabled the *Report on Rationalisation of Hospital Facilities and Services and on Proposed New Charges*, which suggested that States adopt a target of 1100 occupied bed days per thousand population, and adhere effectively to a "no bed growth" principle, which entailed any new beds being offset with the closure of beds elsewhere in the system. The bed day target was apparently based on Victoria's hospitalisation rate (WA Govt 1979b: 68).

The WA government maintained that the target was "only theoretical" and could take a decade to achieve. Despite Commonwealth assurances that the target was endorsed by the Australian Hospitals Association, WA insisted that the 'one size fits all' approach did not recognise underlying demographic differences between jurisdictions such as the higher proportion of indigenous people in WA. With regards to the Commonwealth's no bed growth principle, the State accepted the Commonwealth's policy objective; however, it was pointed out that its practical implementation would depend on there being corresponding stagnancy in demand growth (outside of direct State control) as well as local political acceptance (with bed closures ultimately requiring the support of State Cabinet). The State also took the opportunity to express its disappointment with the Commonwealth's persistent refusal to allow WA to participate in decision making over other parts of the health system — namely the Commonwealth's Medical Benefits Schedule Review Committee, whose decisions affected demand for hospital services.

Another area of policy intrusion was that of private hospital regulation. The Commonwealth pressed the State for greater regulation of bed growth in the private hospital sector. The Fraser government resolved that it would "prefer the State to control private hospitals but if States do not see the necessity, then the Commonwealth will need to be satisfied that sufficient controls do exist". This policy push was successfully countered by the WA government which confirmed that it did not "wish to exercise legislative control over private hospitals", and in fact wanted to encourage private beds as an alternative to the

public system (WA Govt 1977d: 7-11). The Commonwealth remained persistent however. In August 1980, the Fraser government questioned rises evident "in (WA) private hospital beds ... without any corresponding decrease in (bed numbers in) the public sector..." (WA Govt 1980c: 25-6). On this occasion, the Commonwealth was more provocative, refusing to cost share 37 new beds at the Wanneroo Hospital because an expected closure of the private Mount Hospital had not eventuated as anticipated. It was asserted that the State's failure to regulate public and private bed growth was placing undue pressure on the Commonwealth bed subsidies budget.

Again, the State rebutted the Commonwealth's claims, arguing its legislative framework did not, and should not, restrain or otherwise control the size of the private hospital sector. Additionally, the State pointed out that Commonwealth-instigated changes to private health insurance policy had in fact encouraged a shift of patients from private to public hospital beds. Other passive resistance was also evident with a WA hospital administrator suggesting:

I believe we must be very careful not to offer up any staffed public hospital beds to counter the ... Mount Hospital beds ... major developments at the Sir Charles Gairdner Hospital and the Fremantle Hospital will come into operation ...[in July 1981] ... and we must maintain our flexibility to cover these ... substantial operating cost increases ... one thing...is quite clear, that is the Commonwealth is most unlikely to make any increases in its payments ... to accommodate [these hospital developments, thus] any concessions we make elsewhere within the public hospital system to offset the Mount Hospital beds ... would ... play right into the Commonwealth's hands ... the present case which they are pursuing against us is based on very dubious argument (WA Govt 1980c: 31).

As discussed further at sections 5.3 and 5.9, the above evidence on state rebuttal confirms that the Commonwealth's ability to tighten the scope of universal hospital care was inherently constrained by its lack of direct jurisdiction over the relevant policy levers and, at that time, the scarcity of irrefutable data on the hospital system. In spite of the volume of information being requested and the extensive deliberations occurring, ultimately any policy shift involving bed numbers, private patient charges or cost control had to be actively negotiated with the States, with there being no guarantees that the Commonwealth would prevail. Additionally, the Commonwealth faced resistance simply from the ongoing suspicions of the States. For example, the WA government's response to the 1100 bed day target was driven by its concerns that the target would be used as a "blunt instrument" in future funding negotiations (WA Govt 1977d: 8).

5.2.2 Goal clarity — Overall evaluation

Under the Whitlam government, goal clarity was indicative of neither a top-down or bottom-up governance approach, with policy making powers divided fairly evenly between the Commonwealth and the States. This analysis shows that goal clarity was heavily

increased by the Fraser government with quite a remarkable growth in Commonwealth involvement into hospital policy matters, and ongoing attempts at refining and tightening the scope of universal hospital care. The aggressive push for more goal clarity was predominantly motivated by the Fraser government's urgent need to cut the cost of hospital Medibank, as opposed to being driven by an informed desire to improve policy settings. While the Commonwealth was not successful in all its attempts to increase goal clarity, its actions created significant impact on State policy and budget setting processes, and required extensive negotiating effort from the State. The overall impression is of a top-down policy making approach.

5.3 GOAL SETTING

5.3.1 Goal setting — pre 1976 Agreement

When the Fraser government came to power, the States are likely to have been feeling quite smug in the knowledge that the Commonwealth had committed, in writing, to a five or ten year, open-ended 50-50 open cost sharing deal. The new federal government also gave little away, insisting it was not intending "to dictate health policies to any State Government" (WA Govt 1975-76b: 77). The Commonwealth's quite daring decision to proclaim the 1975 Agreements to be legally invalid was most definitely the key turning point in this intergovernmental relationship, shattering any notion that there was some security in signed pacts with the Commonwealth. The Commonwealth's declaration certainly caught the States by surprise and gave the Fraser government a dominant position in the early stages of bargaining. The Australian Financial Review observed that the "Prime Minister's rapid-fire response ... to State obstructionism to his Medibank plans put Gough Whitlam's best efforts at 'crashing through' distinctly in the shade [and] promises to have a profound effect on Australian politics" (WA Govt 1975-76b: 30). The declaration served to highlight States' vulnerability, in terms of their financial dependence on the Commonwealth and the potential volatility of Commonwealth–State agreements. The States' position was quite typical of a federal system characterised by significant VFI:

...because of their financial problems, the States are in a poor position to stand up to any strong Commonwealth pressure ... [they are susceptible] ... to a 'take it or leave it' threat...which would leave them faced with the option of having to carry the full burden of hospital losses if they refused to let the Commonwealth have its way...(The West Australian as quoted in WA Govt 1975-76b: 38-40).

The WA Crown-Solicitor observed the States' helplessness in upholding tied grant arrangements, confirming that their only recourse was "in the political arena" (WA Govt 1976b: 110). As observed earlier, this 'political arena', essentially the electorate, had been cultivated to accept the inevitability of change, with the Commonwealth portraying itself as

a responsible fiscal manager dealing with the budget pressures of hospital Medibank. Whereas under the Whitlam government, the Commonwealth had used the political arena to sway the States towards its universal hospital goal, the same arena was now used to drive the States towards a new financing arrangement. Knowing full well that the open-ended cost sharing deal had been somewhat of a windfall gain and being caught off-guard by the Commonwealth's bold act, it was difficult for the States to mount a prolonged public resistance on the basis of a legal technicality. The Commonwealth had worked the political circumstances in its favour and secured the superior bargaining position with regards to the broad policy setting parameters.

5.3.2 Goal setting — 1976 Agreement

Looking beyond the demise of the 1975 Agreement, however, what of the bargaining associated with defining the new Agreement and then its implementation — was the Commonwealth just as dominant, or did the States manage to claw back some goal setting ground during these subsequent phases of negotiation? Table B.1 outlines the specific policy shifts that evident in the 1976 Agreement. The Commonwealth certainly appears to have had prominent influence in the policy setting, managing to secure State acceptance for:

- 1) removal of daily bed benefit payments (subsidies) for privately insured patients;
- 2) addition of home dialysis to the scope of universal care services;
- 3) exclusion of privately insured patients from universal hospital care;
- 4) inclusions of broad brush qualifications to the delivery of services - qualifiers in terms of 'need' and 'acceptable quality';
- 5) increased private patient charges and a push for more national uniformity in fees;'
- 6) more frequent and precise reporting and greater budget accountability; and, of course,
- 7) new machinery for budget formulation and review of expenditure and fee settings.
including a new emphasis on efficiency and economy.

Each of these policy changes will be considered to assess the extent to which they may have been consistent with State policy preferences or modified by the State, through the negotiation process. With regards to policy shifts (1) and (2), the evidence shows that these goals were entirely unchanged from the Commonwealth's initial intentions. A letter from the Commonwealth to the State Premiers in February 1976 (prior to the declaration of legal invalidity) advised that "decisions ... have been taken in the health area [with a view to

making savings] ... [will] have implications for the States". The language used in the advice clearly conveys the Commonwealth's unilateral stance on these matters (*emphasis added*):

The Government *will* proceed to abolish the \$2 a day Commonwealth hospital benefit for privately insured patients...It is proposed to adjust the current Home Dialysis Scheme with a view to its incorporation in hospital Medibank arrangements. This *will* necessitate negotiations between our officers to make the relevant arrangements. The total estimated amount for all States is \$3 million which *we will* be seeking to have cost-shared.³³

Justifying its decision, the Commonwealth confirmed the \$2 benefit change would save around \$17 million a year: \$12 million for the Commonwealth and \$5 million from State budgets. No heed was paid to a WA government claim that the policy shift would have detrimental effect in the longer term, encouraging people to drop their private health insurance and increasing pressure for publicly funded beds (WA Govt 1975: 42-6). On the addition of home dialysis services, the Budget Papers confirm that this was also a Commonwealth cost-cutting measure. The scope change allowed the Fraser government to shift 50 per cent of these costs on to the State government (Aust. Government 1976a: 18). In contrast, a request by the NSW government for the Commonwealth to expand cost sharing for example to include psychiatric hospitals; flying doctor services; and hospital building commissioning costs was ignored. Policy setting around bed-day payments and the scope of services was clearly Commonwealth-dominated and motivated primarily by its pressing financial pressures (WA Govt 1976b: 48-56).

On policy change (3), the exclusion of people with private health insurance from universal hospital care is likely to have been consistent with WA Government's desire to promote the self-funding of health care. Having said this, the State would definitely have been concerned that the lack of means tests or other restraints to accessing of universal care, would serve to encourage people to drop their health insurance. In terms of policy change 4), the qualifiers around 'need' and 'quality' were too vague to have raised the ire of the State at that stage — although they became more problematic during the implementation phase, when the Commonwealth sought to intervene more closely on bed numbers and other operational matters. With regards to policy change 5), the additional revenues of \$75 million a year that this generated appears to have been the crucial bargaining chip used by the Commonwealth to coerce the States into signing the new Agreement.

³³ Other statements made not directly relating to the 1975 Agreement further demonstrate the Commonwealth's imposing style: "... [the]... Government *has decided* to reduce the proportion of its contribution to the School Dental Scheme on the basis that the States *will need* to increase their contributions by 10 per cent of the overall capital and recurring costs of the Scheme ... In addition, the Commonwealth *will require* a contribution of 25 per cent by the States to a revised dental scholarship program, to commence in 1977, which it is proposed *will be* administered by the States ... [and on the Hospitals Development Program] ... the Government *will not* meet increased costs of approved State programs (*emphasis added*).

Being a financial policy shift, the States really had no choice, knowing the open-ended cost sharing deal was over.

On the associated requirement for greater national fee uniformity, this seems to have been in line with State policy objectives at the time, although the Commonwealth and States appear to have initially held different views on how the goal would be implemented. The Commonwealth insisted that fee variations be negotiated annually through the Standing Committees. Correspondence confirms however that the States preferred annual fee variations to be based on a nationally agreed formula. For a period, the States regretted accepting the loose definition of 'uniformity', with one WA hospital administrator expressing frustration at the Commonwealth's ability to "dictate to the State the level of hospital fees as it has done for the past two years." (WA Govt 1979b: 51-2, 74). By 1980, however, the States had managed to sway the Commonwealth, with the Fraser government supporting a formula approach "as long as realistic base figures are used" (WA Govt 1980d: 70).

Finally, on policy changes (6) and (7), the States would have been very uneasy with these additional clauses — but as noted before, they were necessary compromises for retaining some degree of budget flexibility, as opposed to the fixed budget model which the Fraser government had initially sought to thrust onto the States. The shift in budget formulation authority was certainly profound; under the 1975 Agreement, the Commonwealth had to "accept the States' figures", whereas the 1976 Agreement required the States to justify and seek approval for their budgets (WA Govt 1976b: 38). The WA Crown Solicitor observed: "there is nothing ... to safeguard the State's position ... notwithstanding any political statements as to paying 50 per cent of net operating costs ... this represents a substantial deterioration of the State's position from that existing under the original Hospitals Agreement" (WA Govt 1976b: 110-11). In addition to budget formulation, as already observed, the establishment of the Standing Committees became a significant vehicle for the Commonwealth in securing greater buy-in to broader State policy setting decisions. Although the Fraser government claimed the Committees merely rectified a weakness in the Whitlam government arrangements — which had "provided no provision for participation by the Commonwealth...in the review of expenditure" (WA Govt 1975-76b: 3) — it is clear that this new machinery formalised a continuing role for the Commonwealth in contrast to the more selective participation that was anticipated when the States first signed up to the universal hospital care goal in 1975.

The 1976 Agreement shows that WA managed to preserve the generous non-offsets clause. Further, clauses around doctors' remuneration were also largely retained as were the extra scope advantages secured in the 1975 Agreement. As discussed in Chapter 4, these scope gains included the cost sharing of the Perth Dental Hospital and its clinics; Northwest and Remote Area Medical Service; Remote Area Transport Scheme; Visiting Specialists; Computer Services; and universal outpatient services (WA Govt 1977d: 13-15). The preserving of earlier concessions does not seem to have been secured by the State through heavy bargaining. Analysing the evidence, there is nothing to suggest that the Commonwealth debated these matters at all, certainly the doctors' remuneration goal was consistent with its own desire for greater fiscal economy, and perhaps the view was that having obtained greater involvement into budget setting, the non-offsets clause could be dealt with indirectly. The scoping advantages seem to have been passively accepted also, perhaps because they were not overly transparent at that stage. In fact, the State appears to have widened the cost sharing of central services (accounting and administrative services) further, during post-Agreement negotiations (WA Govt 1977d: 13-15). The universality of outpatient services was an area that the Commonwealth did later attempt to modify (unsuccessfully), as discussed at section 5.4. Finally, there is some evidence that the medical profession sought to have the remuneration clauses amended. The WA medical profession, through the State government, requested an amendment to Clause 19.7 which entailed replacing the principle of 'minimising fee-for-service remuneration' with the 'minimising of medical services cost'. The profession also asked for the removal of Clause 19.9 (b) which provided for national uniformity and machinery, in the setting of wages for hospital medical staff. Both of these requests were flatly rejected by the Commonwealth, a rebuttal that was no doubt gladly accepted by the States given their preference for salaried and sessional remuneration (WA Govt 1976b: 34, 81).

In summary, with regards to the defining of the Agreement, it is apparent that goal setting was heavily Commonwealth dominated, assisted by its financial superiority. Even in those instances where the policy changes were in accordance with State preferences, this appears to have been coincidental, rather than a policy outcome secured by the States through vigorous bargaining.

5.3.3 Goal setting — post 1976 Agreement

Goal setting continued after the signing of the Agreement. During the Whitlam era, at this implementation stage, goal setting powers shifted markedly in favour of the States.

Was this also the case during the Fraser government? We turn our attention to the implementation phase from October 1976 to 1980 in order to assess this more closely.

Examining Standing Committee deliberations for WA, it is apparent that there were a number of roles played by the Commonwealth including: 1) the role of a 'reviewer' which entailed seeking copious amounts of financial and activity information; 2) the role of policy influencer, where the Commonwealth initiated negotiations over ongoing policy adjustments it believed as necessary (usually from the perspective of assisting its own budget woes); and lastly 3) a more coercive policy role, where the Commonwealth was not just trying to *influence and negotiate*, but much more *antagonistically enforce* States to accept its point of view. The first two roles were probably more evident in the early years of implementation, as the Commonwealth settled down its new machinery and began assessing the information flow from the States. Over time however, with no direct control over operational policy levers, the Commonwealth found that these roles provided little more than a capacity to bargain with the States. The delays and uncertainties of such bargaining hindered the Commonwealth's urgent drive to achieve restraint of hospital expenditure. Eventually, the Commonwealth realised its only effective policy lever was finance, with even that being susceptible to political pressure from the States.

The shift in emphasis to financial levers is evident from around 1977. The Commonwealth appears to have grown tired of the tedious to-ing and fro-ing in the establishment of hospital budgets and the ongoing haggling with the States at Standing Committee meetings. Despite intense questioning of hospital governance and line-by-line budget variations, the Fraser government seems to have gained little additional control over service delivery and hospital expenditure. Losing patience, the Commonwealth resorted to a hard-line stance on funding levels, capping its funding for the 1977–78 Budget. Notes from a Standing Committee meeting in November confirm:

Commonwealth officers advised that they were of the view that WA's latest budget was excessive ... [it was] ... explained that ... [they] ... were not empowered to agree to a figure in excess of \$218m. It was therefore agreed that State officers would re-examine revenue and expenditure figures in order to come back to a budget figure of \$218m. The revised RH7 (form) would be submitted to the Commonwealth quickly (WA Govt 1977d: 25).

The State argued that its projected budget growth for 1977–78 reflected current expenditure trends and "the current employment situation [whereby the] filling of vacant approved posts [was] expected to increase". The Commonwealth countered that with the tight budgetary circumstances, WA should be adopting a "negative growth" strategy in staffing levels as were other States and the Commonwealth itself. Although WA attempted

to explain that its current staffing levels were in fact lower than that of other jurisdictions, the Commonwealth would not budge from its initial stance.

As shown in later case studies at Chapter 6, this form of aggressive posturing by the Commonwealth on State 'baseline' funding has become a regular feature of intergovernmental relations in health. In spite of all the additional machinery that had been established to formulate and review budgets, the Commonwealth ultimately opted to pre-set its funding commitment, choosing to disregard underlying differences in input cost structures or output levels between States. Admittedly the quality of hospital statistics at the time would not have assisted.³⁴ Nonetheless, it is clear that the Commonwealth was intent on achieving rapid cuts to expenditure; whether the availability of higher quality data would have made a difference to its decisions at the time is doubtful (Australian Institute of Health 1988; WA Govt 1977d: 35). As discussed further at section 5.6, the Commonwealth appears to have been uninterested in the relative performance of States when it came to enforcing its budget curtailment strategies.

The Commonwealth flexed its fiscal muscle even further during negotiations of the 1978–79 Budget. In early July 1978, the Fraser government wrote to all ministers confirming that escalation rates for the 1978–79 budget would be capped at 5.5 per cent. Several weeks later, the States became aware (through a leaked document) of a looming Commonwealth proposal to scale back 1978–79 funding, with the expenditure cut to be based "on a 5 per cent reduction of the 1977–78 bed utilisation rate, per head of population", or alternatively through the "(freezing of) hospital bed use at the 1977/78 rate of utilisation" (WA Govt 1978c: 59). The States rapidly formulated a political response — using the media to great effect. The NSW Health Minister dramatically claimed:

over 1,000 existing hospital beds ... will have to be closed because of new financial restrictions proposed by the federal government ... the sick will be penalised as a principle of the Commonwealth government's fiscal policies ... staff cuts will be necessary leading inevitably to the dismissal of nurses, doctors, physiotherapists and other health professionals at the same time the Commonwealth has drastically reduced its level of assistance to supporting community health services — a double blow to the public (WA Govt 1978c: 54-57).

The proposal was immediately denied, the Fraser government insisting it was still exploring the matter and criticising the States for claiming irresponsibly, that a firm decision had been made. Later that month, however, the Commonwealth attempted another budget cut, advising the States it would not "approve the expansion of hospital facilities and services

³⁴ The development of reliable and comparable hospital expenditure statistics was very much in its infancy. Evidence reveals significant differences in measurement approaches between States at the time. Fundamental data such as the 'average cost per inpatient bed day' could not be compared between States because of formula variations. No doubt these data constraints frustrated the policy making process, and Commonwealth intentions to better understand hospital activities.

for cost sharing purposes until facilities and services have been reviewed". The WA government quickly objected, the Premier accusing the Commonwealth in the media of backtracking on a commitment given just weeks earlier that it would share the costs of a newly expanded King Edward Memorial Hospital (KEMH). The State's response had the desired political effect, with the Commonwealth agreeing to share the expanded costs of the KEMH by December 1978 (WA Govt 1978c: 39, 47).

In March 1979 the Commonwealth, consistent with State suspicions, advised the State Standing Committee that 1979-80 budget estimates "should be based on a no growth situation or even a reduction in services". Again, the States assembled a political response, with the NSW Minister this time claiming that 10,000 employees would need to be dismissed and 8,000 beds closed (WA Govt 1979b: 45, 48). However, on this occasion, the Commonwealth was unrelenting, pushing for a national review of hospital administration and insisting that funding would be frozen until that review was completed. The Commonwealth also played the media game, claiming that "State governments were battling with their consciences about excessive bed capacity" and once again portraying itself as the responsible party — responsible for taming growth in health expenditure from rates of 14.1 per cent in 1976–77 and 35 per cent in 1975–76 to 10.7 per cent in 1976–78 (WA Govt 1979b: 43-4). Initially the Commonwealth argued for a Royal Commission, but was forced to accept a Committee of Inquiry after public protests from Queensland and NSW that "such a move was unconstitutional" and merely a "delaying tactic to cut costs" (WA Govt 1979b: 42). At a meeting of Health Ministers in June 1979, the States used their commitment to a Committee of Inquiry and threats of "large-scale unemployment" and possible facility closures to argue for a back down on the proposed freezing of cost-sharing budgets (WA Govt 1979b: 36). The Commonwealth was eventually forced to retreat — agreeing to provide escalation funding, although publicly insisting that it had still managed to save "\$54 million (compared to) the budgets submitted by the States". The States also claimed they had secured a "victory over the Commonwealth" (WA Govt 1979b: 32).

In addition to the haggling on funding levels and budget management practices, the States continued to experience the flow-on effects of the Commonwealth's unilateral policy setting on the broader Medibank program. It is noteworthy that the Fraser government implemented no fewer than five iterations of Medibank during its term in office (Gray 1996: 592). The Commonwealth appears to have engaged in a continuous cycle of policy adjustments, centred on scaling back expenditure growth. In May 1978, the States jointly expressed their frustration in not being consulted on a wide range of Commonwealth policy

proposals relating to for example: "hospital fees; levels of benefits in relation to hospital fees, including a bed tax of \$4 per day mentioned in reports; increased patient contributions towards medical fees; front-end deductibles; inclusion of psychiatric hospitals in hospital cost sharing; ...long stay patients in recognised hospitals; and retention of \$16 per day hospital benefit for patients of private hospitals" (WA Govt 1978b: 54).

Hospital fees were a particularly contentious issue. The States were infuriated that in spite of their hospitals experiencing an 18.9 per cent in operating costs between 1975–76 and 1976–77, the Commonwealth had refused to agree to any fee increases between October 1976 and May 1978. On the inclusion of psychiatric hospitals, another point of contention carried over from the 1975 Agreement, the Commonwealth was also unrelenting, insisting quite astonishingly (and impossibly) that States should first agree to the cost sharing "of all nursing homes in the public and private sectors"(WA Govt 1978d: 13). In contrast, the Commonwealth pushed ahead with policy adjustments to patient benefits, co-contributions and front-end deductibles, paying no heed to WA government concerns for private health insurance coverage rates. The WA government warned to no avail: "there would [certainly] be a detrimental effect [on demand for public hospital services and thus States finances] if the swing from private insurance is much greater than 7 per cent".

Another unilateral policy announcement by the Commonwealth affecting private health insurance take-up (further discussed at section 5.4), was its decision to "reduce from 85 per cent to 75 per cent the amount which patients who are insured for hospital benefits will be able to claim from their various funds in recoup of fees charged by their doctors". This decision put the States in a quandary: either they would need to re-negotiate with hospital doctors to accept a lower payment, or they would need to subsidise the additional 10 per cent. Ultimately, the AMA took the Commonwealth to task, and as further discussed later in this chapter, the Commonwealth was compelled to cost share at the 85 per cent rate (WA Govt 1978b: 9, 40-2, 54-61) . In 1978, in another of its adjustments to Medibank, a further reduction was made to Commonwealth medical benefits. The AMA asserted that the Commonwealth's decision would raise the cost of general practitioner (primary) care, encouraging people to use the public hospital system where outpatient services remained free or at minimal charge (WA Govt 1978e: 7). Of most interest is that the Commonwealth Health Minister seems to have argued the same with his Cabinet colleagues; however, fiscal priorities obviously took precedence (Aust. Government 1979). This matter is discussed further at section 5.4.

All in all, it is apparent that the Commonwealth, with its attention firmly focussed on its budget pressures, was rigorously pursuing a whole range of cost-reduction or 'cost-shifting' strategies, to cut back or transfer costs onto the States or the private sector, in an effort to contain Commonwealth expenditure growth. The picture evident is of a reactive Commonwealth engaged in 'damage-control'. This type of short-sighted decision making behaviour could only have been detrimental for the health system as a whole. As the WA Government noted:

To effect any structural changes within the hospital system requires a properly balanced set of policy initiatives not a unilateral attack on the public sector. To do so would indicate a total lack of understanding of the current dilemma and the economic choices that individuals must make in deciding (with their doctor) the type of hospitalisation which they will or can afford to accept (WA Govt 1980c: 28).

In resorting to a phased winding back of Medibank to serve its own political objectives, the Fraser government, like its predecessor, effectively precluded a more holistic and evidence-based policy setting approach.

In summary and in contrast to the earlier stages of goal setting under the Fraser government (where the Commonwealth dominated the negotiations), the implementation phase between 1976 and 1979 shows a mixed picture. Without doubt, the Commonwealth became much more closely involved in budget setting, placing significant administrative burden on the States; and also engaging in considerable unilateral decision making and coercive behaviour. Nonetheless, the States were able, both passively and openly, to resist some of these policy intrusions, with the Commonwealth buckling on a number of significant issues, as a direct result of State pressure. Thus similar to the experience of the Whitlam era, the goal setting powers of the Commonwealth diminished during implementation, due to its lack of direct control over service delivery. The last stage of goal setting that occurred under the Fraser government was the re-negotiation of the cost-sharing deal in 1980 as discussed below.

5.3.4 Goal setting — Identified Health Grant

Tensions mounted as the Commonwealth and States approached 1979–80 and the end of the tortuous 1976 Agreement. It was suggested at the time that the negotiations for a new tied grant would "provoke one of the biggest confrontations between the WA government and Canberra in recent years" (The West Australian as quoted in WA Govt 1979b: 68). Following a number of years of heavy unilateral action by the Commonwealth, the States were staunchly determined to reclaim the bargaining ground they had lost, with the WA Health Minister keen to put a stop to the trend of recent years where the "federal government has ridden rough-shod over the State" (WA Govt 1979b: 67).

This time around, the States jointly and pro-actively geared up to take on the Commonwealth — quite different to the 1976 Agreement where they had been caught off-guard. The WA Premier noted that "a lot of water has flowed under the bridge since the Agreement was first negotiated and we now have the added experience of working under the Agreement and feeling the effects of changes in policy and administrative detail in Canberra" (WA Govt 1979b: 63-4).

Notwithstanding the States' preparation however, the Commonwealth appears to have controlled the 'scene setting' prior to the negotiations. In terms of timeframes, the Commonwealth insisted it would not engage in discussions until 31 December 1979, six months prior to the expiry of the 1976 Agreement (WA Govt 1977d: 12). Another readjustment of the policy framework was also signalled. One possibility raised was the replacement of the cost-sharing deal with a tax-sharing arrangement or some other formula-based grant, based on age and population factors. In spite of the potential policy and administrative relief this might bring, the States remained highly suspicious:

It is apparent that the Commonwealth government will do everything possible to reduce its commitment in relation to hospital operating costs and a completely new proposal such as tax sharing, would present the Commonwealth with a good opportunity to reduce payments to the States... All States were anxious to ensure the retention of the 50/50 cost sharing basis even though it is likely that there would be little reduction in the administrative work and probably even more haggling over detailed budgets (WA Govt 1979b: 50-53).

It is hardly surprising that the States did not embrace a potentially more streamlined and efficient funding arrangement. The Commonwealth's heavy-handed unilateralism and single-minded focus on cost cutting of the past few years had broken the States' trust quite dramatically. The States obviously began to view the administrative pain associated with the tied grant as an unavoidable inconvenience, necessary for preserving funding levels for universal hospital care.

Later in 1981, when the Commonwealth seemed increasingly likely to move to a formula-based block grant, the States, still sceptical, changed their bargaining stance again, arguing for "an approach that built hospital finances back into tax reimbursement allocations". The pursuit of a best practice funding model appears to have become entangled with State anxiety over how to prevent the Commonwealth from manipulating funding parameters, "especially in times of inflation" (WA Govt 1980b: 2). Against State preferences, the Commonwealth replaced the cost-sharing agreements with its Identified Health Grant on 1st September 1981. Under the new scheme, free public hospital care was made "available only to pensioners qualifying for health cards, sickness beneficiaries and people meeting stringent means tests ... [with the grant to be] reduced by amounts deemed to be

collectible at standard fees declared by the Federal Minister for Health” (R. B. Scotton 2000: 9-11). By the end of the Fraser era, it was clear that both Commonwealth and State attention was increasingly centred on the 'quantum of funding'. Additionally, the States were becoming much more cautious and calculating, shifting bargaining positions just as astutely as the Commonwealth when it suited.

5.3.5 Goal setting — Overall evaluation

Unlike the Whitlam era where goal setting was predominantly of a bottom-up nature, the Fraser era reveals a considerable loss of goal setting space by the States. For the most part the Commonwealth held the upper hand, both through its unilateral policy making and its control over the finances. For their part, the States did exhibit passive and open resistance, and were able to thwart Commonwealth intrusions at various stages. Nevertheless one cannot overlook the reality that the entire hospital policy setting agenda during the Fraser era was overwhelmingly driven by the Commonwealth's fiscal objectives and its political desire to wind back Medibank in a manner acceptable to the electorate. On this basis it seems reasonable to conclude that goal setting in the Fraser era was indicative of a top-down policy making approach.

5.4 GOAL CONGRUENCE

The Whitlam era analysis confirmed there was alignment between the Commonwealth and States on the doctors' remuneration goal, but differing policy positions on the universal hospital care goal. There were also considerable goal congruence difficulties at the federal level. The Fraser era reveals similar goal congruence patterns; however, some significant shifts were also evident.

5.4.1 Goal congruence — Commonwealth level

Goal congruence issues at the federal level were much less dramatic than those seen during the Whitlam era; nevertheless they were still a substantial factor in the policy making process. Three key areas of goal incongruence at the federal level are apparent.

The first, as already discussed, was the goal conflict faced by the Commonwealth in continuing with the 50–50 cost sharing deal, against a budget context that demanded fiscal constraint. The Commonwealth Health Minister observed that "Medibank ... has achieved universal coverage, but at the expense of largely disregarding the need for economy and efficiency in overall health care expenditures by the individual and the community" (WA Govt 1975-76b: 83). As mentioned earlier, some of the assertions made by the

Commonwealth with regards to universal hospital care being one of the primary causes of the health expenditure growth appear to have been misrepresented. Indeed in spite of his initial public rhetoric, as the budget reductions continued, the Health Minister himself grew uncomfortable with the conflict between health care and macroeconomic stability (Aust. Government 1979):

The health insurance scheme is not something which can be subjected in isolation, without repercussion, to variation at the whim of Government to meet short-term overall financial problems. It is part of the pattern of society and involves deeply the welfare of the community.

A key issue for the Commonwealth appears to have been the statistical impact of Medibank expenditure on CPI growth. With the Arbitration Commission having commenced the indexation of wages based on CPI, health inflation began creating flow-on wage pressure effects across the wider economy (Duckett 1984: 963; WA Govt 1975-76b: 157-9). A Cabinet Submission on health insurance scheme savings specifically discussed the potential impact of the proposal on CPI, suggesting that this was a matter of importance to the Commonwealth (Aust. Government 1979). In 1978, following a series of revisions to its health insurance policy settings, the AMA accused the Fraser government of making changes that had little to do with the community's health but "were intended to doctor the CPI" (WA Govt 1978e: 7).

A second dimension of internal federal government goal conflict was the Commonwealth's own Cabinet and budget processes. At a Standing Committee meeting in March 1979, Commonwealth officers explained that "the Government was faced with a horribly burgeoning budget and Ministers were coming forward with a record number of ideas for spending money" (WA Govt 1977d: 2). As evident during the Whitlam era, the 50–50 cost sharing deal was continuously under threat by a range of other Commonwealth programs. The end outcome was very much subject to the relative bargaining powers of the Minister for Health, the other Cabinet members and central agencies. For example the AMA suggested in 1978 that (WA Govt 1978e: 7):

One difficulty is that health care policy has largely ceased to be a matter for Health Departments and Health Ministers who might know something about it. Instead it has been taken over by Departments of Treasury and the like.

Hence there was pressure to scale back the size of the tied grant not only from a macroeconomic perspective but also from other Commonwealth stakeholders who wanted to assign it a lower priority compared to their own policy objectives. A similar conflict arose when the Commonwealth came to decide on the future of the cost-sharing arrangement in 1981. The Prime Minister and the Treasury shared a preference for health funding to be absorbed into general revenue grants, passing full responsibility for hospitals back to the

States. However, the Minister for Health and the national Committee of Inquiry (Jamison Review) were in favour of a formula-based grant arrangement that adjusted for population and age shifts. Ultimately, it was the Minister for Health who emerged victorious, arguing that "if ... federal money was not earmarked for health, the State Treasuries would gradually nibble away at it" (WA Govt 1980b: 2-3).

A third area of goal conflict at the federal level was the persistent conflict between the Commonwealth's Medibank policies and its policy setting around other parts of the health system — specifically, the payment of Commonwealth bed day benefits under section 51(23A) of the Constitution; and community health programs. Driven primarily by a need to enforce quick budget cuts, the Commonwealth appeared to behave quite irrationally, focussing its attention on one aspect of the health system at a time, and failing to consider the flow-on impacts across the wider system. This lack of coordination was an issue also during the Whitlam era, with different Commonwealth agencies having been assigned responsibility for different health programs. Under the Fraser government, the coordination complexities increased, with the Commonwealth not having a clear and consistent policy agenda. There is a range of evidence in this area:

- *Hospital cost sharing-community health:* the Fraser government, for budget reasons, reduced its funding commitment for community health programs, apparently unaware that a scaling back in this area was likely to put pressure on the hospital system and thus the 50–50 cost sharing deal. Evidence indicates that the Commonwealth between 1973–74 and 1976–77 contributed between 90–100 per cent of program operating costs and 75–100 per cent of capital costs. By 1978–79, however, its contribution had fallen to 50 per cent of operating costs and capital costs. The States noted in 1979 that compared to the \$1 billion of funding contributed towards the 50–50 cost sharing arrangement, only \$70 million was expended on community health programs (WA Govt 1978d: 32-3).
- *Public-private sector:* as discussed earlier in this chapter, the Commonwealth refused to cost share new beds in the WA public hospital system because it claimed that growth in private sector bed capacity was impeding its bed day subsidies budget. In contrast, the WA government asserted on a number of occasions that the Commonwealth's policy settings around private health insurance were discouraging insurance membership and increasing demand for public hospital care (WA Govt 1979a: 13; 1980b: 9-13). It would appear the Commonwealth was uncertain of how best to manage public—private sector interaction and the appropriate policy levers

to use. Alternatively, perhaps it was unable to use these levers more confidently because of the political commitment it had made to support universal care.

Own source revenue-Commonwealth revenue: the Commonwealth stalled increases in private patient charges for two years, preventing the States from raising more revenue. While the reasons for the Commonwealth's delay are not clear, perhaps it was keen to avoid the broader flow-on effects (rises in hospital fees would have generated insurance premium rises, which in turn would have increased CPI and thus broader wage costs).

The above goal conflicts are not unique to the Fraser era — determining an appropriate goal-mix in the health policy area is an ongoing challenge for any government. However, in this instance, the Commonwealth's policy choices were contradictory and impractical from an implementation sense. Having committed the States to a revised universal hospital care goal (for the 1976 Agreement), the Commonwealth's subsequent policy choices (to tighten grant funding and own-source revenues; as well as reduce incentives for private health insurance and support for community health) are likely to have compromised the effectiveness in which the States could successfully deliver universal care.

5.4.2 Goal congruence — State level

Universal hospital care

In contrast to the Commonwealth's ideological shift on universal hospital care, apart from Victoria and NSW, States had actively embraced the goal they had committed to in 1975 and again in 1976. An analysis of Medibank implementation in January 1976 reveals:

The demand has been such that only half the beds in NSW and Victorian public hospitals have been occupied by free patients ... the low demand for free beds stems from doctors' refusal in many metropolitan hospitals to treat patients in these beds. The hospital arrangements appear to be working best in Queensland and Tasmania which are virtually fully run on salaried and sessional basis. The next best State is Western Australia where there is a mixture of modified fee for service in country areas and salaried and sessional payments in metropolitan hospitals. The proportion of 'free patients' is a high 70 per cent. In South Australia, the hospital scheme is working well in the metropolitan hospitals and in the country government hospitals. But some of the small country community hospitals still have not reached agreement with doctors" (The Australian Financial Review as quoted in WA Govt 1975-76b: 116).

Examining hospital insurance (basic table) coverage rates, which can be an indicator of the use of universal hospital care (PHIAC 2009), varying implementation patterns are evident:

Table 5.1 Hospital insurance coverage rates

	NSW & ACT (%)	Vic (%)	WA (%)	SA (%)
Dec 1976	68.8	71.1	64.5	67.0
Dec 1977	67.9	71.5	60.4	65.6
Dec 1978	65.1	66.4	63.7	67.7
Dec 1979	62.3	66.4	57.9	61.9
Dec 1980	59.0	61.9	51.4	54.9

Hospital insurance coverage rates across Australia pre-Medibank were on average 77.5 per cent. Hence even as early as December 1976, coverage rates had potentially dropped — by 13, 10.5, 8.7, 6.4, and 10.5 percentage points in WA, SA, NSW, ACT and Victoria respectively. Over the next four years, coverage rates fell further — by 13.1, 12.1, 9.8, 9.2, and 12.1 percentage points in WA, SA NSW, ACT and Victoria respectively. The largest reductions in private hospital insurance coverage, and thus by implication, the largest take-up of universal hospital care, occurred in WA and SA, which reached agreement with their medical profession much earlier than other States.

Interestingly, notwithstanding the rapid rate of implementation and the generous financial concessions, goal congruence for the WA government and perhaps other States was merely pragmatic response to most likely political and electoral pressures. Internally, the government remained opposed *in principle* to the universal hospital care goal, taking every opportunity to try and convince the Commonwealth to review its policy settings. The WA Premier wrote to the Commonwealth in January 1976, soon after the federal election:

Quite frankly we would prefer a complete review of Medibank with the possibility of the scheme being abandoned and return to the former system of administering health programmes, with appropriate variations from time to time to meet changing circumstances and need (WA Govt 1975: 49).

While the call was overlooked, the Commonwealth's subsequent fiscal tightening only served to intensify WA's policy desire to return to the pre-Medibank arrangements. Four years on, at a State Standing Committee meeting in April 1980, the WA government continued to impress upon the Commonwealth, its "policy of wanting to charge all inpatients and outpatients (excluding pensioners and specially disadvantaged groups" (WA Govt 1979a: 14). In terms of its internal manoeuvring to have the universal hospital care reviewed, the WA government appears to have stood alone.

At a meeting of State officials in May 1979, a WA government representative noted:

I indicated that WA had advised the Commonwealth that it did not believe that free standard ward treatment in recognised hospitals should continue to be available to all Australian residents irrespective of income and that all those who could afford to do so should be expected to contribute to a health insurance fund or be charged for treatment. It was fairly obvious that the other States had not given any or much consideration to this matter and the Victorian and South Australian representatives doubted if their governments would take any action. Queensland would not as it is contrary to their long standing policy. New South Wales has not come to any conclusion. Tasmania may be prepared to charge. The Northern Territory representatives however advised that the Northern Territory is in favour of raising charges for both inpatients and outpatients who are uninsured" (WA Govt 1979b: 49)

It is likely that the Commonwealth canvassed the other States independently, with the Fraser government confirming at one stage that "no other State, other than Western Australia, will accept the old pre-Medibank system where everyone was charged and if a person could not pay, the charges were written off" (WA Govt 1979b: 9-10, 14).

Salaried and sessional doctor remuneration

As mentioned, the 1976 Agreement preserved all clauses pertaining to the doctors' remuneration goal, with the Commonwealth defiant against AMA pressure to abandon this goal (WA Govt 1976b: 32-7). In particular, the WA government appears to have remained keen for national engagement on wage setting. This is evidenced by the Premier's call in December 1980 for Health Ministers to jointly discuss a range of emerging wage claims which were expected to have flow-on impacts across all States (WA Govt 1980b: 10-11).

Notwithstanding this continuing of policy congruence, there was a critical change in the implementation of this goal. Unlike the Whitlam era where Commonwealth officers closely participated in face to face negotiations with the profession, the Fraser government opted to take a less hands-on approach. The obvious lack of a coordinated approach between the Commonwealth and States allowed the medical profession to regain some policy setting ground. A key example of this is the Commonwealth's decision to reduce its medical benefit payment for medical services, from 85 per cent to 75 per cent of the scheduled fee, from 1 July 1978 (WA Govt 1978b: 38-42) . The decision impacted on modified fee-for-service arrangements in hospitals, particularly in SA and WA where remuneration formulas were linked to the Commonwealth's benefit rate. Being a unilateral decision, the States were simply expected to reduce their payments to hospital medical staff by the 10 per cent reduction, in line with the new Commonwealth policy. This was in fact the initial response of the SA, Victoria and NSW governments, although the SA government had difficulty getting the medical profession on side and ultimately had to seek Commonwealth approval to pay the higher rate.

The WA government, in contrast to the other States, opted to continue payments at the 85 per cent rate, well aware that its policy choice was "ultra vires of the Agreement" (WA Govt 1978b: 38). It argued that the Commonwealth's unilateral decision did not allow for prior consultation with the profession and that the rate cut was "unfair" to doctors. A formal request to the Commonwealth to continue with the higher rates was promptly rejected by the federal Health Minister who required WA to negotiate the lower rate with the medical profession, just as other States had done (WA Govt 1978b: 30-1). A 'blame game' rapidly developed between the Commonwealth and the WA government. In October 1978, the State wrote to the WA branch of the AMA, transferring responsibility for the rate reduction to the Commonwealth (WA Govt 1978b: 21) :

The negotiations which have taken place with the Commonwealth government have not succeeded in obtaining agreement to a continuation of payment at 85 per cent but rather an implied threat that if payments do continue at that level, the Commonwealth will not share the cost of the payment in excess of 75 per cent of the schedule fee.

In November, in response to an enquiry from the federal AMA, the Commonwealth effectively 'handballed' the matter as a State responsibility (WA Govt 1978b: 19):

the Commonwealth has an undoubted interest in these matters...in view of the Commonwealth-State cost-sharing arrangements. Any negotiations on possible reductions in fee for service or change to sessional payments is of course a matter for the individual State and the State branches of the AMA ... approach to Commonwealth will only be necessary if or when approval under Commonwealth-State agreements may be necessary.

The AMA was quick to act on the Commonwealth's 'third party' stance. Whilst agreeing that the negotiations were primarily a State matter, the AMA pointed out that the Commonwealth was nevertheless intimately involved, being responsible for endorsing the final settlements reached for cost-sharing purposes. Observing that all States were offering only the 75 per cent because the "Commonwealth would not agree to other than these terms", the AMA fiercely declared "this is not negotiation", and is "an unjustified use of governmental pressure". Finally, well aware the Commonwealth was on the back foot, the AMA used a powerful bargaining chip (WA Govt 1978b: 16-18):

...it is the country GP doctors most affected and they are angry...governments will be faced with much higher costs if they have to be replaced by resident medical officers ... I am deeply disappointed that within a few weeks of the AMA offering to defer the publication of its list of fees, with the effect that fees would be 'frozen' for a period of 22 months, governments are threatening a segment of the profession in this way and that Commonwealth influence appears to be the main factor... What is needed to defuse the situation, a step which I urge you to consider in the immediate future is a clear statement from you that ... negotiations in the various States should proceed without any preconceptions as to what arrangements or contracts the Commonwealth will find acceptable for the purpose of cost-sharing agreements..

The end result was of no surprise. The Commonwealth buckled under the AMA and media pressure and consented to the 85 per cent rate, concurring that States should have the flexibility to negotiate the terms and conditions that best meet their operating circumstances (WA Govt 1978b: 9-10).

5.4.3 Goal congruence – Overall evaluation

This analysis confirms that in respect of universal hospital care, the Commonwealth persisted with its goal primarily out of electoral pressure. Nonetheless, the implementation efficiency and effectiveness of this goal was heavily compromised. For fiscal and ideological reasons, the Commonwealth chose to convolute the implementation process with ongoing goal refinements, increased prescriptiveness, unilateral policy making across the wider health system and the persistent threats of funding constraint.

In comparison to the Commonwealth's approach, most State governments embraced universal hospital care, having signed the 1976 Agreement and secured Commonwealth financial support. While some States implemented the goal more vigorously than others, the reductions in private health insurance coverage rates would tend to suggest that the goal was advanced across all jurisdictions. All States may have objected to the goal *internally*, particularly as they faced increased financial pressures and administrative burden, but all in all, either willingly or unwillingly, they continued to deliver universal hospital care. Ultimately when the Commonwealth abandoned its goal, this did not arise from State rebuttal or resistance³⁵ but was primarily rooted in the Commonwealth's own ideologies and its pressing need to curtail expenditure growth. On the doctors' remuneration goal, the Commonwealth and the States both remained committed to the goal. In implementing this politically-charged goal however, unlike the Whitlam era, the evidence reveals that the Commonwealth did not always adopt a hands-on approach, thus allowing the medical profession to win policy influence. The reduced implementation effectiveness served to dilute the consensus between Commonwealth and States over this goal. On the whole, goal congruence in the Fraser era is considered to indicate a top-down policy making approach.

³⁵ In 1981, the WA government claimed it "played a key part in persuading the Commonwealth ... to abandon free hospitalisation" (WA Govt 1980d: 5).

5.5 INCENTIVES

As discussed earlier, it is contended that a financial sweetener of \$75 million swayed the States to commit to the revised cost-sharing deal. The context in which this sweetener was provided is however very different to the incentives offered during the Whitlam era. In the 1975 Agreement, it was the States who shrewdly extracted the highly generous financial concessions from the Commonwealth, these concessions genuinely benefiting their existing revenue base, and exceeding their expectations. By comparison, the \$75 million offered during the Fraser era was more in the nature of compensation — provided to *pacify* the States for their loss of a highly opened financial arrangement. At the time the sweetener was offered, the Commonwealth had declared the existing Agreements legally invalid and as such, the States were under considerable political pressure sign the new Agreement if Commonwealth funding was to continue. Ultimately, the Commonwealth already had the States captive, hence the concession was offered in a pragmatic and political sense, as opposed to being a true incentive to sign up to the agreement. In view of the circumstances, the evidence indicates neither a top-down nor bottom-up policy making approach.

It is noteworthy that in an unpublished Commonwealth discussion paper of 1979, the Fraser government signalled the introduction of incentives to "reduce bed occupancy rates, giving part of the resultant Commonwealth savings to...(the States)...to spend on specific community health projects"³⁶ (The West Australian as quoted in WA Govt 1979b: 65). The concept does not appear to have been further developed however, the Commonwealth preferring not to become closely involved with these systemic performance issues.

5.6 ENFORCEMENT

As discussed at sections 5.2 and 5.3, the Commonwealth heavily increased its monitoring and questioning of hospital activities during the Fraser era. There was also considerable rise in the quantum and detail of reporting required from the States (WA Govt 1976b, 1978b, 1979a, 1980c). This included not only regular reporting but also a range of ad hoc requests.

Standardised forms were used to collect data such as:

- gross operating costs per available bed, occupied bed and on a per capita basis;
- net operating payments per available bed, occupied bed and on a per capita basis;
- net operating costs per available bed, occupied bed and on a per capita basis;

³⁶ The Commonwealth suggested that lower bed occupancy rates could be achieved through reforms to "admission policies, reviewing the length of stay of patients and making periodic surveys of medical practice in hospitals".

- bed numbers at 30 June, beds per capita and bed occupancy rates;
- numbers of admitted patients and outpatient services and daily average inpatients;
- number of full time equivalent employees at 30 June;
- staff per available bed and per occupied bed; and
- total salaries and wages per occupied bed.

With regards to *ad hoc* reports, a letter from the Commonwealth in 1977 for example sought information from the WA government on (WA Govt 1977b: 14-16):

- potential cost shifting activity involving pharmaceuticals in North West hospital services and the Perth Chest Clinic. The Commonwealth advises it is acting in response to "recent request for pharmaceutical benefits scrip for Port Hedland Hospital";
- hospital admission procedures. Acting in response to a patient complaint, the Commonwealth claims that patient election processes are prohibiting patients from electing to receive treatment free of charge;
- conditions of service applying to Visiting Medical Officers and medical practitioners employed in teaching hospitals;
- services provided by pathology laboratories of recognised hospitals in respect of outpatients and private doctors;
- supply of disposable syringes at outpatient clinics; and
- all inpatients in State nursing homes.

The frustration of those involved in the process is clearly apparent, with WA hospital administrators commenting (WA Govt 1978c: 40; 1979b: 79):

I am appalled at the tremendous amount of staff time and expense which has been and will continue to be involved in meeting Commonwealth requirements, which include many meetings of officers and a tremendous amount of detail both in respect to budgets and actual experience. Most if not all of this could be eliminated if the State received Commonwealth money as part of tax-sharing arrangements and was left to manage its own programme.

Importantly, from a performance perspective, it is unclear as to the extent to which the Commonwealth actually made use of this information to improve the efficiency and effectiveness of implementation of the 1976 Agreement. The under-developed nature of hospital statistics made it very difficult for the Commonwealth to place reliance on the data. For example, at a State Standing Committee meeting in April 1977, the Commonwealth attempted to criticise WA's excessive "Average Cost per Inpatient Bed Day" in comparison to other States. A subsequent survey of the reporting practices of the NSW,

Victoria and SA governments (initiated by WA) revealed each of the States to be using different formulae to determine the resultant cost, essentially deeming the Commonwealth's comparisons meaningless. The lack of a common reporting framework appears to have enabled the States, or rather the hospitals themselves, to hold the upper hand - the survey confirming that some States "seemed to treat their preparation of the RH3A [form] as a joke, and [had] indicated that their figures were arrived at merely by guesswork" (WA Govt 1977d: 34-6).

The staggering rise in reporting requirements quite clearly indicates a top-down mode of shared governance. From a grant performance perspective, it is important to add that the quality of reporting and the limited use made of reported data by the Commonwealth — both confirm that the increased enforcement added to administrative costs but did not facilitate better implementation of national goals. This is validated further by the fact that despite the greater enforcement activity, the Commonwealth ultimately had to resort to other mechanisms such as the withholding or capping of funding, to achieve its policy objectives.

5.7 LOCAL DISCRETION

A key area of local discretion diminished by the 1976 Agreement was that of private patient fee setting. As discussed previously, the Commonwealth exerted stringent control over the setting of private patient charges, delaying fee increases by two years, much to the irritation of the States (WA Govt 1976b, 1978c, 1979b, 1979a). Other evidence also exists of coercive intrusion into State revenue matters. In late 1982, the Fraser government used its constitutional powers to enforce the withdrawal of a Victorian government levy on private health funds. The levy had been implemented primarily to enable the charging of hospital outpatient services provided to privately insured patients. Essentially it was a 'workaround' designed to overcome resistance from some of the private health insurance funds to accepting the bulk billing of outpatient services. However, the Commonwealth was adamant that withdrawal of the levy was necessary "to protect the insured public and the taxpayer against excessive health cost increase". The Victorian government was furious, threatening that removal of the levy would "cause chaos in the Victorian health funding system and should be a warning to other States of the Commonwealth's willingness to override ... State taxing powers" (The Australian Financial Review as quoted in WA Govt 1975-76b: 1). The Commonwealth was persistently secured its desired end. It is important to note that the States were not always overpowered. For example, the Commonwealth's

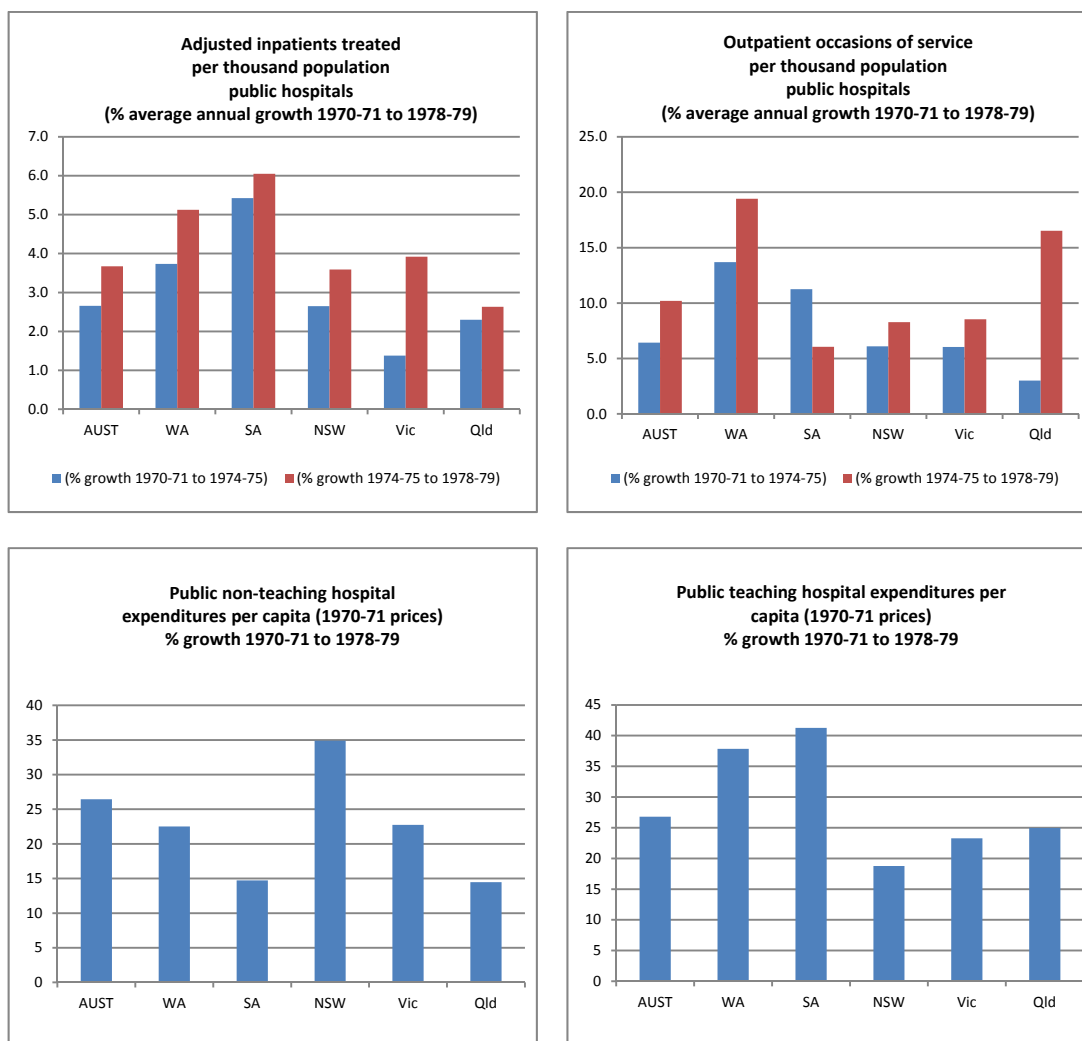
sustained coaxing of the WA government to introduce charges for outpatient services to privately insured patients was repeatedly rebuked (WA Govt 1976b, 1977d, 1979b, 1980b).

Apart from revenue policy setting, levels of local discretion were substantial, as evident during the Whitlam era and as identified by the Jamison Inquiry (1981). Earlier discussion at section 5.3 revealed that under the Fraser government, the States quite capably resisted Commonwealth policy intrusions to restrain planned hospital expansions; introduce bed day targets; scale back on bed numbers in private hospitals; and introduce staffing level ceilings (WA Govt 1976a, 1977d, 1978b). Further evidence that day to day operational control remained very much in State hands is the considerable variations that prevailed in governance structures and policy settings between States, for example in bed classification; the extent of private practice allowed; the availability of private hospitals and private beds; the payment of visiting medical officers; the billing of pensioners; legislative frameworks; and administration and management arrangements (The AMA as quoted in WA Govt 1976a: 45-6). The Commonwealth itself observed the significant variations between States in admission processes, medical protocols and length of stay (The West Australian as quoted in WA Govt 1979b: 65).

The quality and mix of services appears to have been largely in State control, driven by demographic, geographic and other contextual factors. This ample local discretion is confirmed by considerable variations in the implementation of universal hospital care. For example, the charts below³⁷, developed from data reported by the Jamison Inquiry (1981) clearly show that States differed in terms of their hospitalisation rates and take-up of universal hospital care (as evidenced by trends in inpatient and outpatient service growth); and in the service delivery and cost structures underpinning the provision of universal hospital care (as evidenced by the use of teaching versus non-teaching hospitals, the former being the more expensive care setting). A further factor affecting implementation factors was the support of the medical profession which as discussed was secured much earlier in WA and SA than in the larger States.

³⁷ Given the quality of health statistics at the time, the charts should be treated with care and as an indication only.

Figure 5.2 Implementation variations – universal hospital care



Whilst the Fraser government increased prescriptiveness, the universal hospital care goal certainly remained broad enough to allow a whole range of operational choices to be adopted by the public hospitals, without recourse to the Commonwealth.

Nevertheless, the States do appear to have felt increasingly frustrated and inhibited. The pulling back of federal funding, and the growing administrative effort required in dealing with the Commonwealth were clearly major issues — although other causes of discontent are also apparent. A key area of contention for WA was its inability to encourage the private financing and provision of hospital care. The Commonwealth's continued tinkering with private health insurance benefit payments; desire to rationalise private hospital beds (WA Govt 1978d: 44-9); and its public support for universal hospital care led to significant drops in private health insurance coverage rates in WA — a fact regularly bemoaned by the WA government. The Fraser government, similar to its predecessor, failed to identify a clear role for the private sector, preventing the States from utilising that sector more effectively.

In 1980, a number of WA public sector surgeons lamented the wastage of private hospital infrastructure (WA Govt 1979a: 1):

Quite clearly the system of health insurance and hospital charges is driving people out of the private medical funds and therefore of course out of private hospitals ... if this causes a shortage of beds in public hospitals and an over-crowding of them, it appears it is having just the opposite effect on private hospitals. Quite clearly there are empty beds in private hospitals. It seems ludicrous ... that we should be faced with a problem of providing beds when beds exist with good back-up services, including operating theatres, competent staff, adequate kitchen facilities, experienced cleaning staff and the like ... it would be quite clearly in the interests of the State to save capital expenditure and tap into the resources that already exist.

A further source of discontent was the States' inability to plan and manage the supply of health workforce. A letter from the WA Premier to the Commonwealth in late 1980 points out an excessive supply of hospital professionals in comparison to general practitioners, prompting the over-provision of hospital services, as opposed to primary and home care. The same letter observes (WA Govt 1980b: 9):

Public hospitals are being required to do more and more with less and less, and their capacity to cope with further demands is limited. At present there is no real control over the ebb and flow of activity between hospital and extramural services.

Other drivers for State discontent were the Commonwealth's reduced and wavering support for community care; and its predominantly unilateral control over the medical benefits schedule³⁸ (Australian Health Ministers 1983: 21; WA Govt 1978d: 10. 32-3). A further convoluting issue, evident also during the Whitlam era, was the Commonwealth's unilateral provision of grant funding direct to non-government organisations, for example for delivery of indigenous community programs (WA Govt 1978d: 14-15). Thus, while States may have had the final say in most of their local hospital operational decisions, it is apparent the hospital system as a whole was increasingly having to 'react' to flow-on effects from other parts of the health system controlled by the Commonwealth. These flow-on effects diminished State capacity to more strategically and sustainably manage the delivery of hospital care.

It is important to note that this lack of control over the wider health system would not have appeared as significant a problem to the States during the Whitlam era, when their access to funding was virtually unlimited. It is only when the Commonwealth removed the funding security, and the States were forced to provide universal hospital care under constraint, that the stifling of local discretion began to appear more vividly. Had the Commonwealth taken a more collaborative approach, perhaps these issues could have been better

³⁸ At the time, it is apparent that the Medical Benefit Schedule was determined by a committee consisting of Commonwealth officers and AMA representatives. The WA government noted that a "considerable element in the State's share of costs for medical services are due to the level of payment set by this committee" however it was unable to ascertain what elements of the set fee related to professional service and to "equipment and practice expenses". In 1981, after consulting with the AMA, the Commonwealth relented somewhat, allowing State representation on two sub-committees.

discussed and dealt with from a policy sense. This was not to be, however, as the Fraser government, just like its predecessor, opted to place a barrier around the States and the public hospitals, separating them from its policy setting around the wider health system. A further encroachment on States' local discretion during the Fraser era was that the goal of universal hospital care remained too expansive in scope, despite the Commonwealth's scope adjustments. While the generous scope of services was manageable under the initial open-ended cost sharing deal, the unconstrained nature of universal care became a burden for the States when the Commonwealth began to curtail its funding contribution. One must not overlook the fact that the public hospital systems were close to bankruptcy prior to the Whitlam government. The 50–50 open-ended cost sharing deal was no doubt an excessive and extravagant response to the 30 to 33 per cent funding gap that States had identified in early 1970s. However, given that the additional funding went towards the restoring of solvency; the replacement of honorary medical services; and funding the high health inflation of the 1970s, State capacity to cope with sudden reductions in funding is likely to have been limited, without significant microeconomic and structural reforms.

The abovementioned 'big picture' constraints on local discretion reduced the capacity of States to deliver efficient and effective health services. But did these restraints completely stifle State capacity to improve and innovate? One proposition is that a system that is continually in a 'reactive' mode is unable to reach a level of stability that allows innovation and efficiency to be properly fostered. Another is that perhaps the Commonwealth's continual administrative intrusions and its focus on cost cutting had the effect of distracting attention away from more strategic issues. It has already been noted that the Commonwealth's focus on budget estimates provided little incentive for longer lasting structural and governance reform in the system. The incessant haggling on the immediate and short term matters does appear to have cast a dominating shadow over the entire intergovernmental relationship (The West Australian as quoted in WA Govt 1979a: 17):

The AMA called for budgeting changes to encourage efficiency in hospitals by allowing them to retain any surplus saved through cutting costs. It said that at present, the Government demanded the return of the unspent money on the ground that the hospital had been untruthful or incompetent in drawing up its budget...

Nonetheless it was the States that had the final say over the quality and mix of services and underlying clinical and management practices. For example, the medical profession itself was derogatory of State hospital governance (The West Australian as quoted in WA Govt 1979a: 17):

the AMA ... criticised present hospital accounting procedures, which it said, described spending under headings such as wages and provisions instead of specifying how much it was costing to treat patients

with different illnesses ... Hospitals should introduce more efficient rostering of staff to cut overtime payments and should have more freedom to hire and fire staff.

Perhaps the States were unable or unwilling to invest the time and resources needed to respond to these types of shortcomings. Additionally, they may have been unable or unwilling to single-handedly cope with the 'politics' of such reform.

Minutes from National Standing Committee meetings between 1977 and 1981 show both the Commonwealth and the States discussing initiatives to improve the efficiency and effectiveness of hospital service delivery and management practices (WA Govt 1977c, 1980d)³⁹. There is evidence of lively discourse with Commonwealth and States representatives sharing information; cooperating on the development of policy reforms; participating on joint working parties; and preparing discussion papers. The machinery and intent certainly appears to have been in place. In discussing initiatives, the minutes refer to various pilots and trials initiated by individual States — a clear sign that policy innovation and improvement was in fact being fostered at the grassroots level. Additionally, there is evidence that some of the initiatives trialled were eventually adopted by all States as part of their policy settings, for example a goal to increase investment in public health (WA Govt 1980a: 5).

Nonetheless this bottom-up policy making does not seem to have translated into far-reaching or sustainable improvement programs at the ground level.⁴⁰ A number of possible causes are evident. First, it must be recognised that the bottom-up policy making of the National Standing Committee was driven by senior Commonwealth and State bureaucrats. No matter how successful the Committee may have been in developing policy recommendations or guidelines, ultimately the wide-spread adoption of these reforms was dependent on the interest and support of Commonwealth and State Health Ministers; Commonwealth and State Cabinets; and finally the implementing hospitals and clinicians themselves. Additionally, the Committee itself needed to reach agreement first. Given the number of States and the complexity of some of the issues, reaching consensus could take considerable time, both in terms of the underlying research work involved and for States to come to a shared view. The lack of data is likely to have been a major hindrance in this

³⁹ Issues discussed included: national standards on hospital staffing ratios; impact of teaching hospitals on the health system; guidelines on the estimation of need for hospital services; dedicating a fixed proportion of the health budget for preventative health; evaluation of new medical technologies; evaluation of the efficiency and effectiveness of different medical procedures; development of sub-acute care and home care services to reduce use of acute care; the development of national data collections; rights of private practice for salaried specialists; uniform financial reporting; over-servicing by doctors; a cost of living index for hospitals; and the use and value of diagnostic testing in hospitals.

⁴⁰ Although just the opportunity for regular dialogue was valued by the Commonwealth and State representatives, with the Committee agreeing to continue meeting even after the 1976 cost sharing Agreement had been replaced with the Identified Health Grant.

regard. Although the problem was partially overcome through the use of hospital surveys, these instruments were often time-consuming, cumbersome and crude in terms of the data generated. Another factor that would not have assisted the Committee's work was the continual shifting in the Commonwealth's broader policy settings around Medibank. Finally, when compared to the more politically charged budget negotiations, it is quite likely that these more micro-level policy issues did not receive the necessary profile and most crucially, did not have specific funding and accountability attached.

With its fiscal superiority, the Commonwealth was certainly in a prime position to assume a greater agenda-setting role. In some areas, its efforts appear to have been little more than symbolic gestures. For example, in seeking to encourage the development of peer review processes for medical services, the Commonwealth appears to have provided \$150,000 funding to the AMA between 1976 and 1979. The WA government, while supportive of the concept, noted that in view of the data needs alone, "peer review will require ... financial input ... and implementation may take up to five years" (WA Govt 1978a: 50-1). In contrast to the National Standing Committee forums, the Jamison Inquiry (a joint Commonwealth-State venture) appears to have been quite effective in stimulating policy framework change. For example, the WA government seems to have incorporated a range of recommendations coming from the Inquiry into its own policy platform: the improvement of financial management information systems in public hospitals; collection of comprehensive and timely State morbidity data; increased staff rotation between central health authorities and hospitals; tighter management of public hospital bed numbers recognisant of trends in the use of private hospitals; the introduction of centralised purchasing; and closer alignment of policy and planning functions with budget allocation and management functions (WA Govt 1980a: 10-12). It is unclear how successfully these policy initiatives were implemented. There does not appear to have been a framework for monitoring or promoting the speedy implementation of these important policy improvements.

All in all, the combination of tightened funding; stringent control of revenue policy setting; the continued requirement to provide an expansive range of universal hospital services; and the lack of State control over wider health system policy levers — all served to reduce the local operational discretion that States possessed. This was offset by States continuing discretion to determine the quality and mix of services; service delivery and cost structures; the rate of implementation; and clinical and management practice within the hospitals. Overall the evidence suggests there was neither a top-down or bottom-up approach.

5.8 STATE GOVERNANCE BARRIERS

Chapter 4 noted the wide range of governance and management shortcomings that would have operated to stifle the efficient and effective delivery of universal hospital care as identified by the Jamison Inquiry (1981). As discussed, these barriers remained prevalent during the Fraser era — although the Commonwealth’s greater administrative and policy involvement and may have stimulated some improvements. Overall, however, it is considered that the scale of barriers that existed indicate a bottom-up governance approach.

5.9 CONCLUSIONS: BALANCE OF POWERS

The following table summarises the assessment formed against each of the analytical foci:

Table 5.2 Balance of Powers – Fraser Era

Analytical Foci	Indicative Shared Governance Approach
Goal clarity	Top-down
Goal setting	Top-down
Goal congruence	Top-down
Incentives	Neither top-down nor bottom-up
Enforcement	Top-down
Local discretion	Top-down
State governance barriers	Bottom-up
OVERALL ASSESSMENT	TOP DOWN

With regards to its universal hospital care goal, the evidence in this chapter indicates quite clearly that the Commonwealth held the upper hand. Specifically the Commonwealth:

- adjusted the goal to suit its new economic circumstances;
- signed the States up to a tightened but nevertheless an extensive goal, but then subsequently proceeded to financially constrain its provision;
- intruded into State hospital budget formulation decisions, creating administrative burden, but doing little to incentivise well-performing States or facilitate medium or long-term improvements to input cost structures, governance systems or practices;
- made unilateral decisions around other parts of the health system, leaving State hospitals to cope with the flow-on effects; and

- dominated goal setting negotiations and budget formulation deliberations using its fiscal superiority.

The States, for their part were successful in retaining some of the earlier financial concessions from the 1975 Agreement and in resisting some of the Commonwealth's policy intrusions. Nonetheless, for the large part, they were in a reactive mode, responding to the Commonwealth's policy initiatives and budget constraints, as opposed to leading or contributing to the policy making process as an equal partner. At the local operational level, the State hospitals increasingly found their policy making capacity stunted, due to their inability to influence wider health system policy settings. The lack of a holistic policy approach; the overall financial constraints; and finally, the local political barriers faced by the States in instigating operational improvements — all served to make it very difficult for public hospitals to deliver the universal hospital care goal efficiently and effectively .

On the doctors' remuneration goal, while there was consensus, this seems to have been more coincidental from the Commonwealth's perspective, as salaried and sessional remuneration was consistent with its predominant objective to achieve a more economical version of hospital Medibank. Unlike the Whitlam era, the Commonwealth does not appear to have desired a hands-on role in assisting the States to overcoming the political barriers they faced in implementing this goal. For example, the 1976 Agreement removed the requirement for annual joint reviews of implementation progress, and the Commonwealth attempted to distance itself from State negotiations over the reduction in medical benefit rates. The Commonwealth's withdrawal from this policy space affected goal implementation in the larger States and also allowed the medical profession to claim back some of the bargaining ground they had conceded under the Whitlam government. All in all, the shifting policy positions of the Commonwealth, from an ideological, fiscal and implementation perspective, placed the States in a much less commanding role compared to the Whitlam era. Additionally, and most importantly, the Commonwealth's dominance of policy setting created a range of undesirable performance impacts, as discussed below.

5.10 REFLECTIONS ON TIED GRANT PERFORMANCE

The significant decline in policy setting integrity and stability between 1976 and 1980, fuelled primarily by the Commonwealth's unilateral actions and its fiscal dominance, led to significant deterioration of this intergovernmental relationship. The Commonwealth's rash and hasty approach obliterated any prospect for meaningful dialogue on genuine ways and means to improve the current policy settings for community benefit.

5.10.1 Performance advantages of tied grants

The Whitlam era findings confirmed that a cooperative approach to mutually desired and politically-charged goals can be performance advantageous. During the Fraser era, both Commonwealth and States remained committed to the doctors' remuneration goal, however the Commonwealth stepped away from the hands-on approach adopted under the Whitlam government. The reduced collaboration resulted in a slowing of reform momentum and permitted the medical profession to increase its policy influence.

5.10.2 Performance deficiencies of tied grants

Convoluted policy compromises

The Fraser era evidence further confirms the Whitlam era observation that policy bargaining of tied grants can result in 'one-on-one deals' and significant inter-jurisdictional inequities in service delivery and policy outcomes. For example the WA Government appears to have negotiated a generous scope of universal hospital care compared to other States. The Fraser government acknowledged that whilst the "Commonwealth endeavours to achieve equity between States [it] ... recognises that under hospital cost-sharing some States receive more per capita than others" (WA Govt 1977c: 87). The inequities created from one-on-one bargaining can be offset or further aggravated by, inter-jurisdictional differences in service delivery settings — for example in cost and delivery structures, interest group pressures and competing expenditure priorities.

Emphasis on macroeconomic performance

In securing increased policy involvement through tied grants, the Commonwealth appears to centre policy setting on its own macro level policy priorities, thus preventing a more holistic policy discussion on the deep-seated 'structural' reforms necessary for enhancing managerial efficiency. The evidence considered in this chapter confirms that while the Fraser government became heavily involved in hospital budget setting, this was aimed primarily at addressing its immediate economic pressures as opposed to identifying sustainable strategies to improve hospital governance. Despite voluminous information requests and tedious probing of budgets, there was little achieved in terms of instituting meaningful change to service delivery practices at the ground level. The use of grants in a heavily unilateral and prescriptive manner distracts attention from managerial efficiency which ultimately lies in the hands of clinicians and hospital administrators.

Policy bias towards the larger states

The Fraser government's adoption of a bed-day target based on Victoria's hospitalisation rate is further evidence that policy making around tied grants tends to be biased towards the larger States.

Administrative and operational inefficiencies

It is clear that the Fraser government's exhaustive intrusions into hospital operations through the State Standing Committees were not only administratively cumbersome and costly for the States but were also ineffective because of information asymmetries.

These performance observations will be further explored in Chapter 8. The next chapter moves to the Hawke era during which the Fraser government's unwinding of the universal hospital care goal was reversed and the policy reinstated in a different form from 1984.

6 THE HAWKE ERA — REPOSITIONING AND RETREAT

6.1 OVERVIEW

The Hawke era saw a return to the universal hospital care and doctors' remuneration goals after the Fraser government's unwinding of the 1976 Agreement. A notable feature was the relatively submissive acceptance of the universal hospital care goal by the States, in contrast to the fiery opposition of the Whitlam era. This can be attributed to three key factors: 1) the widespread public desire for national universal hospital care which no doubt contributed to Federal Labor's landslide 1983 election victory; 2) four Labor State governments "sympathetic to the scheme" (Cornwall 1989: 183-7; Lord 1984: 620); and 3) a new national interest pressure created by the universal hospital goal forming part of the Accord package, under which the trade union movement had consented to wage restraint in return for the 'social wage' — a universal medical and hospital system.

With universal hospital care becoming an accepted policy setting, this goal faded completely into the background with policy focus shifting dramatically on to the doctors' remuneration goal. Here, the Commonwealth contentiously sought to increase goal clarity, in particular tightening the remuneration arrangements for specialists providing diagnostic services. These adjustments were aimed at efficiency and cost containment, the Commonwealth quite desperate to avoid the inflationary impacts that had damaged the implementation of Medibank under Whitlam and Fraser. In this regard, although Australia had returned to a Labor government, the Hawke era saw a significant shift in Party ideology. The equity and access objectives that had driven the Whitlam government's Medibank were now joined with macroeconomic objectives under the revamped Medicare.

This chapter undertakes an in-depth case study examination of the 1984 Agreement and its immediate successor, the 1985 Agreement. Additionally at the end of the chapter, to extend the longitudinal reach of this research, further high-level case study examination is undertaken on the 1988, 1993 and 1998 hospital funding agreements signed under the Keating and Howard governments.

6.2 GOAL CLARITY

6.2.1 Goal clarity — Analysis

Universal hospital care

The early messages from the Commonwealth indicated an idealistic return to dominant public provision of health services and equality of opportunity principle of the Whitlam era (WA Govt 1985: 4, 104):

Medicare is a major social program ... it will ensure basic medical and hospital cover for all Australians, not leave two million Australians without any health cover as the current inadequate private insurance system does. ...equity ... is a fundamental thing we're trying to do in Medicare ... remove discriminations between disadvantaged and others, have it paid for in a reasonably fair way, make sure that everybody gets access to it ... underpinning ... Medicare is a notion of health care as the basic right of one and all.

Notwithstanding the declared policy likeness, the Labor Party, painfully aware of the costly and drawn out implementation experience of the Whitlam government, tightened and modified goal clarity in several ways.

First, recognising the implementation delays provoked by the Senate, States and medical profession during the Whitlam government, the Commonwealth was determined this time to ensure that "a carefully planned scheme ... be in place for at least two years before an election" (WA Govt 1983c: 108). A public commitment was made for Medicare to be implemented within the first twelve months, by 1 February 1984. Given the ideological factors that had partly driven the dismantling of the 1975 and 1976 Agreements, Labor firmly believed that a sustained period of implementation was critical to its policy longevity. It was noted that: "once people have experienced ... (Medicare's) ... benefits, governments will find, as in Queensland, that they dismantle it at their peril".

Secondly, unlike the Whitlam era implementation, the Commonwealth centred the Medicare grant negotiations predominantly on revenue compensation, as opposed to the sharing of hospital costs. The Medicare Compensation Grant was paid "in addition to, and independently of" the Identified Health Grants and other tax sharing arrangements, and was formula-driven, providing compensation for a range of revenue losses anticipated from the introduction of universal hospital care (Aust. Government 1984; WA Govt 1983c: 12-13, 52-61, 98-9):

- reduction of private patient fees for shared accommodation;
- abolition of outpatient fees;
- abolition of professional service fees;
- shift of public hospital patients from private to public status;

- variations in nursing home type patient arrangements;
- shift of patients from private hospitals to public hospitals; and
- other revenue foregone (the main being facility payments income).

Additionally, the grant also compensated States for additional medical costs expected to arise from a shift of patients from private to public status and growth in public hospital utilisation generally (Aust. Government 1984: 9-10). It was agreed that grant payments relating to in-patient revenue losses and additional medical costs would be adjusted on a quarterly basis for actual outcomes until 30 June 1985. Other components of the Compensation Grant would be indexed on a six-monthly basis to 30 June 1985. After that date, the entire Compensation Grant was to be provided as a block grant, escalated by an agreed annual index until 30 June 1987 (WA Govt 1983c: 92, 52-61, 99).

The Commonwealth argued that by lowering State temptations to use hospital charges as "revenue-raising devices", the compensatory grant would ensure a "stable (national) system of health insurance", thereby addressing the rising insurance contribution rates and falling coverage rates evident (Australian Health Ministers 1983: 86). The focussing of grant discussions on revenue compensation, block funding deals and somewhat abstract indexation factors distanced the Commonwealth from State hospital governance and service delivery policy detail. While one would have expected that such a withdrawal by the Commonwealth would have brought welcome relief for the States, particularly following the gruelling State Standing Committee deliberations of the Fraser era, the situation eventually turned to frustration, as the policy goal of universal hospital care was forced to coexist with extremely tight Commonwealth budgets. Increasingly, as the Commonwealth moved to position itself as a compensating, rather than an equal cost sharing financial partner in the universal hospital care goal, the economic, rather than health service aspects of the grant came to dominate Commonwealth–State deliberations.

The initial policy settings around revenue compensation payments were prescribed in great detail. With regards to private in-patient accommodation fees, the Commonwealth sought for fees to be reduced to \$80 per day, agreeing to a pay a grant subsidy of \$50 per day. The payment formula allowed for a 98 per cent bad debt rate, argued upwards by the States from the initial 96 per cent proposed. Further, the Commonwealth sought to freeze the \$130 daily fee rate for twelve months and agreed to index its \$50 daily grant payment by 4 per cent of Average Weekly Earnings from 1 August 1984. Unlike the Fraser era, the Hawke government appears to have retained control over private patient fees just for the early

stages of Medicare. Presumably it was considered that the indexed compensation grant would more than adequately ensure fee stability over the longer term. Fee adjustments beyond 1 February 1985, agreed to occur every six months, were delegated as a "matter for the States". The Hawke government appears to have retained control over also opted to leave fee settings for single rooms and compensable patients completely in the hands of the States (WA Govt 1983c: 52-61, 98-9). Further, the Commonwealth permitted the charging of outpatients for pharmaceutical and other supplies, under agreement with the federal Minister for Health (WA Govt 1983c: 52-61).

Another area of variation in comparison to the Whitlam and Fraser eras, was in the role to be played by the private hospital sector, within the policy of universal hospital care. Here, the Hawke government was more forthright and articulate (WA Govt 1983c: 109):

There is no evidence to suggest private hospitals will be adversely affected by Medicare, the Government is committed to the continuance of a viable private hospital sector. If the experience of Medicare indicates any significant drop in private hospital occupancy, the Government will take measures to alleviate these problems.

It is noteworthy that earlier under Whitlam, the WA Government had to bargain with the Commonwealth to have private hospital care formally acknowledged in the Agreement, whereas under Hawke, no such prompting was required. The Medicare grant arrangements formally accounted for the potential flow-on effects between private and public health care, the Commonwealth agreeing to compensate States for every additional public patient day in excess of 1982–83 patient numbers. Interestingly, the Commonwealth also tried to shift its responsibilities for the payment of private hospital daily bed subsidies and the inspection of private hospitals on to the States (WA Govt 1983c: 29). However, the States refused, the WA Health Commissioner earmarking this rebuttal as a "particular achievement". The Commonwealth eventually withdrew its push, deciding to channel the subsidies through the private health funds instead (WA Govt 1983c: 37; 1984c: 84). Naturally, the States were not keen to assume the political risk of ensuring the viability of private hospitals while being dependent on Commonwealth funds (WA Govt 1983c: 25). The Medicare policy framework also provided for the "categorisation of private hospitals according to the services they offer" and the payment of differential bed day subsidies. This goal appears to have evolved from the Fraser era push for greater regulation over the private hospital sector which was resisted at the time. It seems the Hawke Government's longer term objective with private hospital categorisation, was to integrate "private hospitals into the public system" (Parl Comm. 1984f; WA Govt 1983c: 52-61, 124-6; 1984f: 201). Whether or not this was the actual long term intention, it is quite clear that the

Commonwealth desired greater control over private hospital viability and growth, and wanted the States to participate towards this end (Australian Health Ministers 1983: 88).

Reporting requirements associated with the Medicare Compensation Grants were framed fairly specifically around the data needs of the various compensation payment formulas. Consistent with its economic focus, the Commonwealth also secured from the States, an in-principle agreement to "cooperate ... to the fullest extent possible" in overcoming fraud and over-servicing. This latter commitment initially involved quite an open-ended requirement for data; however, the States were able to limit this to data of a patient related nature, to be provided within timeframes acceptable to the States (WA Govt 1983c: 30). Additionally, the Commonwealth agreed to finance the information costs involved, should States indicate such data were not readily available. In this regard, the 1984 Agreement provided \$50,000 to WA, for the "development and provision of hospital statistics" (WA Govt 1983c: 52-61; 1984c: 2). Further, similar to the holistic health service aims of the Whitlam government, the Medicare Compensation Grant provided for the reintroduction of the Community Health program. A total of \$20 million was allowed for, of which \$18 million was distributed amongst the States. The initial grant provided for no escalation of the grant, nor any guarantee of its continuity beyond June 1985 (WA Govt 1983c: 52-61).

Special arrangements were allowed for Tasmania and SA where the 1975 Hospital Cost Sharing Agreement continued to apply, and for Queensland which had maintained its universal hospital care in spite of the Commonwealth's withdrawal from this policy during the Fraser era. Tasmania and SA were effectively 'paid out' for their losses from early termination of the 50–50 cost sharing deal, whilst Queensland was offered special annual compensation of \$35 million over and above the Medicare Grant (Parl Comm. 1983; WA Govt 1983c: 100).

Doctors' Remuneration

Whilst the Commonwealth's adjustments to the universal hospital care goal centred on its funding and implementation aspects, the modifications made to the doctors' remuneration goal were in comparison, remarkably prescriptive, and proved to be much more provocative. A number of factors appear to have motivated the Commonwealth to adjust and tighten this policy goal.

The first of these were the obvious implementation gaps apparent after Medibank. The 1975 and 1976 hospital agreements had idealistically attempted to establish salaried and

sessional payments as the main form of doctors' remuneration, with minimisation or abolition of rights of private practice in public hospitals. As discussed at Chapter 4, this goal initially created enormous friction and service disruption, which ended with the Commonwealth having to make compromises, permitting the use of modified fee-for-service contracts in some of the non-teaching and rural hospitals to ensure workforce availability. Additionally, as observed in Chapter 5, the short life of the Whitlam government and the reduced attention given by the Fraser government, meant that even this modified goal was not uniformly implemented in all States — NSW in particular, showing pockets of concentrated resistance. Throughout the Medibank era, for ideological reasons some of the NSW medical profession continued to operate under the former honorary system, with the profession there actively promoting take-up of private health insurance (Larkin 1989: 69-70; McKay 1986: 220-1).

A second factor behind the adjusted policy direction was a set of issues specific to the utilisation and cost of diagnostic services. Here, there were several matters that the Commonwealth sought to address. Primarily, there was the prolonged resistance of the diagnostic profession to universal care and restraints on private practice. The Whitlam government had insisted that diagnostic services be provided free, for both public and private patients. However the Commonwealth was intent on avoiding "the experiences of 1974 when salaried radiologists and pathologists left public hospitals because they did not have rights of private practice". (Adams 1986: 94; Larkin 1989: 69-70; McKay 1986: 220-21; WA Govt 1983b: 243). To counter the expected resistance, the Hawke government decided it would pay medical benefits for diagnostic services provided to private patients in public hospitals, with appropriate cost controls (Committee of Inquiry et al. 1984: 1; Larkin 1989: 69). A further policy intention with respect to the diagnostic profession, was the Commonwealth's desire for greater uniformity in private practice rights and fee splitting arrangements. During the Medibank era, a myriad of arrangements had emerged, with wide variations between States, hospitals, and grades of professional. The push for greater uniformity actually began during the Fraser government. A Commonwealth–State Working Group on Diagnostic Services had recommended that private practice rights: (WA Govt 1977a: 72):

[and] fee-sharing arrangements ... be formalised throughout Australia on a uniform basis and recognised at a national level. Every effort should be made to identify what fraction of the fee can be attributed to the professional input that is made to any particular service. In addition fee sharing arrangements should be determined in a manner that would allow each hospital to audit services provided and revenue generated.

The recommendation was accepted by a National Standing Committee (a bureaucratic group) in 1977 but was not implemented, allowing jurisdictional variations to continue.

Finally, the Commonwealth sought to address medical fraud. In the early 1980s, there was significant 'noise' around fraud and over servicing with a 1982 Joint Parliamentary Public Accounts Committee estimating potential losses of \$100 million a year (Committee of Inquiry et al. 1984: 5-6). The accuracy of this figure and its relevance for public hospitals was questionable (Penington 2005: 588):

We had a protracted chase to get data from the federal government which purported to show excessive private use of pathology and radiology facilities in public hospitals. In reality, the rapidly expanding use of such services was outside the public hospitals, but the advisors who developed the legislation thought control could only be achieved in public hospitals.

Notwithstanding, the Commonwealth chose to address the issue through its tied grant arrangement with the States, insisting there was a need to "strengthen the management capacity" of public hospitals to facilitate tighter monitoring and control of service utilisation (Committee of Inquiry et al. 1984: 95-6).

In summary, it is apparent that the Commonwealth was compelled to re-shape its doctors' remuneration goal for a range of pragmatic reasons — medical profession resistance; greater national uniformity; and a desire to control the price effects of its cautious policy acceptance of modified fee-for-service arrangements.⁴¹ The Commonwealth gave indication of its policy shift prior to the 1983 federal election, albeit in very broad terms. According to a pre-election speech in 1982, the Labor Party confirmed it had (Parl Comm. 1984e; WA Govt 1984f: 199):

put aside any primary emphasis on salaried or capitation systems in pragmatic recognition of the prevailing culture and attitudes in this society and in its effort to secure widespread community support for its program ... private fee-for-service medicine is deeply entrenched in Australian society, strongly defended by the medical profession, and favourably evaluated by the population at large. That is a fact of life and whatever changes we desire in that system will have to take place gradually and incrementally.

Its accompanying policy insistence on cost control was also articulated, with the Labor Party declaring it would (Lord 1984: 627):

build into the health system restraint on medical fees and make conditional the use of public health facilities on the observance of fee constraint ... this stems from Labor's belief that in the field of curative medicine at least, cost containment will be most effective through pressure on the supply side by encouraging restraint by the providers of health care services - doctors, specialists, hospital administrators and hospital proprietors.

The policy journey between these statements of policy intent and the final prescriptive amendments to section 17 of the Health Insurance Act 1973 and accompanying Commonwealth guidelines is an unclear one.

⁴¹ In its Second Reading speech justifying the supporting legislation, the Commonwealth also cited the Fraser government's Jamison Inquiry, which recommended in 1981 that private practice rights be urgently reviewed, limited in scope and gradually phased-out (Senate Hansard 1984a).

At the first post-election Health Ministers Conference in April 1983, the Commonwealth and States discussed the issue of uniform rights of private practice but settled on a passive information gathering exercise as opposed to any radical reform (Australian Health Ministers 1983: 28):

an inquiry into private practice arrangements, simply to determine and examine the nature of those arrangements which at present operate in a hospital; we could then look at approaches to that....

Interestingly, at the instigation of the NSW government, all parties went so far as to have the policy matter removed from future Conference agendas. By July 1983 however, considerable momentum appears to have gathered for more aggressive reform. WA government notes from the July 1983 meeting of Health Ministers records that the "Commonwealth proposes to legislate to preclude payment of medical benefits to salaried/sessional doctors employed by hospitals under private practice arrangements for diagnostic services to inpatients unless: a) a contract exists between the doctor providing the service and the hospital concerned; and b) the Commonwealth agrees to the terms of such contracts" (WA Govt 1983c: 61). By October 1983, the Commonwealth's proposal was transformed into a highly prescriptive goal, embodied within the legislation and guidelines associated with the 1984 Agreement. The revamped goal had the Commonwealth detailing the specific diagnostic services⁴² to be covered by the arrangements, and stipulating that hospital contracts granting rights of private practice adhere to the following policy requirements (Parl Comm. 1984d, 1984c; WA Govt 1983c: 117-19,22; 1983b: 148-51):

- All accounts to be raised by the hospital on behalf of the doctor;
- All charges to be at or below the schedule fee;
- All revenue received on behalf of the specified services to be treated as (and paid into) one (trust) fund. The fund would also include revenue from non-diagnostic services performed by the same doctors under rights of private practice;
- Separate funds to be maintained for full-time and visiting practitioners;
- Funds to be applied in the following order:

Full-time staff

- administrative and collection costs;
- facility charges to the hospital, in a form acceptable to the Commonwealth Minister;
- drawings by the doctor at a level determined by the State, up to 25 per cent of full-time specialist salary;
- any residual to be applied following guidelines set by the State Minister for Health.

Visiting Staff

- facility charges to the hospital, in a form acceptable to the Commonwealth Minister;
- drawings by the doctor at the following rates:
 - (i) where total income, including sessional or other contract payments does not exceed 125 per cent of the full-time specialist salary - full rate;

⁴² In introducing its legislation, the Commonwealth identified pathology, radiology, radiotherapy and nuclear medicine as services where "there is not usually any direct doctor-patient contact ... [and] ... there is substantial scope for generating additional revenue and ... significant technical content to the service which is provided by the hospital rather than the doctor" (Parl Comm. 1984b).

- (ii) where total income, including sessional or other contract payments exceeds 125 per cent of the full-time specialist salary but does not exceed 175 per cent of the full-time specialist salary - full rate up to 125 per cent of full-time specialist salary plus 75 per cent of earnings over 125 per cent of salary; and
- (iii) where total income, including sessional or other contract payments, exceeds 175 per cent of the full-time specialist salary - drawings under (ii) plus 60 per cent of earnings in excess of 175 per cent of full-time salary.

- any residual to be applied following guidelines set by the State Minister for Health.

The Commonwealth Minister insisted that "all existing and new arrangements conform with the proposed guidelines by 31 January 1984" (WA Govt 1983b: 62).

The redefined national goal embodied four principles: 1) that hospitals (as opposed to medical practitioners) issue all accounts for prescribed services provided to private patients; 2) that all medical charges be at or below the schedule fee; 3) that a facility charge be raised for services using high cost technology; and 4) that there be constraints on income received by diagnostic professionals. (WA Govt 1983d: 124). The above clauses were much more onerous than the arrangements under Whitlam and Fraser which had simply provided that modified fee-for-service contracts be kept at a minimum and remain at or below the schedule fee (WA Govt 1983b: 243-4). While the 1975 and 1975 Agreements had been viewed as a substantial intrusion into the profession's autonomy, the earlier version of the goal now paled in comparison. The AMA protested that unlike Medibank, the Medicare arrangements "significantly disturbed" the balance that had been reached between private practice and the 'industrialised' remuneration conditions for the treatment of public patients (WA Govt 1984e: 59). The Commonwealth was careful to point out that its objective was not to abolish rights of private practice but to ensure "cost containment" and reduce "incentives for over-servicing" (WA Govt 1985: 124). Additionally, it asserted that the goal would facilitate better data on private practice and more "reasonable and responsible" allocation of funds (Parl Comm. 1984b).

The Commonwealth's justifications did little to pacify the profession with the revamped remuneration goal causing unprecedented professional revolt and service disruption over the next eighteen months. The Hawke government was accused of circumventing the Constitution and attempting "nationalisation through the back door" (Parl Comm. 1984f). The Opposition claimed it had "not seen anything like section 17 in the history of industrial relations since the Federation" (Parl Comm. 1984a).

The Agreement

Assessment of the 1984 Agreement (Aust. Government 1976b, 1984) reveals the following key changes in goal clarity compared to the Fraser government's 1976 Agreement:

- A broadening of the coverage of universal hospital care, consistent with the Whitlam era version. Additionally, although there was greater acknowledgement of privately insured patients, the 1984 Agreement was tainted toward public provision, deeming all eligible persons as public patients unless otherwise elected;
- Inclusion of all inter-hospital patient transfers into the service scope, but a narrowing of outpatient service scope;
- No formal guarantee that the Medicare Compensation Grant would not be offset against other General Purpose Grant revenues, unlike the arrangements under Whitlam and Fraser;
- An emphasis on cost reduction and *high* service standards, as opposed to '*acceptably high standards*' and '*operating economies*'. Whilst the Fraser government had attempted to bring greater efficiency into universal hospital care, the Hawke government set higher expectations, aiming for high quality services, at reducing cost;
- Additional scope and machinery around joint Commonwealth-State review of health policy, financial and statistical reporting, and health service and workforce planning. A formal mechanism for joint review of the Agreement at the end of the grant period was also included.

Appendix B.2 outlines the significant variations in more detail.

6.2.2 Goal clarity — Overall evaluation

Overall, on the universal hospital care goal, the 1984 arrangements included greater prescription on implementation timeframes; grant formulae; and interactions between private and public hospital sectors. On the latter, the Commonwealth incorporated provisions aimed at increasing State regulation over the private hospital sector, although this seems to have been resisted in practice. There was also greater intergovernmental machinery established around service and workforce planning; uniform financial and statistical reporting; grant re-negotiation; and policy setting (WA Govt 1984f: 149).

These increases in goal clarity were offset in a number of ways. First, the scope of services under universal hospital care continued to be defined quite broadly, leaving decisions about service priorities and mix completely with the States (Parl Comm. 1985). Unlike the Fraser government, the Hawke government confirmed it would not intervene in operational decisions such as bed numbers and the length of stay (Australian Health

Ministers 1983: 88). Additionally, on private patient fees, while there was some control by the Commonwealth in the first twelve months of Medicare, the States were allowed flexibility to set their own fees beyond that period. Significantly, the Commonwealth also abandoned the onerous scrutiny of hospital budgets that had characterised the Fraser era. Reporting requirements were instead framed quite specifically, with the Commonwealth even contributing to some of the information costs. Whilst the grant funding formula was very detailed, there appears to have been close consultation with the States during its development. All in all, there is neither predominantly top-down nor bottom-up approach evident.

On the doctors' remuneration goal, the Commonwealth withdrew from its earlier push for a predominantly salaried and sessional medical workforce and joint Commonwealth–State wage setting. These provisions were however replaced with a much tighter and aggressive approach to constraining doctors' rights of private practice. From the perspective of this goal, goal clarity was of a heavily top-down nature. Overall, goal clarity is considered to have been neither top-down or bottom-up dominated. The next sections on Goal Setting and Goal Setting will assess the negotiation and implementation process more closely to identify the extent to which goal clarity was influenced by the Commonwealth or States.

6.3 GOAL SETTING

6.3.1 Goal setting — 1984 Agreement

Universal hospital care

The early stages of negotiation reveal a general willingness on the part of the Commonwealth to seek State involvement. Policy detail was scripted in cooperation with the States, with the Commonwealth establishing a Ministerial Advisory Committee including State representatives, and pledging to implement "proper consultative mechanisms ... to oversee the development and working of the scheme". The States were also offered a participatory role in the Commonwealth's review of the medical benefits schedule (WA Govt 1984a: 112-14). In this regard, the ongoing interaction with the States was quite different from the Commonwealth's early bargaining approach under the Whitlam and Fraser governments. The increased cooperation was consistent with attitude shifts occurring in the wider federal landscape. The Commonwealth and States acknowledged that "Federal-State relations ... [were] ... at one of their lowest ebbs since Federation" and buoyed by the predominance of Labor governments "for the first time in decades", there was a desire to correct the divides that had developed.

In a letter to the Prime Minister and his three Labor counterparts, the Victorian Premier observed the "political combativeness" that had characterised the Fraser era and encouraged reform⁴³ (WA Govt 1983a: 24; 1984d: 81-6).

The Commonwealth commenced its negotiations with a number of objectives: 1) "to adequately compensate States for revenue foregone; 2) to have continuing adjustment of the grant in light of experience for a reasonable period of time, say five years"; ... and 3) to provide "freedom for the States to organise the overall delivery of their health services" (Australian Health Ministers 1983: 87-8). The States accepted this broad policy framework subject to assurance over three matters of detail. Two of these — the six-monthly escalation of grants, and the use of the 1982–83 year as a base year for grant calculations — were agreed to by the Commonwealth. The third refinement sought — "assurance that the compensation provisions would last for five (or ten) years" — was refused, the Commonwealth insisting that the timeframe of the compensation grant would be best determined as part of a "review of identified health grants and tax sharing relativities" expected to take place prior to 30 June 1985. The States did later manage to secure extension of the grant to 30 June 1987 (WA Govt 1983a: 46-7, 114-15; 1983c: 8-9, 13-14); however, there was no such success from States' push for the formal inclusion of a non-offsets clause similar to the 1975 and 1976 Agreements (WA Govt 1983b: 36; 1983c: 8-9, 25, 50).

On other aspects of the Agreement, a WA Government request for a post-implementation review of the grant arrangements was adopted, with the Commonwealth agreeing to an evaluation after eighteen months (WA Govt 1983a: 53-4). The Commonwealth was also agreeable to the inclusion of a formal dispute resolution clause (WA Govt 1983b: 41). Further, State bargaining resulted in Commonwealth consensus to the charging of outpatients for pharmaceuticals (WA Govt 1983c: 51). Finally, the States managed to secure a once-off indexation of private patient fees on 1 August 1984. On the other hand, calls for indexation adjustments to be continued on a six monthly basis were rejected. Instead the Commonwealth insisted that once States assumed control over private patient fees from

⁴³ The Victorian Premier argued "Premiers Conferences were a charade under Fraser ... the agenda and proceedings have ... been determined principally by the Commonwealth with no effective consultation with the States ... For electoral reasons, Premiers traditionally have sought to portray the outcome of the Conferences as either success in wringing something out of Canberra or an illustration of a discriminatory attitude toward their State by Canberra ... Under the Fraser government, this approach by the States became politically de rigueur regardless of whether there was a basis for legitimate public complaint ... there is (now) however a fraternal spirit among the Labor governments. This must offer the chance to develop a modus operandi by which differences can be worked through to contain to the greatest extent possible, the prospect for adoption of public positions which might cause political damage to one Government or another".

February 1 1985, they could recover indexation adjustments through patient fee increases (WA Govt 1983c: 8-9, 50). The Commonwealth also chose to overlook a request for removal of "aftercare" from the scope of services. The Hawke government appeared unconcerned by WA's assertion that the inclusion could "cause much misunderstanding, particularly amongst general practitioners and is ... likely to inflame unnecessary political reactions and affect introduction of Medicare ... in hospitals" (WA Govt 1983b: 39-40).

Considerable deliberation appears to have occurred over the three indexation factors⁴⁴ included in the 1984 Agreement, negotiated between Commonwealth and State Treasuries. Both parties were in agreement that inpatient revenue compensation would be indexed by average weekly earnings. There was discord, however, on the composite (CPI and wage based) index to be applied to grant payments for other revenue losses and additional medical costs. While WA managed to secure a 75/25 weighting in the wage/CPI index (compared to the 70/30 proposed the Commonwealth), it was unsuccessful in convincing the Commonwealth to use average weekly earnings instead of weekly award rates, which tended to grow at a slower rate (Aust. Government 1984; WA Govt 1983b: 27-36). The establishment of indexation factors was marred also by a lack of time and hospital specific data. The States were wary that the indexes had been compiled from existing statistics "designed to measure movements in community wages and consumer prices rather than hospital wages and costs" (WA Govt 1983b: 31-2). In this regard, the WA Government called for the development of an "appropriate hospital cost index" for the block funding grant arrangement to be implemented beyond 30 June 1985 (WA Govt 1983c: 8-9).

While there was an initial period of cooperation, this dwindled as health negotiations progressed and policy setting was increasingly impacted by the Commonwealth's macroeconomic objectives. It is noteworthy that for the first time, the Treasurer began attending Premiers Conferences, a telling sign of the prevailing economic focus (WA Govt 1983a: 11). Faced with an unanticipated budget deficit of \$9 billion for 1983-84, the federal Health Minister warned the States there were "clear restraints on what the Commonwealth can do in relation to the development of its Medicare program" (Australian Health Ministers 1983: 86). Having accepted the universal hospital care policy however States could ill-afford to accommodate a tightening of finances, already carrying funding issues from the Fraser era Identified Health Grant (IHG). The States claimed a \$26.4 million shortfall in 1982-83 baseline IHG funding levels, arising from a Commonwealth formula

⁴⁴ Indexation factors were established for the following compensation grant streams: 1) inpatient revenues foregone; 2) other revenue foregone and additional costs associated with Medicare; and 3) the block grant to be paid after 30 June 1985 (WA Govt 1983d:27-28).

error. Additionally, the States argued that indexation of the Identified Health Grant was inappropriate — with escalation linked to the rate of increase in Commonwealth taxation receipts, as opposed to actual hospital costs (WA Govt 1983c: 12). Unswayed, the Commonwealth insisted it would not re-open former government decisions (WA Govt 1983a: 51).

Despite the financial uncertainties and their highly unsatisfactory experiences under the Fraser government, the States maintained their commitment to the universal hospital care goal. It would appear that the pressure of public opinion, the new compensatory grant funds and the promise of long term wage restraint arising from the Accord seem to have been too significant to ignore. As apparent prior to Medibank, there is evidence that the public hospitals were suffering revenue difficulties, with WA hospitals in a deficit position (WA Govt 1984c: 16). For the four State Labor governments there also would have been the political pressure to be supportive of federal Labor's policy platform. In July 1983 for example, the WA Labor Government flatly denied an Opposition claim that universal hospital care would cause patient shift from private to public hospitals of as many as 120 beds per day. The Minister for Health asserted that:

a major shift from private to public hospitals is not foreshadowed as a result of Medicare. Sufficient capacity exists within public hospitals to accommodate any increase in demand which may occur" (WA Govt 1983c: 40).

Similarly, in September 1983 the WA Government publicly denied that universal hospital care would create flow-on demand pressures to hospital emergency departments whilst general practitioner services involved a 15 per cent out of pocket cost for patients (WA Govt 1983c: 113). The State was well aware the grant arrangement did not recognise such financing or capacity risks, yet the issue does not appear to have been raised in negotiations with the Commonwealth. Perhaps the States' oversight could be attributed to policy naivety, given the data shortcomings evident at the time. The more likely proposition however is that electoral and political pressure compelled the States to sign up to this goal. As evident in the goal setting under the Whitlam and Fraser governments, policy making deliberations were also heavily hospital-centric, overlooking the efficiency, effectiveness and integration of the broader health system.

Doctors' remuneration

The battle to constrain doctor's rights of private practice in public hospitals was a lengthy and costly one for the Commonwealth. The friction began in the second half of 1983 — first with the Health Ministers' consensus, and then with the passing of the highly controversial amendments to section 17 of the *Health Insurance Act 1973*. The profession objected to

Commonwealth control of the detail of contracts; the requirement to adhere to the medical benefits schedule; to the imposition of national facility charges that may not recognise local circumstances; the requirement for 'institutional billing'; and the condition that 'monies be handled through hospital (trust) funds' (Committee of Inquiry et al. 1984: 2-3). There was also fear that the provisions would be extended from diagnostic services to all clinical services over the longer term.

The heart of the battle lay in NSW. Here, the Commonwealth entered a goal setting environment that was already "fairly explosive", with the NSW government in animated pursuit of hospital reform, including a contentious "Beds for the West" policy (Larkin 1989: 68). As discussed further at Goal Congruence, the NSW government was in fact pursuing much more expansive remuneration reforms than those encompassed in the 1984 Agreement. Relationships with the profession were extremely strained, with the State government using the media to taint the community's image of doctors, and accusing professionals of "over servicing and coercing patients into keeping their private health insurance". A looming State election further contributed to the highly agitated policy environment. (McKay 1986: 221-2).

Despite the strains appearing in NSW, the Commonwealth appears to have adopted the goal with dogged determination, setting an implementation date of 1 February 1984 which left leaving little room for engagement with the profession. The federal Liberal Opposition declared that the Hawke government "would go down in history as the one government which provoked a doctors' strike, the first in the history of this country" (Parl Comm. 1984a). Further, the Health Minister was described by the Opposition as "a man obsessed ... locking the Hawke government into a confrontation which never should have happened" (Parl Comm. 1984a). Similar observations of unnecessary Commonwealth haste and coercion have been made by other key stakeholders. A former Secretary of both the NSW and Commonwealth Departments of Health and the SA Minister for Health recall (Cornwall 1989: 183-7; McKay 1986: 222):

there were a number of occasions on which a different response to the problems confronting us, might have stopped, or at least defused, the dispute without great sacrifice of principle on either side..

..I had serious doubts about the tactical wisdom of confusing section 17 type amendments with the principles and practice of Medicare ... I felt very strongly that it was important to introduce the scheme and gain public acceptance for its simple principles of equity and access ... questions like remuneration of procedural specialists, the growing disparities in incomes between medical specialists generally, and the growing gap between the income of specialists and general practitioners and adequate funding for public hospital equipment could all be addressed later...

Medicare, in fact, enshrined fee for service so it was both foolish and unnecessary for the Federal government to 'take-on' the medical profession at large. And the amounts of public money involved in the dispute were peripheral to the total public health cost nationally of more than \$8 billion ... In the circumstances the immediate requirement that all doctors using or working in the public hospital system

sign contracts was a tactical error. It ensured that even general practitioners servicing country hospitals were drawn into a set of solidarity with the high flying procedural specialists.

The AMA was passionately opposed to the "unfettered" powers it perceived as available to the Commonwealth, and the overlooking of doctors' rights of appeal. A constitutional challenge in the High Court and far-reaching service disruptions were among the threats issued. Notably, it was not just the diagnostic profession that was against the legislation, the surgical workforce was a highly vocal opponent insisting they were "not going to be pushed around" (WA Govt 1983c: 208-9,12). The continued protest forced the Commonwealth to back down on its proposed guidelines in January 1984, before Medicare had even commenced. The Commonwealth offered to scale back its goal to just three components effective from March 1 1984: the raising of accounts by hospitals; patient charges levied at or below the schedule fee; and the payment of private patient revenues (after deduction of State-determined facility charges) into a trust fund. To further appease the profession, the Commonwealth proposed the parliamentary scrutiny of future guidelines; deferral of other contractual reforms; and establishment of an independent inquiry into rights of private practice (Parl Comm. 1984d; WA Govt 1983b: 69). The AMA remained defiant however, its stance prompting the Commonwealth to announce it would proceed with its 1 February implementation date regardless. Although the AMA labelled the action as "dictatorial" and "tyranny", it eventually agreed to the tabled offer and to participate in the inquiry, bringing a temporary truce to the standoff, although both sides claimed victory (Adams 1986: 96-7; WA Govt 1983b: 69-71).

In addition to the negotiations between the Commonwealth and national AMA, deliberations also took place at the State level. Unlike the Whitlam era, these negotiations appear to have involved the WA Minister and the state AMA, as opposed to hospital boards bargaining on a one on one basis with their clinicians (WA Govt 1983b: 174). The negotiations overall also seem to have been considerably less dramatic than during the implementation of the 1975 Agreement. An initial stand-off took place between the WA government and the AMA following the introduction of a *WA Hospitals Amendment Bill* with little prior consultation. However, negotiations then centred on twelve claims put forward by the AMA state branch (WA Govt 1983c: 230-32, 35-6):

Table 6.1 Negotiation claims from the WA AMA Branch

1.	An appointments committee to be established at each hospital to assess recruitment of medical professionals;
2.	Appointments committee recommendations to be put forward to the hospital Board or the Minister;
3.	The right of appeal to a 'board of reference' when an applicant fails to be recommended;
4.	The board of reference to consist of a member nominated by the Minister, a member nominated by the applicant and an independent chairman acceptable to both parties;
5.	The board of reference to make recommendations, with Minister to hold full and final discretion over the appointment decision;
6.	The terms and conditions of appointment to be agreed between the Minister and the AMA. Where there cannot be agreement reached, the matter to be referred to independent arbitration. Letters of appointment to be given to individual practitioners, in teaching hospitals "a letter confirming the application of the existing teaching hospital agreement is all that is required";
7.	Fee for service arrangements shall not be below 80 per cent of the schedule fee for the duration of the Medicare Compensation Grant. The introduction of salaried and sessional services will not be precluded but "shall only be considered after consultation with the AMA";
8.	Clinical aspects of private medical services currently subject to Ministerial direction "shall be effected only after consultation with the hospital board and an appropriately constituted medical advisory committee";
9.	Clinical privileges to be "administered by the medical advisory committee of the hospital" within policy guidelines established by the Minister and the Board;
10.	No further facility charges to be introduced, beyond those for the prescribed services already in place;
11.	The scope of services covered by section 17 to be limited to the list of prescribed services currently outlined by the Commonwealth. The power of the State Minister should not extend beyond this scope of services;
12.	Establishment of a Hospital Services Advisory Committee including an AMA representative to consider and make recommendations to the Minister on: "aspects of the provision of medical services at public hospitals and associated health services".

In contrast to the Whitlam era, where doctors remuneration contracts were settled only after tied grant Agreements were signed, the WA government reached consensus with the profession in December 1983, two months prior to the scheduled commencement of Medicare. All twelve claims were agreed to, with the WA government declaring that the accord was a "remarkable step bearing in mind the contentious nature of any attempt to regulate the medical profession". Having secured a consensus, the WA government attempted to distance itself from the ongoing hostility evident between the Commonwealth and the federal AMA. The WA Health Minister asserted that the federal level dispute would have "little impact" on the State, with WA public hospitals showing none of the "exploitation of private patients ... as had been alleged in other States".

The Minister even went so far as to claim that the WA branch of the AMA had been "more cooperative and responsible than its counterparts in other States" (WA Govt 1983c: 235-6, 48; 1983b: 87-9). Despite the Minister's confidence however, WA would not remain completely immune from the dramatic events which unfolded elsewhere. The federal AMA and other specialist lobby groups were aggressive in their push to widen the doctors' dispute nationally, presumably as a means of consolidating and enhancing their political and policy influence.

The bargaining advantages of 'nationalisation' were already well recognised by the Commonwealth, with the prescriptive doctors' remuneration goal and section 17 amendments being largely driven by circumstances largely centred in NSW. In this regard, it is no accident that the epicentre of the doctors' dispute lay in NSW. The evidence suggests that at the time, NSW firmly stood out as a jurisdiction that had failed to gain any significant ground on doctors' remuneration reform since the commencement of the 1975 Agreement (WA Govt 1983b: 63). The Royal Australasian College of Radiologists asserted at the time that the Commonwealth's goal would bring very little by way of cost savings "except with NSW full time specialists and those few areas where visiting radiologists are coping with double their normal workloads due to national radiological manpower shortages" (WA Govt 1983d: 92-4). National implementation of the section 17 amendments offered the Commonwealth vital political support to hasten the lacklustre pace of remuneration reform in the more hostile professional environment of NSW. Through the Whitlam and Fraser eras, reform inertia in NSW resulted in that State having a relatively lower provision of universal hospital care than the smaller States. To ensure a truly national system of universal care, it was imperative that the tied grant arrangement be firmly embedded in NSW policy settings. Further, there were significant economic stakes involved with successful implementation in NSW essential for assuring the wage restraint promised under the Accord.

In addition to nationalisation, the Commonwealth and NSW government appear to have used collaborative and dispersed bargaining to assist in resolving the NSW dispute, similar to the bargaining tactics applied in the Whitlam era. Larkin (1989: 67, 69-71, 75-76) describes how the NSW dispute was essentially a State based one to begin with, until the NSW government sought Commonwealth intervention, "thrusting the dispute back into the federal arena and on to the federal government's agenda". The necessity for Commonwealth involvement appears to have arisen partly from shortcomings in the handling of the negotiations by the NSW government, with the Premier considered to have

adopted a "draconian" approach to both the policy negotiations and in the pursuit of other broader hospital reforms. Larkin (1989: 67, 69-71, 75-76) also confirms that the most militant of the profession was the surgical workforce who considered the negotiating position of the federal and NSW branches of the AMA as "weak". The heightened tensions in the surgical workforce is attributed to there being a comparatively smaller private hospital sector in NSW, leaving little scope for surgeons to compensate their losses in the public sector by private work externally. There was also a "rift" between the specialists of the teaching hospitals (where salaried and sessional remuneration was prevalent) and those in the peripheral hospitals (where the honorary system prevailed). Finally, there were tensions apparent between the federal AMA and its state branches, the latter noted to "have been jealous guardians of their autonomy". Policy agreements reached between the federal AMA were not necessarily binding on the state branches. Larkin argues (1989: 74-5) that in resolving the doctors' dispute, the Commonwealth and the NSW government manoeuvred quite tactically around the gaps in professional resistance:

By choosing to negotiate with the federal AMA...Mr Hawke effectively isolated the smaller section of the militants in NSW with their radical demands for change and enabled the broadly representative, larger and more moderate AMA to negotiate a settlement with the federal government.

The federal government's decision to negotiate with the doctors and to grant the particular 'concessions' that were eventually agreed to in the April settlement was also influenced by the government's desire to exploit the divisions between the militant surgeons...and the federal and state branches of the AMA. The divisions enabled the government to isolate the most militant sections of the profession and forge a settlement which incorporated the more moderate demands.

Interestingly, Larkin (1989: 72-3) observes that the 1984 doctors' dispute precipitated an inquiry by the AMA into its own governance structure. Having that the shortcomings of its negotiating powers had been severely exposed, a range of reforms were identified, including "the removal of branch autonomy".

Collaborative and dispersed bargaining with the medical profession thus played an important role in the 1984 Agreement as in the case of the 1975 Agreement. There was a fundamental difference in how such bargaining occurred however. In the 1984 Agreement, the Commonwealth took advantage of the more moderate demands of the *federal* AMA to overcome powerful resistance at the local level in NSW. In comparison, as discussed at Chapter 4, negotiations for the WA 1975 Agreement were centred around the more adaptable views of the local *state branches* of the AMA, this enabling the Commonwealth and State to overcome a consolidated resistance from the federal AMA. It was the latter approach that enabled the WA government to reach settlement with the local profession well before the start of the 1984 Agreement. Evidence shows that in the lead up to the signing of the Agreement, the WA government and Commonwealth were adept

negotiators, working jointly, and granting strategic policy concessions as necessary. Continuous dialogue seems to have occurred with the Commonwealth including the cross-checking advice received from the federal and state AMA. For example, in early 1984 the State liaised with the Commonwealth to verify whether facility charges would be negotiated between individual States and the AMA, or set uniformly at a national level. Preferring the option of uniform facility charges, the WA government sought Commonwealth intervention to thwart a push by the local profession for State-based facility charges. Similarly, when the federal AMA demanded the inclusion of a right of appeal and annual review of remuneration contracts, the Commonwealth circumvented the AMA by referring the matter to the State, alerting the State government of its referral. The close interaction between the two levels of government appears to have enabled them to optimise their bargaining outcomes. The profession was forced to deal with two 'masters' who coordinated their actions strategically, using available loopholes to try and secure the best of the situation at hand (WA Govt 1983d: 99-100; 1984a: 37). The interventions by the Commonwealth into the NSW and WA government negotiations confirm the potential advantages of the Commonwealth being selectively involved with a State government to overcome local barriers to a jointly desired policy end. This tied grant performance matter will be further discussed at the conclusions Chapter 8.

6.3.2 Goal setting — post 1984 Agreement

Universal hospital care

The implementation of the 1984 Agreement was characterised by ongoing struggle between the Commonwealth and States over grant funding levels. A driving factor cited by the Commonwealth was the NSW doctors' dispute which added \$70 million a year to program costs — an unwelcome impost on a Commonwealth already facing budget pressures. These financial constraints did not however prompt a review of the universal hospital goal or its scope. With a clear mandate to implement universal hospital care, the Hawke government chose to leave the shape of its health policy intact, and instead renege on its Agreement with the States, by varying the financial terms and conditions established (WA Govt 1984c: 89-91).

The corrosion of the Commonwealth–State relationship was progressive, heating up during 1985–86. The beginning of the implementation phase saw the States quite successfully securing funding adjustments, albeit through protracted negotiations with the Commonwealth. Discussions revolved around funding formulas and relevant patient and

activity data. For example in respect of the compensation grant for shift of patients from private to public status, as early as May 1984 WA data was reporting a shift in the ratio of public patients from 50 to 64 per cent over 1982–83 to 1983–84. Naturally the WA Government anticipated an automatic rise in the compensatory grant. The patient data seems to have caught the Commonwealth by surprise, however, their budget forecasts not allowing for such a rapid increase. A lesser funding offer was put forward to the State, but the WA Government pressed on with its original claim, confident that "any hold back of grants in 1983–84 would naturally be unacceptable to the States and a favourable decision is therefore expected" (WA Govt 1984c: 16-18). Presumably keen to ensure that universal care would be established smoothly, the Commonwealth relented and honoured its commitment to adjust the Medicare grant for actual outcomes up to 30 June 1985 (WA Govt 1984c: 28-30).

The end result was not so positive for the States the following year when four jurisdictions including WA, reported "negative utilisation", that is, a drop in bed occupancy. Although the 1984 Agreement did not specifically provide for situations where there was a decline in activity, the Commonwealth insisted that it share in the benefits of the lower utilisation and proceeded to reduce the compensation grant (WA Govt 1984c: 83, 103). Although privately conceding "there is a degree of logic in the Commonwealth's proposal", the States decided to mount a joint resistance (WA Govt 1984c: 106). The States counter-argued that: 1) the Commonwealth was overlooking the issue of fixed costs, which prevent drops in activity from translating into a correlating drop in hospital costs; 2) the Commonwealth's actions represented a departure from the 'letter' of the Agreement; and, 3) admission rates would be a superior measure of hospital costs than bed occupancy rates (WA Govt 1984c: 109-11). Their objections were somewhat effective, with the Commonwealth agreeing to scale down its funding adjustment and referring the matter to the Premiers' Conference. A WA administrator lamented:

This is simply burying the matter from the Commonwealth's standpoint and will make it very difficult for the States to pursue this argument any further without giving the Commonwealth the opportunity to indicate that they may have to reduce general grants which would otherwise be payable to the States..(WA Govt 1984c: 181-2)

There was no further compensation for the States at the Premiers' Conference. The Commonwealth persisted with a fairly loose assertion that State revenues would be more than fully compensated by anticipated growth in private patient fees (WA Govt 1984c: 184-6).

Despite the difficulties they were experiencing with formula funding, the States pushed for it to be retained to 30 June 1987. There seems to have been apprehension around the reversion to a block grant as signalled in the 1984 Agreement. Naturally the States were keen to ensure that the final year of formula funding would serve as an appropriate base year for future block grants, which would simply be indexed, as opposed to being adjusted for actual outcomes. The Commonwealth was partially accommodating, agreeing to continue formula based compensation to 30 June 1986. There was no such empathy, however, given to NSW and Victorian requests for a formula review, to change the rate of compensation for increased medical costs (from \$25 to \$35 per day). The Commonwealth was adamant that it would not consent to "individual components" of the formula being "varied at this time". Also rejected was State requests for additional funding to compensate for lower than anticipated private practice trust fund revenues. The Commonwealth's response was to point to new capital funding that had been provided as part of settling the NSW doctors' dispute (WA Govt 1984c: 69-79). In August 1985, just months after agreeing to continue formula funding, the Prime Minister announced the government would "remove [from the 1984–85 grant, the once-off] escalation of ... inpatient fee reduction ... which the Commonwealth agreed to meet in the first year to ensure no fee increase occurred during the first twelve months of Medicare". This unilateral decision resulted in a permanent reduction to State baseline funding. The Commonwealth argued that the Agreement should not provide "windfall gains" and that the States could exercise their policy discretion to raise private patient fees to offset the grant reduction if necessary (WA Govt 1984c: 90).

Although the Agreement delegated control over patient fees to the States after January 1985, there appears to have been an ongoing wrangle over private patient revenues. In November 1984, both the Commonwealth and WA were concerned at the proposed 18.4 per cent rise in fees to take effect from 1st February 1985. The State's response was to call for an increase in the compensatory grant to prevent "a further decline in private fund membership". The Commonwealth on the other hand sought "the State's reaction" to a deferral of the fee rise. Interestingly, this request does not appear to have been purely to ensure the stability of the private insurance coverage, but more politically orientated, with a WA Government administrator observing it seemed to be "because of a possible election in the Eastern States" (WA Govt 1984c: 46-7).

In May 1985, during the scheduled review of the Medicare grant arrangements, the Commonwealth retreated from its earlier position of delegating patient fee control to the

States, proposing that "uniform increases" in hospital fees apply from 1 July 1985. The Commonwealth argued that "uniformity confers portability of benefits between States and adds stability to the insurance sector". The States gave their in-principle support to the use of a formula approach to fee increases, but indicated there may be practical difficulties in enforcing such a requirement. It was pointed out that while the States had agreed to a uniform fee rise for 1 February 1985, two jurisdictions had opted to implement a lower increase (WA Govt 1984c: 73). This example by individual States acting autonomously was not an isolated one. At the same Medicare Review, the Commonwealth expressed its concerns over a NSW and NT government proposal to pass on the costs of treating traffic accident victims to Medicare. Highly alarmed, the Commonwealth raised its objections to the potential changes in workers compensation insurance arrangements, confirming it would not "accept any unilateral decision by States" (WA Govt 1984c: 79).

The toughened stance on private patient fees and grant funding by the Commonwealth appears to have stemmed from the unexpected costs of the settlement of the NSW doctors' dispute. A number of unilateral departures from the terms and conditions of the 1984 Agreement were openly justified on this basis. While the downward funding adjustments were applied uniformly across all States, the WA Premier hastened to point out that not all the States had experienced the professional resistance as NSW and Victoria. Over 1984–85 and 1985–86, the re-introduction of universal hospital care seems to have proceeded comparatively smoothly in WA, with hospital activity "patterns ... stabilised to a large degree", and no "major industrial difficulties". Thus the distribution of the costs of the NSW dispute across all States may have assisted the Commonwealth's macroeconomic objectives, but it also penalised states which had been more successful implementers of the grant. The Commonwealth repeatedly asserted that States would be able to offset grant reductions with higher than expected private practice revenues. However, States such as WA which were more advanced implementers were well aware that they would not benefit from additional private practice income to the same extent as that anticipated in NSW (WA Govt 1984c: 110-13).

Inequities such as that described above were not always to the favour of the larger States. As apparent in the Whitlam era, States benefited both from collective negotiations with other jurisdictions, as well as through their own one-on-one bargaining with the Commonwealth. This resulted in variations in policy settings between States, created both by differing negotiation skills and policy priorities. For example, the WA Government appears to have secured a clause in its 1984 Agreement under which the Medicare grant

would compensate for additional medical costs associated with growth in outpatient service utilisation (WA Govt 1984a: 48). As discussed at Chapter 5, WA had experienced significant growth in outpatient services under the Fraser era and hence it was probably in a more informed position to negotiate this clause pre-implementation. In comparison, the Agreement with NSW did not provide for such compensation at the time of signing. The NSW government was forced to raise it as an issue in the 1985 review of the Medicare grant, following significant increases in demand for outpatient services in that State (WA Govt 1984f: 173).

Doctors' remuneration

As noted earlier, the WA government managed to secure a compromise with the medical workforce prior to February 1 thus the post-Agreement period was relatively subdued, in comparison to the Whitlam era. This is in marked contrast to circumstances in NSW where the advent of Medicare triggered a lengthy and bitter battle between the Commonwealth and NSW Governments and the federal and NSW branches of the AMA.

The Commonwealth's initial back down in January 1984 resulted in a scaling back and deferral of the contractual requirements and the instigation of an independent inquiry. This however had only a temporary effect in soothing professional unrest. As discussed at Goal Congruence, section 17 (viewed by the profession as a form of 'price control') was just one of the drivers for the warfare that erupted. Complicating the issue were simultaneous and equally controversial legislative amendments being implemented by the NSW government. A detailed account of the series of events is provided by Adams and Larkin (1986: 96-102; 1989: 69, 71-2). What began initially as a revolt by a section of the surgical workforce rapidly escalated to a more widespread dispute involving both visiting and salaried medical workforce. The NSW government was particularly taken aback at having to battle the salaried workforce, appeasing them with "very lucrative concessions" to try and contain service disruptions. It was observed that "salaried professionals ... [could] ... hold Governments to ransom as easily as their fee for service colleagues".

In June 1984, in response to mass resignations by visiting medical officers, the NSW Premier introduced legislation to restrain officers from resigning, including the imposition of a seven year embargo on reappointment for those that did resign (McKay 1986: 223-4). This heavy handed policy decision intensified the dispute and the NSW government was quickly forced to repeal its reappointment ban. The profession was unrelenting, however, and by July 1984 its negotiating committee had submitted an "ambit claim worth \$175 million per

annum, requesting among other things a doubling of the V.M.O. sessional payment rate and the right of each doctor to have a mix of sessional and fee-for-service income". The profession also staunchly refused to resolve the dispute through an arbitration court.

Having no room to manoeuvre, the NSW government was compelled to rescind its legislative amendments. This had little effect however. In October 1984 the "profession came forward with yet more proposals including the expansion of fee-for-service payments to those "country ... and peripheral city hospitals where only sessional fees had previously been paid". Around the same time, the independent (Penington) Inquiry established by the Commonwealth (at the profession's insistence) reported its findings, its recommendations being accepted by the Hawke government. Although the federal AMA concurred that the recommendations "provided the basis for a 'workable compromise'", the conflict continued. The militant profession in NSW used the media to great effect, swaying public opinion towards them. In December 1984, following considerable deterioration in the availability of services with the resignation of "hundreds of surgeons", a one-month moratorium was suggested by the State government, but again rejected by the AMA. The AMA continued adding to its demands including requests to address issues such as the "closure of hospital beds, under-funding of the health system [and] inadequate staffing".

Between December 1984 and April 1985, the Commonwealth and NSW governments struggled to reach a compromise with the profession, with significant concerns "that the dispute might spread to other States". An initial "peace package" was offered by the Prime Minister and NSW Premier in January 1985. This included the provision of an "unequivocal guarantee that medical practice in Australia will not be nationalised and the private medical practice in public hospitals would be promoted". The penultimate peace deal was reached in April 1985, a costly consensus involving 80 per cent of the medical workforce. The long-awaited settlement included the repeal of section 17 effective from 1 September 1985. Key aspects of the settlement as articulated in the Minister's Press Release (WA Govt 1984f: 216-17) and by Adams (1986: 101) included:

- significant increases in remuneration for doctors treating Medicare patients in public hospitals, and the option of fee for service payment to doctors working in major country and metropolitan district hospitals over three years (subject to the AMA going to arbitration on the level of visiting medical officer sessional fees);
- the automatic classification of privately insured patients as 'private patients' unless they opted to be treated as Medicare patients;
- changes to health insurance provisions including a replacement of the basic hospital table with a comprehensive table which will cover bed-day charges; the introduction of benefits for implanted surgical devices; coverage for the difference between the Medicare benefit and the Schedule fee for medical services provided in hospitals; and an expansion of the range of private insurance tables which can be offered;

- support for the principle of community rating by providing that all insurers who offer health insurance must do so under the conditions of the National Health Act; and
- a three year \$150 million capital equipment program for teaching hospitals.

Although the settlement appears to be a victory for the medical profession, Larkin (1989: 73) argues that the end outcome was in fact a compromise for both the profession and government. Notably, from the profession's perspective the settlement did not address the calls for:

an extension of the fee for service method of payment for Medicare patients treated by visiting medical officers or fully satisfy other core demands, such as rescission of section 32, under which private hospitals were classified for the purposes of Commonwealth subsidies, and section 57 of the Health Legislation Amendment Act 1983 which made medical (non-hospital insurance) a government monopoly financed by the tax levy..

Additionally, some of the concessions made were in fact beneficial for the Commonwealth:

the increases in remuneration for doctors treating Medicare patients in public hospitals removed a source of discrimination whereby doctors antipathetic to the Medicare scheme favoured private patients ahead of public for economic reasons; the injection of Commonwealth funds into Australian teaching hospitals was an inevitable step for improving health facilities in NSW and satisfying moderate sections of the profession who were concerned about deteriorating conditions in some hospitals...; and the expansion of the range of private insurance tables offered shifted some of the costs of financing health insurance from the public to the private sector without destroying the principles of Medicare..

Offsetting these Commonwealth gains was the fact that the repeal of section 17 removed the Commonwealth's formal regulatory powers over doctors' remuneration contracts, this being replaced by a somewhat weaker mechanism: the ability to "closely monitor the incidence of charging above the schedule fee in hospitals".

From the perspective of the NSW government, archives show that although the settlement was "significant and costly" from a budget perspective, the resulting policy adjustments on "methods of remuneration and state legislation controlling the conduct of visiting medical officers and the private hospital system" were actually not significantly in variance from the State's original policy stance. Further, the NSW government benefited from the Commonwealth's contribution towards the settlement costs, particularly those associated with allowing "fee for service remuneration for the treatment of public patients, in all but teaching hospitals" (WA Govt 1984f: 17-18).

In WA, despite the State government's pre-implementation accord with the state AMA, the dispute in NSW brought unrest amongst the local profession. A first sign was the refusal of large numbers of clinicians to sign new remuneration contracts which made reference to the federal policy conditions and section 17. A range of mechanisms were engaged to overcome the profession's stance. Some of these were of an intimidating nature, for example, the government's verbal compelling of the profession that with section 17 enacted, "we must obey the law of the land". Further, the State repeatedly maintained its

position that Medicare had "caused no problems in teaching hospitals in WA" (WA Govt 1984f: 55-6, 60). Other approaches were rooted in pragmatism. For example, following the concessions agreed between the Commonwealth and the federal AMA in early 1984, the WA government deemed all existing contracts as adequately meeting grant conditions, at least until the inquiry into rights of private practice was completed (WA Govt 1984a: 66). In overcoming professional resistance, the Commonwealth and States seem to have worked together. The SA Health Minister recalls for example (Cornwall 1989: 183-7):

As the (NSW doctors') dispute worsened, the Commonwealth asked the four Labor States to examine what legal devices or sanctions were available to them to get the doctors' compliance. This became a well-publicised but undefined 'secret strategy' as we moved into the second half of February.

Other States also faced similar pressures from their profession. The SA government was particularly keen on deflecting any flow-on effects of the NSW peace package. The government argued that States be consulted before any national application of compromises negotiated with the NSW profession. For example, on the compromise to automatically classify all privately insured patients as private patients, the SA government argued that it had long before overcome professional resistance and successfully implemented this patient election reform in 1975 (WA Govt 1984f: 126). Ultimately, and perhaps predictably, the States were unable to fully deflect the policy setting flowing from the NSW dispute. As early as February 1985, the WA branch of the AMA was pressing the State to re-open negotiations in light of the "crisis in NSW" (WA Govt 1984f: 10). In May 1985, the WA branch confirmed there would be three areas of potential re-negotiation arising from NSW settlement: 1) levels of remuneration and the predominance of fee for service in non-teaching hospitals; 2) admission processes for private patients in public hospitals; and 3) amendments to State legislation to compliment the repeal of section 17. Finally, by October 1985, the WA AMA had compiled a much more comprehensive response, a "WA Package", that was aimed at unravelling the remuneration arrangements that had progressively evolved from the Whitlam era.

The AMA was persistent that the NSW settlement "created the expectation that new arrangements will be entered into in this State to address the same issues (WA Govt 1984e: 55-66). The Commonwealth warned States in March 1986 that "any cost increases incurred from granting increases to doctors would not necessarily be compensated ... by an increase in the Medicare grant". While it is true that the NSW "dispute never really got off the ground in other States", the WA government did have to engage in extensive deliberations with the profession in order to calm the turbulence that had developed (McKay 1986: 225; WA Govt 1984e: 157-61). WA government files show detailed negotiations occurring

between October 1985 and March 1986 on *eighty* separate operational and remuneration issues including, for example: appointment terms; assurance of professional independence; appeals mechanisms; operation of the Ministerial Advisory Committee; maintenance of medical records; rights around patient transfers; review of salary structures and sessional remuneration; rostering and on-call arrangements; and terms and conditions for university clinicians. The cost of the remuneration claims lodged was estimated to be \$17 million per annum (WA Govt 1984e: 104-22, 59).

In addition to destabilising existing remuneration Agreements, the NSW dispute also gave rise to an amended Medicare grant agreement in July 1985. According to a Commonwealth summary, the amended clauses concerned: "prosthesis (charging); day care benefits; hospital capital program; extension of the Medicare agreements; (repeal of) section 17; and patient election procedures" (WA Govt 1984f: 267). Table B.3 further details the policy shifts (Aust. Government 1984; WA Govt 1984f: 291-301). Most notable in the 1985 Agreement is the absence of any conditions relating to rights of private practice and also the revised patient election procedures. When combined with the initial downgrading of the salaried and sessional remuneration goal in the 1984 Agreement, the Commonwealth's retreat on the rights of private practice in the 1985 Agreement effectively marked the end of Commonwealth involvement in the regulation and reform of doctors' remuneration, a goal pursued since the Whitlam era.

6.3.3 Goal setting — Overall evaluation

The earlier analysis of goal clarity confirmed the Commonwealth to be the predominant policy setter in terms of: implementation timeframes; the use of formula funding and indexation factors; and private patient fees in the first twelve months of universal hospital care. There was also evidence of an accommodating Commonwealth with regards to the flow-on effects from the private hospital sector and the burdens of grant reporting. The preceding discussion of goal setting further refines these findings, revealing that the States in fact had input into policy settings over the grant timeframe and the indexation factors. Further, the States claimed a number of other concessions such as the inclusion of a dispute clause and a post implementation review. On the other hand, the analysis confirms that the Commonwealth was the dominant party with regards to the determination of State baseline funding; formula changes; and the omission of a non-offsets clause in the Agreement (Australian Health Ministers 1983: 14-16, 21).

The goal setting analysis also gives us further insight into the Commonwealth's negotiating approach and its early willingness to open dialogue with the States, an important feature of the policy setting deliberations. In terms of the universal hospital care goal under the Hawke government, the tussle between Commonwealth and State was a multifarious affair, quite different to the Fraser government's antagonism towards the States. The Commonwealth was aware of its desired end objectives, but rather than immediately resorting to a unilateral stand, it actively engaged with the States in a fairly healthy bargaining process, giving ground here and there, as considered appropriate. For example, in addition to the evidence already discussed, WA Government records show the Commonwealth initiate the scheduled review of grant arrangements during 1985; respond positively to State' requests for advice on continuity of Community Health funding; and genuinely seek evaluative feedback from the States (WA Govt 1984f: 2, 155). The extent of consultation with the States seems to have been greater in policy areas where the Commonwealth had little intimate service delivery knowledge. In this regard, there was close liaison with the States on goals pertaining to the private hospital sector and the expansion of day care clinics (WA Govt 1984f: 218-19). Consultation also appears to have been greater at the beginning of the grant period when the Commonwealth was under pressure to establish Medicare, with intergovernmental cooperation deteriorating from 1985–86. Notes from a Health Ministers meeting in April 1987 reveal that the Commonwealth was less obliging on State requests to commence negotiations on the next Medicare agreement in a timely way and fund specific initiatives to reduce waiting times and improve the effectiveness of acute care services — although there was cooperation evident on joint workforce planning (Australian Health Ministers and Taylor 1987: 3,12,15-16).

The States were not reticent in negotiating, securing policy ground and even unilaterally adjusting policy settings to their advantage in a number of instances. Their policy positions varied, depending on whether the impact would be beneficial or otherwise. For example, in debating formula funding, the States were supportive when the utilisation data stood in their favour, but resistant to the negative utilisation adjustments instigated by the Commonwealth. Although initially supporting a formula-based grant, once the Commonwealth began tightening its formula funding, the WA government moved to support a block grant beyond 30 June 1986, arguing it would simplify administration and prevent "the potentially unfavourable consequences of the proposed changes to the existing Agreement being sought by the Commonwealth" (WA Govt 1984f: 190).

This stance was taken in spite of being well aware of the risks associated with a block grant — the inherent risk of being short-changed on baseline funding, and the loss of a nexus with hospital activity levels. All in all, both the Commonwealth and States were competent policy negotiators, shifting position when it was necessary. On the universal care goal, goal setting was neither top-down or bottom-up.

Assessment of the doctors' remuneration goal setting is more complicated. Here, it was the Commonwealth and the NSW government who dominated policy setting, achieving mixed results. On the positive side, there was enhancement in the participation of the NSW profession in remuneration reform and universal hospital care. The Commonwealth and NSW government worked collaboratively to secure this outcome, astutely taking advantage of distributive political bargaining. These policy gains were, however, offset by extensive and costly compromises to the design of both goals — not only in NSW but also flowing through to the other States, as the state branches of the AMA took the opportunity to press for national application of the deal forged in NSW. The flow-on effects appear to have diminished previously acquired policy gains in States such as SA and WA, who had managed to overcome professional resistance and implement reforms much earlier, under the Whitlam and Fraser governments.

Some of this policy retreat could have been avoided. First, it appears that the doctors' remuneration goal was pursued much too quickly and in a manner that was overly aggressive and prescriptive. The Commonwealth's own independent review found that the implementation plan was poorly designed. It observed that the States and hospitals had a (Committee of Inquiry et al. 1984: 15, 96-7)

poor understanding of, or ... confused" with the policy settings, much of which was due to the Commonwealth's haste, to introduce Medicare in its first twelve months in office. Notwithstanding the extensive intergovernmental liaison that occurred, implementation was poorly coordinated, with "confusion between Commonwealth and State plans.

As discussed at section 6.2, serious doubts were also subsequently cast over the definition of the policy goal itself. The (Penington) Committee of Inquiry (1984: 6-7, 52) found that the cited growth in hospital diagnostic services was in fact "substantially less" than growth in the non-hospital sector, and negligible, when compared to population growth over the same period. The Committee also noted that the growth could be partly attributed to advances in medical knowledge and technology not dissimilar to trends in comparable countries. The Committee eventually proposed that:

regulation will be more effectively achieved through selective surveillance at the level of the hospital, the State and the Commonwealth, using systems designed to address specific problems rather than through relatively arbitrary regulation of total budgets of public hospitals in the States or through an essentially external 'policing system' ...

control of utilisation...must be achieved at the level of doctor ordering the tests...rather than at the level of the provider of diagnostic services through income limitation or some other control...controls must be developed and they must be of a kind appropriate to supporting the most worthwhile developments for good health care rather than 'blanket' or 'indiscriminate' negative curbs on expenditure which do not allow for selectivity...

Additionally, in response to the singular focus on curbing rights of private practice, the Committee advocated a more flexible approach, finding that fee-for-service arrangements could actually be more economical than salaried or sessional arrangements, depending on the circumstances. These findings indicate that the Commonwealth's prescriptive doctors' remuneration goal was in fact a crude instrument for constraining service utilisation and costs. The Committee's view was that it was much more preferable for the medical profession itself to assume an active role in regulating utilisation, with monitoring best done at the service delivery coalface through systems encompassing "positive incentives" rather than penalties.

A number of conclusions can be drawn on the goal setting around doctors' remuneration. Similar to the Whitlam era, goal setting was primarily bottom up, and driven more by the clinicians rather than the States. Admittedly, the settlement with the medical profession can be construed as a compromise by all parties; however, the ultimate removal of all Agreement clauses relating to doctors remuneration operated heavily in the medical profession's favour, excluding the Commonwealth from future involvement with medical wage setting. Throughout the Whitlam and Fraser eras, it was evident that when a collaborative approach was taken between the Commonwealth and the States, this permitted them to better overcome the resistance of the medical profession. Hence the abolition of a Commonwealth role eliminated an extremely important negotiating mechanism that had worked very effectively to that point, when used. Perhaps the loss was inevitable, given that the AMA moved to re-align its governance structures to address the political gaps exploited by the Commonwealth and States. One can only speculate that reform efforts may have been more effective over the longer term had the Commonwealth and NSW governments adopted a less brutal and more far-sighted approach with the profession.

On the whole, it can be concluded that goal setting during the first term of the Hawke government was bottom-up, primarily because the policy ground eventually secured by the medical profession out-weighed the more balanced outcomes evident in the Commonwealth–State policy negotiations on universal hospital care.

6.4 GOAL CONGRUENCE

6.4.1 Goal congruence — federal

Universal hospital care

During the Hawke government, implementation of the universal hospital care goal was affected by three areas of goal conflict at the federal level: 1) the Commonwealth's economic priorities; 2) discord between the hospital care goal and policies to foster other forms of health care; and 3) tension between policies for privately and publicly funded hospital care.

The most significant area of goal conflict was the Hawke government's struggle to simultaneously enhance social and economic outcomes. The marriage of economic and social policy platforms in the Labor Party's pre-election Accord with the union movement was upheld as a "considerable achievement". The Accord was conceived as a unique "arrangement between the industrial and political wings of the labor movement .. [involving] ... a trade-off between ... a prices and incomes policy (to control inflation) and a stimulatory Keynesian fiscal policy [to restore the social wage⁴⁵ and generate employment]" (Stilwell 1986: 8,11). As discussed earlier, a critical component of the 'social wage' element of the Accord was the Commonwealth's Medicare program. Universal medical and hospital care were both viewed as an integral part of the Commonwealth's strategies for economic recovery and addressing inflation, with the introduction of the policy expected to reduce CPI by 2.6 per cent over the first two quarters of 1984 (Parl Comm. 1984c; WA Govt 1983c: 91). This linking of economic and social priorities proved to be highly difficult to manage in implementation, resulting in convoluted negotiations and diluted end outcomes, for both the community and the States.

Constraints on the implementation of the Accord appear to have begun even before the Hawke government entered office. During the election campaign, the Opposition Leader, apparently without the consent of the Parliamentary Caucus, bound the Labor Party to a fiscal policy platform known as the Trilogy. The Trilogy, described appropriately as a "self-imposed fiscal straight jacket", committed the Hawke government to freezing as a percentage of GDP: total taxation; total government expenditure and the size of the budget deficit; over the government's first term. Subject to there being adequate economic growth, these explicit fiscal targets, in particular the constraints around government

⁴⁵ The Accord defined the social wage as "expenditure by governments that affect the living standards of the people by direct income transfers or provision of services". Stilwell (1986: 70) suggests the 'social wage' incorporates Commonwealth expenditure on "education, health, social security and welfare, housing and regional development, culture and recreation".

expenditure clearly had the potential to conflict with, and place a firm financial boundary around, Commonwealth capacity to deliver the promised social wage. In April 1983, following the federal election, the Commonwealth called a National Economic Summit, attended by business and union representatives, State Premiers and others. Although the Summit Communiqué reaffirmed a commitment to universal health care and wage constraint "as a matter of urgency", the forum is claimed to have further watered down the Accord, with the pre-election compact shifting from a bipartite to tripartite one, the Commonwealth deciding to include business groups as an additional policy setter. It is contended that the involvement of the business representatives caused yet another setback to the "social reform tenor of the Accord" such that "increases in the social wage were less definite". It seems this outcome was not circumstantial but deliberate on the part of the Commonwealth. Stilwell (1986: 13,15,63) argues that the Commonwealth acted opportunistically, using the forum to significantly adjust its electoral commitments whilst getting "credit for making the changes" (WA Govt 1983c: 46).

Compromises to the Accord continued into 1985 and 1986. Business group pressures to restrain wage growth resulted in the Hawke government negotiating an Accord Mark II with the unions in 1985. The second iteration of the Accord involved the unions consenting to wage restraint in return for promised cuts to taxation and increased superannuation provisions. While the Commonwealth may have managed to achieve a truce between business and union interests, the Accord Mark II placed further strain on its ability to finance the social wage⁴⁶. A May 1985 mini-budget trimmed \$1.25 billion from the forward estimates, the cut worsened by the Treasurer's decision to relate "the Trilogy commitment ... to the year ahead rather than to the full three year term of government as had previously been indicated". The budget deficit fiscal target was also modified, the Commonwealth now committing to reducing the monetary value of the budget deficit, rather than maintaining the deficit as a proportion of GDP. It was observed at the time that the "work of the Fraser government's razor gang was starting to look rather feeble in comparison to the continuing efforts of the Expenditure Review Committee under Labor". An internationally sparked economic crisis in 1986 once again stirred the Accord deal, the Commonwealth finding itself having to develop yet a third version of the compact. The Accord Mark III involved a "clear break with the commitments entered into when the Accord Mark II was negotiated ... to pacify the further demands of business and financial

⁴⁶ The Trilogy commitment tied the Commonwealth to providing its promised tax sweetener within the existing budget bottom-line, thus necessitating even tighter restraint on government expenditure.

markets". A further significant brake was placed over government expenditure and thus the delivery of the social wage, with the 1986–87 federal budget involving around \$2.4 billion of spending cuts, much larger than expected by economic commentators (Stilwell 1986: 17-18, 20, 64-7).

Unlike the Whitlam government, which had idealistically and somewhat singularly focussed on social outcomes and attaining "redistribution without tears" (Stilwell 1986: 148), the overwhelming priority of the Hawke government was to foster economic growth, with redistribution afforded a lower importance. This philosophical transition by the Commonwealth appears to have been played out in a number of ways. Firstly, as discussed earlier, goal conflict tensions evident between the Commonwealth's Trilogy commitment to business groups, the Accord commitment to unions and its election commitments to the community. It is apparent that goal conflict was also evident within the Commonwealth bureaucracy, with the Treasury and Department of Finance assuming more prominence and control, whilst the Department of Premier and Cabinet was "stripped of the central policy control it enjoyed under the Fraser government". Further, in the political context, it is evident that imbalances between the Labor Party's left, centre left and right wing factions added to the dominant pro-market stance of Commonwealth policy setting at the time. This may also have been reflected in the policy making dynamics within the federal Cabinet, the Health Minister later recalling that (Blewett 1999: 1):

when the Hawke government was formed in 1983 I was banished as Health Minister to the outer Ministry and attended Cabinet meetings only when summoned usually when health issues were before Cabinet.

Finally, at a wider level, with the opening of the economy, the Commonwealth was increasingly captive to international stakeholders. By the end of its first term, Stilwell (1986: 67, 115, 20, 48) suggests that the Commonwealth's "budgetary policy had become geared more to the demands of speculators in international currency markets than to domestic economic management" (WA Govt 1984f: 190). The earlier discussion at section 6.3 revealed the gradual deterioration in Commonwealth–State goal setting in 1985–86, coinciding with the financial burden created by the settlement of the NSW doctors' dispute. It is now clear that broader economic events, the progressive decline of the Accord deal and competing expenditure pressures, were also causal factors behind the Commonwealth's more stringent approach in deliberations with the States over Medicare grant funding. Tied grant goal setting was now firmly positioned against wider national agendas of productivity, employment and international benchmarks.

In addition to causing a tightening of funding available for the universal hospital care program, the conflict with Commonwealth economic objectives infiltrated health policy making deliberations between the Commonwealth and the States in other ways. Goal setting generally became an increasingly convoluted and politically-charged exercise. For example, correspondence between the NSW Premier and the Prime Minister in early 1984 reveals a scuffle over competing policy interests involving the CPI. The NSW government pushed for the CPI to be adjusted to remove the effect of Medicare (so as to optimise State allocations from federal tax-sharing grants), whereas the Commonwealth preferred an unadjusted (and lower) CPI, the more beneficial stance from its perspective for national wage fixing and economic management. Ultimately, the Commonwealth stood firm, its Press Release asserting that tax sharing and Identified Health grants would increase by a CPI rate of 6.5 rather than 8 per cent, with the allocation to "more than fully (offset) benefits to the States, in terms of their lower wage costs as a result of the Medicare effect on CPI". The States were compelled to accept a rather loose link between macroeconomic policy and hospital funding needs, although well aware that "predicting the decisions of wage fixing tribunals is a risky business and in the event that wages increase above the CPI, we would be disadvantaged". Funding deliberations generally were also considerably distorted by political considerations and gaming. Notes from the June 1984 Premiers' Conference show a fiscally suffering WA privately debating the extent of new funding likely to be granted by the Commonwealth. It is suggested that the Commonwealth "may be tempted to gamble that only some of the states will radically increase taxes and charges", and would view such taxation increases to be less "visible politically" than a uniform increase in Commonwealth taxation. (WA Govt 1984d: 13, 34, 38-9; 1984a: 60).

Additionally, there is evidence of questionable intermingling of hospital funding and other intergovernmental finance negotiations. Notes from the February 1984 Premiers' Conference reveal acrimony between the WA government and the Commonwealth over the potential inclusion of Medicare grant funding in the Commonwealth Grants Commission (CGC) review of relativities used to inform State general purpose funding grants. WA had initially consented to universal hospital care on the basis of a concession from the federal Health Minister that new hospital funding would be quarantined from the CGC review. Later however, a "Mexican standoff" ensued when the Health Minister's deal was reversed by the federal Treasury. The Commonwealth, wary of a backlash from WA and similar responses from other States was keen to quickly resolve the dispute. The Commonwealth attempted to appease WA by suggesting it would provide "an increased allocation for

semi-government borrowers" whilst WA sought a \$21 million increase to its general purpose capital funds and an increased limit for "larger authorities' borrowings". Ultimately a truce was reached: the State signing up to universal hospital care in return for the Commonwealth agreeing to compensate for any loss arising from the Commonwealth Grants Commission review and also offering the possibility of exempting certain government trading agencies from the diesel excise (WA Govt 1984b: 3).

These examples very clearly show that financial dealings over universal hospital care had shifted drastically from the much more focused hospital cost-sharing discussions of the Whitlam and Fraser eras. Tied grant funding for public hospitals was now tainted by haphazard policy deals with little direct correlation to hospital costs, community needs, or service delivery structures. It is hardly any wonder that State Premiers came to regard dealings with the Commonwealth to be akin to "horse-trading" as opposed to a logical policy discourse centred on the "facts" (Cain 1995: 157). These characteristics once again resonate with earlier performance themes identified from the Whitlam era that excessive policy setting involvement by the Commonwealth brings increased politicisation and undesirable policy compromises.

In addition to goal conflicts arising from the Commonwealth's economic policies, it seems that similar to the Whitlam era, the universal hospital care goal was hampered by coordination weaknesses in federal health policy setting generally. For example, there are shortcomings evident in the Commonwealth's integration of policies for universal hospital care and aged care. It was observed at the time that insufficient funding and policy attention had been given to the transfer of long term patients from hospitals into aged care, as a result of "rivalry between [federal] departments ... as to which is the most appropriate department to run the new office of the care of the aged" (WA Govt 1983c: 127). Additionally, the Commonwealth appears to have overlooked the flow-on effects of its primary care policies and medical benefits schedule. Within weeks of introducing universal hospital care in WA, the proportion of public patients increased from 60 to 75 per cent in Royal Perth Hospital and from 57 to 70 per cent at the Queen Elizabeth Medical Centre. It was observed that there were "more people attending the emergency department with minor conditions ... [possibly] to avoid payment of the 'gap'" associated with general practitioners.

Further, the Commonwealth seems to have continued to grapple with defining an optimal role for the private sector, within the context of universal health care.

Although it was observed earlier that the Hawke government more openly acknowledged a role for private health care compared to the Whitlam government, the policy settings continued to be debated, for example with some critics questioning the dropping of taxation rebates for private health insurance and the flow-on effects this brought to the public system. As evident since the inception of universal hospital care in 1975, the Commonwealth was unable to resolve the policy dilemma between universal and privately financed hospital care, this being aggravated by the policy adjustments it was compelled to adopt as a result of the NSW doctors' dispute. Admittedly, the Commonwealth was successful in securing additional legislative powers to regulate the planning and approval of private hospital beds; however, even on this front, the implementation process was burdened by information gaps and States' hesitation to participate (WA Govt 1983b: 77,90; 1983d: 84-5; 1984a: 56). All in all, in terms of the universal hospital care goal, there were a number of significant tensions at the federal level which compromised the Commonwealth's policy setting and implementation of universal hospital care.

6.4.2 Goal congruence — intergovernmental

Universal hospital care

In terms of intergovernmental goal congruence on universal hospital care, electoral pressure, the predominance of Labor State governments, and the federal compact with the unions made it very difficult for States to reject universal hospital care as a policy goal. Although Queensland put up an initial resistance, its objections were certainly not policy related, but similar to the 1975 negotiations, stemmed from a States rights and financial perspective. The WA government publicly affirmed its support of the "federal government's election mandate" and even promoted the anticipated benefits of "considerable cost savings to low and middle income earners." (WA Govt 1983c: 39-40). It is unclear, however, whether such public displays of support were matched with a true ideological acceptance of the policy (based on the evidence reviewed, it would seem this was not the case). Due to the electoral, political and economic reasons mentioned, universal hospital care became an 'untouchable' from a policy sense — hence the States simply pragmatically got on with the task of securing adequate Commonwealth funding for the cause. The convoluted financing 'deal' forged by the WA government for example, in return for its acceptance of Medicare, shows that the States did not passively accept the ideology of universal hospital care, but pushed the Commonwealth as far as possible to pay a fair price for its goal.

A former Secretary of the NSW Health Commission confirms that the NSW Health Minister had no "detailed interest in Medicare except to protect the States' financial interest" (McKay 1986: 223). As discussed at Section 6.5, it would seem that for the NSW Labor government, and perhaps also the other States, the balancing of hospital budgets and addressing known efficiency gaps in hospital governance were much more pressing policy matters than universal hospital care. Well before Medicare commenced, the NSW government had been actively pursuing a health policy agenda of its own, involving reforms to doctors' remuneration and hospital configuration. The simultaneous thrusting of the Commonwealth's Medicare goals onto the State was not welcomed, and appears to have tainted longer term micro-efficiency improvements being pursued at the time.

Doctors' remuneration

During the Whitlam era, there was very clear goal congruence between the Commonwealth and States around doctors' remuneration — in particular, the desire to replace the honorary system with salaried and sessional arrangements, and the establishment of national wage setting machinery. By the time of the Hawke government, however, for a range of reasons this goal congruence had become much more convoluted, with divergence evident both between the Commonwealth and the States and between the States themselves. As discussed previously, between 1975 and 1984, each State had experienced different rates of success in shifting their medical workforce to salaried, sessional or modified fee for service arrangements. Also, the policy focus on salaried and sessional payments that was first compromised during the Whitlam era negotiations had been further watered down with the benefit of experience. The States had come to acknowledge that "the right of private practice is generally regarded nowadays as a condition of service for medical practitioners. It is considered part of the employment package and is used particularly by hospitals as an attraction and retention condition of service" (Australian Health Ministers 1983: 5-8). Finally, interstate uniformity had also been affected by the Fraser government's distancing from doctors' wage setting, a step which appears to have allowed the profession to extend its policy setting ground, with differing outcomes across the States.

Having reached workable compromises with their local medical workforce over a number of years, most States seemed less keen to 'rock the boat' by the time of the Hawke government's election, preferring more gradual and passive approaches to further reform. In WA, for example, the State government's policy platform provided for *long-term* transition to a complete salaried and sessional workforce, whilst in the short and medium

term, the State engaged in an ongoing dialogue with the profession on reforms to peer review, hospital accreditation, recruitment processes, quality of care and rationalisation of services (WA Govt 1984f: 194; 1984a: 26-7). There were, however, two notable exceptions to States' inclination towards incremental reform. All States continued to be interested in national cooperation and coordination — mainly from a desire for better health workforce planning and medical wage stability. On the latter, the States sought to stem the tide of spiralling wage costs, caused by wage determination spillovers from State to State (Australian Health Ministers and Taylor 1987: 4, 14, 29). The other exception was in NSW.

Having fallen behind on remuneration reform, the NSW had been pursuing some quite controversial reforms since 1976. These reforms which went to the heart of traditional practice included the rationalisation and regional realignment of services; drastic cuts to hospital budgets; pressure for efficiency improvements; and tighter regulation over doctors' remuneration. A contentious *Public Hospitals (Amendment) Act*, introduced in July 1983, gave the State government new powers over the "appointment, management and government of V.M.O.s", including the ability to control the terms and conditions of employment, rates of private patient charges and the volume of private practice activity. Clinicians were particularly opposed to clauses allowing "the Health Minister to determine the role, functions and activities of a hospital without consultation with the board of the hospital concerned" and "attach conditions to the payment of subsidies to hospitals". Additionally, the *Private Health Establishments Act 1982* granted additional powers over the "establishment, organisation and funding of private hospitals". With 81 per cent of beds in public hospitals at the time, this move disturbed the surgical workforce who with the looming introduction of Medicare, desired expansion of the private hospital sector (Adams 1986: 94-5; McKay 1986: 68-71).

Even with these developments and their desire for national cooperation, the States do not appear to have pressed for greater involvement from the Commonwealth at the time. As discussed earlier, at the Health Ministers' Conference in April 1983, all parties expressed concern at the extent of divergence that had developed in private practice arrangements between States; however, neither the Commonwealth nor the States were prepared to launch an aggressive response at the time.⁴⁷ Victoria specifically warned of potential "industrial consequences" and budget difficulties for the States should any "precipitant

⁴⁷ This attitude was consistent with the consensus reached by a Commonwealth-State Working Party on Diagnostic Services which was convened by the Fraser government. All parties agreed to improve the quality of diagnostic data in hospitals and participate in a national survey, prior to determining a policy response (WA Govt 1977a).

action" be taken. SA and NSW indicated they had reviews and reforms underway, with NSW explicitly asking that its own plans for "action", not be "inhibited" by any proposed national venture (Australian Health Ministers 1983: 5-8). In fact, although there was ultimately a very close resemblance between the NSW government remuneration reforms and the Commonwealth's doctors' remuneration goal, this does not appear to have come from a joint decision for reform. Whilst the medical profession claimed the similarities were evidence of a Commonwealth–State conspiracy to "nationalise medicine", a former Secretary of the NSW Health Commission confirms that this was not the policy intention, with NSW having commenced its reforms much earlier, and also having framed a more intense reform package than that prescribed by the Commonwealth (McKay 1986: 223).

Nevertheless, it must be acknowledged that all States did sign up to the remuneration goal. They do not seem to have been coerced, with evidence that the Commonwealth consulted on an ongoing basis during the formulation of the goal. The publicly conveyed view was that of a consensus: "as a number of the concerns of the Commonwealth in the provision of services to private patients were shared by the States and in some instances obstacles to rectification of anomalies existed within the States, it was resolved (at the July 1983 Health Ministers Conference) to proceed with amendment to section 17..." (Committee of Inquiry et al. 1984: 1). However, the States seem have carried private reservations and eventually after the NSW dispute broke out, it is apparent that most came to regret concurring with the Commonwealth (Cornwall 1989: 183-7).

The dominating role played by the Commonwealth becomes quite clear when reviewing the report of the (Penington) Committee of Inquiry. Victoria, WA and SA confirm that while they generally agreed on the need for better accountability in private practice arrangements, the preference was for the detail of such policy measures to be determined and implemented by the States, within "basic objectives and principles set by the Commonwealth ... rather than through the present [S17] legislation". On the proposed reform to limit fees according to the medical benefits schedule (MBS), the States pointed out a need to restructure the MBS as a first step, to make it more suitable for fee setting in hospitals. With regards to the Commonwealth requirement for institutional billing, the States held different views: QLD and WA did not support the idea; Victoria indicated in-principle support subject to there being no additional cost to the hospital; NSW believed institutional billing would be applicable for full-time medical staff and visiting medical practitioners for diagnostic services only; SA supported the concept but only for full-time medical staff. On the establishment of facility charges, again the States varied: NSW, WA

and SA believed the facility charge should be based on the MBS, after it had been restructured to recognise a professional and equipment component; whilst Victoria viewed the facility charge as a 'revenue raising measure' and thus need not be linked to cost. In terms of Commonwealth conditions around limitations on private practice income, all States generally agreed with the 25 per cent limit, but were dissatisfied with the tapering provisions proposed by the Commonwealth. Finally, on the requirements pertaining to contracts and trust accounts, again the States argued that this level of policy detail was best left to each State government to formulate (Committee of Inquiry et al. 1984: 97-104).

Given the extent of goal dissent, one has to question why the States passively signed up to the ambitious doctors' remuneration goal. There are a number of plausible explanations. First, timing was certainly a factor: the Commonwealth legislation seems to have been pushed through very quickly, within two months of the broad agreement reached at the July 1983 Health Ministers' Conference. Secondly, it is also quite possible that States simply underestimated the response of their local medical profession. Jurisdictions such as WA and SA who had stabilised their relationship with the profession may not have anticipated the strength of flow-on effect that would emanate from NSW. This could also be said of the Commonwealth who, despite instigating the remuneration goal, does not seem to have intended to battle with the profession or assume a 'hands-on' implementation role. It was suggested at the time that the federal Health Minister was caught "unprepared", believing that NSW doctors had "adopted a quite conciliatory attitude in an approach to the NSW Premier" (WA Govt 1983b: 67-8). All in all, it is apparent there was significant confusion of policy agendas. As discussed at Goal Clarity and Goal Setting, the Commonwealth appears to have been driven by a short-term and singular focus on ensuring cost containment of the Medicare program (WA Govt 1983d: 124). The States on the other hand had a much broader and longer term policy agenda to enhance hospital governance and efficiency.

The bitter clash of policy interests could have been avoided as discussed previously at Goal Setting. Had the Commonwealth not been so prescriptive with its legislation and guidelines, the effect on the smaller and more stable States would have been minimised. States such as WA, SA and Victoria, for the most part, were already largely compliant with the Commonwealth's goal (Parl Comm. 1984b, 1984d). In these States, the 1984 Agreement conditions requiring the complete replacement of existing contracts triggered unnecessary industrial unrest and antagonism. In a press release of March 1984, the WA Health Minister is forced to plead with the state AMA: "why should the eastern states AMA mandarins manipulate us here in WA — we are already doing what is required of us.

In fact most doctors have been doing it for years" (WA Govt 1984a: 70). The Commonwealth's zealousness certainly did not aid the ongoing deliberations with the profession that was occurring in these States. For example, a WA medical professional lamented in early 1984 that the Commonwealth's push for increased standardisation of contracts was distracting attention from more pragmatic local issues such as the availability of workforce for rural areas and after-hour services in general (WA Govt 1983b: 209). Another factor that did not assist the States was the Commonwealth's simultaneous push to address concerns over medical fraud. Apart from using the media to voice its allegations, there was increased investigative activity by the Commonwealth Department of Health and the federal police. These actions spurred mistrust and anxiety amongst the profession, impairing State relationships with clinicians and making remuneration and reform negotiations more difficult (WA Govt 1984a: 24).

It must be recognised, too, that similar to the Commonwealth's misjudgement, the NSW government also appears to have been excessively ambitious and confrontationist in its approach. These errors of judgement appear to have been partially caused by inadequate policy coordination between the Premier, Minister for Health and the NSW Labor Party (McKay 1986: 223-4). While the NSW Premier claimed that "all that's happening at the moment is that the national government ... is bringing NSW doctors' earnings into line with the rest of Australia", the NSW policy agenda was undoubtedly much more expansive and complicated (WA Govt 1983b: 62-3). Ultimately, it was only through a more moderate attitude, that both levels of government were able to end the dispute. A more successful policy outcome may have ensued had the Commonwealth adopted a broader goal, and then worked closely with the NSW government to achieve reforms over a longer timeframe, and also using financial sweeteners more effectively. The Commonwealth seems to have been motivated mainly by the threat of the Medicare implementation failing in NSW and the immediate implications for its Accord commitments (WA Govt 1983d: 10-11). As discussed at Goal Setting, in the hurry to see Medicare bedded down, with "little time for reflection" (McKay 1986: 222), it is apparent that the Commonwealth instigated unnecessary implementation trauma and policy damage.

6.4.3 Goal congruence — Overall evaluation

In terms of the universal hospital care goal, there were significant goal conflicts at the federal level. The policy compromises arising from these conflicts resulted in the tightening of hospital grant funding and increased demand for public hospital services. As these compromises only made delivery of the universal hospital care goal more difficult, the

States did not secure any significant policy making advantage from the goal conflicts evident. With regards to goal congruence between the Commonwealth and the States there was considerable public consensus on universal hospital care; however, it must be recognised that this came as a result of electoral, political and economic pressures on the States. Thus the overall indication is of a top-down mode of governance. Admittedly the States did retain primary control over policy decisions around service mix and quality, however such discretion was inherently constrained by the Commonwealth's financial and wider health system policy influence.

On the doctors' remuneration goal, the analysis indicates that the Commonwealth and States were in general agreement over the policy direction, with States at differing degrees of compliance, and NSW pursuing more rigorous reforms. Despite the Accord, however, it would appear that from an implementation sense, the States had preferred to pursue the policy goal in a more flexible and localised manner, with selective involvement from the Commonwealth, as opposed to the prescriptive and nationalised approach that was taken. The lack of congruence at this practical implementation level brought unnecessary confusion into the policy making process that eventually resulted in the medical profession becoming the more dominant policy setter. The Commonwealth was forced to adjust its universal hospital care goal and also completely withdraw its doctors' remuneration goal. Further, some of the earlier reform success of the smaller States was unwound. Whilst it was observed earlier in this chapter that the Commonwealth's intervention was critical to resolving the NSW doctors' dispute, the more significant issue is that the NSW doctor's dispute itself may have been averted or at least defused, had the Commonwealth assumed a less involved policy role to begin with (McKay 1986: 225-6).

Overall, the evidence on goal congruence points to neither a top-down or bottom-up of shared governance, with the Commonwealth dominant from the perspective of the universal hospital care goal and the medical profession gaining greater policy advantage on the doctors' remuneration goal.

6.5 INCENTIVES

Having substantial backing for its policy goals from an electoral, political and union perspective, the use of incentives were more on a one-on-one basis, rather than in a sweeping manner as in the Whitlam era.

A notable incentive payment was a special grant offered to Queensland to compensate for its long standing policy of universal care. Even this was determined unilaterally, with the

Commonwealth rejecting repeated calls by the State to address a baseline funding shortfall, insisting that: "we cannot correct all the errors and ... the false bases of the past". Queensland was one of the last States to sign the Agreement, its heated opposition eventually resulting in a deal that purportedly involved "an unprecedented agreement to retrospectivity by the Grants Commission on any additional funds...recommended for Queensland". While the deal appears to have favoured Queensland, it was claimed to be a "substantial back down" by the Queensland Premier (The West Australian as quoted in WA Govt 1983b: 88).

The Commonwealth was quite selective with its incentive payments too, refusing for example to recognise a similar situation in NSW where a universal service had been provided for disadvantaged outpatients (WA Govt 1983a: 49-50). Notably, such biases were never consistent, with different States benefiting at various times. Later, when Queensland expressed discontent with a deal struck with NSW concerning the formula funding of nursing home type patients, the Commonwealth acknowledged: "...each individual State received preferential treatment in some way in the negotiations..". Queensland was simply asked to refer to the Commonwealth Grants Commission process (WA Govt 1984c: 78). Similarly as mentioned earlier, it is apparent that the WA government benefited from a one-on-one deal with the federal Health Minister and Treasurer to counter the Commonwealth's decision to include new hospital funding in the Commonwealth Grants Commission review of relativities (WA Govt 1984b: 3).

There may have been many more one-one-one deals with the States that were never formally documented. Whilst incentives were limited, the incentives that were used did influence the States to sign up to the 1984 Agreement, thus a top-down mode of policy making is evident.

6.6 ENFORCEMENT

A number of key features are apparent in Commonwealth enforcement under the Hawke government. First, there was a new emphasis on the collection of information to assist with detection of medical fraud. The Commonwealth sought monthly admission and discharge data for public and private hospitals for its Fraud and Over-servicing Detection System. These data were intended to enable the monitoring of trends such as MBS payments by regional areas; incorrect MBS payments; and potential fraud in charges levied for private and public hospital accommodation. A Commonwealth–State working group was also formed to review potential incidents of MBS fraud that were identified (WA Govt 1984f:

139). The States were accommodating of the Commonwealth's requests; however, they countered that the information costs be met by the Commonwealth, and that reporting timeframes be State-determined. The Commonwealth appears to have accepted these conditions (WA Govt 1983c: 30-32).

Secondly, whilst detailed activity data were sought on a monthly basis similar to the Fraser era, the Commonwealth pushed for this to be electronically based, and was prepared to assist the States to finance the associated system costs. Effective from October 1983, detailed patient episode data (by hospital) was collected via magnetic tapes. Additionally form-based monthly data was sought on aggregate bed-day statistics (by category including public, private and compensation patients). The data collected were similar to the Fraser era, although there were some new data requirements, in particular to enable monitoring and assessment of the doctor's rights of private practice conditions within the 1984 Agreement. All data requirements were deliberated on during the July 1983 Health Minister's Conference; however, the practicalities appear to have continued to be negotiated during implementation. For example, in November 1983, the WA government advised the Commonwealth that some of the data would not be readily available from its system. Four possible solutions were put forward with an associated cost, from which the Commonwealth selected one, confirming that it did not intend "to impose duplicate statistical reporting systems on States". In 1984–85, a total of \$331,000 was added to the Medicare Compensation grant for WA to reimburse the State for statistical reporting requirements. This was on top of capital funding of \$50,000 provided earlier for the modification of existing computer systems (WA Govt 1983c: 132-46, 202-4, 24; 1983b: 110-20; 1984c: 32-33, 37).

Thirdly, there were data gathered specifically for the determination of funding — including baseline funding and the ongoing Medicare grant funding (WA Govt 1983c: 31). Fourthly, the Commonwealth appears to have adopted a cooperative approach in establishing its reporting framework, liaising closely with States during its development, and accommodating of changes where States advised the information was not available in the format or timeframe requested. For example, the Commonwealth agreed to streamline its bed-day statistical data collection to require "only that information necessary for calculation of the compensatory grant" be provided, in response to feedback from States. Additionally, after "all States commented unfavourably on the contents", the Commonwealth redrafted its collection form pertaining to data needs for determination of formula based grant funding. Overall, the data collection forms certainly appear much

simpler and congenial than that of the Fraser era (WA Govt 1983d: 188; 1984c: 14, 39, 155-57).

Finally, it would seem that the States adapted to the Commonwealth's requirements fairly smoothly, assisted by the Commonwealth's funding assistance and accommodating approach. It is also evident that the Commonwealth's requirements may have assisted the States to enhance their reporting systems. A State Circular on the reporting requirements notes too that the additional statistical information "will assist with the preparation of Management Reports", an indication that some of the reporting needs were simultaneously of assistance to the State's own monitoring and accountability framework (WA Govt 1983c: 35; 1983b: 115). All in all, the Commonwealth approach appears to have a cooperative, as opposed to an overbearing one. Notably, State concerns seem to have been responded to, and compensating funds provided to recognise the cost impost of reporting obligations. The evidence on enforcement therefore suggests a balanced mode of shared governance that was neither overwhelmingly top-down or bottom-up.

6.7 LOCAL DISCRETION

The evidence on local discretion reveals a mixed picture. On certain aspects, the Commonwealth appears to have been the dominant policy maker in other areas it is the States that had the final say. As discussed earlier in this chapter, with regards to the regulation of fees for private patients, initially the Commonwealth sought control only for the first twelve months of Medicare, but later began pushing for uniformity in fee structures and rises across States. This push does not seem to have eventuated into excessive coercion or control, however. The evidence indicates that States were generally the primary policy setters, being closely consulted on the setting of facility charges; the Commonwealth endorsing WA's' requests to charge for pharmaceuticals provided as part of outpatient services; and States openly resisting uniformity when desired. Admittedly, though, State discretion was affected by delays in securing Commonwealth feedback on proposed fee rises (WA Govt 1983c: 28; 1983d: 98-9; 1984a: 50, 103; 1984c: 73, 117-21, 67, 85).

On issues of workforce, it is apparent that it was the Commonwealth held the upper hand. For example, in late 1984, the WA government expresses its concerns over the Commonwealth's lack of consultation on a decision to transfer nursing education from the public hospitals. The WA government observes that the transfer will result in the "withdrawing (of) student labour from hospitals ... [creating] a demand of some 500 trained

nurses in WA alone" (WA Govt 1985: 64-6). Also, in 1987 States complained that nursing and medical specialist shortages were causing significant waiting times in public hospitals. The Commonwealth and States agreed to work more closely on workforce planning and forecasting; nonetheless, the federal government retained primary control over training places and funding (Australian Health Ministers and Taylor 1987: 3, 12). Similarly, on issues of wider service configuration, the States seem to have been constrained. In mid-May 1986, the WA government explored the possibility of privatising or out-sourcing the provision of some of its outpatient services to the private sector, only to find that the 1984 Agreement would preclude such a proposal. While the concept could certainly be construed as cost-shifting, it is equally relevant that such investigations probably also arose from a bona fide need to arrest hospital cost growth. Similarly, the State was prohibited from using its \$50 million capital funding allocated as part of the NSW doctors' dispute settlement, on non-teaching or psychiatric hospitals (WA Govt 1984e: 94, 152-56).

The Commonwealth seems to have held the upper hand in terms of the MBS, although there is a more accommodating approach evident, compared to the Fraser era. Early on, following State protests over the lack of participation in MBS, the Commonwealth was non-committal and "vague" (Australian Health Ministers 1983: 21). Subsequently, however, the States were consulted and even allowed representation on an MBS Review Committee (WA Govt 1984a: 112-14). Nonetheless, it is unclear as to whether the States had any significant policy input. Certainly the predominant parties seem to have been the Commonwealth and the AMA. A key policy objective pursued was to bring greater uniformity in MBS fees across States. Initially a gradual approach was sought, with fees increased or reduced progressively across States to allow uniformity to be achieved at no additional cost. However, in August 1986, the Commonwealth announced that a uniform MBS would be introduced "at the level of the highest current rate". Presumably the States would have had to deal with the impact of this announcement on the cost of hospital fee-for-service contracts. Notably too, the Commonwealth did not always get its own way, failing in an attempt to bring greater uniformity to screening tests for sexually transmitted diseases in May 1985. The States adamantly defended their own testing regimes in spite of the Commonwealth offering to fund the tests through the MBS (WA Govt 1984e: 139; 1984f: 7, 9, 156).

On the basis of the evidence available, and largely consistent with findings from the Whitlam and Fraser eras, it is apparent that during the Hawke government, the Commonwealth predominated in terms of policy framework issues such as health

workforce supply, wider health system service configuration and the setting of the MBS. The States on the other hand were the more significant policy players in issues such as private fee setting, local clinical practice and as discussed earlier in this chapter, the details of doctors' remuneration contracts. The overall indication therefore is one of a balanced mode of shared governance.

6.8 STATE GOVERNANCE BARRIERS

The primary State governance barriers evident during the Hawke government were very much in line with those under the Whitlam and Fraser governments: 1) medical profession resistance; and 2) hospital governance shortcomings. As we have discussed so far, the barriers put up by the NSW profession led to the withdrawal of the goal to constrain rights of private practice. Further, apart from some improvements to reporting systems; some potential reduction of medical fraud; and potential gains from the new Commonwealth-State machinery established to improve performance; it would appear that the Commonwealth was able to secure little ground in enhancing hospital governance. The indication is of a bottom up mode of governance.

6.9 CONCLUSIONS: BALANCE OF POWERS

The following table summarises the assessment formed against each of the analytical foci:

Table 6.2 Balance of Powers – Hawke Era

Analytical Foci	Indicative Shared Governance Approach
Goal clarity	Neither top-down nor bottom-up
Goal setting	Bottom-up
Goal congruence	Neither top-down nor bottom-up
Incentives	Top-down
Enforcement	Neither top-down nor bottom-up
Local discretion	Neither top-down nor bottom-up
State governance barriers	Bottom-up
OVERALL ASSESSMENT	NEITHER TOP-DOWN NOR BOTTOM-UP

The overall indication for the 1984-88 Agreement is a balanced mode of shared governance and policy making. While the Commonwealth drove the policy setting around universal hospital care, the States were not completely overtaken, capably resisting or re-shaping some of the policy intrusion and bargaining effectively for appropriate funding, with success rates greater in the early life of the grant. On the doctors' remuneration goal, the Commonwealth's initially prescriptive policy impositions were undoubtedly a top-down

form of policy making. Ultimately on implementation however, it was the medical profession that secured the greater policy advantage. The outcomes of the NSW doctors' dispute are claimed to be a compromise by all parties. Nonetheless, the complete removal of Agreement clauses requiring Commonwealth involvement in hospital medical wage setting; and the detrimental flow-on effects to other States, including the adjustments to the universal hospital care goal, and the unwinding of earlier reform gains in some of the States — were all significant policy consequences. These end outcomes clearly suggest that the medical profession attained important and strategic policy space in terms of future hospital policy setting negotiations.

6.10 REFLECTIONS ON TIED GRANT PERFORMANCE

6.10.1 Performance advantages of tied grants

The 1984 Agreement provided for the successful establishment of national Liver and Cardiac Transplant Centres in NSW. The tied grant can thus play a beneficial role in facilitating national economies of scale (WA Govt 1984c: 85). Further, as discussed in Chapter 4, this case study further confirms that use of the tied grant can be performance advantageous, where there is significant goal congruence between the Commonwealth and States and goal implementation is subject to local political barriers. Under the Whitlam government, it was noted that the Commonwealth's involvement allowed the smaller States to overcome local professional resistance to remuneration reform. This was also initially the experience during the Hawke era — in the smaller States. The Hawke government's ultimate failure to implement this goal nationally reveals some important qualifiers to the earlier Whitlam era findings.

Two key factors explain the different outcomes which prevailed under the Whitlam and Hawke governments. One notable factor is the highly prescriptive nature of the 1984 goal and guidelines compared to the broader policy frame of the 1975 Agreement, which simply advocated more salaried and sessional remuneration arrangements, and left the policy detail in the hands of the States and hospitals. As suggested earlier in this chapter, the Commonwealth may have been more successful in NSW and sacrificed less from a policy setting perspective, if a more flexible approach had been allowed for, both by the Commonwealth and the State governments. A second factor is the extent of congruence between Commonwealth and State goals. During the Whitlam era, the States were on a fairly level playing field, except Queensland and Tasmania who had forged ahead with salaried and sessional arrangements earlier. In contrast, under the Hawke government, the

policy environment was more divergent, with NSW clearly being behind the other States. While some States may have only required minor policy fine-tuning, it is apparent that the Commonwealth opted to pursue a highly detailed goal and guidelines, to address the policy needs of NSW. In its push for a sweeping national approach, the Commonwealth damaged the policy progress that had been secured in the smaller States and finally lost the policy battle with the medical profession.

6.10.2 Performance deficiencies of tied grants

Convoluting policy compromises

The Hawke government evidence reveals that the use of complex funding formulas, indexation factors and sometimes dubious indicators of activity and cost in tied grants can make tied grant negotiations highly arbitrary, and most importantly, disassociated from the hospital coalface. The WA Government observed "there is no doubt that the formulae in the Agreement do produce 'hypothetical' results and can easily be the subject of debate" (WA Govt 1984c: 83). Under the Hawke government there was a dramatic loss in the integrity of funding negotiations relative to the Whitlam and Fraser eras where funding deliberations were predominantly centred on actual hospital costs, a much more pragmatic focal point. Secondly, the Commonwealth's tendency to refer tied grant funding disputes to the Grants Commission or other forums such as Premiers' Conferences significantly reduces the transparency and accountability of the policy setting process. As observed in this chapter, such referrals allow the Commonwealth to side-step or avoid the difficult policy issues, and convolute negotiations with other competing policy agendas. Finally, accountability was also reduced by the Commonwealth's offering of incentives not directly related to hospital care or tied grant funding. During the Hawke era, the scope and type of incentives was considerably extended, including for example offers for taxation relief and increased borrowing limits. The linking of tied grant negotiations to such economic and taxation agendas and the wider fiscal federal arrangements precluded a clear link between public hospital costs and grant funding.

Emphasis on macroeconomic performance

A common theme in all of the case studies examined is that Commonwealth dominance in policy setting both *diverts* and *prevents*, necessary attention being given to managerial efficiency. During the Whitlam era, governance shortcomings were overlooked in the haste to secure State and professional participation for Medibank and the associated national social benefits. The Fraser government's attempts to improve managerial efficiency were

administratively tedious and largely tokenistic, driven primarily by pressing national economic concerns. Finally, the Hawke government was unsuccessful in its efforts to implement doctors' remuneration reform and enhanced managerial efficiency. Under Hawke, the Commonwealth's policy actions were primarily driven by its immediate need to fulfil the Accord and secure the associated national economic benefits. As suggested by the Commonwealth's own Committee of Inquiry, rigid tied grant mechanisms such as the budget and regulatory controls adopted over doctors' remuneration can be much too imprecise to have the type of in-depth and long-lasting impact on hospital governance that is necessary to build a more efficient and effective hospital system. The Commonwealth, impeded by a lack of direct constitutional jurisdiction, has a tendency to overlook the finer details of service delivery. Yet it must be recognised that most decisions affecting managerial efficiency are made at the point of service delivery — primarily by the health workforce. The support of the health workforce is therefore critical for advancing such reforms, and it is the States who are ideally placed to assume the lead role in fostering the necessary productive working relationships with the workforce.

Policy bias towards the larger states

A further theme re-confirmed by this case study examination is that unilateral Commonwealth policy setting has a tendency to be biased towards larger States. Under the Hawke government, the highly prescriptive doctors' remuneration goal was in fact a policy goal specific to the larger States, mainly NSW in this instance. The Commonwealth's nationalising approach resulted in sweeping policy compromises, some of which resulted in undesirable policy setbacks for smaller States.

Tendency for sub-optimal policy solutions

As discussed earlier in this chapter, the diagnostic cost pressures driving the Commonwealth's remuneration goal were found to be more apparent outside, rather than within, the hospital system. Thus the Commonwealth's tied grant goal appears to have been a convenient conduit for Commonwealth policy intervention in this area of concern, there being no reliable mechanisms for the Hawke government to regulate private diagnostic practice outside the hospital system.

The above reflections on tied grant performance will be further discussed in Chapters 7 and 8.

6.11 CONSOLIDATION — LONGITUDINAL CASE STUDY ANALYSIS

Prior to moving to Chapter 7 and the comparative case study of tied grants for public schools, this last section completes and consolidates the longitudinal study of the public hospital tied grant. Firstly, summarised findings are presented on three subsequent public hospital tied grant agreements signed in 1988, 1993 and 1998, under the Hawke, Keating and Howard governments. Following this, the findings of all six hospital grant case studies (1975 to 2003) are reflected on, as part of a consolidated discussion of Goal Consistency and Funding Shares — the two remaining analytical foci of the case study framework.

6.11.1 High level case study examination of subsequent hospital tied grants

Key findings from a high level examination of subsequent agreements signed under the Hawke, Keating and Howard governments are summarised below.

Table 6.3 Balance of Powers — Hawke-Keating and Howard Eras

Case Study	Balance of Policy Making Power	Performance effects evident
1988 – 1993 Agreement (Appendix B.4 & C.1)	Neither top-down nor bottom-up	<ul style="list-style-type: none"> · Convoluting policy compromises · Policy bias towards the larger States · Accountability shortcomings · Administrative and operational inefficiencies · Emphasis on macroeconomic performance
1993 – 1998 Agreement (Appendix B.5 & C.2)	Top-down	<ul style="list-style-type: none"> · Convoluting policy compromises · Policy bias towards the larger States · Accountability shortcomings · Administrative and operational inefficiencies · Emphasis on macroeconomic performance
1998 – 2003 Agreement (Appendix B.6 & C.3)	Bottom-up	<ul style="list-style-type: none"> · Convoluting policy compromises · Accountability shortcomings · Administrative and operational inefficiencies · Emphasis on macroeconomic performance

Key features of these Agreements have been summarised by Duckett (2004: 5):

Table 6.4 Agreements signed in the Hawke-Keating and Howard Eras

Agreement	Political Objective	Key Principles
1984–88 : Labor (Medicare Compensation Agreement)	Introducing Medicare	Compensation for cost increases and revenue losses
1988–93 : Labor (Medicare Agreement)	Consolidating Medicare Growth and reform of public provision	Incentives for system reform Penalties for lower public:private bed day shares and excess private medical service use
1993–98 : Labor (Medicare Agreement)	Entrenching Medicare Expansion of public provision	Reward for relatively higher levels of public provision and for increasing public provision relative to other states Post 1996, accountability for negotiated outcomes
1998–2003 : Coalition (Australian Health Care Agreement)	Continuing with Medicare Increased Commonwealth funding with increased accountability for states	Increased accountability on states for activity level changes Increased clarity of Commonwealth responsibility if health insurance levels change
2003–08 : Coalition (Australian Health Care Agreement)	Continuing with Medicare Slowed Commonwealth funding growth Increased accountability for states	Improved reporting, including of state spending Requirement on states at least to match Commonwealth funding increases

More detailed comparative tables highlighting the main variations in the grant arrangement over the period 1988 to 2003 can be found at Appendix B. Further, a comprehensive analysis of each grant arrangement is at Appendix C.

6.11.2 Consolidated Findings on Goal Consistency — Whitlam to Howard

Over the case study timeframe 1975 to 2003, the Commonwealth’s policy intervention into public hospitals centred on two fundamental national goals — universal hospital care and doctors’ remuneration reform. As indicated below, the balance of policy making powers fluctuated considerably over this period. While the Commonwealth may have pursued the same goals over time, these results confirm that in practice, there were ongoing variations in goal definition and implementation, and thus *no overall goal consistency*.

Table 6.5 Balance of Powers — Hawke-Keating and Howard Eras

ANALYTICAL FOCI	1975 Agreement	1976 Agreement	1984 Agreement	1988 Agreement	1993 Agreement	1998 Agreement
	(Whitlam era)	(Fraser era)	(Hawke era)	(Hawke era)	(Keating era)	(Howard era)
<i>Goal clarity</i>	Neither top-down or bottom-up	Top-down	Neither top-down nor bottom-up	Neither top-down nor bottom-up	Top-down	Bottom-up
<i>Goal setting</i>	Bottom-up	Top-down	Bottom-up			
<i>Goal congruence</i>	Top-down	Top-down	Neither top-down nor bottom-up			

ANALYTICAL FOCI	1975	1976	1984	1988	1993	1998
	Agreement	Agreement	Agreement	Agreement	Agreement	Agreement
	<i>(Whitlam era)</i>	<i>(Fraser era)</i>	<i>(Hawke era)</i>	<i>(Hawke era)</i>	<i>(Keating era)</i>	<i>(Howard era)</i>
<i>Incentives</i>	Bottom-up	Neither top-down nor bottom-up	Top-down	Neither top-down nor bottom-up	Top-down	Bottom-up
<i>Enforcement</i>	Bottom-up	Top-down	Neither top-down nor bottom-up			
<i>Local discretion</i>	Bottom-up	Top-down	Neither top-down nor bottom-up			
<i>State governance barriers</i>	Bottom-up	Bottom-up	Bottom-up			
OVERALL ASSESSMENT	BOTTOM-UP	TOP-DOWN	NEITHER TOP-DOWN NOR BOTTOM-UP	NEITHER TOP-DOWN NOR BOTTOM-UP	TOP-DOWN	BOTTOM-UP

Reflecting on the key findings of each case study, the goal deviations are clearly apparent.

Universal hospital care

The Whitlam government sought to aggressively introduce universal hospital care but it was compelled to offer costly financial concessions and limit goal prescription in order to secure the acceptance of mostly non-Labor States. Under the 1975 Agreement, goal implementation was predominantly in the control of hospital administrators and the medical profession, with significant state governance weaknesses serving to reduce implementation efficiency and effectiveness. After the demise of the Whitlam government, the Fraser government moved to substantially tighten goal clarity and cap its funding contributions in response to national economic and budget pressures in the 1976 Agreement. Goal enforcement was also significantly increased with new intergovernmental machinery introduced and highly intrusive Commonwealth engagement into hospital budget and operational settings. Data limitations and state resistance prevented the Commonwealth from gaining any major influence over goal implementation, this remaining in the hands of the hospitals and clinicians. An exception was in the area of private patient

fee settings where the Fraser government's rigid control frustrated States. The Commonwealth was also highly coercive, unilateral and prescriptive in most of its dealings with the States, making continuous changes to policy settings across the wider health system and creating detrimental flow-on effects to public hospitals which reduced States' local policy flexibility and discretion. Ultimately, for ideological and fiscal reasons, the Commonwealth abandoned its universal hospital care goal completely.

The Hawke government, with the support of a strong electoral mandate and the promise of economic gains under the Accord, adopted a much more collaborative approach in re-establishing the universal hospital care goal with the predominantly Labor States. The States were not backward in reclaiming policy influence, successfully resisting and reshaping Commonwealth proposals, and extracting financial concessions during negotiation of the 1984 Agreement. Funding of the goal was significantly altered under the Hawke government with the Medicare grant focussed on compensating States for their revenue losses as opposed to the 50-50 reimbursement of hospital costs by the Whitlam government. The initial atmosphere of intergovernmental cooperation was not sustained as the Commonwealth shifted its attention to macroeconomic objectives and grant funding was tightened. Goal implementation remained in the hands of the States, assisted by the Commonwealth's retreat from the Fraser government's onerous monitoring and intrusion into hospital operations and private patient fees. The Commonwealth did little to facilitate more efficient and effective goal implementation, although there was increased recognition of data limitations with the Commonwealth investing in system improvements. The Commonwealth also continued to make unilateral decisions across the wider health system which had flow-on effects to the public hospitals and reduced their policy flexibility.

Having successfully established universal hospital care, in the 1988 Agreement, the Commonwealth sought to extend its policy control. The Hawke-Keating government increased goal prescription and introduced penalty clauses to improve the provision of universal hospital care particularly in the larger States. Grant funding of \$1.8 billion which had been made available as an untied grant by the Fraser government was consolidated with the Medicare grant, increasing the Commonwealth's policy capacity. The Commonwealth also continued to focus on its macroeconomic objectives, tightening grant funding and ignoring flow-on demand pressures to the public hospitals from unilateral Commonwealth decisions across the wider health system and falling private health insurance coverage. Through their bargaining and resistance, the States managed to stifle Commonwealth proposals around penalty clauses, reporting requirements and goal

prescription. The Agreement included an Incentives Package in recognition of continued calls from the States for the development of non-hospital alternatives, although this funding was minor compared to the main grant. Despite the investment in data improvement and systems, information asymmetries prevailed, enabling the States to retain firm control over the efficiency and effectiveness of goal implementation.

Faced with significant macroeconomic pressures, goal prescription was further increased in the 1993 Agreement with a remarkably complicated funding formula introduced. The Keating government also increased reporting requirements, continued with the use of penalty clauses and sought to develop performance-based grant funding. Grant negotiations were convoluted with the Commonwealth Grants Commission process, the Commonwealth's unilateral decisions creating confusion and funding uncertainty for the States. The States managed to reshape or avert some of the Commonwealth's goal adjustments, although some of these 'gains' proved to be ineffective in practice, with the Commonwealth holding the upper hand in terms of its adherence to grant terms and conditions. While the States managed to extract significant funding guarantees to counter the effects of the new funding formula, ultimately some of the financial concessions secured by smaller States were redistributed, as the Commonwealth struggled with budget pressures and reduced its funding commitment to universal hospital care. There was continuing focus on improvement of hospital governance and datasets, but goal implementation remained under State control.

By the 1998 Agreement, the States had learnt from the difficult implementation of the 1993 Agreement and were experiencing their own fiscal pressures in continuing to deliver universal hospital care. Improved policy making capacity and health data allowed the development of more comprehensive policy positions by both levels of government, but particularly the States who took a lead role in putting forward detailed policy options. Despite a coercive Commonwealth and considerable political pressure, the States delayed and resisted their re-commitment to universal hospital care, forcing the Commonwealth to respond with generous sweeteners and better policy offers. The States also successfully unravelled or diluted some of the Commonwealth's goal adjustments and again retained primary control over goal implementation.

Doctor's remuneration reform

Despite being a policy end sought by both the Commonwealth and the States, the life of the doctor's remuneration goal was dramatically cut short by the NSW Doctors' Dispute which

dominated the negotiation of the 1984 Agreement. The demise of the goal was caused by the Commonwealth's quite astonishing increase in goal prescription in the 1984 Agreement, in contrast to the more flexible approach adopted under the 1975 and 1976 Agreements. Remuneration reforms commenced under the 1975 Agreement were stalled or partly unwound under the Fraser government which opted to take a less hands on approach to implementation. However the Hawke government's aggressive approach, driven by its macroeconomic pressures and an urgent need to enhance goal implementation in NSW, resulted in a dramatic showdown with the medical profession which ended with the complete withdrawal of this goal. Although the States remained keen for national cooperation on doctors' remuneration and continued to push this policy agenda through Health Ministers' meetings, the goal was distinctly absent from the 1988, 1993 and 1998 Agreements.

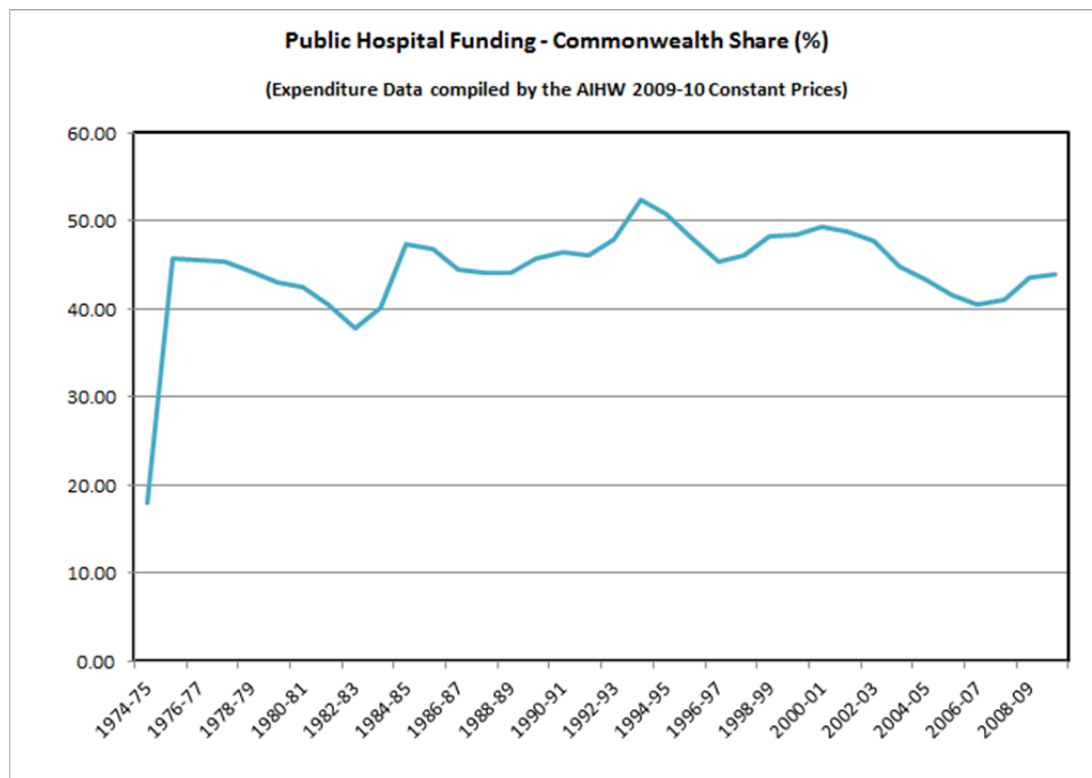
6.11.3 Consolidated Findings on Funding Shares — Whitlam to Howard

In examining the evidence on funding shares, a number of complexities are apparent. Firstly, findings appear to vary depending on the data source used. A state-commissioned report (Access Economics Pty Ltd 1998: 11, 19) outlines varying findings emanating with the use of ABS; Commonwealth Grants Commission; State Budget; or Australian Health and Welfare Institute (AIHW) data⁴⁸, with AIHW and State Budget data sources proposed as the most relevant for determining relative funding shares. A second complexity also noted by Access Economics is that "relative financing efforts cannot be sensibly assessed without regard to the wider ... [fiscal federal] ... picture". It is important to recognise that State financing of public hospitals is not only dependent on tied grants but also general purpose revenue grants and private financing. Any fall in the latter two sources of funding can have significant impact on the State capacity to *maintain* funding share. In view of these complexities, this thesis: 1) adopts data from the AIHW to assess funding shares; and 2) in order to remove the distractions of inter-dependencies between State general purpose and specific purpose funding, opts to focus discussion on Commonwealth funding share. In support of the latter, Deeble (2002: 2), after examining the relationship between Commonwealth funding shares and hospital expenditure growth, argues that "both parties have reacted to each other. But despite their mutual dependency, all of the evidence suggests that it is ultimately the Commonwealth which 'drives' expenditure growth, not the States".

⁴⁸ The report indicates: "the differences between the data sets are principally in the way the data is aggregated and the purpose for which the data is collected and used ... the treatment of various issues can result in differences between the expenditure estimates of ... up to \$800 million".

The following *indicative* longitudinal analysis of the Commonwealth’s funding share has been prepared using data provided by the AIHW (2012).⁴⁹ Over the case study timeframe, the average Commonwealth funding share has wavered between 44 to 48 per cent:

Figure 6.1 Commonwealth Funding Share — Whitlam to Howard



The trend in average funding shares indicates that the Commonwealth has remained fairly steady in its commitment to universal hospital care over the case study timeframe. While annual fluctuations are apparent,⁵⁰ the Commonwealth has not dominated the financing of universal hospital care, its contribution generally remaining under 50 per cent. This analysis of funding shares thus further confirms the discussion at Section 6.11.2 that the balance of policy making power has fluctuated over time. As shown at Table 6.6, the above results based on AIHW data are quite reasonable when assessed against average funding shares published earlier by Deeble and Duckett at Figures 6.2 and 6.3 (1982: 719; 2002: 14).

⁴⁹ The public hospitals expenditure data was compiled by the AIHW specifically in June 2012 for this study and draws on the online data cubes: *National health expenditure, current and constant prices* for the periods 1985/86 to 2002/03 and 2003/04 to 2009/10. The latter period data was adjusted to ensure a consistent time series. Further, data for the period 1974/75 to 1984/85 was extracted from the AIHW Health expenditure database and adjusted for inflation using the ABS Government Final Consumption Expenditure hospitals and nursing home deflator, the standard deflator used by the AIHW to deflate hospitals expenditure.

⁵⁰ Access Economics (1998:1) confirms that some of the year-to-year movement in Commonwealth funding shares is attributable to the timing of grant cashflows, with States often seeking advance payments in the early years of a grant.

Table 6.6 Commonwealth Funding Share — Whitlam to Howard

Case Study Timeframe	Commonwealth Funding Share (%)											
	1975 Agreement		1976 Agreement		1984 Agreement		1988 Agreement		1993 Agreement		1998 Agreement	
	1974-75	18.0	1976-77	45.6	1983-84	40.1	1988-89	44.2	1993-94	52.4	1998-99	48.2
	1975-76	45.8	1977-78	45.4	1984-85	47.4	1989-90	45.8	1994-95	50.9	1999-00	48.4
			1978-79	44.3	1985-86	46.9	1990-91	46.5	1995-96	48.2	2000-01	49.3
			1979-80	43.1	1986-87	44.5	1991-92	46.1	1996-97	45.4	2001-02	48.7
			1980-81	42.5	1987-88	44.0	1992-93	47.9	1997-98	46.1	2002-03	47.7
Average Commonwealth Funding Share (AIHW)	45.8		44.2		44.6		46.1		48.6		48.5	
Average Commonwealth Funding Share (Duckett 2002)	-		-		42.7		43.2		46.1		45.0	
Average Commonwealth Funding Share to 1978-79 only (Deeble 1982)	41.0		42.7		-		-		-		-	

Figure 6.2 Average Commonwealth Funding Shares — Duckett (2002:14)

Agreement	Political Objective	Key Principles	Average funding shares
1984-88 ('Medicare Compensation Agreement')	<ul style="list-style-type: none"> • Introduction of Medicare 	<ul style="list-style-type: none"> • Compensation for cost increases and revenue losses • Transparency • Accountability • Dynamic 	Commonwealth: 42.7% State: 46.5% Private: 10.8%
1988-93 ('Medicare Agreement')	<ul style="list-style-type: none"> • Consolidating Medicare • Growth & reform of public provision 	<ul style="list-style-type: none"> • Incentives for system reform • Penalties for lower public:private bed/day shares and excess private medical service use 	Commonwealth: 43.2% State: 47.2% Private: 9.6%
1993-98 ('Medicare Agreement')	<ul style="list-style-type: none"> • Entrenching Medicare • Expansion of public provision 	<ul style="list-style-type: none"> • Reward for relatively higher levels of public provision & for increasing public provision relative to other states. • Past 1996, accountability for negotiated outcomes 	Commonwealth: 46.1% State: 45.4% Private: 8.5%
1998-2003 ('Australian Health Care Agreement')	<ul style="list-style-type: none"> • Continuing with Medicare • Increased Commonwealth funding with increased accountability for states 	<ul style="list-style-type: none"> • Increased accountability on states for activity level changes • Increased clarity of Commonwealth responsibility if health insurance levels change 	1998/99 Commonwealth: 45.0% State: 47.4% Private: 7.7%

Figure 6.3 Average Commonwealth Funding Shares — Deeble (1982:719)

Table 3. Payments for general hospitals and medical services 1969–1970 to 1978–1979 percentage composition, by source of finance

	Government		Total	Insurance	Private Recipients	Total
	Commonwealth	State				
<i>General Hospitals</i>						
1969–1970	21	49	70	21	9	30
1972–1973	16	50	66	22	13	34
1974–1975	13	55	67	26	6	33
1975–1976	41	36	77	16	8	23
1976–1977	43	35	77	18	5	23
1977–1978	43	33	76	19	5	24
1978–1979	42	33	75	20	5	25
<i>Medical Services</i>						
1969–1970	34	—	34	27	39	66
1972–1973	50	—	50	27	23	50
1974–1975	46	—	46	36	18	54
1975–1976	86	—	86	4	10	14
1976–1977	56	—	56	32	12	44
1977–1978	34	—	34	52	12	64
1978–1979	35	—	35	50	15	65

Sources: Deeble J. S. and Scotton R. B. Health services and the medical profession. In *Economics of the Australian Service Sector* (Edited by Tucker K. A.) p. 323. Croom Helm, London, 1977. Commonwealth Department of Health, *Annual Report 1972–73*. Commonwealth Department of Health, *National Health Account—A Study*, AGPS, 1978: Data supplied by the Commonwealth Department of Health.

SECONDARY CASE STUDY

TIED GRANTS

FOR PUBLIC SCHOOL SERVICES

The *in-depth* case study examination of public hospital tied grants over the period 1975 to 2003 reveals the balance of policy-making power within tied grants to be a wavering one. This outcome is essentially a reflection of Australia's constitutional framework and vertical fiscal imbalance, both of which make it difficult for either level of government to be singularly dominant. The case studies also identified a range of political, administrative and accountability inefficiencies. The Commonwealth's use of tied grants increases the risk of: convoluting policy compromises; a policy bias towards the larger States; accountability shortcomings; administrative and operational inefficiencies; and an over-emphasis on macroeconomic performance.

Two important nuances apparent in the performance of tied grants was that: 1) inefficiencies are more prevalent when the Commonwealth acts unilaterally and is heavily prescriptive in its policy making; and 2) under certain circumstances, the Commonwealth's involvement can in fact prove beneficial to policy making. On the latter, the evolution of the doctors' remuneration goal clearly highlights the potential policy making advantages to be gained when tied grants are used to facilitate a policy goal that is congruent with States' preferred policy directions and targeted at policy reforms burdened by local political barriers.

The aim of Chapter 7 is to further test the veracity of the key findings evident from Chapters 4, 5 and 6, within the policy context of public schools. The schools policy area has been selected for its significance, and in view of the similar features shared with the tied grant funding of public hospitals. Like the public hospitals, Commonwealth involvement in the funding of public schools began before the 1970s, but it was only under the Whitlam government that the federal government firmly established its policy intervention capacity, through significant increases in funding. Also consistent with the public hospitals, policy making in the schools area has been affected by ideological differences between the major political parties. In this regard, the Labor Party has traditionally emphasised greater public provision and collaborative national policy frameworks, whereas the Liberals, in particular over the past decade, have focused on enhancing non-government sector provision (as a

means of offering the community greater 'choice'), whilst adopting a "managerialist" or a "steering from a distance" approach to national policy outcomes⁵¹ (Connors 2000: 20; Angus in Connors et al. 2007: 115; Lingard 2000: 48-9; Reid 2009: 5). Further, in both policy areas, the Commonwealth has claimed a strong 'national interest' in school education funding and outcomes, this interest evolving from a social equity concern under Whitlam to primarily a macro and micro economic concern since the Hawke government, although the social equity agenda was revived by the Rudd government (Lingard 2000: 27-8, 34, 41, 50-1; Reid 2009: 6-7). A final parallel is that the delivery of public policy in the schools area is reliant upon the grassroots implementers — the teaching profession, who are represented by quite powerful union groups, albeit perhaps not as influential as the health workforce unions. One marked variation from the public hospitals policy context is that the Commonwealth has been only a minor funding partner in public schools, with the States carrying primary responsibility. Whilst this has by no means thwarted the Commonwealth from involving itself in school policy making, the positioning of the Commonwealth as a lesser funding player does offer an interesting contextual variation for comparative analysis.

Being a *high-level case study* and aimed primarily at testing the conclusions reached so far in this study, Chapter 7 is structured around those conclusions, as opposed to the analytical foci applied earlier. The chapter draws on interviews conducted with senior WA public servants, which provided a first-hand account of the policy making processes associated with the formulation of national goals for public schooling (Member of State policy community 2009-10d, 2009-10a, 2009-10b; WA Department of Education 2008). Additionally, a range of relevant secondary literature sources with evidence pertaining to the thirty year period under examination, were reviewed to verify and elaborate on these personal reflections. The secondary literature selected was limited by availability, given the paucity of existing research on tied grants. More in-depth examination of the archival documentation underpinning these grants using the case study analytical foci would allow the generalisations and conclusions emanating from this study to be further validated.

⁵¹ It must be noted that the ideological divide over the 'choice of school' is one that has narrowed considerably over the years, electoral inclinations encouraging the Labor Party to realign its policy platform with the Liberals' stance.

7 A COMPARATIVE ANALYSIS OF TIED GRANTS FOR SCHOOLS

7.1 OVERVIEW

In the public schools area, the Commonwealth has carved out an influential role in policy setting and implementation, through its tied grants to the States and private sector providers, and active participation on intergovernmental committees. Commonwealth involvement, in the various forms it has taken, has proved both beneficial and detrimental, depending on the policy making role that it has assumed.

7.1.1 Sweeping Policy-Making Role (the nationalisation of schooling)

According to interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008), one major policy role of the Commonwealth has been to pursue greater standardisation and systemisation of schooling at a national level. This has involved the Commonwealth attempting to coordinate and secure national agreement around policy issues such as curriculum, starting ages and literacy standards. Being located in the 'bread and butter' policy space tightly shielded by the States, this policy realm has been characterised by negotiation, compromise and consensus, with Commonwealth influence by no means guaranteed. Operating mainly through intergovernmental forums, the Commonwealth has been compelled to debate and compete for policy space with the States, leading to a mixed success rate that is volatile and heavily dependent on political, financial and ideological circumstances at any given point in time. Both efficiencies and inefficiencies are apparent from the Commonwealth's activities in this realm of policy making.

7.1.2 Targeted Policy Making Role (addressing of specific policy gaps)

Another significant role of the Commonwealth according to interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) has been to address known or perceived gaps in State funding or services. This policy realm has offered the Commonwealth greater scope for unilateral policy intrusions, although the extent of policy control secured appears to have varied between programs. Commonwealth programs fitting into this category include targeted funding and programs to promote for example: English as a Second Language (ESL), primary school science, library resources and computer resources in public and private schools. From a performance perspective, the States seemingly have little objection to targeted policy interventions that are minimalist, consistent with, and peripheral to, State service delivery. Nonetheless, the evidence of considerable inefficiencies within this realm of policy making

suggests that significant shortcomings exist in the Commonwealth's policy making approach, as further discussed later in this chapter. The secondary literature (Lingard 2000: 27) draws a distinction between 'Commonwealth' and 'National' schooling goals. The former refers to those policy goals set primarily by the Commonwealth, whereas the latter encapsulates goals that have been formulated through a process of negotiation between the Commonwealth and the States. This distinction aligns well with the 'sweeping' and 'targeted' Commonwealth policy making roles identified above:

Table 7.1 Traits of Policy Making in Tied Grants for Public Schools

<i>Types of schooling policy goals</i>	<i>Types of Commonwealth policy making role</i>	<i>Policy making dynamics</i>
Commonwealth	Targeted	Primarily unilateral
National	Sweeping	Negotiation-consensus

7.2 EXAMINATION OF POLICY MAKING DYNAMICS FOR SCHOOLS

7.2.1 Sweeping Policy Making (the nationalisation of schooling)

As mentioned, in policy matters affecting the day-to-day running of schools — for example school curriculum, testing, and literacy and numeracy benchmarks — the States have jealously protected their policy independence. The Commonwealth's nationalising policy influence has thus mainly been facilitated through its participation on the AEC and its successors MCEETYA and MCEEDYA, where it sits as an equal member alongside each of the States⁵² (Lingard et al. 1995: 60; Lingard 2000: 42). Both as a result of this policy setting environment and presumably also because of its lack of status as a financier of public schools, historically, Commonwealth policy advances have been prone to delay and reshaping. The AEC and its successors are considered to have (Lingard 2000: 43, 52):

mediated the Commonwealth agenda so that it became the national agenda and national became a notion over which the Commonwealth and States fought and sought to protect and pursue their interests.

Locally driven policies

A number of traits are apparent within this realm of policy making. It is evident for example that the more successful of the Commonwealth's 'sweeping' policies have been based on evidence and policy reforms already being fostered at the State level. In considering the nationalisation agenda of the Rudd government for example, the policy advances secured by the Commonwealth were considerably aided by the federal agenda being a

⁵² It is notable that the States did not invite the federal Minister to participate as a member of the Australian Education Council (AEC) until 1972. The States also managed to reject a Commonwealth push to become sole funder of a secretariat and permanent chair of MCEETYA when it was first established.

consolidation and reflection of a range of best practice policy reforms unilaterally developed by the States — for example, the national reform agenda work of the Victorian government (Hinz 2010: 11), literacy and numeracy programs of the WA government and teacher quality programs of the NSW government. Additionally, in interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) it was noted that Commonwealth goals on principal autonomy and teacher quality pursued by the Howard and Rudd governments were derived from a research base common to that used to inform State goal setting processes.

It appears to be a matter of timing, with the Commonwealth having greater surety of securing a national consensus when policy evolution at the State level is more aligned between States. Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) confirmed for example the policy developments on early childhood which commenced in Victoria and were gradually adopted by other States, thus making it easier for the Commonwealth to include the States in a national policy consensus. A similar cascading effect was evident in the policy setting around school leaving ages with WA, Queensland and South Australia moving to raise the school leaving age, these advances paving the way for the Commonwealth to attempt a national agreement on the issue. National testing is another area where the Commonwealth has managed to coax the States gradually towards a consensus, first securing their commitment to a national testing regime, and after a long period of deliberation, managing to sway MCEEDYA to make the results of individual schools publicly available.

The Commonwealth as an agenda setter

In addition to the potential for facilitating an *already emerging* national consensus, it appears that the Commonwealth has also been effective at stimulating policy debate and hastening the development of embryonic policy reforms. Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) confirmed that the Commonwealth could add considerable impetus to policy advances at a State level, through its advocacy of agendas in forums such as the COAG and MCEEDYA; promotion of international benchmarks such as those of the OECD; and through targeted injections of funding. An example quoted was the Commonwealth's commissioning of national evaluations on literacy and numeracy standards, which is claimed to have assisted the Rudd government to invigorate national debate in this policy area. Further, interviews confirmed that the impetus of new Commonwealth funding was a crucial motivator for the national policy reforms progressed by the Rudd government. The capacity of the Commonwealth to

serve as a "positive force" in policy formulation is noted also by Angus (in Connors et al. 2007: 112).

The triangulation of Commonwealth policy and State policy preferences, and contemporary school education research appears to be enhanced by the establishment of direct links to State policy-setting processes. Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) revealed for example, the Rudd government's recruitment of Victorian government experts to assist shape its national agenda. Additionally, the considerable negotiating and data proficiency of the Commonwealth was noted, interviews suggesting that Commonwealth officials can be highly adept at facilitating timely and productive discourse on policy reforms, utilising national datasets to great effect. Such converging of agendas is not always an assured path for the Commonwealth, however. As discussed further below, policy accord can be complicated by the extent of political and ideological partisanship with the States. Additionally, it was noted in interviews that a fine balance appeared to be required in terms of Commonwealth policy stimulation, with performance problems arising when the nationalistic push was overly aggressive or prescriptive. This is particularly the case with day-to-day operational policy detail where there can be significant variations in practices between States. In these micro-level policy issues, excessive prescription by the Commonwealth is asserted to have brought a "lowest common denominator" policy making approach (Reid 2009: 15).

The influence of the larger States

A further characteristic that is apparent in the Commonwealth's pursuit of nationalised policy settings in the schools area is the policy dominance of the larger States of NSW and Victoria (Jones 2008: 166). Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) suggested that this is primarily due to the greater resource base and thus policy making capacity of these States, which often has them assuming the 'policy pen' and a default leadership role. This is not to say that the smaller States lack an effective voice. In the most recent Rudd government negotiations for example, interviews suggested that a Victorian-dominated curriculum setting agenda was modified to suit the smaller States following their objections, this compromise interestingly being brokered by the Commonwealth as part of its concern to reach a national consensus. Nonetheless, it is apparent that the policy acceptance of larger States can 'make or break' a Commonwealth policy goal or reform. An example cited is of the Howard government's push for a common school starting age, which after much delay and complication, was adopted by some of the smaller States, but ultimately stifled by NSW and Victoria. Whilst the extent of reform effort

involved in NSW and Victoria was claimed to be comparatively minimal, their lack of policy commitment eventually forced the Commonwealth to abandon its goal.

The policy clout of the larger States also has other subtle impacts on intergovernmental negotiations. Not surprisingly, the Commonwealth has been known to focus its bargaining strategy and efforts on the larger States, as obviously goal acceptance in those jurisdictions can quickly legitimise and elevate the weight of a policy goal. In this regard, the bargaining dynamics associated with the establishment of ACARA was recalled in interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011). Whilst the States were initially united in their objection to providing any funding increase to the new curriculum and testing agency, the Commonwealth eventually managed to bring NSW and Victoria on side, which placed the smaller States at a bargaining disadvantage and compelled them to fall into line. The lobbying of the bigger States is not just a Commonwealth practice. Conversely, the smaller States are also understood to lobby the larger States to influence the shape or destiny of a proposed Commonwealth policy goal. Finally, the larger States have also been known to co-opt the smaller States in efforts to enhance their bargaining power vis-à-vis the Commonwealth. The process of intergovernmental negotiation and bargaining is characterised by continually shifting alliances as the Commonwealth or individual States re-align their allegiances to suit their needs.

Political partisanship

As noted, the success of Commonwealth policy making appears to depend on the extent of political partisanship with individual States — which can vary significantly over time. Experience shows that the Commonwealth is a more influential policy player when the majority of States are of the same political persuasion. This was certainly the case during the Hawke government, with the Labor Party's domination allowing the Commonwealth to secure an in-principle agreement with all States on the National Goals for Schooling (the Hobart Declaration); and curriculum statements and profiles in eight areas of learning (Lingard et al. 1995: 49; Mann 1994: 45). These policy advances by the Commonwealth were quickly contained, however, by a change in States' political composition from the early 1990s. Despite the prior consensus reached, at an AEC meeting in Perth in 1993, the Liberal states, led by the charring WA Liberal government, abruptly opted to 'delay' their formal endorsement of the accord, seeking time for further review and consultation. It has been argued that the faltering of the non-Labor states was in fact a strategic move on their part to "seize the initiative in the AEC on 'national' issues in education". Their defiance

resulted in the “maximalist ‘national agenda’ of the Commonwealth ... [being slowed down] ... to the minimalist agenda driven by the States and Territories” (Bartlett et al. 1994: 30, 42). With the States now free to interpret and adapt the curriculum statements and profiles, goal implementation “manifested in somewhat different ways in each State and Territory”. States rebadged and reshaped the curriculum statements and profiles, choosing different implementation timeframes and approaches, with varying levels of policy prescription provided to schools and teachers (Mann 1994: 46). Lingard (2000: 44-5) describes how the “balance of power was ... taken back by the States”. Not to be deterred, the Commonwealth began to overcome its marginalisation by the States in the 1990s “by granting professional development funding directly to professional associations” and establishing an “Accord between the national teachers union and the (federal) Government” (Bartlett et al. 1994: 42).

The issue of political partisanship has an important impact not only on the Commonwealth–State relationship but also on intergovernmental accord across States. It was observed in interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) that that smaller States of a different political persuasion to the larger States of NSW or Victoria can be overlooked or suffer reduced influence in policy negotiations. The performance and implementation disadvantages of continually shifting ideological agendas were also highlighted. It was noted that State education agencies are often in an ongoing state of flux, having to respond to policy realignments emerging from changing ideologies at both levels of government.

The influence of Commonwealth funding

The status of the Commonwealth as the lesser funding partner certainly does appear to act as a constraint. It has been observed, for example, that the significant implementation costs associated with various reforms sought by the Commonwealth (including curriculum and school starting age reform and the establishment of national standards and benchmarks) has allowed the States to resist or delay goal acceptance and implementation (Connors et al. 2007: 40; Jones 2008: 167). Unlike the public hospital grants, generous financial concessions do not appear to have played a major role in intergovernmental negotiations — although interviewees (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) noted their awareness of undisclosed, one-on-one deals struck with individual States, to allow the Commonwealth to finalise a national consensus or silently compensate States that may have been disadvantaged as the result of such consensus. Notwithstanding the more selective use of

financial persuasion when compared to the public hospital grant negotiations, there have been occasions when the Commonwealth has used its fiscal superiority (deliberately or inadvertently) to compel States towards a desired end. In this regard, Lingard (1995: 61) claims that the cutting of general purpose grants to the States in the late 1980s left the States with little option but to agree to partner with the Commonwealth on the development of national curriculum profiles and statements. Further, the Howard government, frustrated by lengthy MCEETYA negotiations, attempted to hasten policy progress by incorporating reforms such as national testing and benchmarks, performance pay for teachers, compulsory history and a common starting age as conditions of its funding (Reid 2009: 3). Interestingly, however, while these moves from the Commonwealth may have pressured the States into a consensus at the time, the States ultimately appear to have retained the upper hand, convoluting and delaying the policy design and implementation process once having signed up to an accord (Jones 2008: 168-9). Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) noted for example, how one of the most controversial conditions introduced by the Howard government — a requirement to present results as 'A' to 'E' grades when reporting to parents — was overcome by the States (led by Victoria) through a wording loophole in the signed Agreements. Further, it was observed that teachers were inclined to continue their everyday assessment practices according to known and existing methods (as they had evolved under the curriculum statements and profiles) and simply converted their results into the Agreement's required format as a final presentation step. Thus while the Commonwealth may appear outwardly successful in pushing a particular policy direction, whether it is accepted in the hearts, minds and practices of State bureaucrats and the teaching profession itself seems to be an entirely separate matter.

State resistance to national goals

An important reflection on State resistance put forward in interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) is that it is rare for such resistance to lead to the complete demise of a policy objective. It was suggested that States prefer to persist in an ongoing bargaining process, both passively and openly defying and delaying goals until a suitable compromise is reached with other States and the Commonwealth. This trait is apparent both in the shaping of national goals and in the implementation of accepted goals. For example, a previous study analysing the national policy advances made by the Hawke–Keating government found that the Commonwealth's policy gains were in fact heavily regulated by State preferences. Interviews revealed that

while States had always wanted curriculum profiles and statements, their concurrence with them at that particular point in time was in fact a "defence mechanism to obviate the (looming) possibility of rigid national testing". The States are asserted to have employed a range of bargaining strategies to ensure that outcomes would be resolved in their favour. Negotiations within the AEC forum were stalled until the membership and "balance of power ... [rested comfortably with] ... the States". Quite significantly, the Commonwealth's proposed framework was accepted only incrementally, the States initially consenting to the outcomes-focused national profiles and statements but deferring the endorsement of the proposed competencies, and thereby demonstrating to the Commonwealth, their considerable capacity to define the timing for realisation of national policy ambitions (Lingard et al. 1995: 50, 52).

From an implementation perspective, passive and open resistance by the States has been assisted by the broad nature of Commonwealth goals. Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) confirmed that initially Commonwealth goals are agreed with the States at a high level, with tighter goal clarity being derived only through an ongoing process of negotiations and interaction between the Commonwealth and individual States. The 'fluidity' available in terms of goal interpretation has allowed the States considerable control over the extent of policy change practically implemented, and permitted the local identity of their programs to be retained. Essentially, by demonstrating a reasonable 'fit' between their existing programs and Commonwealth goals, States have been able to mould Commonwealth goals in their favour. An implementation study of national curriculum profiles and statements introduced between 1988 and 1993, for example, reveals marked variations in the implementation between the States. NSW adopted the 'least change'; Tasmania and South Australia implemented in full; Victoria adopted a modified version; and other states used the framework only in a limited capacity (Kennedy et al. 1996: 39; Member of State policy community 2009-10c). The "charade" of State policy acceptance is also noted also by Connors (2007: 33-34).

As further evidence of the considerable policy discretion held by the States, interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) pointed out the highly devolved governance approach of the Victorian public schools system as opposed to the highly centralised model adopted in NSW, with WA somewhere in between the two — all of these configurations co-existent within the same 'national' policy framework. It was asserted too that in spite of the more

recent Rudd government push for greater devolution, it is unlikely that State programs will eventually be identical, with ample policy space available for States to interpret 'devolution' in a manner that suits local needs and preferences. By way of other evidence, Angus (in Connors et al. 2007: 113,15) highlights the significant and quite complex variations that exist in the resource allocation models used across States, and observes State reluctance to commit to a "national system of school funding" due to the "constraint ... [it would place] ... over ... [States' responsiveness to local] ... spending priorities".

Typically, there appears to be considerable rivalry between States and it is unusual for best practice programs to be copied in its entirety by another State. Programs, whether adapted on a national or interstate model, tend to be rebadged and re-shaped at the discretion of individual States to allow for a unique local identity. Other policy intervention barriers faced by the Commonwealth are the weaknesses in its monitoring framework and the autonomy of the teaching profession. It was observed for example that Commonwealth endeavours to assess State compliance with 'national' standards can be hampered by performance measures being imprecise and open to interpretation. Additionally, both interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) and Connors (2007: 41) confirm that there are certain aspects of schooling that remain firmly out of the Commonwealth's reach — including the manner in which 'national standards' are taught and assessed by individual teachers. Reid (2009: 4) adds the further observation that at no stage is the support of the States completely certain; their potential withdrawal from a national goal remains an ongoing possibility.

7.2.2 Conclusions on Sweeping Policy Making (the nationalisation of schooling)

Table 7.2 summarises the policy making characteristics identified in the above discussion. In conclusion, it is clear that the policy making dynamics underlying the development of 'national' goals for schooling is by no means a dichotomous or assured affair, the evidence indicating that there are a range of factors that affect the acceptance of Commonwealth goals by the States:

Table 7.2 Traits of Commonwealth goals ('sweeping')

General traits of 'sweeping' Commonwealth policy goals
Ongoing negotiation through intergovernmental forums such as MCEEDYA
More successful goals derived from State policy developments and a common evidence base
Policy emphasis on the larger States of NSW and Victoria
Subject to political partisanship between the Commonwealth and the States
Subject to budget flexibility available at the State level
Subject to individual State's interpretation of Commonwealth goals

The establishing of 'sweeping' or nationalised policy goals involves considerable emphasis on negotiation and consensus, both between States and between the Commonwealth and States. This would tend to explain the prolonged nature of the Commonwealth quest to establish 'national' standards for example in curriculum, testing and starting ages. Lingard (2000: 29, 41-2) asserts for example that in the period from 1972 to 2007, the most significant advances in 'sweeping' policy making came during the Whitlam and Hawke–Keating governments, with the former securing a 'systemising' of Commonwealth policy involvement, and the latter successfully establishing a national leadership role in policy making, aided of course by its political partisanship with the States. Certainly, the journey has by no means been a steady one, with the Commonwealth asserted to have achieved only incremental progress during the Fraser and Howard governments. Lingard (2000: 45) further observes that between 1993 and 1996, the States firmly held the reins over the rate of national policy reform, "pursuing it on their terms and in a ... minimalist manner". Even during the supposedly cooperative period under the Hawke–Keating governments, it is apparent that the States retained final discretion over implementation patterns, one study concluding that the "corporatist development" of policies by no means guaranteed the Commonwealth a "corporatist implementation" (Kennedy et al. 1996: 39, 41). The picture evident is that of a distributive bargaining process under which the Commonwealth has no certain or timely route to either the formation or implementation of its desired policy goals.

7.2.3 Targeted Policy Making (addressing of specific policy gaps)

In contrast, within the realm of targeted policy making, the Commonwealth has certainly enjoyed greater prospects to act unilaterally, being less inhibited by intergovernmental forums and the need to attain unanimous goal acceptance. Even here, though, the Commonwealth has not completely dominated.

Varying forms of policy influence

Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) conveyed that historically, the Commonwealth's targeted policy making has been aimed at addressing specific service gaps considered to be of national interest, some quite genuine, others based on the ideological whim of the presiding federal Minister or Cabinet. Generally forming a part of the Commonwealth's budget or election commitments, targeted policies may well be little discussed within the MCEETYA or other such forums prior to their introduction. Interviews noted many forms of Commonwealth policy intervention, including targeted grants provided through the State government, public and private schools, local committees or universities.

The extent of policy prescription and governance arrangements has varied considerably between policy programs. For example, grant funding provided to the States for English as a Second Language (ESL), drug education, values in education, and a Commonwealth literacy and numeracy program for indigenous students, are all asserted (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) to have been associated with a very broad set of guidelines, thus leaving service design and resource allocation primarily in the hands of the States with the Commonwealth in an oversight capacity. The primary science program was cited as a policy initiative that was independently developed by the Commonwealth and offered to the States with adoption and implementation remaining completely at the discretion of the individual States. Other programs, such the Supplementary Recurrent Assistance for indigenous students and assistance for schools in drought-affected areas, were noted to have been more tightly controlled by the Commonwealth with prescriptive guidelines and detailed reporting requirements. On grants provided outside of the State governments, the Commonwealth's Quality Teacher program was cited as an example of a grant provided to, and primarily administered by a Commonwealth-established local committee, with some State government involvement in service design. A specific performance issue raised in interviews with regards to targeted funding is the Commonwealth's penchant for offering such grants directly to schools, circumventing State budgetary processes and often duplicating or contradicting existing State programs.

In addition to Commonwealth policy goals being pursued through *new* grant funding streams and some State design involvement, interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) also observed cases where such policy goals were simply incorporated as additional

conditions into *existing* grants, the unilateral policy push leaving the States little or no choice over goal acceptance. The Howard government's decision to introduce “enrolment benchmark adjustment funding” is cited as one such policy goal. The Commonwealth sought to implement a compulsory downward budget adjustment to public schools which had experienced a loss of students to non-government schools. This is claimed as a flawed goal to begin with, the Commonwealth overlooking in its policy design, the fixed and marginal costs associated with student transfers (Connors 2000: 24). In the end, political pressures forced the Commonwealth to return the funds to State governments — though requiring that the monies be directed on a range of federally-prescribed policy priorities.

Administrative inefficiencies

The evolution of Commonwealth policy making in this realm appears to have occurred over several decades with the range of policy programs proliferating quite wildly, creating unwelcome inefficiencies in policy coordination and an onerous range of reporting requirements. Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) noted the considerable time and effort that was spent in identifying and mapping such programs during the tied grant rationalisation process instigated by the Rudd government. It is also suggested that collectively, the States and also the Commonwealth itself were unaware of the comings and goings of many of the programs, with funding having gone direct to schools and other providers, and originating from different Commonwealth sources.

Not surprisingly, the highly anarchic nature of the Commonwealth's targeted policy making resulted in mixed policy outcomes. While some grant programs proved effective and were retained by the State even after Commonwealth funding had ceased, others such as the Homework Centres, National School Chaplaincy and Country Area programs were cited in interviews and others as being ineffective, introduced with little consultation with the States or even the local schools for that matter (Connors et al. 2007: 32). Interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) noted a Commonwealth reading program discontinued by the State but subsequently made available by the Commonwealth to the non-government schools, in spite of State advice that the programs had proved to be ineffective. Other programs such as the Commonwealth History and School Safe programs, being rooted in particular ideological or perhaps populist policy objectives of the Commonwealth, had only marginal benefits due to their short term and small-scale nature. Programs involving infrastructure were observed to

be a particular source of frustration, with the Commonwealth funding usually being time-limited, and States compelled to accept longer term budget responsibility.

The States seem to have become more proficient at resisting such policy impositions over time. In the recent Rudd government negotiations for example, the WA government is understood to have adamantly refused to share financial responsibility for Commonwealth election commitments (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) . Although the Barnett government concurred generally with policy goals to increase computer access and provide trade training centres, there was staunch resistance to the contribution of additional State resources, with the call for cost neutrality emanating primarily from the State's central agencies. Additionally, Commonwealth calls for the State to contribute new (matching) funds for its national policies around teacher retention and development and early childhood were successfully negated, the WA government managing to convince the Commonwealth that a 're-badging' of its existing programs and funding allocations would be sufficient to meet national policy requirements. Interviews suggested that the tougher stance by WA is consistent with that taken by other States. The changed approach is said to be the result of a reconfiguring of the State's bargaining framework, with the central agencies of Treasury and Premier playing a core role in the intergovernmental negotiations for the first time.

Impact to State policy control

In spite of the numerous performance and coordination problems associated with targeted Commonwealth policy programs, interviewees (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) agreed that such intrusions have at no stage enabled the Commonwealth to override the policy space occupied by the States *completely*. The view put forward was that at most, the Commonwealth's involvement has increased the profile of, and the funding allocated to, specific policy issues, some genuine, others ideological. Additionally, legal barriers can also stifle the Commonwealth's capacity to impose its policy will. Both the Howard and Rudd governments attempted to influence State industrial relations policy settings, the former with its requirement for Technical College staff to be employed under workplace agreements, the latter with its push to link student outcomes with performance pay. In both instances, the Commonwealth's position was essentially one of an influencer only, with States possessing the ultimate discretion over the passing of necessary amendments to their legislative frameworks (Connors et al. 2007: 33-34).

The Commonwealth's main means of regulating the implementation of targeted policy grants appears to be its power to scrutinise and approve State implementation plans against Commonwealth-prescribed guidelines. Based on interview observations (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008), however, even this lever appears to serve more as an instrument of validation as opposed to a means of exerting meaningful policy influence. In submitting proposed implementation plans, it is apparent that the States are highly competent negotiators who are usually able to steer the Commonwealth towards an outcome that meets their local policy needs and program preferences. In negotiating with the Commonwealth, the States seem to face little risk of losing Commonwealth funding (federal bureaucrats tend to dissuade unspent or returned grants) and are able to adopt a very liberal attitude to the interpretation of the grant guidelines, to the extent of being able to ignore Commonwealth-concerns over program compliance quite openly. Interviews also noted the discretion held by the States in terms of grant acceptance, with some schools known to have rejected available Commonwealth funding to avoid the tedious reporting requirements. Even with regards to the highly criticised requirements of the Howard government on school flagpoles and 'Safe Schools' posters, interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) suggested that the Commonwealth was ultimately reliant upon faithful implementation and reporting by individual schools — in no respect a watertight policy control. Such requirements appear to have been more of an administrative inconvenience to the States as opposed to a policy intrusion of any special significance. Interviews also noted that in spite of increasingly detailed reporting requirements, the Commonwealth did not appear to act on this information, with no recollection of sanctions or penalties being applied for non-compliance, and little interaction over positive or negative State results. Part of the reason for this could be due to limitations in the Commonwealth's "institutional capacity" (Hinz 2010: 12).

The 'toothless' nature of Commonwealth enforcement of its policy goals is plainly evident. It was observed in interviews (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011; WA Department of Education 2008) that requirements such as those involving the school flagpoles, were essentially a reflection of the Commonwealth's underlying inability to control school policy at the coalface level. The argument put forward is that the Commonwealth resorts to such requirements simply because it has no other feasible route through which to signal or exert a visible policy influence. Interviewees also

observed that Commonwealth enforcement has not been a steady one — tending to be greater in the early life of a grant and shifting with changes in government and ideological priorities. It was also pointed out that States have become more proficient over time in addressing Commonwealth reporting requirements, improving systems and processes so as to reduce the resource impost of such requirements.

7.2.4 Conclusions on Targeted Policy Making (addressing of specific policy gaps)

Table 7.3 summarises the policy making characteristics identified in the above discussion. Although the Commonwealth’s targeted policy making *begins* in a unilateral manner, it is clear that the States retain their position as the main decision makers on local policy design and implementation approach. In fact, the most significant policy influence made by the Commonwealth appears to have come from its policy making activities *outside* of the public schools arena. As discussed later, it is certainly arguable the flow-on effects of the Commonwealth's funding of non-government schools have created much more significant and detrimental impacts on the performance and functioning of public schools than the more direct sweeping or targeted policy making.

Table 7.3 Traits of Commonwealth goals ('targeted')

General traits of 'targeted' Commonwealth policy goals
Unilaterally imposed by the Commonwealth
Aimed at addressing a perceived area of need - genuine or ideological
Subject to individual State’s interpretation of Commonwealth goals
Varying forms of governance model - from prescriptive to more broadly stated requirements
Generally peripheral to the core policy and financial space controlled by the States
Subject to State concurrence with the 'need' being addressed
Increasingly subject to the extent of budget flexibility available at the State level

7.3 ASSESSMENT AGAINST FINDINGS OF PUBLIC HOSPITAL CASE STUDY

Two principal findings of the public hospital case studies were that: 1) policy making control within tied grants is neither one-sided nor consistent; and 2) the performance problems associated with tied grants appear more prevalent when the Commonwealth has taken a unilateral and highly prescriptive policy setting role. Using the preceding discussion of Commonwealth–State policy making dynamics, an assessment can now be formed about policy control and performance of tied grants within the hospitals and schools policy areas.

7.3.1 Policy Making Control within Tied Grants

As apparent in Table 7.4, policy making control for public schools is by no means a simplistic or one-dimensional affair, similar to the findings of the public hospitals case study:

Table 7.4 Balance of Powers – Public Schools and Hospitals

Goal setting features	'Sweeping' or national schooling goals	Targeted schooling goals	Universal hospital care goal	Doctors' remuneration goal
Goal formulation dominated by	Commonwealth and States	Commonwealth	1975 & 1976 goal - Commonwealth, inconsistent with State policy preferences 1984 & 1985 goal - Commonwealth, accepted by the States mainly due to electoral expectations 1988 goal – Commonwealth and States 1993 goal – Commonwealth 1998 goal – States	1975 & 1976 goal - Commonwealth, consistent with State policy preferences 1984 goal - Commonwealth, the level of prescription was inconsistent with State policy preferences
Goal implementation dominated by	States and local schools	States and local schools	Commonwealth and States	1975 goal - the States and medical profession 1976 & 1984 goals - the medical profession
Overall	States and local schools	Commonwealth and States	Commonwealth and States	States and medical profession

Thus it can be concluded that the schools evidence verifies the earlier findings about policy making control.

A further aspect of policy making control worth considering at this point is the influence of the medical and teaching professions. The public hospitals case study highlighted the powerful capacity of the medical profession to stifle, delay and reshape policy reforms. In contrast to the highly visible and politically-charged policy presence of their medical counterparts, the policy input of the teaching profession appears to have occurred through more indirect avenues such as advocacy activities and invited interactions with the State governments. Nonetheless, it was noted (Member of State policy community 2009-10d, 2009-10a, 2009-10b, 2009-10c, 2011) that in some jurisdictions, local professional groups had successfully managed to stifle controversial policy reforms such as greater principal autonomy and performance pay. Interviews suggested that the close involvement of the Rudd government in such reforms enabled States to secure greater reform progress than may have been feasible if they had acted independently. For example, interviews cited the productive discourse between COAG and professional group unions and the benefit of Commonwealth interactions with school principals following their quite vocal objections to the proposed *My School* website. Thus in line with some of the goal implementation experiences discussed in the Whitlam and the Hawke case studies, the schools evidence offers further support for the proposition that by acting jointly, the Commonwealth and the States are able to achieve greater implementation certainty on specific policy reforms, countering the stalling or stifling actions of local professional groups.

Finally, this discussion on policy making control within the schools arena cannot be completed without considering the Commonwealth's funding of non-government schools which has grown monumentally since the Whitlam government.⁵³ Watson (in Connors et al. 2007: 145, 49) portrays the Commonwealth's unilateral decision making on the funding and regulation of non-government schools as highly dysfunctional. She asserts that the lack of a holistic policy making framework encompassing both public and private schools has brought growing "social (and resourcing) stratification between schools". Both Connors (2007: 22) and Watson (in Connors et al. 2007: 145) suggest that a range of inequities and inefficiencies arise from the present framework, a key criticism being that in offering a 'right of choice' for parents, current policy settings have failed to "place any limits on the scope of publicly subsidised choice", with the effect of "leaving states and territories to deal with problems from any resultant misdistribution of school places in relation to population demand". The potentially detrimental flow-on effects apparent from unilateral policy

⁵³ Connors (2007: 16) confirms that whereas 70 per cent and 27 per cent of Commonwealth funding was directed towards government and non-government schools in 1974, this proportion had shifted markedly to 31 per cent and 69 per cent respectively by 2006-07.

making in the non-government schools sector resonate quite strongly with similar observations made in the public hospital case studies. There it was repeatedly noted that the Commonwealth's independent decisions in aged care, MBS and private health insurance created significant flow-on effects to the public hospital system. A further flow-on effect common to both the schools and hospitals policy arena is that of workforce planning decisions, with the Commonwealth unilaterally regulating the quantum of local growth in the teaching and health workforce (Connors et al. 2007: 56-9).

A key observation made in the earlier chapters, and one that can now also be drawn for the schools policy arena, is that that *these types of flow-on effects serve to diminish the policy making control secured by States under tied grant arrangements*. Thus while the balance of policy-making powers within the tied grant arrangement itself is quite capable of fluctuating between the Commonwealth and the States, it must also be recognised that tied grants are but one part of a broader policy setting context. Through alternative policy levers *outside of the tied grant*, the Commonwealth can impose indirect, but quite significant (and damaging) policy and performance impacts to State delivery systems that are the subject of tied grants. Policy making control is thus a highly complex affair and subject to the extent of alignment between all relevant Commonwealth policy levers, not just the tied grant itself.

7.3.2 Performance of Tied Grants

The analysis of policy making dynamics in the schools area allows us to also form a number of conclusions on tied grant performance.

First, in terms of performance issues, it was the targeted policy making that appeared to create the more notable administrative and accountability inefficiencies. This is not surprising given that within this realm, the Commonwealth had a propensity to act unilaterally, respond to ideological whims and heavily prescribe accountability requirements. These policy-making traits were also evident at various stages in the formulation and implementation of the universal hospital care goal, and in the failed doctors' remuneration goal of 1984. Thus the schools evidence validates the performance issues that arise from unilateral, ideological and closely administered Commonwealth goals.

Secondly, it can be observed that the Commonwealth appeared to achieve greater success with its 'sweeping' or national school goal setting when goals were derived from policy directions being pursued by the States and also stated in broad terms, allowing States to mould goals to suit local needs and preferences. These positive policy-making

characteristics were also apparent in the 1975 doctors' remuneration goal. The schools evidence therefore confirms that the Commonwealth can be a highly effective agenda setter and facilitator of implementation. One contrasting feature in the schools area is the ongoing role of MCEEDYA and its predecessors as a forum for detailed policy discussion between the Commonwealth and the States. Whilst MCEEDYA policy deliberations can be drawn-out, this forum has nevertheless served a highly useful purpose in facilitating productive policy discussion and the reaching of policy accords. This level of collaboration and consensus-forming deliberation has not been evident in the formulation and implementation of the universal hospital care goal which was more or less imposed onto the States. On the doctors' remuneration goal, in both the 1975 and 1984 iterations, some Commonwealth–State cooperation occurred, but mainly outside the Health Ministers' Conference forum and was short-lived.

A third performance issue apparent in the schools policy-making analysis is the significant potential for biases in Commonwealth policy making. These biases included: 1) the disproportionate influence of the larger states of NSW and Victoria; and 2) the effects of Commonwealth–State political partisanship. A further bias not previously discussed is the tendency for the Commonwealth's macroeconomic objectives to affect its decision making in specific policy areas. In this regard, Reid (2009: 11) cites the example of the school building program of the Rudd government which satisfied a genuine need for additional investment in school infrastructure, but was primarily timed and designed as a vehicle to address the Commonwealth's macroeconomic goals following the 2008 global financial crisis. While goal conflict may have been minimal in this instance, the building program does demonstrate the Commonwealth's propensity to compromise policy choices by imposing its wider priorities into the policy making process. It is highly significant that the three areas of potential policy bias identified in the schools policy arena were also evident in both the universal hospital care and doctors' remuneration goals at various stages of their evolution. The biases also raise questions about the appropriate design of intergovernmental negotiation machinery and its ability to provide sufficient transparency around decision-making and evidence-based policy formulation.

In summary, the performance of a tied grant appears to be favourably affected by the extent of goal consensus and collaboration between the Commonwealth and the States; and the broad statement of national goals, which allows the States flexibility to tailor such goals to their local needs. On the other hand, tied grant performance seems to be adversely affected by the Commonwealth acting unilaterally or purely ideologically; or attempting to

regulate State implementation too tightly through highly prescriptive policy guidelines and reporting requirements.

The findings of Chapter 7 and the earlier case studies will continue to be discussed in the following Conclusions Chapter 8 which consolidates and assesses findings against the research questions of Chapter 1; and the normative framework of Chapters 2 and 3.

CONCLUSIONS

8 CONCLUSIONS

The aim of this study was to learn more about the balance of policy powers and performance effects of tied grants and the resulting implications for federal system governance and performance.

8.1 BALANCE OF POWERS IN TIED GRANT ARRANGEMENTS

Considering, first of all, the balance of powers within tied grants as discussed at Chapter 1, there are conflicting views in the federalism literature about the degree to which central governments can exercise effective policy dominance through tied grants. One school of thought is that the Commonwealth is the dominant player, using its fiscal superiority to intrude into policy matters of State jurisdiction. Alternatively, there is a much less visible scholarly view which asserts that the image of an overbearing Commonwealth ‘riding roughshod’ over the States is exaggerated — the States being competent negotiators retaining substantial real control over implementation, quite capable of holding significant policy autonomy. The case studies examined in this thesis have repeatedly demonstrated that policy making control in tied grant arrangements cannot be explained as a simple dichotomy, but is a complex and more contingent affair, varying over time, and at different stages of grant operation. Section 8.1.1 looks back briefly at the key findings of the case studies.

8.1.1 Case study observations

Section II revealed a range of characteristics of policy control within tied grants.

Goal clarity

Although the Commonwealth increased prescription around some aspects of grant operation and policy settings over time, hospital grant goals remained fairly broad and ambiguous enabling implementation policy control to be predominantly held at the State level. In fact, it was evident that information asymmetries and under-developed analytical capacity tended to result in the public hospitals holding the dominant policy making position. This finding was also true in the schools grants where the States very capably upheld their own program identities and implementation preferences.

The case studies also revealed that the uniform policy settings established unilaterally through tied grant arrangements are mostly of a minimalist nature. In implementing its universal hospital care goal, the Commonwealth was unable to overcome inter-jurisdictional variations for example in regulatory frameworks, bed configurations, staffing

configurations, medical practices, private bed availability; service configuration, cost structures and resource allocation processes. Even where there was goal congruence with the States — as in the case of the doctors' remuneration goal under the Whitlam and Fraser eras — the Commonwealth was forced to accept a more flexible policy setting to overcome political pressure from the medical workforce. In the schools area, 'national' programs were rarely implemented in an identical fashion across States due to differences in local preferences, needs and regulatory settings. For example, within a 'national' policy framework, it was still possible for Victoria to operate under a devolved governance model, whilst NSW was more centralised and WA a hybrid of these two approaches.

Goal setting

In terms of relative bargaining positions, the Whitlam era demonstrated that while the Commonwealth can use tied grants to introduce national goals, this can involve significant policy and financial compromises that water down and reduce the efficiency and effectiveness of such goals. The push for policy compromises can come from a range of sources, including State bargaining; Senate pressure; medical profession or other interest group pressures; other federal agencies such as the Commonwealth Treasury; or looming federal or state elections. The Fraser and Hawke era cases confirmed however that as a grant arrangement matures, the Commonwealth is less inclined to compromise. Intergovernmental cooperation declined significantly during the Fraser years, towards the end of the Hawke government's 1984 Agreement and in the Keating government's 1993 Agreement. Once community expectations are established and States are locked into a policy setting, the Commonwealth seems to enjoy a stronger bargaining position.

From the State perspective, the case studies confirmed that States are highly shrewd negotiators, not at all backward in shifting their bargaining or policy positions to suit their circumstances. For example, during the Hawke era, States fluctuated in their commitment to a block funding model or formula funding depending on the relative advantage or disadvantage to their funding positions. In the schools case, the smaller States lobbied alongside or against the larger States depending on the policy outcome being sought. The case studies also indicated that State policy making capacity matured over time, this permitting them to be much more pro-active in the formulation of countering policy positions as apparent in the Howard era evidence.

State resistance to goals

The hospitals case studies showed that in addition to facing open resistance during negotiations, the Commonwealth's goals can also be subject to passive and hidden resistance from the public hospitals and doctors after implementation begins. For example, the manipulation of admission practices and a proliferation of private practice trust funds were both 'loopholes' through which the terms and conditions of the hospital tied grant were covertly overcome. The schools case study also revealed that the States held firm control over the timing and scope of policy goals. For example, in terms of national curriculum statements, profiles and national testing, the States were successful in downgrading these goals and prolonging goal acceptance as it suited them. Even under the Howard government where such policy reforms were incorporated as conditions of grant funding, the States overcame requirements through wording 'loopholes' and secured firm control over local policy design and the timing of implementation.

In general, the States tend to be highly persistent in their bargaining over time, openly and passively defying and delaying goals until a suitable compromise is accepted by the Commonwealth. Nonetheless State resistance is not impenetrable, with the Commonwealth often successfully breaking down States' collective stance with the discreet offering of one-on-one sweeteners.

Enforcement

On the enforcement of tied grant goals, it was apparent that the monitoring and review activities of the Commonwealth were largely ineffective in ensuring the efficiency and effectiveness of national goal compliance. During the Whitlam era, the Commonwealth had no opportunity to enforce the implementation of its goal because goal resistance forced it to accept a lengthy negotiation process. Whilst there was a monumental rise in enforcement activities during the Fraser era, the quality of health data and other information asymmetries prevented these resource-intensive investigations from having any major impact on implementation. Under Hawke, the Commonwealth retreated from the heavily scrutinising approach of the Fraser government. The Commonwealth was also much more accommodating of State limitations, assisting them to address data and system gaps. Notwithstanding its collaborative efforts to develop State systems however, throughout the case study timeframe, data limitations, inter-jurisdictional variations and resource constraints served as a significant barrier to Commonwealth enforcement.

The schools case study similarly showed that Commonwealth enforcement of national goals is very much hampered by the quality of data available. Where national standards or benchmarks are open to interpretation, it can be difficult for the Commonwealth to assess State compliance. Even in terms of the controversial schools flag pole policy, the Commonwealth ultimately had to rely on the participation of individual schools and did not have firm assurance over compliance. In this case study also, there was evidence to suggest that the Commonwealth bureaucracy has insufficient capacity to enforce its goals properly.

State governance barriers

With regards to state governance barriers, the hospitals case studies showed there to be little change in barriers (including for example poor planning machinery, cost control, workforce planning and political resistance to improvements) over the case study timeframe. Although these barriers reduced the efficiency and effectiveness of national goals, and joint Commonwealth–State machinery was repeatedly established to address some of the governance weaknesses, ultimately progress was slow-moving due largely to the distributive bargaining involved, funding shortfalls and the lack of policy profile for such issues. All in all, whilst the Commonwealth may have intruded into State hospital budget formulation decisions and created administrative burdens, little was gained in terms of motivating or facilitating States to pursue improvements to their cost structures, governance systems or practices. The States clearly held control over their service delivery structures. Similarly in the schools area, the Commonwealth was unable to intervene directly in issues of State governance, the States and teaching profession being avid protectors of their operational discretion.

Local discretion

Whilst the Commonwealth had wavering involvement in operational issues such as patient election processes and private patient fee setting, the hospital case studies repeatedly confirmed that States hold the primary position in terms of the implementation of tied grant goals. Variations in service configuration, cost structures, resource allocation and policy outcomes across States validate that the Commonwealth’s intervention through tied grant remains at a broad level only.

Other Commonwealth policy levers

The case studies confirmed that the Commonwealth has significant capacity to create ‘flow-on’ effects to the public hospitals and school systems through its unilateral decision making in policy areas under federal constitutional jurisdiction — for example, aged care services,

medical benefits and private insurance subsidies and private school grants. From a policy control perspective, a key observation was that these flow-on effects served to diminish the implementation control that is secured by States under tied grant arrangements. Decisions taken by the Commonwealth on medical benefits, for example, exposed the public hospitals to unanticipated demand and budget impacts. The case studies thus confirmed that policy control can be quite an obscure affair, dependent not only on the tied grant arrangement itself but also on the extent of alignment between all relevant Commonwealth policy levers.

Goal consistency

On the stability of tied grant goals, it appears that the Commonwealth is highly prone to goal inconsistency. Its universal hospital care goal was continually re-shaped during the Fraser, Hawke, Keating and Howard eras to suit national macroeconomic objectives. Commonwealth funding caps created considerable goal conflict, with States required to fulfil the ambiguous universal hospital care obligations under constrained financial circumstances. Ideological differences between the major political parties over the public provision of health care also resulted in fluctuating Commonwealth commitment to the universal hospital care goal (with policy shifts occurring both explicitly and by stealth). These goal fluctuations had a destabilising effect on the efficiency and effectiveness of public hospitals, yet the Commonwealth seemed oblivious, being far removed from the coal-face of service delivery. This dynamic was also apparent in the schools area, with ideological differences purported to have placed State education agencies in a constant state of policy flux.

Funding shares

Much has been said about the policy impacts of VFI. There is no doubt that the Commonwealth's fiscal supremacy does allow it to be coercive in the establishment of tied grant goals. However, when it comes to local adaptation and implementation of such goals, the case studies showed that the States are quite adept at manipulating the situation to their benefit. For example, it is claimed that the States had always desired the development of a national curriculum, profiles and standards but were aware that Commonwealth financial involvement would be necessary. However, rather than allowing the Commonwealth the opportunity to overtake the policy making process, the States flexed their policy powers — the capacity to stifle and delay the acceptance of goals and control implementation design. By allowing only incremental change, the States were able to assert their own policy making authority. Similarly, the hospitals case studies confirmed that whilst funding controls allowed the Commonwealth to expand or contract the scale of

universal hospital care, there is no assurance for the federal government over the quality, efficiency and effectiveness of goal implementation, with program delays, modifications and defiance being completely at the discretion of the States and medical profession.

8.1.2 Case study generalisations — tied grant policy powers

In terms of policy control, the above discussion confirms that from the Commonwealth's perspective, *the tied grant is a highly imprecise policy making instrument*. This explains the wavering balance of policy control that is evident in the case studies. As open ended as section 96 may appear, the policy reach of the Commonwealth is inherently constrained by constitutional barriers. While the tied grant provides the Commonwealth with a powerful capacity to introduce national goals, experience indicates that States will negotiate for such goals to remain minimalist from a national uniformity perspective, thus allowing them, their agencies or local professional groups to retain the more significant implementation policy control.

At all stages of the policy making process, the Commonwealth can face open or passive resistance from States and professional groups that can delay, stifle or even quash tied grant goals. The Commonwealth's position is also not assisted by its own tendency for goal inconsistency, arising from major ideological differences between the major political parties and ongoing internal conflict between tied grant goals and the Commonwealth's macroeconomic objectives. These inconsistencies remain a persistent threat to the efficient and effective implementation of tied grant goals, as are the state governance barriers that are mostly outside of the Commonwealth's reach. While the tied grant provides ample opportunity for the Commonwealth to monitor and scrutinise State service delivery, data shortcomings and information asymmetries mean that the Commonwealth's enforcement activities are largely ineffectual. Finally, although the Commonwealth can use its fiscal supremacy to coerce acceptance of, and compliance with, tied grant goals, this has been shown to be a crude means of policy control that has not permitted meaningful or sustained policy influence.

With the emergent picture of the tied grant as a 'blunt' or 'hit and miss' instrument of policy control, perhaps it is not surprising that its heavy use by the Commonwealth is persistently argued to have caused significant administrative, program and political inefficiencies and problems of accountability. These performance contentions are now considered.

8.2 POLICY SETTING PERFORMANCE OF TIED GRANTS

The tied grant has been long associated with performance deficiencies. How accurate is this claim? Have the States contributed to these results or is the Commonwealth tied grant solely to blame? Is there a valid role for the tied grant in Australia's federal system? Performance outcomes relevant to the different case studies were discussed at Section II. This evidence is now reflected upon, to form a conclusive assessment about tied grant performance, and the implications for effective federal governance.

8.2.1 Case study observations

Performance deficiencies of tied grants

a) Tendency for sub-optimal policy choices

When applied in a unilateral manner the tied grant was shown to have a tendency to lead to sub-optimal policy solutions. This trait is rooted in the Commonwealth's constitutional limitations. Although the tied grant provides powerful capacity for policy input, such capacity does not extend to allowing the Commonwealth to operate State service delivery machinery directly. To overcome this implementation uncertainty, the Commonwealth has a partiality for policy solutions that minimise the risk of State and stakeholder resistance or rejection of goals. The Whitlam era provided the most significant example of this tendency. The selection of the universal hospital care goal, driven by the Commonwealth's desire for a speedy and politically secure implementation, resulted in the undermining of an alternative policy proposal to expand community health services. The latter was the preferred policy option of the States, who sought a less institutionalised system as the most effective means of improving health service access and sustainability. The flow-on effects of this structural policy choice continues to linger on three decades later, with the "focus on hospital care rather than integrated care ... [asserted to be] ... poor and out dated conceptual thinking" (Dwyer 2002: 18).

b) Policy bias towards larger States

A second area of deficiency arising from unilateral policy making through tied grants are the obvious biases evident towards the more populous States. In the Whitlam era analysis, it was observed that the Commonwealth's formulation of the universal hospital care goal appeared to be driven primarily by the policy needs of NSW and Victoria. The Commonwealth's propensity to adopt a 'one size fits all' approach can cause the overlooking of specific strengths and nuances of smaller States. A similar observation can be made in regard to the Fraser government's adoption of a bed day cap based on

Victoria's hospitalisation rate and the Hawke government's goal to restrict doctors' rights of private practice. The latter goal arose from the Commonwealth's desire to contain the cost of hospital services, particularly in NSW where doctors' remuneration reform had been lagging behind other jurisdictions. The tailoring of the Commonwealth's goal to the needs of NSW had adverse flow-on effects to the smaller States, with SA and WA forced to backtrack on their early policy successes in this area. The analysis of the Keating government's 1993–98 Agreement at Appendix C provides further examples of this deficiency. Negotiation of this Agreement was significantly tainted by a competing Commonwealth agenda to redistribute grant funding from the smaller to larger States, with the Bonus Pool arrangements and funding guarantees aimed at encouraging greater public provision of hospital services in NSW and Victoria. With the implementation lag in Victoria and NSW having been evident as far back as the Fraser era, the Commonwealth's desire to expand universal hospital care in those States, and thereby strengthen national implementation of this goal, is not at all surprising. By way of another example from that era, the Commonwealth's push to curtail numbers of medical workforce were shown to have been based on an oversupply in NSW and Victoria, ignoring the considerable regional and remote workforce shortages evident at the time in Western Australia. The skewing of policy setting towards bigger States was also evident in the schools case study where interviewees claimed that NSW and Victoria 'could make or break' a national goal depending on their support. It was further observed that both the Commonwealth and smaller States had a propensity to side with the larger States as it suited them.

c) Emphasis on macroeconomic performance

A third area of deficiency that is apparent in tied grant policy making is the priority attached by the Commonwealth to redistributive and macroeconomic policy objectives, as opposed to managerial efficiency objectives, a more pressing concern for the States.

During the Whitlam era, the issue of managerial efficiency in the hospital system was overshadowed by the Commonwealth's haste to secure participation for universal hospital care and the national social benefits this policy would bring. The Hawke government too was driven by broader national objectives, with the Medicare program being an essential piece of its wages Accord with business groups and the unions. Admittedly, both these governments focussed on doctors' remuneration reform as a means of constraining program cost and enhancing access to services; however, little ground was gained in addressing the many other governance shortcomings of the public hospitals. The Fraser government made significant efforts to understand and tackle the concerns of managerial

efficiency, but information constraints and state resistance prevented any progress. Finally, under pressure to fulfil its role as the nation's primary economic manager, the Commonwealth retreated from its agenda, opting instead to shrink the universal hospital care goal quite abruptly.

Over the Keating and Howard eras, grant funding was dedicated towards initiatives for improving managerial efficiency however investment remained tokenistic when compared to the overall grant. Ongoing budget cuts also did not assist States to establish a stable context for progressing of managerial reform. More recent evidence from Reid (2009: 1, 11) confirms that while the school building program of the Rudd government may have satisfied a genuine need for additional investment in school infrastructure, it was also mainly initiated as a vehicle to address the Commonwealth's macroeconomic goals following the 2008 global financial crisis. The program inflexibility and prescriptive administrative arrangements associated with these grants validate the Commonwealth's propensity to lose sight of local managerial efficiency (ANAO 2010; Harrison 2010).

d) Increased risk of policy compromises

Another source of performance deficiency in tied grant policy making were the extensive policy compromises associated with the establishment of Commonwealth goals. The public hospitals case studies revealed that compromises can be apparent at all stages of a grant goal — at the Commonwealth level during goal establishment; between the Commonwealth and States during goal negotiation and implementation; and finally between the State governments and their bureaucracy and workforce during goal implementation. The schools case study also showed that policy compromises cause the moderation of policy objectives and create a 'lowest common denominator' effect in schools policy setting. This result was also evident in the doctors' remuneration goal of the Hawke era.

e) Administrative inefficiencies

The case studies substantiated practitioner views that the use of tied grants increases administrative inefficiency. A further subtlety that also emerged is that this inefficiency is attributable not only to the additional administrative burdens placed on State bureaucrats⁵⁴ but also because of the inconsequential nature of much of the Commonwealth's enforcement. A key reason for the Commonwealth's lack of effectiveness is the ambiguity and incomparability of performance data — which makes it difficult to evaluate and ensure

⁵⁴ It is noteworthy that the administrative burden can decrease to some extent over time as States become more proficient in meeting the Commonwealth's reporting requirements.

the efficient and effective achievement of policy goals. This trait was evident in the schools grants where the satisfaction of Commonwealth reporting and implementation requirements was mostly at State discretion. For example, despite seemingly rigid Commonwealth requirements for State implementation plans, State bureaucrats were quite adept at negotiating for these plans to remain consistent with their existing programs and policy preferences. The Australian National Audit Office (2007: 13, 15-17) also observes that the Commonwealth is heavily reliant on State cooperation for “evidence of systemic or ongoing non-compliance”. Further, it found that data limitations and the Commonwealth’s “limited resources and lack of jurisdiction over public hospitals restricted the collection of evidence ... [and the regular analysis of] ... performance data supplied”. The Keating and Howard era case studies also highlighted the inefficiencies created by the Commonwealth’s use of complex funding formulas and ‘blunt levers’ such as minimum thresholds to regulate State hospital activity and expenditure.

Offsetting these performance deficiencies were some beneficial effects of Commonwealth enforcement. For example, analysis of the Hawke and Keating eras showed that the Commonwealth can play a capacity building role in health data. By investing in State information systems, the Commonwealth fostered more streamlined and improved reporting practices. More recent developments confirm that Commonwealth can use its enforcement levers to increase public accountability. For example the Rudd–Gillard government’s requirement for States to report data on the *MySchools* and *MyHospitals* websites has increased public transparency over State performance. Further, the ongoing push for Commonwealth funding to be attached to performance targets has stimulated State government efforts to ensure and improve the quality and reliability of data. For example, following damning claims by the Victorian Auditor-General of data manipulation in Victorian hospitals, the State government was compelled to quickly address the issue, its response no doubt driven by Commonwealth funding threats (Auditor-General 2009; Medew 2009; The Age 2009). This example proves that greater Commonwealth–State collaboration can assist the overcoming of local political barriers to data enhancement.

f) Accountability shortcomings

The case studies also verified some of the commonly cited accountability shortcomings arising from the use of tied grants. A prime example was the Hawke government’s delinking of funding and hospital costs, in grant arrangements for universal hospital care. This placed the Commonwealth at an arms-length relationship with hospital cost growth and left the States with ongoing uncertainty over the financial risks associated with the delivery of

hospital care. The movement away from the more pragmatic 50–50 cost sharing arrangement of the Whitlam era to complex funding formulas, indexation factors and sometimes dubious indicators of activity and cost in tied grants made grant negotiations highly arbitrary, and most importantly, disassociated from service delivery at the hospital coalface.

The Fraser, Hawke and Keating eras also saw increasing referral of tied grant funding disputes to the Grants Commission or other forums such as Premiers' Conferences. This was another area of loss in the transparency and accountability of the tied grant arrangement. Such referrals allowed the Commonwealth to side-step or avoid the difficult policy issues, and complicate negotiations with other competing policy agendas. A similar obscuring of transparency was evident in the offering of incentives. During the Hawke era, the scope and type of incentives was considerably extended, including for example offers for taxation relief and increased borrowing limits. The entwining of tied grant negotiations with such economic and taxation agendas precluded a core policy focus on public hospitals.

Outside of the tied grant, the case studies also revealed accountability shortcomings arising from the Commonwealth's unilateral control of the wider health system and its funding of private schools. For example, throughout the case study timeframe there was evidence that Commonwealth reductions in medical benefits for GP services increased demand for hospital emergency services; and shortages in aged care caused longer than necessary hospital stays (Cormack 2002: 28-30; Davison 2002: 14-15; J. Deeble 2002: 4). By the Howard era, Commonwealth bureaucrats (Bigg et al. 1998: 10) were openly acknowledging:

both the Commonwealth and States see the current Agreements as reinforcing artificial boundaries within the health system. They not only encourage cost-shifting games, but also discourage health care providers from considering clinically appropriate and potentially more cost-effective treatments which could be delivered outside the traditional hospital setting, thus making integrated or coordinated care more difficult.

The schools case study highlighted the socio-economic imbalances between private and public schools, arising from the Commonwealth's unilateral financing decisions in the private schools sector. A complication with such 'flow-on' effects is that they are highly difficult to measure and monitor, allowing the Commonwealth to avoid accountability for their impact on the State delivery systems.

Performance advantages of tied grants

In addition to substantiating known performance deficiencies, the case studies also highlighted a performance advantage of tied grants, this being that the Commonwealth can be a highly effective policy agenda setter.

The smaller States' experiences with the doctors' remuneration goal during the Whitlam era offers a prime example in this regard. A collaborative Commonwealth–State approach was a critical factor in enabling policy makers at both levels of government to overcome professional interest group opposition to the goal. During the Fraser era, the lack of hands on participation from the Commonwealth led to the States suffering setbacks in policy implementation with the medical profession clawing back policy space. Under the Hawke government, again, a collaborative approach in the smaller states allowed policy makers to take advantage of dispersed political bargaining and secure the participation of hospital medical staff to tied grant goals. On the other hand, an overly prescriptive and aggressive approach by the Commonwealth in NSW resulted in a dramatic loss of policy reform capacity for both levels of government.

This trait was apparent also in the schools case study. It was observed that the Commonwealth has played a value-adding role in assisting States to overcome local resistance to controversial policy reforms such as greater principal autonomy and performance pay. Interviews suggested for example that the close involvement of the Rudd government had enabled States to secure greater reform progress than may have been feasible if they had acted independently. Examples cited were the productive discussions that took place between COAG and professional group unions, and Commonwealth interactions with school principals following their objections to the proposed *MySchools* website.

8.2.2 Case study generalisations — tied grant performance

Having confirmed some of the circumstances under which the tied grant has either detrimental or beneficial effects on service delivery and policy setting performance, some generalisations can now be formulated. Earlier we confirmed that the Commonwealth's *tied grant is an imprecise policy making instrument*. It is now additionally apparent that the *tied grant can be a useful mechanism for advancing mutually desired goals burdened by local political barriers*. The fragmented or dispersed nature of policy making under tied grants and a joint approach from the Commonwealth and States appears to work advantageously, assisting in breaking down interest group and stakeholder pressures and

permit advances in local policy reform. A further clarification is that *tied grant goals perform better when they are derived in a bottom-up manner from policy directions already being pursued by the States and are designed in a manner that allows the States flexibility to tailor such goals to their local needs.*

It can also be stated that the cited performance problems of tied grants are indeed valid, with the evidence confirming that tied grants cause the adoption of sub-optimal policy solutions; a policy making bias towards the larger States; a bias towards macroeconomic as opposed to microeconomic performance; inefficient policy compromises; administrative inefficiencies and accountability shortcomings. Further clarifying these performance flaws, however, the evidence also demonstrated that such flaws were mainly apparent when *the Commonwealth acted unilaterally or ideologically; or attempted to regulate States implementation too tightly through highly prescriptive policy guidelines and reporting requirements.*

8.2.3 Case study generalisations — federal system performance

Having formulated these conclusions about the tied grant as a policy making instrument, what are the implications for broader federal system performance? In Chapter 2, a normative summary was compiled on the diverse and competing performance effects of federal systems. This study validates some of the economic, equity, political and administrative performance implications that were identified.

On the economic performance implications discussed in Chapter 2, the case studies confirmed that when acting unilaterally and prescriptively, a central government can inhibit policy innovation; local responsiveness; and allocative and technical efficiency. Two key examples in this regard were the Whitlam government's favouring of universal hospital care over a community health based policy solution; and the Commonwealth's ongoing unilateral control of wider health and school policy settings in areas such as aged care, private health insurance, primary care and private schools. In both examples, the study showed that central government dominance inhibited States from fostering a more integrated, efficient, innovative and responsive health and schooling system. An important qualifier also confirmed in this study however, is that innovation, efficiency and local responsiveness can be equally stifled by State governance shortcomings, for example, in

resource allocation and workforce planning; and by the ambiguity of hospitals and schools performance data⁵⁵.

On the political and administrative performance implications of federal systems, the case studies confirmed that a unilateral and prescriptive central government can cause increased intergovernmental conflict, technocrat influence and information costs; and also reduced local political opportunism, interest group influence and political accountability. In terms of interest group influence, the Whitlam and Hawke government's role in the reform of doctors' remuneration in the smaller States demonstrated that central governments operating in a flexible and collaborative manner can very successfully assist state governments to mitigate local political barriers to policy reform. On reduced political accountability — the hospital case studies demonstrated that national or 'one-size-fits-all' solutions can involve the use of ambiguous funding formulas, convoluted incentive payments and one-on-one deals with States, inhibiting a transparent relationship between funding and service delivery outcomes.

Finally, on the performance implications concerning distributive equity, this study shows that while centralised governance increases the *capacity* to enhance equity, end results are likely to be imperfect — particularly while implementation patterns remain firmly in State hands. The case studies showed that in spite of vigorous pursuit of national policy settings, inter-jurisdictional and intra-jurisdictional inequities prevailed with considerable variations in programs, cost structures and hospital and school outcomes both within and across jurisdictions. Additionally, the case studies confirmed that the attainment of enhanced distributive justice and equity can be hampered by data limitations inhibiting reliable measurement of outcomes; and the Commonwealth's own ideological inconsistencies. For example, the Howard government's preferential funding of the private school sector is asserted have widened socio-economic inequities between government and non-government schools.

8.3 CONCLUSIONS ON THE ROLE OF TIED GRANTS

On the role of the tied grants in the Australian federal system, this study finds that:

a) *The tied grant is a highly crude and imprecise policy making instrument*

In spite of its fiscal superiority and the apparent open-endedness of section 96, the tied grant does not remove the constitutional barriers that exist around Commonwealth policy

⁵⁵ Connors (2007: 28) asserts that "policy development and debate on schools funding in Australia are bedevilled by the difficulties of establishing valid and reliable data".

making. Case study evidence confirms that the States ultimately retain control over the policy implementation process, and tend to push for a minimalist national agenda, either openly during the negotiation of the grant, or passively, at the implementation stage. For the Commonwealth to successfully secure more than a minimalist national agenda, history confirms that significant financial and policy concessions are generally involved, these serving to water-down or attach a higher price to the Commonwealth's policy objectives. Connors (2007: 8) example observes that Commonwealth attempts to override its constitutional barriers in the schools policy area tend to result in a "slide in its role towards political opportunism" and an "obscuring" of the "real (policy) priorities". Further the case studies proved that the levers used in tied grants, for example funding caps and utilisation targets are much too imprecise to have sustained or effective impacts on service efficiency.

b) *Tied grants are most effective when used to integrate converging policy directions at a State level rather than as a mechanism for imposing its own ideological or macroeconomic policy preferences*

A recurring theme in the case study analysis was that the Commonwealth can be highly successful and integrating and stimulating converging policy advances being made by individual States. The doctors' remuneration goal and the sweeping national goals of the schools tied grant proved that the Commonwealth can facilitate worthy policy reforms when it acts strategically and opportunistically to build on policy advances that are already being progressed. In contrast, significant performance shortcomings arose when the Commonwealth pursued its own policy preferences in a top-down manner for example, the Whitlam government's pursuit of universal hospital care and the Howard government's targeted goal setting for schools. In fostering policy integration, the tied grant is best used with subtlety, whereby the Commonwealth cultivates progress already occurring within the States, playing on their inter-jurisdictional rivalries and securing national uniformity by stealth, than by force. Achieving greater national uniformity in this manner allows States to carry the initial risk associated with policy innovation and learn from the lessons and experiences of State implementation processes. It also dissuades the Commonwealth from policy spontaneity and ideological virtuousness, thus facilitating a more pragmatic and evidence based policy setting process.

c) *Tied grants are effective in enabling States to overcome and alleviate local political barriers to mutually desired policy goals*

Evidence both from the hospitals and schools case studies showed that the involvement of the Commonwealth, through tied grants, can provide the States with potent leverage to break down local political and interest group pressures delaying or preventing worthwhile

policy reforms. As an agenda setter, the Commonwealth has significant policy and financial powers to foster and build momentum for State-sought policy reforms that may be far-reaching or controversial. This positive aspect of the tied grant is presently little discussed, but is highly relevant for stimulating greater performance in the health system where “poor management skills, rivalries and professional myopia” are cited as examples of obstacles preventing the establishment of more integrated health services (J. Deeble 2002: 5).

d) *Tied grants perform better when goals are flexible and not prescriptive*

Repeatedly, the case study analysis confirmed that the Commonwealth is much more successful in implementing its objectives when the States are allowed flexibility and policy space to tailor policy responses to their own unique operating circumstances. Commonwealth endeavours to impose ‘one-size-fits-all’ solutions onto the States generally result in policy bias towards the larger States and the unnecessary overlooking or superseding of policy solutions that may be perfectly adequate for the smaller States.

e) *Despite three decades of heavy tied grant use, there are a range of shortcomings in public hospital governance. Tied grants could have a major role to play in this untapped territory of microeconomic reform*

State governance barriers were described in detail in the Whitlam era analysis. Admittedly the State context has changed significantly since then, however many of the fundamental weaknesses remain — for example, in workforce planning, resource allocation, cost control, utilisation review, clinical practice variations and others. The gradual addressing of these governance issues will involve investment of time and resources, and in particular, the buy-in of clinical staff and overcoming of local political and cultural resistance. While hospital governance is firmly a matter for the States, it is clear from the case study evidence that the Commonwealth could have a potentially significant role to play in raising the profile and stimulating the policy agenda and progress in this area. The WA government’s experience with the implementation of the doctors’ remuneration goal confirms that there are significant benefits to be gained from partnering the differing policy and governance capacities of the Commonwealth and the States. Securing managerial reform in a cooperative manner can enhance the efficiency and long term sustainability of services.

f) *Tied grants are one of many Commonwealth policy levers. Weaknesses in the coordination of these policy levers constrains federal system performance*

The schools and hospitals cases highlighted the significant detrimental performance effects arising from the Commonwealth’s unilateral decision making in the wider health and schooling systems. It is critical that tied grant arrangements are viewed in their broader context, as a policy mechanism competing and interacting with other Commonwealth

policy instruments. Much of the so-called blame game appears to originate from within the Commonwealth, with goal inconsistencies and federal bureaucracies not acting in synchronisation. The performance and governance issues associated with the public hospitals will not be fully addressed until an integrated and holistic approach is adopted for federal policy formulation.

g) *The absence of a clear link between grant funding and actual service costs reduces the transparency and accountability of tied grants*

A key reason for the poor political accountability associated with tied grants are the convoluted funding arrangements: the use of ambiguous funding formulas, incentive payments and one-on-one financing deals struck with individual States. There is much to be said for the simple and transparent link that was introduced by the Whitlam government's 50-50 cost sharing arrangement.

h) *Tied grants are more effective when Commonwealth enforcement activities are focussed on strategic and targeted monitoring rather than compliance*

A persistent finding in the hospitals and schools case studies was that information asymmetries and data shortcomings make Commonwealth compliance activity essentially futile. However tightly reporting and accountability requirements may be framed, they generally prove ineffective, with implementation remaining firmly in State hands and the Commonwealth politically or institutionally unable to act on potential breaches of compliance. By contrast, the Commonwealth is a more influential and useful policy player when its policy and financial leverage is used to enhance public accountability and transparency and improve the quality of national and State datasets. Commonwealth involvement can facilitate State consensus around performance measurement and thereby enable greater comparability of performance between jurisdictions. These powerful outcomes are a much more effective tool for generating long lasting policy and operational reform, compared to the more conventional administrative assessment of State compliance with tied grant agreements.

In conclusion, by contrast with those who advocate return to a more 'coordinate' model of federalism, this historical analysis of tied grants finds that within the hospitals and schools area a cooperative model offers distinct policy-making advantages — provided the Commonwealth remains a refined and strategic player. If the efficiency and effectiveness of the Australian federal system is to be improved, the Commonwealth must learn to detach itself from the myriad of policy-setting roles it has attempted to play in the past, and instead concentrate on using the tied grant in a much more selective manner that is

founded on a sound policy consensus between the Commonwealth and the States. It is quite understandable that the Commonwealth can become impatient with the States in its deliberations over policy reform. However, this apparent policy 'sluggishness' should be viewed as part of the reality of implementing policy reform. Rather than resorting to coercive approaches, the Commonwealth must recognise the considerable journey that lies between a policy idea and operational delivery — a journey that involves policy learning and negotiation, and systems and organisational adjustments at the ground level. There should be no doubt over the performance deficiencies that arise from expedient, unilateral or excessively regulated approaches. To motivate and sustain tied grant and federal system performance over the long run, and move beyond superficial 'fixes', the key is step back and allow those who implement policy — the States and local stakeholders — to drive policy-making and performance improvement. In this regard, the tied grant reforms introduced in January 2009 within the *Intergovernmental Agreement on Federal Financial Relations* (COAG 2009) would seem to be very much a step in the right direction. Ultimately, unless the hearts and minds of the local service providers remain engaged in policy reform processes, little lasting benefit will be gained for the Australian federation (Ramamurthy in Kildea et al. 2012).

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APPENDIX A - DEVELOPMENT OF CASE STUDY ANALYTICAL FRAMEWORK

A.1 SUMMARY OF SELECTED ANALYTICAL MODELS FROM THE LITERATURE

The following tables summarise relevant models selected from the literature and highlight common themes evident, these being building blocks for the design of the case study analytical framework.

Table A.1 Analysis of Selected Analytical Models from the Literature

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOCI (As extracted from the literature)	COMMON THEMES	INDICATOR -POLICY MAKING APPROACH
(Van Meter and Van Horn 1975)	Analyse policy implementation to evaluate and explain the degree to which desired goals are delivered	Top down implementation Organisational change and innovation theory	6 broad variables are proposed to explain the link from policy to program performance: <ul style="list-style-type: none"> • Policy standards and objectives • Policy resources • Inter-organisational communication and enforcement activities • Characteristics of the implementing agencies • Economic, social and political conditions • Disposition of implementers 	<ul style="list-style-type: none"> • Clarity of policy standards and objectives • Accuracy and consistency in communication of policy standards and objectives • Circumstances under which adjustments were made to policy standards and objectives • Central government funding contribution • Use of persuasive strategies or incentives to promote implementation • Attitudes of state (acceptance or rejection) • Coercive or gentler mechanisms used to ensure implementation • Sanctions applied or funding withdrawals or complete takeover; State response to this • Instances of non-compliance, ramifications • Degree of specificity in procedures from central government • Ongoing technical assistance from central government • Extent of monitoring and oversight by central government • Use of monitoring and oversight information by central government • Extent of professional alliance between national and local actors • Capacity differences between the States • Degree of hierarchical or devolved control within the implementing state agency 	<ul style="list-style-type: none"> → Goal clarity → Goal consistency → Goal setting → Funding shares → Incentives → Goal congruence → Enforcement → Local discretion → State governance 	<ul style="list-style-type: none"> • More goal clarity – top down • More goal consistency – top down • More state actor input into goal setting – bottom up • More central government funding share – top down • More incentives and persuasion – top down • More central-state goal congruence – bottom up • More enforcement occurring – top down • More local discretion – bottom up • More devolved management capacity – bottom up

Table A.1 Analysis of Selected Analytical Models from the Literature (cont.)

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOC (As extracted from the literature)	COMMON THEMES	INDICATOR -POLICY MAKING APPROACH
(Ingram 1977)	Examination of a poorly performing intergovernmental grant program in a policy area under central government jurisdiction	Bottom up implementation	Conceptual framework to assess the extent to which the grant program is a bargaining strategy as opposed to a superior-subordinate based implementation instrument	<ul style="list-style-type: none"> • Complex succession of bids and counterbids between federal and state agencies • Extent to which states have used their collective power to influence goal setting • Extent to which states are able to restrain performance standards such that they remain consistent with their past results • Extent to which state innovation has driven goal setting • Extent to which local political factors restrain the central government's scope to alter program goals or cease programs • Extent to which state government is unable to reject program goals due to local political factors • Extent to which central government is willing to compromise conditions to ensure national program is established • Extent to which state government must make concessions to facilitate grant agreement • Extent to which political factors reduce the central government's ability to enforce grant conditions • Monitoring and oversight occurs • Extent to which monitoring results in corrective action being pursued or poor performance publicly reported • Procedures and rules are established • Penalties applied 	<p style="text-align: center;">↑ Goal setting</p> <p style="text-align: center;">↑ Enforcement</p>	<ul style="list-style-type: none"> • More state actor input into goal setting – bottom up • More enforcement occurring – top down

Table A.1 Analysis of Selected Analytical Models from the Literature (cont.)

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOCI (As extracted from the literature)	COMMON THEMES	INDICATOR-POLICY MAKING APPROACH
(Ingram 1977) (cont.)	Examination of a poorly performing intergovernmental grant program in a policy area under central government jurisdiction	Bottom up implementation	Conceptual framework to assess the extent to which the grant program is a bargaining strategy as opposed to a superior-subordinate based implementation instrument	<ul style="list-style-type: none"> • Extent to which incentives are offered to coerce participation • Other federal agencies and actors involved • Extent to which national goal is misaligned with state goals • Attitudes of local implementers including officials and interest groups • Extent to which central government becomes involved in local decision making by establishing its own management entities • Extent to which the grant program results in state objectives shifting to mirror national objectives • Extent to which local political factors reduce state's ability to not accept or comply with grant conditions • Extent to which compliance costs lead to a state rejecting a grant • Extent to which goals or performance standards are vague or clear 	<p style="text-align: center;"> Incentives → Goal congruence → Local discretion → Goal clarity → </p>	<ul style="list-style-type: none"> • More incentives and persuasion – top down • More central-state goal congruence – bottom up • More local discretion – bottom up • More goal clarity – top down

Table A.1 Analysis of Selected Analytical Models from the Literature (cont.)

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOCI (As extracted from the literature)	COMMON THEMES	INDICATOR –POLICY MAKING APPROACH
(Van Horn 1979)	Longitudinal analysis of the implementation process of three federal grant programs involving multiple policy areas	Top down implementation	<p>Six areas of analysis proposed to address implementation questions – “what happened” and “why did it happen this way”:</p> <p><u>What</u></p> <ul style="list-style-type: none"> Who governs? How are funds spent? Who benefits? <p><u>Why</u></p> <ul style="list-style-type: none"> Policy standards and performance The national policy environment The local policy environment 	<ul style="list-style-type: none"> Participants in policy making, relative influence Responsibility for oversight of grant agreement Monitoring/oversight activities, resources committed to this, volume of activity, rise or fall in monitoring and oversight Procedural requirements, technical assistance Sanctions Changes made to policy guidelines or goals emphasised by central government during course of grant agreement Resource allocation at state level, participants, impact of grant on state budget processes, constraints as a result of the grant Extent to which additional autonomy used when grant conditions relaxed Changes in state program mix over the life of the grant agreement Target groups of central government receive intended support Funding contribution of central government Policy statements of intent, state and federal interpretations Attitudes of local implementers including officials and interest groups Other central government actors and agencies involved Political standing of state agency, skill capacity, political climate 	<p>→ Goal setting</p> <p>→ Enforcement</p> <p>→ Goal consistency</p> <p>→ Local discretion</p> <p>→ Funding shares</p> <p>→ Goal congruence</p> <p>→ State governance</p>	<ul style="list-style-type: none"> More federal actor influence – top down More enforcement occurring – top down More goal consistency – top down More local discretion – bottom up More central government funding share – top down More central-state goal congruence – bottom up More goal clarity – top down More devolved management capacity – bottom up

Table A.1 Analysis of Selected Analytical Models from the Literature (cont.)

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOC (As extracted from the literature)	COMMON THEMES	INDICATOR-POLICY MAKING APPROACH
(Goggin et al. 1990)	Study of intergovernmental policy implementation from a state level to assess why implementation varies across states	Hybrid model of implementation Communications theory	<p>Communications model of intergovernmental policy implementation</p> <p>Three groups of variables are proposed to explain state implementation:</p> <ul style="list-style-type: none"> • Inducements and constraints from the top (federal level) • Inducements and constraints from the bottom (state and local levels) • State decisional outcomes and capacity 	<p>Federal inducements and constraints:</p> <ul style="list-style-type: none"> • Clarity of policy, outcomes, performance standards • Consistency of central government decisions and goals, extent to which state implementation experiences influence changes to goals • Procedural specificity • Flexibility of central government in enforcement of goals, standards and procedures • Sanctions, importance of sanctions to the state • Frequency of communications from central government • Agreement among central government actors over national goals • Type of policy – distributive or redistributive • Attitudes of state implementers • Legitimacy and credibility of federal officials and their policy messages as perceived by the state • Complexity-politics attached to policy problem • Cause and effect reliability of a policy, certainty of policy outcomes • Funding contribution of central government • Anticipated effects on existing power arrangements 	<p>Goal clarity</p> <p>Goal consistency</p> <p>Enforcement</p> <p>Goal congruence</p> <p>Funding shares</p> <p>Local discretion</p>	<ul style="list-style-type: none"> • More goal clarity – top down • More goal consistency – top down • More enforcement occurring – top down • More central-state goal congruence – bottom up • More central government funding share – top down • More local discretion – bottom up

Table A.1 Analysis of Selected Analytical Models from the Literature (cont.)

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOCI (As extracted from the literature)	COMMON THEMES	INDICATOR –POLICY MAKING APPROACH
(Goggin et al. 1990) (cont.)	Study of implementation from a state level to assess why implementation varies across states	Hybrid model of implementation Communications theory	<p>Communications model of intergovernmental policy implementation</p> <p>Three groups of variables are proposed to explain state implementation:</p> <ul style="list-style-type: none"> • Inducements and constraints from the top (federal level) • Inducements and constraints from the bottom (state and local levels) • State decisional outcomes and capacity 	<p>State and local inducements and constraints:</p> <ul style="list-style-type: none"> • Attitudes of state actors: interest groups, elected officials, state agency • Extent of influence by various state actor groups • Partisan support and priority over policy • Salience of policy problem to state • Demographic and socio-economic compatibility with policy • Public opinion on the policy • Legislative changes to support the policy <p>State decisional outcomes and capacity:</p> <ul style="list-style-type: none"> • Delivery structure (complex or simple, hierarchical or devolved), includes non-government organisations • Adoption of national goal within agency, communications between head, regional and local offices • State skills capacity • State fiscal capacity 	<p>Goal congruence</p> <p>State governance</p>	<ul style="list-style-type: none"> • More central-state goal congruence – bottom up • More devolved management capacity – bottom up

Table A.1 Analysis of Selected Analytical Models from the Literature (cont.)

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOCI (As extracted from the literature)	COMMON THEMES	INDICATOR -POLICY MAKING APPROACH
(Hedge et al. 1991)	Examination of intergovernmental program to assess the extent to which federal agencies are able to influence the regulatory behaviour of state agencies	Principal agent theory Top down implementation	A range of variables proposed to assess the extent to which a principal-agent model can sufficiently explain program implementation	<ul style="list-style-type: none"> • Attitudes of local implementers including officials and interest groups • Funding contribution of central government • Extent of monitoring and oversight by central government, volume of activity • Skill capacity, expertise of state agency, political climate • Percentage of state budget spent on policy area • Politics involved with implementation, interest group power, competing stakeholders 	<p style="text-align: center;"> </p>	<ul style="list-style-type: none"> • More central-state goal congruence – bottom up • More central government funding share – top down • More enforcement occurring – top down • More devolved management capacity – bottom up

Table A.1 Analysis of Selected Analytical Models from the Literature (cont.)

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOCI (As extracted from the literature)	COMMON THEMES	INDICATOR –POLICY MAKING APPROACH
(Bossert 1998)	Analyse decision space in policy implementation to evaluate impact on innovation	Principal agent theory Top down implementation	5 broad variables are proposed to assess the extent of decision space available to local implementers: <ul style="list-style-type: none"> • Finance • Service organisation • Human resources • Access rules • Governance rules 	<ul style="list-style-type: none"> • Decisions on local resource allocation decisions • Decisions on revenue raising • Autonomy of delivery organisations • Flexibility for innovation • Decisions on access to services • Decisions over governance structures and membership • Decisions on service delivery structure and linkage with private sector • Decisions on program standards • Sanctions applied or funding withdrawals or complete takeover; State response to this • Extent of monitoring and oversight by central government • Extent to which program is important for organisational survival (federal) • Use of monitoring and oversight information by central government • Use of persuasive strategies or incentives to promote implementation • Incentive systems at state level and how they interact with national program incentives • Politics involved with implementation, interest group power, competing stakeholders • Extent of dependence on national funding as a funding source 	<p style="text-align: center;">Local discretion</p> <p style="text-align: center;">Goal setting</p> <p style="text-align: center;">Enforcement</p> <p style="text-align: center;">Incentives</p> <p style="text-align: center;">Goal congruence</p> <p style="text-align: center;">State governance</p> <p style="text-align: center;">Funding shares</p>	<ul style="list-style-type: none"> • More local discretion – bottom up • More enforcement occurring – top down • Conflict between local and national incentive systems – bottom up • More incentives and persuasion – top down • More political implementation environment – bottom up • More central government funding share – top down

Table A.1 Analysis of Selected Analytical Models from the Literature (cont.)

AUTHOR	PURPOSE	UNDERLYING THEORIES	ANALYTICAL MODEL PROPOSED	POTENTIAL ANALYTICAL FOCI (As extracted from the literature)	THEMES	INDICATOR -POLICY MAKING APPROACH
(Kronebusch 2004)	Analysis of an intergovernmental grant program to assess effectiveness of attaching non-financial conditions to promote compliance	Top down implementation	A range of variables are proposed to evaluate the extent of compliance with national goals and conditions attached to intergovernmental grants	<ul style="list-style-type: none"> Degree of disparity between federal and state policy preferences Willingness of state officials to follow federal requirements Ability and willingness of federal officials to monitor the states Visibility of the activity that needs to be monitored Willingness of federal officials to take enforcement action Magnitude of the potential penalties for non-compliance Extent of uniformity in policy settings and results across states 	<p>Goal congruence</p> <p>Enforcement</p> <p>Local Discretion</p>	<ul style="list-style-type: none"> More central-state goal congruence – bottom up More enforcement occurring – top down More local discretion – bottom up
(Manna 2006)	Analysis of an intergovernmental grant program to assess implementation approach used by central government	Hybrid model of policy implementation Principal agent theory Policy network theory	A range of variables are proposed, grouped according to two forms of top down policy making: <ul style="list-style-type: none"> Implementation by control Implementation by persuasion 	<ul style="list-style-type: none"> Clarity of policy goals Minimum policy standards Consistent statements about policy goals and standards Goals and conditions adjusted or stated in broad terms to reflect state operating circumstances Participatory approach to the setting of national goals Sanctions for non-compliance, “tough talk” Use of persuasive strategies or incentives to promote implementation, “conciliatory talk” 	<p>Goal clarity</p> <p>Goal consistency</p> <p>Goal setting</p> <p>Enforcement</p> <p>Incentives</p>	<ul style="list-style-type: none"> More goal clarity – top down More goal consistency – top down More state actor input goal setting – bottom up More enforcement occurring – top down More incentives and persuasion – top down

A.2 APPLICATION OF ANALYTICAL FRAMEWORK — POTENTIAL EXPLANATORY FACTORS

To assist with the application of the analytical framework, a range of potential explanatory factors were identified from the literature as shown in the following figures.

Table A.2 Potential explanatory factors

<p>GOAL CLARITY</p>	<ul style="list-style-type: none"> - Clarity of national policy objectives, performance standards and outcomes
<p>GOAL SETTING</p>	<ul style="list-style-type: none"> - Mix of participants in the goal setting process and relative influence - Participatory approach to setting of national goals - Evidence of a succession of bids and counter bids between national and state governments - Extent to which states use their collective bargaining power - Extent to which states avoid raising of performance standards - Extent to which state innovations have influenced national policy goals - Extent to which political factors prevent alteration, termination or non-acceptance of national goals - Extent to which national government compromises its goals to ensure grant agreement is reached - Extent to which state government must make concessions to facilitate grant agreement is reached - Extent to which national government adjusts grant conditions to accommodate state circumstances
<p>GOAL CONGRUENCE</p>	<ul style="list-style-type: none"> - Multiple federal agencies and actors involved - Partisan support, priority for national goals - Degree of disparity between national goals and state goals - Salience of policy problem to state - Complexity, politics attached to policy problem - Certainty attached to policy outcomes, cause and effect reliability - Demographic and socio-economic compatibility with national goals - Type of policy: distributive or redistributive - Public opinion on policy - Attitudes of state implementers: elected officials, agency, interest groups, front-line managers, clients - Extent of influence, power of various sub-national actors - Willingness of state officials to follow federal requirements - Legitimacy and credibility of federal officials as perceived by the state - Differing federal and state interpretations in implementation of national goals - Compatibility of grant agreement with other policy instruments at state level - Compatibility of grant agreement with incentive systems at state level, perverse incentives evident - Competing policy objectives: political and administrative trade-offs occurring, aggregate effect - State legislation underpins national goals

Table A.2 Potential explanatory factors (cont.)

<p style="text-align: center;">INCENTIVES</p>	<ul style="list-style-type: none"> - Use of persuasive strategies or incentives to promote implementation - Extent to which incentives are used in a coercive manner to ensure participation - Use of "conciliatory" talk
<p style="text-align: center;">ENFORCEMENT</p>	<ul style="list-style-type: none"> - Coercive or gentler mechanisms used to ensure implementation - Sanctions applied, funding withdrawals, complete takeovers, State response to these - Sanctions are threatened, "tough" talk, state response to these - Importance of sanctions to state, magnitude of potential penalties - Willingness of national government to sanction or take other enforcement action - Extent to which political factors reduce national government's ability to enforce grant conditions - Instances of non-compliance, national government response - Degree of specificity in procedures from national government - Frequency of communications from national government - Ongoing technical advice from national government - Extent of monitoring and oversight by national government, changes over life of agreement - Willingness and ability of national agency to monitor the states, resources committed to this - Visibility of activities being monitored - Use of monitoring and oversight information by national government - Public reporting of poor performance or pursuit of corrective action - Flexibility in national government enforcement of goals, standards and procedures - Extent to which national program is important to national agency's organisational survival - Extent of professional alliance between state and national actors
<p style="text-align: center;">GOAL CONSISTENCY</p>	<ul style="list-style-type: none"> - Accuracy and consistency in communication of national policy objectives & performance standards - Changes made to policy goals initiated by national government over life of grant - Changes made to policy goals initiated by state government over life of grant - Particular goals emphasised by national government over life of grant

Table A.2 Potential explanatory factors (cont.)

<p>LOCAL DISCRETION</p>	<ul style="list-style-type: none"> - Extent to which national government establishes own management entities for local decision making - Extent to which grant results in state objectives shifting to national goals over time - Extent to which local political factors reduce state's ability to not accept, comply with grant conditions - Extent to which compliance costs lead to a state rejecting a grant - Impact of grant on state budget processes, resource allocation decision making - Extent to which grant constrains state financial management, revenue raising - Changes in state program mix over the life of the grant agreement - Target groups of national government receive intended support - Extent to which policy is implemented uniformly or differently across implementing sites - Extent of lateral influence of national government across local policy instruments, organisations - Extent to which incentives, conditions used to coerce states toward specific policy choices or trade-offs - Autonomy of delivery agencies, extent to which grant constrains - Extent to which a state used additional autonomy when grant conditions relaxed - Flexibility for innovation - Decision making on access to services - Decision making over state governance structures and membership - Impact of policy on workloads of agency front line staff
<p>STATE GOVERNANCE BARRIERS</p>	<ul style="list-style-type: none"> - Delivery structure (complex or simple), linkages to non-government and private sector - Degree of hierarchical or devolved control within the implementing state agency - Political standing of state agency - State political climate - Adoption of national goals within agency, communication between head, regional and local offices - Enforcement of national goals within agency, between head, regional and local offices - State skills capacity, expertise of state agency - State fiscal capacity - Percentage of state budget spent on policy area - Extent of politics involved with implementation, interest group power, competing stakeholders
<p>FUNDING SHARES</p>	<ul style="list-style-type: none"> - National government funding contribution - Extent of dependence on national government as a funding source

**APPENDIX B - COMPARISON OF PUBLIC HOSPITAL FUNDING
AGREEMENTS**

B.1 COMPARISON OF 1975 AND 1976 PUBLIC HOSPITAL FUNDING AGREEMENTS

Table B.1 Comparison of 1975 and 1976 Agreements (significant changes)

CONDITION	1975 WA Agreement	1976 WA Agreement	Comments
Term of Agreement	31 Jul 1975 to 30 Jun 1980 (unless ext. to 30 Jun 1985 by agreement before 31 Dec 1979).	1 Oct 1976 to 30 Jun 1980 (unless ext. to 30 Jun 1985 by agreement before 31 Dec 1979)	No change to end date.
Universal Hospital Care	<p>Clause A stated "it is the policy of Australia to ensure that every person has access to comprehensive hospital care, including medical treatment, provided without charge and without means test in standard beds of public hospitals but in such a way as will not place any impediment in the way of persons being able to seek private treatment in public hospitals if they so wish".</p> <p>Clauses 6.1 and 6.2 require the State to ensure services are available to "all eligible persons in the State who wish to receive them".</p>	<p>Equivalent Clause 8.1.</p> <p>A new Clause 24.1 additionally states "...Western Australia shall make beds available for hospital patients or private patients according to patient demand and degree of need for care and treatment".</p>	<p>Clause A epitomises the vague and highly open-ended nature of the first Agreement.</p> <p>Clauses 6.1 and 6.2 reflect the open-ended nature of the first Agreement.</p> <p>In the second iteration of the Agreement however, the open-ended provision of care was qualified with notions of "patient demand", "degree of need" inserted into the wording. Noticeably, these qualifications were attached specifically to <i>bed availability</i> - bed numbers being identified as a mechanism to control the level of services being provided.</p>
	Clause 6.3 outlines the scope of services	Clauses 8.1 and 24.1 to 25.1 outline the scope of services.	The two Agreements largely retain the same scope of services. Notably Clause 42.1 of the 1976 Agreement additionally provided that home dialysis services shall be added to the scope of services.

Table B.1 Comparison of 1975 and 1976 Agreements (significant changes) (cont.)

CONDITION	1975 WA Agreement	1976 WA Agreement	Comments
Universal Hospital Care (cont.)	Clause 7.1 requires the State to provide hospital inpatient and outpatient treatment free of charge to all eligible persons. Clauses 7.2 and 7.3 specify there will be no means testing.	Clause 26.1 requires the State to provide hospital inpatient treatment free of charge to all eligible people other than a privately insured person.	The second iteration of the Agreement restricted 'universal hospital inpatient care' to people with <i>no private health insurance</i> . Outpatient care remained universal under both Agreements as was the prohibition of means testing.
Financial Provisions Offset clause	Clause 5.6 indicates grant will not be offset against General Revenue Payments to the State.	Clause 7.1 indicates grant will not be offset against General Revenue Payments to the State.	States were able to retain the non-offsets provision they negotiated with the Whitlam government and unique to this tied grant arrangement.
50-50 cost sharing	Clause 4.1 requires the Commonwealth to pay "50 per centum of the net operating costs of all the recognised hospitals in the State".	Clauses 4.3, 5.1, 12-1 to 18.1 and 22.1 require the Commonwealth to pay 50 per cent of the net operating costs based on 'approved annual budgets' and approved variations thereto formulated by the State Standing Committee and approved by the Minister for Health and the Western Australian Minister. Operating costs include the costs of recognised hospitals and central services.	The 50-50 cost sharing arrangement was no longer predominantly at the discretion of the States but subject to detailed review and assessment by a joint Commonwealth-State committee.
Mode of payment	Clause 5.1 to 5.5 specifies the payment of daily bed benefits direct to hospitals (by the Commonwealth).	No equivalent clauses.	The 1976 Agreement simplified payment arrangements with all payments being made to the State government.
Setting of private patient charges	Clause 8.3 specifies that private patient charges will be adjusted from time to time for "cost increases or other relevant factors" as agreed between Commonwealth and State Health Ministers	Clause 29.1 allows for adjustments to charges as per the first Agreement but additionally Clause 30.1 states that patient charges shall be assessed by the joint Commonwealth-State Standing Committee "with a view to achieving uniformity between States".	New machinery for the setting of fees, and also an added policy emphasis on national uniformity in patient charges.

Table B.1 Comparison of 1975 and 1976 Agreements (significant changes) (cont.)

CONDITION	1975 WA Agreement	1976 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Setting of budgets</p>	<p>Clause 10.1 requires the State to "from time to time as appropriate during the preparation of its budgets, inform Australia of estimated gross operating costs, revenue, net operating costs, approved subsidies and other agreed information..."</p> <p>Clause 10.2 states "for the purpose of joint participation of the Governments in budget preparation, Western Australia will, from time to time as appropriate, provide to Australia, in an agreed form, estimates of operating receipts and payments for each recognised hospital and central service in the State".</p>	<p>Clauses 12.1 to 18.1 specify the procedures for setting of hospital budgets.</p> <p>Clause 11.1 assigns responsibility for formulation of budgets to the joint Commonwealth- State Standing Committee.</p> <p>Clause 11.3 requires the Committee to "apply principles aimed at achieving operating economies..." whilst "maintaining or achieving an acceptably high standard of health care..."</p> <p>Clauses 12.1 to 18.1 specify detailed role of the Standing Committees at their March and November meetings.</p> <p>Clause 33.1 requires the State to provide in an agreed format, the proposed monthly budget for the ensuing financial year. Clause 33.4 requires the State to detail variations in service levels due to the opening or closing of hospital or central services.</p>	<p>The 1976 Agreement included new machinery for the setting of budgets.</p> <p>Further, there was considerable increase in the budget information required to be provided to the Commonwealth.</p> <p>There was also a new policy emphasis on operational efficiency, effectively qualifying the open-ended sharing of costs.</p> <p>The 1976 Agreement placed somewhat of a qualifier on the quality of services with the insertion of words "acceptably high standard" of care.</p>

Table B.1 Comparison of 1975 and 1976 Agreements (significant changes) (cont.)

CONDITION	1975 WA Agreement	1976 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Revisions to budgets</p>	<p>Clause 10.4 requires the State "from time to time as appropriate, provide to Australia details of revisions to the annual estimates".</p> <p>Clause 11.2 states "If actual gross operating costs of a recognised hospital exceed substantially that hospital's approved annual budget ... the parties may jointly authorise such investigations as are necessary to establish how the situation may be corrected".</p>	<p>Clause 34.1 requires the State to provide details of proposed budget variations, and explanations as "to why the variations are necessary" to the State Standing Committee.</p>	<p>The 1975 Agreement was fairly 'loose' in terms of budget revisions, the States were left with considerable discretion over the overall quantum of hospital costs.</p> <p>In comparison, the 1976 Agreement include tighter procedures for budget variations, with States having to explain and have variations formally considered by the State Standing Committee.</p>
<p>Outcomes Reporting</p>	<p>Clause 10.3 requires the State to provide the Commonwealth "after the end of each agreed period" with information on actual receipts and payments, with "minor hospitals" to be reported in aggregate</p> <p>Clause 13.1 requires the State to "provide statistics in such manner and at such times as are so agreed".</p>	<p>Clause 35.1 requires the State to provide quarterly information on actual receipts and payments for hospitals and central services.</p> <p>Clause 35.3 stipulates that actual results may also need to be reported on a monthly basis by the State "if the Commonwealth reasonably requests" this.</p> <p>Clause 36.1 requires the State to provide statistics, "including listings of individual patients in recognised hospitals in a form as required by the Commonwealth".</p> <p>Clause 37.2 requires the State to provide an audit certificate covering the operating revenues and payments associated with the grant.</p>	<p>The 1976 Agreement was more precise in its requirements for reporting of actual outcomes, with the implication that such reporting is also more frequent.</p>

Table B.1 Comparison of 1975 and 1976 Agreements (significant changes) (cont.)

CONDITION	1975 WA Agreement	1976 WA Agreement	Comments
Service delivery	Clause 6.4 assigns responsibility for staffing levels and staffing appointments to the States	Clause 25.2 assigns responsibility for staffing levels and staffing appointments to the States	States retained local discretion over staff recruitment and configurations.
	No equivalent clause	Clause 43.1 stipulates that the Hospital and Allied Services Advisory Council or a National Standing Committee within that Council will "consider broad policy issues related to joint Commonwealth and State examinations of hospital expenditure ... [and] ... make recommendations with a view to improving efficiencies and achieving rationalization of hospital services".	The 1976 Agreement included specific machinery to enable the Commonwealth to become more closely involved in identifying measures to improve efficiency within the public hospital system.
	Clause 16.1 to 16.8 require the State to engage medical staff on a salaried or sessional basis, or alternatively on other contractual basis as agreed between the Commonwealth and State.	Clauses 38.1 to 38.8 require the State to engage medical staff on a salaried or sessional basis, or alternatively on other contractual basis as agreed between the Commonwealth and State.	The policy emphasis on salaried or sessional doctor remuneration was retained under the 1976 Agreement. The 1975 Agreement (Clause 16.9) stipulated that annual joint reviews would be conducted on this policy goal, to assess "additional action" necessary for "replacing fee-for-service payments with salaried and sessional payments". No such monitoring or review was included in the second iteration of the Agreement, implying that the Commonwealth's emphasis on this policy goal decreased.
	Clause 16.10 and 16.11 stipulate that the Commonwealth and State will "participate jointly" in wage negotiations with medical staff, with a view to "achieving uniformity between states and territories and ultimately to establishing national machinery..."	Equivalent Clause 38.9.	The 1976 Agreement retained the Commonwealth's involvement in wage setting for medical staff, a goal that for which there was considerable State support in the 1975 Agreement.

B.2 COMPARISON OF 1976 AND 1984 PUBLIC HOSPITAL FUNDING AGREEMENTS

Table B.2 Comparison of 1976 and 1984 Agreements (significant changes)

CONDITION	1976 WA Agreement	1984 WA Agreement	Comments
Term of Agreement	1 Oct 1976 to 30 Jun 1980 (unless ext. to 30 Jun 1985 by agreement before 31 Dec 1979).	1 February 1984 to 30 June 1987.	The Medibank era provided for five or ten year terms. Whilst policy longevity was a desire of the Hawke government, a shorter timeframe was adopted presumably to facilitate early evaluation of the program.
Review of Arrangement	No equivalent clause.	Clause 1.5 stipulates that the grant arrangement will be jointly reviewed by the Commonwealth and the State to ascertain its "appropriateness".	In addition to indicating that the Agreement may be varied from time to time, the Medicare grant also provides for a formal review prior to the end of the second year.
Universal Hospital Care	Clause 26.1 requires the State to provide hospital inpatient treatment free of charge to all eligible people other than a privately insured person. Clause 24.1 additionally states "...Western Australia shall make beds available for hospital patients or private patients according to patient demand and degree of need for care and treatment".	Clause 6.1 requires the State to provide universal hospital care to all eligible people. Clause 6.3 requires the State to ensure universal care is "accessible as practicable to all eligible persons" and that "all eligible persons are able to elect to be private patients". Clause 8.3 states that any eligible inpatient will be "deemed to have elected" to be a public patient "unless he specifically elects to be a private patient".	The 1984 Agreement moved back to a broader client scope - requiring States to provide services to "all eligible people". Whilst the 1976 Agreement mandated that privately insured people would not be entitled to universal hospital care, the 1984 Agreement left this option in the hands of the patient, and the election they choose to make. The 1984 Agreement recognised the co-existence of private health insurance more explicitly than the 1975 Agreement. Not surprisingly however the bias towards public provision of hospital care is clearly evident.
	Clauses 8.1 and 24.1 to 25.1 outline the scope of services.	Clause 6.2 outlines service scope.	A number of variations are evident in the service scope. The 1976 Agreement provided for in-patient accommodation to be "appropriate to the patient's medical condition" whilst the 1984 Agreement specified accommodation as "standard ward". The 1984 Agreement listed "casualty and emergency services" specifically whereas the 1976 Agreement did not.

Table B.2 Comparison of 1976 and 1984 Agreements (significant changes) (cont.)

CONDITION	1976 WA Agreement	1984 WA Agreement	Comments
Universal hospital care (cont.)	Clauses 24.1 to 25.1 outline the scope of services.	Clause 6.2 outlines service scope.	<p>The 1984 Agreement included "transfer, where medically necessary, of (public and private) patients between recognised (public) hospitals" and "aftercare".</p> <p>The 1976 Agreement included "radiotherapy services" whereas the 1984 Agreement does not list this.</p> <p>With regards to out-patients, the 1976 Agreement required States to provide a comprehensive service omitting only the cost of accommodation. However the 1984 Agreement adopted a smaller scope of out-patient service - permitting the States to exclude surgical aid appliances, prostheses, drugs, biological and related preparations from the universal service.</p>
Financial Provisions Offset clause	Clause 7.1 indicates grant will not be offset against General Revenue Payments to the State.	No equivalent clause	An offsets clause was not formally included in the 1984 Agreement. However the WA Government did secure the Commonwealth's assurance that compensation grant payments would be held "outside any assessment of relativities by the Grants Commission" (WA Govt 1984a: 51).
Mode of payment	The 1976 Agreement entailed all payments being made to the State government.	The 1984 Agreement entailed all payments being made to the State government.	Unlike the 1975 Agreement which paid part of the grant as bed day subsidies direct to the hospital, the 1976 and 1984 Agreements stipulated that all grant payments would be paid to the State government.

Table B.2 Comparison of 1976 and 1984 Agreements (significant changes) (cont.)

CONDITION	1976 WA Agreement	1984 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>50-50 cost sharing</p>	<p>Clauses 4.3, 5.1, 12.1 to 18.1 and 22.1 require the Commonwealth to pay 50 per cent of the net operating costs based on 'approved annual budgets' and approved variations thereto formulated by the State Standing Committee and approved by the Minister for Health and the Western Australian Minister". Operating costs included the costs of hospitals and central services.</p>	<p>Clauses 4.1 to 4.11 detail the formulae to be used to calculate the grant. Essentially under Clause 4.1,, the State is compensated for 1) "revenue losses and additional costs resulting from the removal of inpatient and outpatient fees for eligible persons who elect to be treated free"; 2) revenue losses resulting from a reduction of fees for private patients.."; and 3) "certain expenditure for other health purposes other than hospital services".</p>	<p>The Commonwealth's cost-sharing role whereby it reimbursed States for 50 per cent of the net operating costs of hospitals and central services was transformed into a 'revenue compensation role.</p>
<p>Setting of private patient charges</p>	<p>Clauses 28.1 to 28.2 require private patients to be charged for accommodation costs at prescribed the rates.</p> <p>Clause 29.1 allows for adjustments to charges but requires these to be agreed between the Commonwealth and State Health Ministers.</p> <p>Clause 30.1 states that patient charges shall be assessed by the joint Commonwealth-State Standing Committee "with a view to achieving uniformity between States".</p>	<p>Clause 9.2 requires private patients to be charged for accommodation costs. The charges are specified for the period to 30 June 1985 but thereafter are left "as may be determined by the State".</p>	<p>The Commonwealth maintained tight control over hospital charges only in the first eighteen months of the 1984 Agreement. There was most definitely a reduction in administrative machinery compared with the Fraser era agreement.</p>

Table B.2 Comparison of 1976 and 1984 Agreements (significant changes) (cont.)

CONDITION	1976 WA Agreement	1984 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Payment of private hospital daily bed subsidies</p>	<p>No equivalent clause</p>	<p>Clauses 10.1 to 10.3 allow the States to assume responsibility for the payment of private hospital bed day subsidies if they choose. States are given the freedom to set the rates and conditions for such payments if such a transfer of responsibility is agreed to.</p> <p>Clause 10.4 requires the Commonwealth and State Ministers for Health to consult over the approval and categorisation of private hospitals.</p>	<p>This policy move is consistent with earlier, more informal attempts by the Commonwealth during the Fraser era, to cajole States into assuming a greater regulatory role over the private hospital system. The 1984 Agreement also built in additional machinery to facilitate this.</p>
<p>Setting of budgets</p>	<p>Clauses 12.1 to 18.1 specify the procedures for setting of hospital budgets.</p> <p>Clause 11.1 assigns responsibility for formulation of budgets to the joint Commonwealth-State Standing Committee.</p> <p>Clause 11.3 requires the Committee to "apply principles aimed at maintaining or achieving operating economies..." whilst "maintaining or achieving an acceptably high standard of health care..."</p>	<p>Clause 11.7 requires the State to provide an annual budget for proposed community health services.</p> <p>Clauses 4.1 to 4.11 outline the formulas to be used to calculate grant payments.</p> <p>Clause 12.1 establishes a Commonwealth and State Standing Committee on Health Services.</p> <p>Clause 12.5 stipulates that the Committee shall make recommendations on the quantum of grants and agreed indexation factors.</p>	<p>The rigorous and somewhat pedantic budget formulation and review processes of the 1976 Agreement were significantly watered down for the 1984 Agreement. The latter simply concentrated on revenue compensation and prescribed in great detail, the grant formulae. The variables involved in calculating grant payments was much more streamlined compared to the 1976 Agreement which had considered each hospital cost line. Whilst the Standing Committee machinery was carried forward into the Hawke era, its role was much less involved, compared to the detailed responsibilities outlined in the 1976 Agreement.</p>

Table B.2 Comparison of 1976 and 1984 Agreements (significant changes) (cont.)

CONDITION	1976 WA Agreement	1984 WA Agreement	Comments
Financial Provisions (cont.) Setting of budgets	<p>Clause 12.1 to 18.1 specify detailed role of the Standing Committees at their March and November meetings.</p> <p>Clause 33.1 requires the State to provide in an agreed format, the proposed monthly budget for the ensuing financial year. Clause 33.4 requires the State to detail variations in service levels due to the opening or closing of hospital or central services.</p>	<p>Clause 12.7 requires the joint Committee to "apply principles aimed at reducing operating costs in recognised hospitals and other health services, consistent with maintaining or achieving a high standard of health care".</p>	<p>Whilst the 1976 Agreement emphasised maintenance or achieving operating economies, the 1984 Agreement is focussed just on reducing operating costs. In terms of the quality of care, the 1976 Agreement settled on "an acceptably high standard" whilst the 1984 Agreement is less ambiguous, requiring the standard of care to be "high".</p>
Revisions to budgets	<p>Clause 34.1 requires the State to provide details of proposed budget variations, and explanations as "to why the variations are necessary" to the State Standing Committee.</p>	<p>Clause 12.12 states that the Commonwealth State Standing Committee may consider and make recommendations to the federal and State Ministers for Health on variations to grants due to unforeseen circumstances.</p>	<p>Provisions relating to budget adjustments were streamlined in the 1984 Agreement compared to the 1976 Agreement. This is consistent with the shift from detailed line item budgeting to revenue compensation.</p>
Outcomes Reporting	<p>Clause 35.1 requires the State to provide quarterly information on actual receipts and payments for hospitals and central services.</p>	<p>Clause 4.7 indicates that grant payment calculations will be based on "official data of the Commonwealth and of the State". This relates to data on the various areas of revenue loss to be compensated by the grant. Clause 13.1 requires the State to provide monthly patient utilisation data at the end of each quarter.</p>	<p>While the 1984 Agreement gave the Commonwealth some broad powers to collect statistical information, the regular reporting provisions appear much less comprehensive than the requirements of the 1976 Agreement.</p>

Table B.2 Comparison of 1976 and 1984 Agreements (significant changes) (cont.)

CONDITION	1976 WA Agreement	1984 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Outcomes Reporting</p>	<p>Clause 35.3 stipulates that actual results may also need to be reported on a monthly basis by the State "if the Commonwealth reasonably so requests".</p> <p>Clause 36.1 requires the State to provide statistics, "including listings of individual patients in recognised hospitals in a form as required by the Commonwealth".</p> <p>Clause 37.2 requires the State to provide an audit certificate covering the operating revenues and payments associated with the grant.</p>	<p>Clause 13.2 seeks annual information on bed numbers and major services offered at each hospital.</p> <p>Clause 14.1 is a broad clause committing the State to providing any statistics agreed between the federal and State health ministers. Clause 14.5 stipulates that the State must comply with "any reasonable request" for information from the Commonwealth relevant to the administration of the Agreement.</p> <p>Clause 14.2 requires the State to provide patient information on a monthly basis in computerised format. Under Clause 14.4, the Commonwealth offers to cover "reasonable costs" involved in establishing systems to collect the statistical information required.</p> <p>Clauses 15.1 to 15.2 require an annual certificate to confirm bona fide expenditure of grant funds, signed by the department head.</p>	<p>The regular data collection focused on the specific data needs for grant calculation, as opposed to the line item budgeting information gathered under the 1976 Agreement. Activity data such as bed numbers were collected annually, and the patient information collection is computerised, with the Commonwealth also offering to contribute to some of the system establishment costs.</p>
Service delivery	<p>Clause 25.2 assigns responsibility for staffing levels and staffing appointments to the States</p>	<p>No equivalent clause.</p>	<p>The 1984 Agreement presumably assumed this power rested with the State.</p>

Table B.2 Comparison of 1976 and 1984 Agreements (significant changes) (cont.)

CONDITION	1976 WA Agreement	1984 WA Agreement	Comments
Service delivery (cont.)	Clauses 38.1 to 38.8 require the State to engage medical staff on a salaried or sessional basis, or alternatively on other contractual basis as agreed between the Commonwealth and State.	No equivalent clause. The requirement for salaried or sessional arrangements and minimisation of modified fee for service contracts was downgraded (WA Govt 1983c: 27).	The policy emphasis on salaried or sessional doctor remuneration that the Commonwealth had persisted with from 1975 to 1981 was omitted from the 1984 Agreement. The Commonwealth's focus shifted to the constraint of rights of private practice.
	Clause 38.6 stipulates that in those circumstances where modified fee-for-service contracts are necessary, the payment shall not exceed "the relevant medical benefit for the time payable".	Clauses 7.1 and 7.2 require States to permit rights of private practice for medical professionals only where there is an approved agreement that complies with section 17 of the Health Insurance Act 1973 and federal government guidelines.	The 1976 Agreement sought for modified fee for service contracts to be minimised to those circumstances where it was absolute necessity and for payments to remain within the schedule fee. The 1984 Agreement however accepted rights of private practice as a reality and included powers for the Commonwealth to regulate and tightly monitor such arrangements.
	Clause 38.9 stipulates that the Commonwealth and State will "participate jointly" in wage negotiations with medical staff, with a view to "achieving uniformity between the states and territories and ultimately to establishing national machinery..."	No equivalent clause.	Unlike the Whitlam and Fraser eras, 1984 Agreement saw the Commonwealth step back from a hands-on role in wage negotiations with medical professionals. Also there were no specific commitments made to achieving greater uniformity although the need to reduce inter-state and inter-hospital variations was often mentioned by the Commonwealth in its promotion of the reforms. Ultimately the Commonwealth was unable to disconnect itself from wage negotiations at the State level, with the NSW government seeking its assistance to overcome the strong professional resistance to Clauses 7.1 and 7.2 of the 1984 Agreement.

Table B.2 Comparison of 1976 and 1984 Agreements (significant changes) (cont.)

CONDITION	1976 WA Agreement	1984 WA Agreement	Comments
Service delivery (cont.)	No equivalent clause.	Clause 6.4 stipulates that the State can enter into an agreement with a private hospital to provide universal hospital care with Clause 6.6 requiring the Commonwealth to be advised of any such arrangements.	The 1984 Agreement was more forthright about the interactions and flow on effects between the public and private hospital sectors than the 1975 and 1976 Agreements.
	Clause 43.1 stipulates that the Hospital and Allied Services Advisory Council or a National Standing Committee within that Council will "consider broad policy issues related to joint Commonwealth and State examinations of hospital expenditure ... [and] ... make recommendations with a view to improving efficiencies and achieving rationalization of hospital services".	Clause 12.5 provides for the Commonwealth and State Standing Committee to review the "development, modification and funding of health services" of interest to federal and state governments. Additionally Clause 12.10 stipulates that the Committee shall consider proposals to change or transfer financial responsibilities of the Commonwealth or State governments under the Agreement. Clause 12.13 establishes an Australian Health Services Council, a bureaucratic body to report to the Australian Health Ministers Conference. Clause 12.18 confirms that the Council shall provide advice as required on the operation of health service programs across the States; the development, modification and funding of health service programs; development of uniform financial reports and health statistics; health service priorities and objectives; and health workforce availability and training.	Intergovernmental machinery around health policy setting; financial and statistical reporting; health workforce and health service planning - were all increased in the 1984 Agreement. The Commonwealth confirmed it would seek greater interaction with the States (with a view to achieving economies) on issues such as peer and utilisation review; hospital audits; hospital accreditation; assessment of need for high technology equipment; fee restraint; and growth in public and private hospital beds (Parl Comm. 1984c; WA Govt 1983c: 28).

B.3 COMPARISON OF 1984 AND 1985 PUBLIC HOSPITAL FUNDING AGREEMENTS

Table B.3 Comparison of 1984 and 1985 Agreements (significant changes)

<i>Policy issue</i>	<i>1984 Agreement</i>	<i>1985 Amended Agreement</i>
Term of Agreement	1984–87	1984–88
Grant composition	Compensation for revenue losses.	Compensation for revenue losses and capital equipment.
Rights of Private Practice	Permitted only when an approved contract is signed between the clinician and the hospital.	All clauses relating to rights of private practice were removed.
Patient admission	An eligible inpatient deemed to be a public patient unless specifically elects to be a private patient.	A privately insured patient deemed to be a private patient unless specifically elects to be a public patient.
Scope of universal services for private patients	Universal care includes the cost of "prosthesis implanted during treatment or necessary for discharge".	Universal care <u>does not</u> include the cost of "prosthesis implanted during treatment or necessary for discharge".
Charges for private patients who are day patients	No specific recognition of day patients.	Charge to not exceed the Commonwealth's "prescribed day patient benefit".
Capital equipment funding	None provided.	State's share of the \$150 million allocated nationally. Condition that State shall continue funding capital equipment from own source revenues at the average level of expenditure incurred in 1983, 1984 and 1985. Condition that State must provide the Commonwealth with an annual expenditure plan, prepared in consultation with the AMA and the Australian Hospitals Association. A requirement to report annually to the Commonwealth on actual expenditure within three months of the year end. A requirement that capital equipment purchased under the program exceed a threshold of \$50,000 per item. Condition that the Commonwealth be given due recognition for items acquired with these funds.

B.4 COMPARISON OF 1984 & 1985 AND 1988 PUBLIC HOSPITAL FUNDING AGREEMENTS⁵⁶

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
Term of Agreement	1 February 1984 to 30 June 1988	1 July 1988 to 30 June 1993	The 1988 Agreement was signed 29 May 1989 but was deemed effective from 1 July 1988. The delay in signing indicates a lengthy negotiation process.
Review of Arrangement	Clause 1.5 stipulates that the grant arrangement will be jointly reviewed by the Commonwealth and the State to ascertain its "appropriateness".	Clause 1.5 indicates that the "Agreement may be varied from time to time by a further Agreement". Clause 1.6 states the Agreement "shall be prior to the end of the fourth grant year, jointly reviewed by the Commonwealth and the State with a view to ascertaining their appropriateness".	No major changes, both Agreements allow for a formal evaluation process around the end of the grant term.
Recognised Hospitals	Clause 3.3 indicates that the "State Pathology Laboratories shall be deemed to be a recognised hospital for the purpose of this Agreement".	The 1988 Agreement did not identify the State Pathology Laboratories as a recognised hospital.	
Universal Hospital Care Patient election	Clause 8.3 indicates that any eligible inpatient who is privately insured, will be "deemed to have elected" to be a private patient "unless he specifically elects to be a hospital (public) patient".	Clause 4.3(c) requires patients to elect as public or private patients "at the time of admission...or as soon as practicable thereafter".	Whilst the 1985 Agreement mandated that privately insured people would not be automatically entitled to universal hospital care unless they specifically elected to be (an outcome of the 1985 NSW doctors' dispute), the 1988 Agreement left the election option up to the patient. This shift is in fact a restoration of the original terms of the 1984 Agreement and so represents a reclaiming of policy ground from the medical profession to the Commonwealth.

⁵⁶ This Appendix should be reviewed in conjunction with Appendix 9.9.

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes) (cont.)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Access to services</p>	<p>Clause 6.3 requires the State to ensure universal care is "accessible as practicable to all eligible persons" and that "all eligible persons are able to elect to be private patients".</p> <p>Clause 6.4 allows the State to enter into arrangements with private hospitals to provide universal hospital care, with Clause 6.6 requiring the Commonwealth to be advised of any such arrangements.</p> <p>Clause 6.7 states "Nothing in this Agreement shall preclude the State entering into an Agreement with any other State ... in connection with the provision of hospital or other health services".</p>	<p>Clause 4.3 (a) and (b) expands on Clause 6.3 stating that where it is not possible for the State to provide the service, the State <u>will be</u> responsible for "referring or transferring the person to where the necessary care and treatment is available" and that "eligible persons are not precluded from receiving such care and treatment because of limitations on its availability at a particular recognised hospital or within its recognised hospital system".</p> <p>Clause 4.4 requires the State to advise the Commonwealth of any transfer/referral arrangements with other States or private sector.</p>	<p>Whereas the 1984/85 Agreement was a bit more subtle, the 1988 Agreement more tightly clarified the "national" nature of universal hospital care, compelling the States to ensure the availability of services either through their own service delivery systems, other State delivery systems, or the private sector.</p>
<p>Service scope</p>	<p>Clause 6.2 outlines in detail the specific services included in universal hospital care in great detail.</p> <p>Clauses 11.1 to 11.8 outline conditions relating to the funding of community health services under the Agreement.</p>	<p>Clause 4.2 outlines the services included in universal hospital care. Clause 4.3 (g) specifies that universal hospital care shall be made available to AIDS patients.</p> <p>Clause 4.5 states that "the State will continue to maintain its commitment to community health services".</p>	<p>The 1988 Agreement defined universal hospital care less broadly because this policy concept was well established by the second Agreement. Also a health policy priority at the time – AIDS, was identified separately.</p> <p>The emphasis on community health services was reduced in the 1988 Agreement, most likely replaced by the Incentives Package established to promote more day procedures, post-acute care and palliative care.</p>

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes) (cont.)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Service scope</p>	<p>Clauses 11A.1 to 11A.2 outlined terms and conditions pertaining to funding for Capital Equipment Grants (an outcome of the NSW Doctors' Dispute).</p>	<p>Clauses 5.1 to 6.5 outline an Incentives Package (project funding) aimed at encouraging the "development of specific new initiatives for day only procedures, post-acute and palliative care services". A range of conditions are specified to qualify for the funding. The key aim of the Package appears to be to: encourage more day procedures and therefore better hospital throughput and reduced waiting times; "enable earlier discharge to post-acute home care"; "provide palliative care to prevent admissions and reduce periods of hospitalisation"; and "facilitate the development and evaluation of new practices which have the potential for general adoption as normal hospital practices".</p> <p>On the latter, Clause 5.5 indicates that such projects could include "the development of cost based case mix systems" but these will be subject to "approval by the Commonwealth Minister".</p>	<p>It appears that the capital funding negotiated by the medical profession in 1985 was discarded by the Commonwealth in the 1988 Agreement.</p> <p>While there is a lower profile to 'community health services', the 1988 Agreement placed greater policy emphasis on day procedures, post-acute and palliative care services – all aimed at reducing costs - through faster and greater throughput. Nonetheless one could argue that the emphasis was fairly minor - in comparison to the \$3.042.88 billion made available for hospital care, there was \$35.67m made available for these important reforms (around 1% of total funding).</p> <p>The 1988 Agreement also encouraged the addressing of governance shortcomings in hospitals, specifically endorsing the further development of casemix funding systems, albeit in consultation with the Commonwealth.</p> <p>The 1988 Agreement had a focus on hospital managerial efficiency however funding significance was not great. The 1984 Agreement placed heavy reliance on the reform of doctors' remuneration for greater hospital efficiency. But the abandonment of this approach in the 1985 Agreement led the Commonwealth to pushing for broader reforms of clinical and governance practices. The latter involved clinicians but in a less contentious manner than the direct reform of doctors' remuneration.</p>

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes) (cont.)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Service scope</p>	<p>No equivalent clause</p>	<p>Clause 6.3 states that “the Commonwealth Minister...shall at least annually, consider for approval proposals for projects to develop cost based case mix systems”.</p> <p>Clause 6.4 states that proposals “may be received from the State and other interested persons. Proposals which impinge on State responsibilities ... will be forwarded to the State for comment”.</p> <p>Clause 6.5 specifies conditions relating to the access of project funding for casemix funding systems – including that such funding should assist in the: “development of State wide morbidity systems”; “development of hospital cost systems based on morbidity data” and development of “pilot cost based case mix systems which could be adopted by the States”.</p>	<p>The push for cost case mix funding and more evidence based hospital governance is clearly evident in Clauses 6.3 to 6.5. Clause 7.1 indicates that around \$5m may have been allocated nationally for the development of case mix funding.</p> <p>The Commonwealth encouraged investment in morbidity systems, costing systems and case mix funding. It is willing to finance pilot projects and in Clause 6.2 committed to consolidating the disseminating the outcomes back to all States (this Clause actually relates to <u>all</u> the Incentive Package projects, not just those related to the advancement of casemix funding).</p>

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes) (cont.)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
<p>Financial Provisions</p> <p>Funding formula</p>	<p>Clauses 4.1 to 4.11 detail the formulae to be used to calculate the grant. Essentially under Clause 4.1, the State is compensated for 1) "revenue losses and additional costs resulting from the removal of inpatient and outpatient fees for eligible persons who elect to be treated free"; 2) revenue losses resulting from a reduction of fees for private patients..."; and 3) "certain expenditure for other health purposes other than hospital services".</p>	<p>Clause 7.1 offers "assistance in meeting the costs" of recognised hospitals through a fixed block grant (distributed according to weighted population); and indexed annually by weighted population changes, CPI changes and shifts in the Award Rates of Pay Index for adult wage and salary earners.</p>	<p>The 1984/85 Agreement began with a revenue compensation approach and evolved into an indexed block funding grant by the end of the grant term. The nexus between funding and hospital service costs was firmly broken.</p> <p>The 1988 continued with the block grant and same indexation factors.</p>
<p>Sanctions</p>	<p>No equivalent clause.</p>	<p>Clause 7.2 sets out a range of circumstances when grants will be reduced by the Commonwealth: 1) when total public patient bed days in a State fall to lower than 53% of total patient days in both State public and private hospitals; 2) when per capita in-hospital MBS payments rise to more than 5% of national per capita in-hospital MBS payments; 3) when there is any financial advantage secured by the State at the expense of the Commonwealth as a result of not complying with the requirement to provide universal hospital care to all eligible persons; and 4) when the States do not comply with reporting requirements under the Agreement.</p>	<p>The Commonwealth took a much harsher stance with State compliance in the provision of universal hospital care and reporting requirements. The earlier controls of the 1984 Agreement around constraint of private practice and draw on the MBS were targeted specifically at the medical profession and their remuneration arrangements. With the closing off of this approach following the NSW Doctors' Dispute, the Commonwealth then reverted to even more blunt levers such as establishing minimum thresholds for public patient bed days and caps on use of in-hospital MBS. Essentially this was about containing Commonwealth expenditure whilst at the same time ensuring that universal hospital care was maintained and not discreetly scaled back by the States or medical profession.</p>

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes) (cont.)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Setting of private patient charges</p>	<p>Clause 9.2 requires private patients to be charged for accommodation costs. The charges are specified for the period to 30 June 1985 but thereafter are left "as may be determined by the State".</p>	<p>Clause 9.2 indicates that private patients, nursing home type patients, compensable patients and ineligible patients "may be charged an amount determined for those categories by the State Minister".</p> <p>Clause 9.3 specifies the scope of services to be subject to charges, and requires the State to agree any scope changes with the Commonwealth.</p> <p>Clause 9.4 allows States to charge ... [as the State Minister determines] ... eligible persons ... [other than compensable patients] ... for various services: dental, spectacles and hearing aids, pharmaceuticals, surgical supplies, prosthesis, appliances and home modifications, and any other services agreed with the Commonwealth.</p>	<p>The 1988 Agreement continued the approach commenced under the 1984 and 1985 Agreements whereby the setting of private, nursing home type and compensable patient charges is left to the discretion of the State.</p> <p>The 1988 Agreement allowed States to charge patients for a range of services provided as a part of out-patient, casualty and ED services. This appears to be a formalising of policy ground negotiated by the States progressively, through the earlier Agreements.</p>
<p>Payment of private hospital daily bed subsidies</p>	<p>Clauses 10.1 to 10.3 allow the States to assume responsibility for the payment of private hospital bed day subsidies if they choose. States are given the freedom to set the rates and conditions for such payments if such a transfer of responsibility is agreed to.</p> <p>Clause 10.4 requires the Commonwealth and State Ministers for Health to consult over the approval and categorisation of private hospitals.</p>	<p>No equivalent clauses.</p>	<p>The Commonwealth seems to have abandoned its push for greater State regulation over private hospitals, following the lack of cooperation from the States.</p>

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes) (cont.)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Setting of budgets and other collaboration</p>	<p>Clause 12.1 establishes a Commonwealth and State Standing Committee on Health Services.</p> <p>Clause 12.5 stipulates that the Committee shall make recommendations on the quantum of grants and agreed indexation factors.</p> <p>Clause 12.11 states “unless the Minister for Health and the State Minister otherwise agree in writing, any matter affecting the funding arrangements shall first be considered by the Committee”.</p> <p>Clause 12.12 states that the Commonwealth State Standing Committee may consider and make recommendations to the federal and State Ministers for Health on variations to grants due to unforeseen circumstances.</p>	<p>Clause 14.1 continues the Commonwealth State Standing Committee on Health Services.</p> <p>Clause 14.4 states that the functions of the Committee are to advise the Commonwealth and State Minister on any matters associated with, or recommended variations to, the Agreement. Additionally the Committee is to undertake any other “activities” requested of it by Ministers or the “Australian Health Ministers Advisory Council”.</p>	<p>The 1984 and 1985 Agreements allowed for a more collaborative approach in the determination of grant amounts. This was probably associated with the transitional arrangements under those grants whereby a revenue compensation grant was used initially, as the basis for determining the quantum of the eventual block funded grant. In contrast the 1988 Agreement makes no specific reference to a joint setting of grant amounts. Instead the objective of the collaborative machinery is left broad and open ended. This would seem to permit a more unilateral approach in terms of determination of Commonwealth funding.</p>
<p>Performance standards</p>	<p>Clause 12.7 requires the joint Committee to “apply principles aimed at reducing operating costs in recognised hospitals and other health services, consistent with maintaining or achieving a high standard of health care”.</p>	<p>Clause 14.5 requires the joint Committee to have “regard to the need for recognised hospitals to operate on a cost-effective basis whilst maintaining an acceptably high standard of health care”.</p>	<p>The 1984 Agreement emphasised cost constraint, whereas the 1988 Agreement is more balanced in its performance expectations, requiring ‘cost effectiveness’. The 1988 Agreement moved back to the 1976 Agreement approach with the adoption of an “acceptably” high standard of care, as opposed to the “high” standards required of the 1984 and 1985 Agreements.</p>

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes) (cont.)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
<p>Service delivery</p> <p>Reporting</p>	<p>Clause 13.1 requires the State to provide monthly patient utilisation data at the end of each quarter.</p> <p>Clause 13.2 seeks annual information on bed numbers and major services offered at each hospital.</p> <p>Clause 14.1 is a broad clause committing the State to providing any statistics agreed between the federal and State health ministers. Clause 14.5 stipulates that the State must comply with "any reasonable request" for information from the Commonwealth relevant to the administration of the Agreement.</p> <p>Clause 14.2 requires the State to provide patient information on a monthly basis in computerised format. Under Clause 14.4, the Commonwealth offers to cover "reasonable costs" involved in establishing systems to collect the statistical information required.</p> <p>Clauses 15.1 to 15.2 require an annual certificate to confirm bona fide expenditure of grant funds, signed by the relevant department head.</p>	<p>Clause 13.2 requires States to provide on a quarterly basis, data on: admissions, day admissions, outpatient services and ED services (provided in public hospitals). Also States are required to report total admissions and day admissions in private hospitals.</p> <p>Clause 13.1 states that "each party will comply with any reasonable request from the other to supply to it such information or statistics as the party requested has and which the party requesting requires for the operation of this agreement".</p> <p>Clause 13.3 requires the State to provide an annual expenditure report.</p> <p>Clause 13.4 commits the Commonwealth to providing data on in-hospital MBS payments each quarter.</p> <p>Clause 13.5 commits the Commonwealth to establish a national statistics database (with the data collected) to be accessible by all States.</p> <p>Clause 13.6 commits the State to establish a morbidity database according to ICD codes and including ALOS data.</p> <p>Clauses 11 and 12 establish annual reporting requirements around the Incentives Package funding.</p>	<p>The 1988 Agreement moved to quarterly patient utilisation reporting but as a new addition, requires States to include private hospital data. The requirement to report on bed numbers and services at each hospital has been removed. The 1988 Agreement changed the requirement for statistical information to a mutual one, whereby both States and Commonwealth are able to instigate information exchange. The exchange of MBS data is presumably to allow States to monitor the caps established in the Agreement around in-hospital MBS payments. Also the 1988 Agreement encouraged the enhancement of national datasets and formal morbidity datasets at the State level, presumably as a means of encouraging more evidence based policy setting and funding into the future.</p>

Table B.4 Comparison of 1984 & 1985 and 1988 Agreements (significant changes) (cont.)

CONDITION	1984 & 1985 WA Agreements	1988 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Link to private hospitals</p>	<p>Clause 6.4 stipulates that the State can enter into an agreement with a private hospital to provide universal hospital care.</p>	<p>Clause 4.4 permits the State to enter into arrangements with private hospitals for the “provision of care and treatment which is unavailable or cannot be provided within the recognised hospital system”.</p>	<p>The 1984 Agreement appears to be more open in terms of the use of private hospital facilities. The 1988 Agreement added a restraint that the private hospitals should be engaged only where services are unavailable or cannot be provided within the public system.</p>
	<p>Clause 12.5 provides for the Commonwealth and State Standing Committee to review the "development, modification and funding of health services" of interest to federal and state governments.</p> <p>Clause 12.10 stipulates the Committee shall consider proposals to change or transfer financial responsibilities of Commonwealth or State governments.</p> <p>Clause 12.13 establishes an Australian Health Services Council, a bureaucratic body to report to the Australian Health Ministers Conference.</p> <p>Clause 12.18 confirms that the Council shall provide advice as required on the operation of health service programs across the States; the development, modification and funding of health service programs; development of uniform financial reports and statistics; health service priorities and objectives; and health workforce availability and training.</p>	<p>No equivalent clause.</p>	<p>There were no significant additions to intergovernmental machinery in the 1988 Agreement.</p>

B.5 COMPARISON OF 1988 AND 1993 PUBLIC HOSPITAL FUNDING AGREEMENTS⁵⁷

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
Term of Agreement	1 July 1988 to 30 June 1993	1 July 1993 to 30 June 1998	Signed on 30 June 1993. Further agreement variations were agreed to in 1995-96.
Review of Arrangement	Clause 1.5 indicates that the "Agreement may be varied from time to time by a further Agreement". Clause 1.6 states the Agreement "shall be prior to the end of the fourth grant year, jointly reviewed by the Commonwealth and the State with a view to ascertaining their appropriateness".	Clause 15 deals with variation and termination of the Agreement but is silent on how the Agreement will be renegotiated at the end of its term. Catastrophe clause: Clause 16.1 commits the Commonwealth to reviewing the level of funding "in the case of substantial and unavoidable increases in costs".	The silence of the 1993 Agreement on the renegotiation process indicates that the Commonwealth's discretion in this area has been increased. The 1998 Agreement provided a safeguard for the State in the event of unusual business circumstances and abnormal rises in hospital costs.
Universal Hospital Care Medicare Principles and Commitments	No equivalent clause	Clause 3.1 outlines a number of principles for universal hospital care: <ul style="list-style-type: none"> - <u>Choices of services:</u> Eligible persons must be given the choice to receive public hospital services free of charge as public patients - <u>Universality of services:</u> Access to public hospital services to be on the basis of clinical need - <u>Equity in service provision:</u> To the maximum practicable extent, State to ensure the provision of public hospital services equitably to all eligible persons, regardless of geographical location. 	The 1993 Agreement introduced a set of Medicare principles and commitments and required this information to be formally conveyed to patients.

⁵⁷ This Appendix should be reviewed in conjunction with Appendix 9.10.

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Medicare Principles and Commitments</p>	<p>No equivalent clause</p>	<p>Clause 3.1 outlines a number of principles for universal hospital care:</p> <ul style="list-style-type: none"> - <u>Information about service provision</u>: The Commonwealth and State must make available information on the public hospital services eligible persons can expect to receive as public patients. - <u>Efficiency and quality in service provision</u>: The Commonwealth and the States are committed to making improvements in the efficiency, effectiveness and quality of hospital service delivery. <p>The Preamble to Clauses 5 to 9 also confirms that there are three key objectives in adopting a national approach to health: equity of access; standards of access and care; and global management of expenditure.</p>	
<p>Access to services</p>	<p>Clause 4.3 (a) and (b) expands on Clause 6.3 stating that where it is not possible for the State to provide the service, the State will be responsible for “referring or transferring the person to where the necessary care and treatment is available” and that “eligible persons are not precluded from receiving such care and treatment because of limitations on its availability at a particular recognised hospital or within its recognised hospital system”. Clause 4.4 requires the State to advise the Commonwealth of any transfer/referral arrangements with other States or private sector.</p>	<p>Clause 8.2 requires universal hospital care to be provided in “metropolitan and rural areas of the State consistent with acceptable clinical and health practices”.</p> <p>Also it is indicated that “where this is not possible the State accepts responsibility for referring or transferring the eligible person to where the necessary hospital services are available”.</p>	<p>The 1993 Agreement continued with the ‘national’ access to services, whereby States must transfer patients if services are not available locally.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Service scope</p>	<p>Clause 4.2 outlines the services included in universal hospital care.</p> <p>Clause 4.3 (g) specifies that universal hospital care shall be made available to AIDS patients.</p> <p>Clause 4.5 states that “the State will continue to maintain its commitment to community health services”.</p> <p>Clauses 5.1 to 6.5 outline an Incentives Package (project funding) aimed at encouraging the “development of specific new initiatives for day only procedures, post-acute and palliative care services”. A range of conditions are specified to qualify for the funding. The key aim of the Package appears to be to: encourage more day procedures and therefore better hospital throughput and reduced waiting times; “enable earlier discharge to post-acute home care”; “provide palliative care to prevent admissions and reduce periods of hospitalisation”; and “facilitate the development and evaluation of new practices which have the potential for general adoption as normal hospital practices”.</p> <p>On the latter, Clause 5.5 indicates that such projects could include “the development of cost based case mix systems” but these will be subject to “approval by the Commonwealth Minister”.</p>	<p>Clause 8 outlines the State’s requirement to provide universal hospital, out-patient and emergency care.</p> <p>Schedule G outlines details of funding for AIDS; day surgery; post-acute care; and palliative care.</p>	<p>In the 1993 Agreement, the Commonwealth continued to encourage greater efficiency and effectiveness of hospital services by maintaining funding for day surgery; post-acute care; and palliative care ... AIDS funding is also continued.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Mental health reform</p>	<p>No equivalent clause</p>	<p>Outlined at Schedule F (1993-94 and 1994-95) and Schedule F1 (1995-96, 1996-97 and 1997-98).</p> <p>Schedule F outlines funding for mental health reform to be distributed on a per capita basis. Schedule F is less prescriptive than Schedule F1, with the State required to submit an annual strategic plan consistent with the national mental health policy and identifying specific reforms. There is also a small amount of funding available for “projects of national significance” that will enhance innovation and acceleration of mental health reform. This funding is available subject to Commonwealth endorsement of a project plan. Also the State commits to annual reporting, cooperating in the development of performance indicators and ‘maintenance of effort’.</p> <p>Schedule F1 continues with base and project funding and adds a new funding pool which is subject to the State meeting performance targets. Also requirements for annual reporting, cooperating in the development of performance indicators ‘maintenance of funding effort’ are retained.</p>	<p>The 1993 Agreement put a policy focus on mental health and the structural reform of mental health service delivery. Also emphasis was placed on the development of mental health datasets and national performance framework. In the last three years of the Agreement the Commonwealth moved to allocate part of the funding on the basis of State achievement of performance targets.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Potential transfer of outpatient services</p>	<p>No equivalent clause.</p>	<p>Clause 9.3 (c) require the Commonwealth and State to “consider the possible transfer of functional responsibility for aspects of outpatient services to the Commonwealth”. The requirement is linked to Clause 9.3 (a) which is concerned with the interface between the hospital sector and MBS and PBS, and the potential for cost-shifting.</p>	<p>Clause 9.3 is an example of the additional focus placed on ‘cost shifting’ in the 1993 Agreement. The Commonwealth sought to absorb outpatient services into its functional role, so as to prevent this service area from being used to shift costs to the Commonwealth.</p>
<p>National agenda setting</p>	<p>No equivalent clause.</p>	<p>Clause 7 outlines the Commonwealth’s commitment to play a “leading and coordinating role” in development of national health policy in partnership with the States. Under Clause 4.4 of Schedule E, the Commonwealth indicates it will have a national role in disseminating information about Commonwealth-funded projects funded under the Incentives Package. Further the States are required to “encourage Commonwealth funded participation in relevant conferences, workshops and other forums”.</p>	<p>The 1993 Agreement increased the agenda setting role of the Commonwealth in terms of hospital micro-efficiency improvements, and cross-jurisdictional learning and information sharing.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Financial Provisions</p> <p>Funding formula</p>	<p>Clause 7.1 offers “assistance in meeting the costs” of recognised hospitals through a fixed block grant (distributed according to weighted population); and indexed annually by weighted population changes, CPI changes and shifts in the Award Rates of Pay Index for adult wage and salary earners.</p>	<p>Clause 5.1 outlines the key funding components of the Agreement:</p> <ul style="list-style-type: none"> - “assisting the State in meeting the costs of providing public hospital services (the base grant)” - Bonus payments aimed at improving public hospital service access - Incentive payments to encourage more effective provision of health services - “assisting the State to meet the costs of reforming mental health services” - “assisting the State in meeting the costs of providing other nominated health services subject to agreed outcomes measures”. <p>Detailed funding formulae are set out in Schedules C, D, E, F and G of the Agreement.</p> <p>Indexation factors used are CPI and Award Rates of Pay index as per the 1988 Agreement.</p>	<p>The 1993 Agreement involved a considerable increase in the detail and complexity of funding formulae. Formulae are outlined at Schedules C D (applicable for 1993-94 and 1994-95), and D1 (applicable for 1995-96, 1996-97 and 1997-98).</p> <p>Over the first two years, the 1993 Agreement included Bonus Pool funding which rewarded States that maintained or increased their share of public bed days and penalised States where the share of public bed days fell. Such penalties were redistributed to other States as reward payments.</p> <p>Over the last three years, the 1993 Agreement included Bonus Pool funding of which part of distributed across the States by weighted population and of which part is distributed according to State meeting of established performance targets. Performance targets related to admitted public patient activity, elective surgery wait times and emergency department wait times.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
Financial Provisions (cont.) Funding formula			The operation of the bonus pools is more subdued in the last three years, with for example Clause 5.8 requiring the Commonwealth to take into account whether there were reasonable causes for the non-meeting of performance targets by the State; and Clauses 5.11 and 6.3 which committed the Commonwealth to reinvest any unallocated State funds towards national projects which benefit the State.
Broadbanding	No equivalent clause.	Clause 9.3 (e) requires the Commonwealth and States to “examine Health Specific Purpose Payments with a view to broadbanding on or after 1 July 1994. This would include the development of agreed outcome-based accountability measures”.	The 1993 Agreement put forward an option to broadband the different health tied grants, this appears to have been a policy response designed to satisfy State concerns as to the expanding number of tied grants.
“Catastrophe Clause”	No equivalent clause.	Clause 16.1 commits the Commonwealth to reviewing the level of funding “in the case of substantial and unavoidable increases in costs...(for example)...due to acts of nature or availability of new treatments where there are very substantial costs of provision because of the volume of treatments to be provided or the very high costs of individual treatment”.	The 1993 Agreement included an additional safeguard clause for the States to provide for unusual business circumstances which cause abnormal rises in hospital costs.
Link to Private Health Insurance Rates	No equivalent clause	Clauses 16.2 and 16.3 indicate that the Commonwealth will review its funding levels “whenever the percentage of the national population who at 30 June 1993 are covered by a supplementary hospital table falls by at least 2 percentage points or a multiple thereof...”	The 1993 Agreement formally recognised the flow on effects to the State hospital system as a result of changes in private health insurance coverage rates.

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
Financial Provisions (cont.) Sanctions	<p>Clause 7.2 sets out a range of circumstances when grants will be reduced by the Commonwealth: 1) when total public patient bed days in a State fall to lower than 53% of total patient days in both State public and private hospitals; 2) when per capita in-hospital MBS payments rise to more than 5% of national per capita in-hospital MBS payments; 3) when there is any financial advantage secured by the State at the expense of the Commonwealth as a result of not complying with the requirement to provide universal hospital care to all eligible persons; and 4) when the States do not comply with reporting requirements under the Agreement.</p>	<p>Schedule C Clause 2.3 indicates that the base grant will be reduced if “the level of Commonwealth ... MBS ... expenditure paid in the relevant grant year...is greater than the national average MBS per capita expenditure multiplied by 1.11”.</p> <p>Clause 8 of Schedule E relating to the Incentives Package funding indicates that should a State “not comply with the agreed processes and undertakings set out....the Commonwealth may withdraw or withhold payments under this Agreement in part or in full.”</p> <p>Clause 12.5 indicates that the Commonwealth has a right to reduce grant funding “in the event that the State does not provide the kinds of data required ... [in terms of statistics and reporting requirements] ... within the times required or agreed”.</p>	<p>Similar to the 1988 Agreement, the 1993 Agreement penalised the State when MBS payments exceeded a defined threshold. The scope of MBS payments was however no longer just in-hospital MBS payments but state-wide MBS payments. Also the national average threshold was modified for the 1993 Agreement.</p> <p>Further, in the 1993 Agreement, the Commonwealth took a harsher stance in terms of its push to improve hospital micro-efficiency. Not only were there more prescriptive requirements outlined for the micro-efficiency reforms compared to the 1984 Agreement, there was also a greater emphasis on possible sanctions for those States who did not comply with the requirements.</p> <p>The 1993 Agreement continued with the 1988 Agreement of potential grant sanctions for States who did not meet statistics and other reporting requirements.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Setting of private patient charges</p>	<p>Clause 9.2 indicates that private patients, nursing home type patients, compensable patients and ineligible patients “may be charged an amount determined for those categories by the State Minister”.</p> <p>Clause 9.3 specifies the scope of services to be subject to charges, and requires the State to agree any scope changes with the Commonwealth.</p> <p>Clause 9.4 allows States to charge ... [as the State Minister determines] ... eligible persons ... [other than compensable patients] ... for various services: dental, spectacles and hearing aids, pharmaceuticals, surgical supplies, prosthesis, appliances and home modifications, and any other services agreed with the Commonwealth.</p>	<p>Clauses 10.2 and 10.3 permit the States to charge private patients fees “as determined as prescribed under the relevant State statute”. Also States are permitted to charge private patients, private nursing home type patients, compensable patients and ineligible persons fees for “professional services (including diagnostic services), dental services, prostheses and such other services as may be agreed between the Commonwealth and State Minister”.</p> <p>Clause 8.9 (f) requires the State to ensure that “aftercare services for public patients and outpatient and accident and emergency services do not attract claims for Medicare benefits”.</p> <p>Clause 8.9 (g) requires the State to ensure that “except in an emergency, a recognised hospital does not issue a prescription to an inpatient on discharge, an outpatient or an accident and emergency patient that would attract” PBS benefits.</p>	<p>The 1993 Agreement continued the approach of the 1988 Agreement whereby the setting of private, nursing home type and compensable patient charges was largely left to the discretion of the State. Clause 8.9 (f) and (g) are examples of the added emphasis on ‘cost shifting’ apparent in the 1993 Agreement.</p>
<p>Cross-border patient flows</p>	<p>No equivalent clauses.</p>	<p>Clause 7.1 (d) commits the Commonwealth to working with the States to develop better methods of accounting for inter-jurisdictional patient flows. Clauses 7.2 and 7.3 also establish the Commonwealth as an adjudicator in the event of inter-jurisdictional disputes.</p> <p>Clause 8.4 sets out suggested processes for negotiating funding adjustments for cross-border patient flows.</p>	<p>The Commonwealth assumed a coordinating and leadership role in accounting for cross-border patient flows.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
Financial Provisions (cont.) Setting of budgets and other collaboration	<p>Clause 14.1 continues the Commonwealth State Standing Committee on Health Services.</p> <p>Clause 14.4 states that the functions of the Committee are to advise the Commonwealth and State Minister on any matters associated with, or recommended variations to, the Agreement. Additionally the Committee is to undertake any other “activities” requested of it by Ministers or the “Australian Health Ministers Advisory Council”.</p>	<p>Clause 11 provides for the establishment of a “consultative body or consultative bodies as the need arises to consider matters relating to this Agreement”.</p>	<p>The 1993 Agreement made no specific reference to the Standing Committee on Health Services which featured in the 1984 and 1988 Agreements. Instead the issue of a ‘consultative body’ is left open and to be determined as the need arises.</p> <p>This change however does need to be considered alongside Schedule E Clause 2 which establishes a State Strategic Planning Group with Commonwealth and State representation.</p>
Performance standards	<p>Clause 14.5 requires the joint Committee to have “regard to the need for recognised hospitals to operate on a cost-effective basis whilst maintaining an acceptably high standard of health care”.</p>	<p>Clause 9.3 (b) requires the Commonwealth and State to “clarify links between different service providers and explore the desirability of establishing national guidelines for appropriate levels of access for outpatient services”.</p>	<p>The 1993 Agreement opened the possibility for greater standardisation of access to outpatient services across States. The 1988 Agreement clauses around required standards of health care and the cost effectiveness of care were replaced by the Medicare Principles and Commitments in the 1993 Agreement.</p>
Service delivery Matching State legislation	<p>No equivalent clause</p>	<p>Clause 3.2 requires the State to either adopt the above principles as service delivery guidelines, or “to make reasonable efforts to” enact “legislation by that date”. Reasonable effort is defined as “the introduction of a Bill the aim of which is to establish the Medicare Principles and Commitments as guidelines”.</p>	<p>The 1993 Agreement extended the Commonwealth’s reach by requiring States to incorporate universal hospital care into State legislation and guidelines.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
Service delivery (cont.) Patient Charter and Independent Complaints Body	No equivalent clause	Clause 4 requires the State to establish a Public Patients' Hospital Charter in consultation with the Commonwealth and a Complaints Body that is "independent of the State's hospitals and the State's Department of Health" and has a role "in recommending improvements in the delivery of hospital services in respect of which the Commonwealth provides financial assistance".	The 1993 Agreement extended the Commonwealth's policy reach by requiring States to establish a Public Patients Charter and a Complaints Body. The 1993 Agreement ensured that defined standards of universal hospital care were firmly embedded into the State's policy framework and into community expectations.
Patient election	Clause 4.3(c) requires patients to elect as public or private patients "at the time of admission...or as soon as practicable thereafter".	Clause 8.5 requires the States to ensure that "an eligible person, at the time of admission to a recognised hospital or as soon as practicable thereafter elects or confirms whether he or she wishes to be treated as a public patient or a private patient using a standard set of questions to be agreed between the Commonwealth and the State". Clause 8.5 also requires that the "eligible person is informed of the consequences of electing to be treated as a public patient and not as a private patient or vice versa.	The 1993 Agreement allowed patient election to be determined by the patient (as opposed to defaulting to a specific status as per the 1985 Agreement). However the 1993 Agreement increased Commonwealth influence by requiring that patient election forms be designed with the involvement of the Commonwealth. Hence the Commonwealth appears to have secured back some policy space foregone in the 1988 Agreement.
Link to private hospitals	Clause 4.4 permits the State to enter into arrangements with private hospitals for the "provision of care and treatment which is unavailable or cannot be provided within the recognised hospital system".	Clause 8.3 allows States to enter into arrangements with private hospitals or other States for hospital services, with States required to advise the Commonwealth of such arrangements.	The 1993 Agreement continued the 1988 Agreement provision enabling States to enter into arrangements with the private sector or other States.

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Casemix development and other hospital governance reform</p>	<p>Clause 6.3 states that “the Commonwealth Minister...shall at least annually, consider for approval proposals for projects to develop cost based case mix systems”.</p> <p>Clause 6.4 states that proposals “may be received from the State and other interested persons. Proposals which impinge on State responsibilities ... will be forwarded to the State for comment”.</p> <p>Clause 6.5 specifies conditions relating to the access of project funding for casemix funding systems – including that such funding should assist in the: “development of State wide morbidity systems”; “development of hospital cost systems based on morbidity data” and development of “pilot cost based case mix systems which could be adopted by the States”.</p>	<p>Clause 7 provides for Commonwealth involvement in a range of improvement projects in the areas of: Area Health Management; Hospital Access (elective surgery) Program; Devolution of Clinical Budgets; Strategic Capital Planning of Hospital Infrastructure; National Quality Assurance Program; Health Communication Network (telehealth); and Casemix Development.</p> <p>Schedule E Clause 2 indicates that a “State Strategic Planning Group” be established on which the Commonwealth is to be represented. Clause 4.1 provides for national coordination of state strategic planning. Clause 5.1 indicates that strategic plan initiatives that are funded by the Commonwealth are on a year- to-year basis only, with the Commonwealth having annual discretion to cease funding if deemed necessary.</p> <p>Schedule E Clauses 2.3 and 2.4 indicate that planning for mental health reform and casemix development be undertaken with reference to AHMAC (who is overseeing the implementation of the National Mental Health Plan) and the Casemix Project Board who is overseeing casemix development at a national level.</p>	<p>The Commonwealth expanded its reach into the improvement of micro-efficiency within hospitals in the 1993 Agreement, compared to the 1988 Agreement.</p> <p>Whereas in the 1988 Agreement, its influence was implemented through the review and control of project funding, the 1993 Agreement allowed for the Commonwealth to be represented on a State-level Planning Group which implies a more direct, and frequent means of policy and serviced influence.</p> <p>The Commonwealth also appears to have flexed its financial muscle through the one-year limited funding of strategic plan initiatives, leaving States at the mercy of the Commonwealth in terms of the ongoing continuity of these projects. This funding uncertainty is likely to have been detrimental to the strategic planning of improvement projects which had a medium or long term focus.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Casemix development and other hospital governance reform (cont.)</p>	<p>Clause 13.5 commits the Commonwealth to establish a national statistics database (with the data collected) to be accessible by all States.</p> <p>Clause 13.6 commits the State to establish a morbidity database according to ICD codes and including ALOS data.</p>	<p>Clause 7.1 (c) commits the Commonwealth to maintaining a national statistical register.</p> <p>Clause 7.1 (h) commits the Commonwealth to provide a “leading and coordinating role in the evaluation of the performance of the Commonwealth and the State on matters covered by this Agreement including the development of performance indicators...”</p> <p>Clause 6 and 7 of Schedule E sets out specific reform requirements. States are required for example to:</p> <ul style="list-style-type: none"> - “move towards funding and management of health service provision on the basis of the assessed health needs of the populations in discrete geographical areas”; - “move progressively to standardised definitions and information systems to allow consistent and comparative reporting on a population’s health status and hospital products and costs”; - “move progressively toward hospital funding arrangements that promote efficiency and micro-economic reform”; - “reform the management of elective surgery booking systems” and provide “nationally consistent and comparable data on waiting lists and waiting times”; - refine “current capital management...processes, with the aim of ...utilising (these) in the most cost effective manner”. 	<p>The Commonwealth continued to play a national coordinating role in the improvement of health data and national performance evaluation. The 1993 Agreement saw a major increase in Commonwealth involvement in State resource allocation approaches; elective surgery management and capital planning. This appears to be a return to the intrusive approach of the Fraser government, however this time it is ‘governance capacity’ that is the focus of the Commonwealth, as opposed to the predominantly input-based budgets focus of the Fraser government.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Service Integration</p>	<p>No equivalent clause</p>	<p>Clause 7.1 (e) commits the Commonwealth to “work together with the State to ensure that the Commonwealth and State health and related care programs are complimentary”. Further Clause 7.1 (g) commits the Commonwealth to “ensure that the MBS and the PBS or alternative mechanisms assist access to appropriate technology and medical practice”.</p>	<p>The 1993 Agreement more formally recognised the need for better integration between Commonwealth-provided health services and public hospital services.</p>
<p>Reporting</p>	<p>Clause 13.2 requires States to provide on a quarterly basis, data on: admissions, day admissions, outpatient services and ED services (provided in public hospitals). Also States are required to report total admissions and day admissions in private hospitals.</p> <p>Clause 13.1 states that “each party will comply with any reasonable request from the other to supply to it such information or statistics as the party requested has and which the party requesting requires for the operation of this agreement”.</p> <p>Clause 13.3 requires the State to provide an annual expenditure report</p>	<p>Clauses 12.2, 12.3 and Schedule J outline regular reporting requirements. The quarterly reporting of the 1988 Agreement is continued, with bed-day statistics sought in addition to admission statistics. Further, there are data requirements specific to assist with the development of a national casemix system. States are also required to provide data on waiting lists. Under Schedules H and I, the State commits to providing a range of data and cooperating with the Commonwealth, to establish national health outcome indicators to measure access, equity, quality, and efficiency. On the latter, a five year timetable is outlined.</p>	<p>The 1993 Agreement extended reporting requirements on the State. There appears to be a focus on developing outcomes based performance measures and national health goals and targets in the 1993 Agreement. The Commonwealth created policy momentum around improved health datasets and outcomes based accountability.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Reporting (cont.)</p>	<p>Clause 13.4 commits the Commonwealth to providing data on in-hospital MBS payments each quarter.</p> <p>Clause 13.5 commits the Commonwealth to establish a national statistics database (with the data collected) to be accessible by all States.</p> <p>Clause 13.6 commits the State to establish a morbidity database according to ICD codes and including ALOS data.</p> <p>Clauses 11 and 12 establish annual reporting requirements around the Incentives Package funding.</p>	<p>Clauses 12.4 and 12.5 require the State to provide expenditure and activity estimates by 31 March each year and updates, within one month of the State Budget.</p> <p>Clauses 12.4 and 13.1 require annual reports to be provided to the Commonwealth on expenditure and activity.</p> <p>Clause 13.3 requires the State to incorporate its Commonwealth reporting in its agency annual reports tabled in the State Parliament.</p> <p>Clause 12.1, similar to Clause 13.1 of the 1988 Agreement requires the Commonwealth and States to mutually comply with any reasonable requests for statistics and information.</p> <p>Clause 8.7 requires the State to “cooperate in monitoring and reporting on progress towards national health goals and targets”.</p> <p>Clause 8.8 requires the States to “actively participate in the development and implementation of health outcome indicators and measures”.</p> <p>Clause 8.9 (c) requires the State to “contribute to the development of outcomes based accountability”.</p> <p>Clause 8.9 (h) requires the State to “actively participate in the evaluation of the performance of the Commonwealth and the State under this Agreement”.</p>	<p>Some of the reporting additions are likely to have been desired also by the State, for example the additional information requirements associated with national casemix development and also outcome based accountability.</p> <p>But there are some additional requirements, for example the commitment to table Commonwealth reporting in State Parliament and the requirement to report expenditure estimates before and after the State Budget that are likely to have created administrative impost on the State.</p>

Table B.5 Comparison of 1988 and 1993 Agreements (significant changes) (cont.)

CONDITION	1988 WA Agreement	1993 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Reporting (cont.)</p>		<p>Clause 9.3 (a) require the State to work with the Commonwealth to establish “uniform data bases on out-patient services that will address access and equity issues and also issues concerned with the interface of the ... [MBS and PBS] ...with the hospital sector and cost-shifting”.</p> <p>Schedule E Clause 4 and 5 outline reporting requirements for the Incentives Package funding component of the grant. The States must provide “comprehensive annual reports to the ... [State Strategic Planning Group] ... quarterly financial reports and quarterly project progress reports consistent with sound structured project management principles. The content and format of these reports will be as agreed between the Commonwealth and the State. In general, reporting requirements will be the minimum consistent with effective management and accountability at both Commonwealth and State levels”.</p>	<p>Although there is a continuation of a 1988 commitment for both Commonwealth and States to exchange and share information, the 1993 Agreement does not include a specific commitment for the Commonwealth to share MBS data with the State. Replacing this perhaps is a requirement that the Commonwealth and States work together on improving outpatient datasets and better understanding the interface between MBS, PBS and hospital outpatient services. In this regard, there is an added emphasis in the Agreement on the notion of ‘cost-shifting’. There appears to be an increase in reporting prescription around the Incentives Funding in the 1993 Agreement. Nonetheless, there is recognition of the efficiency impact, with the Agreement stipulating that reporting requirements shall be shaped jointly by the Commonwealth and States and shall be minimised.</p>

B.6 COMPARISON OF 1993 AND 1998 PUBLIC HOSPITAL FUNDING AGREEMENTS⁵⁸

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
Term of Agreement	1 July 1993 to 30 June 1998	1 July 1998 to 30 June 2003	
Review of Arrangement	<p>Clause 15 deals with variation and termination of the Agreement but is silent on how the Agreement will be renegotiated at the end of its term.</p> <p>Catastrophe clause: Clause 16.1 commits the Commonwealth to reviewing the level of funding “in the case of substantial and unavoidable increases in costs ... [for example] ... due to acts of nature or availability of new treatments where there are very substantial costs of provision because of the volume of treatments to be provided or the very high costs of individual treatment”.</p>	<p>Clause 8 stipulates that the Agreement may be varied or terminated. The ‘catastrophe clause’ negotiated in the 1993 Agreement is continued.</p>	<p>The 1998 Agreement continued to provide a safeguard for the State in the event of unusual business circumstances and abnormal rises in hospital costs.</p>
	No equivalent clause.	<p>Clauses 9 -12 stipulate that where there is a “substantial breach of a term of the Agreement” or “evidence of adverse financial impact arising from a change in any health services policy ... of such a magnitude as to warrant a variation in financial assistance”, the parties have 3 months to resolve the dispute, after which it will be referred to an “independent person”. The “independent person” can be nominated by either party, or if no agreement reached within 8 weeks, is appointed by Productivity Commission.</p>	<p>The new clauses appear to protect the States from unilateral decision making by the Commonwealth on the size of the grant. Presumably the involvement of an “independent person” is intended to reduce State funding uncertainty and the Commonwealth’s fiscal leverage over the States.</p>

⁵⁸ This Appendix should be reviewed in conjunction with Appendix 9.11.

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
Review of Arrangement (cont.)	No equivalent clause.	The independent person is responsible for identifying a dispute resolution. The Commonwealth is not permitted to “reduce the amount of financial assistance” unless there is prior agreement with WA or where the independent person adjudicates this as reasonable.	
<p>Universal Hospital Care</p> <p>Medicare Principles and Commitments</p>	<p>Clause 3.1 outlines a number of principles for universal hospital care:</p> <ul style="list-style-type: none"> - <u>Choices of services:</u> Eligible persons must be given the choice to receive public hospital services free of charge as public patients. - <u>Universality of services:</u> Access to public hospital services is to be on the basis of clinical need. - <u>Equity in service provision:</u> To the maximum practicable extent, a State will ensure the provision of public hospital services equitably to all eligible persons, regardless of their geographical location. - <u>Information about service provision:</u> The Commonwealth and a State must make available information on the public hospital services eligible persons can expect to receive as public patients. 	<p>Under Clause 13, the “Medicare Principles and Commitments” were replaced by three “principles”:</p> <ul style="list-style-type: none"> - “Eligible persons must be given the choice to receive public hospital services free of charge as public patients. - Access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period. - Eligible persons should have equitable access to public hospital services, regardless of their geographical location”. 	<p>The Choice of Service and Equity in Service Provision principles are unchanged. The Information about Service Provision and Efficiency and Quality principles were omitted in the 1998 Agreement. The Universality of Services principle was expanded, such that services are not only to be provided by States on the basis of clinical need, <i>but also within clinically appropriate timeframes</i>. Admittedly however, Clause 13 does permit the WA Government to meet these principles to the “greatest extent practicable”, this acting to water down the expectations around clinically appropriate timeframes.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Medicare Principles and Commitments</p>	<p>Clause 3.1 outlines a number of principles for universal hospital care:</p> <ul style="list-style-type: none"> - <u>Efficiency and quality in service provision</u>: The Commonwealth and the States are committed to making improvements in the efficiency, effectiveness and quality of hospital service delivery. <p>The Preamble to Clauses 5 to 9 also confirms that there are three key objectives in adopting a national approach to health: equity of access; standards of access and care; and global management of expenditure.</p>	<p>The “Medicare Principles and Commitments” were replaced by three broad “principles”:</p> <ul style="list-style-type: none"> - “Eligible persons must be given the choice to receive public hospital services free of charge as public patients. - Access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period. - Eligible persons should have equitable access to public hospital services, regardless of their geographical location”. 	<p>Although the Information about Service Provision and the Efficiency and Quality principles were omitted, there are still references made in the 1998 Agreement to these features:</p> <ul style="list-style-type: none"> - The Preamble to the Agreement mentions that the Commonwealth and State will “strive for continuous improvement in State funded health services” and develop reforms and improvements across “mental health and palliative care services”. - Clause 14 confirms that National Health Policy will be founded on four key issues: equity of access, standards of access and care, patient outcomes and cost effective use of health resources. - Clause 18 commits the Commonwealth and State to “sharing...information to gain a better understanding of the changing dynamics of the Australian health system”.
<p>Access to services</p>	<p>Clause 8.2 requires universal hospital care to be provided in “metropolitan and rural areas of the State consistent with acceptable clinical and health practices”.</p> <p>Also it is indicated that “where this is not possible the State accepts responsibility for referring or transferring the eligible person to where the necessary hospital services are available”.</p>	<p>No equivalent clause.</p>	<p>These specifics are covered under the broad principles of the 1998 Agreement. With universal hospital care now firmly embedded into the health policy environment, it was probably unnecessary to continue prescribing these policy details.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Service scope and national agenda setting</p>	<p>Clause 8 outlines the State’s requirement to provide universal hospital, out-patient and emergency care. Schedule G outlines details of funding for AIDS; day surgery; post-acute care; and palliative care.</p> <p>Clause 7 outlines the Commonwealth’s commitment to play a “leading and coordinating role” in development of national health policy in partnership with the States.</p> <p>Under Clause 4.4 of Schedule E, the Commonwealth indicates it will have a national role in disseminating information about Commonwealth-funded projects funded under the Incentives Package. Further the States are required to “encourage Commonwealth funded participation in relevant conferences, workshops and other forums”.</p>	<p>Clause 18 commits the Commonwealth and State to work together to implement the “Second National Mental Health Plan”; and an agreed “National Palliative Care Strategy”. Further, both parties commit to an Agreement implementation that is consistent with the “Aboriginal and Torres Strait Islander Health Framework Agreement”.</p> <p>The States are also committed to “participate in a forum convened by the Commonwealth to advise on overall directions for the Casemix program”.</p>	<p>The 1998 Agreement continued a policy focus on mental health, casemix funding and palliative care, commenced in the previous two Agreements.</p> <p>There are also more references made to established policy frameworks, this presumably being a reflection of a more advanced health policy making environment.</p>
<p>Potential transfer of outpatient services</p>	<p>Clause 9.3 (c) require the Commonwealth and State to “consider the possible transfer of functional responsibility for aspects of outpatient services to the Commonwealth”. The requirement is linked to Clause 9.3 (a) which is concerned with the interface between the hospital sector and MBS and PBS, and the potential for cost-shifting.</p>	<p>No equivalent clause.</p>	<p>This policy option was dropped in the 1998 Agreement.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Mental health reform</p>	<p>Outlined at Schedule F (1993-94 and 1994-95) and Schedule F1 (1995-96, 1996-97 and 1997-98).</p> <p>Schedule F outlines funding for mental health reform to be distributed on a per capita basis. Schedule F is less prescriptive than Schedule F1, with the State required to submit an annual strategic plan consistent with the national mental health policy and identifying specific reforms. There is also a small amount of funding available for “projects of national significance” that will enhance innovation and acceleration of mental health reform. This funding is available subject to Commonwealth endorsement of a project plan. Also the State commits to annual reporting, cooperating in the development of performance indicators and ‘maintenance of effort’.</p> <p>Schedule F1 continues with base and project funding and adds a new funding pool which is subject to the State meeting performance targets. Also requirements for annual reporting, cooperating in the development of performance indicators ‘maintenance of funding effort’ are retained.</p>	<p>Outlined at Schedule B of the Agreement.</p> <p>The Schedule, consistent with the National Mental Health Strategy provides for a “cooperative approach to mental health reform” across specific ‘action’ areas.</p> <p>Clause 6 and 7 of the Schedule commit the State to the joint development of performance measures and targets, and collection of various datasets.</p> <p>Clause 8 of the Agreement also requires the State to commit “a separate program budget for mental health services covering relevant services provided in public hospitals, psychiatric hospitals and the community”.</p> <p>Schedule B Clause 9 requires ‘maintenance of effort’ such that grant funds are not to be used to effect a reduction in the State’s mental health funding.</p> <p>Clause 10 requires the State to “maintain a mental health consumer advisory group” to provide “open and independent advice” to the State Minister and State line agency “on mental health issues”.</p>	<p>The 1998 Agreement built on the platform established in the 1993 Agreement to increase policy focus and effort on mental health services and the structural reform of mental health service delivery.</p> <p>There was also ongoing attention on the development of mental health datasets and a national performance framework including measures and targets in the areas of: “promotion and prevention; partnerships in service reform and delivery; and quality and effectiveness”.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Universal Hospital Care (cont.)</p> <p>Cost-shifting</p>	No equivalent clause.	<p>Clause 19 commits both parties to avoid arrangements which “unreasonably impose an additional financial burden on the other party.”</p> <p>Additionally, Clause 19 notes that “where it can be demonstrated that a change in service delivery arrangements would improve patient care or patient outcomes, the Commonwealth and WA undertake to implement such changes and modify responsibilities by agreement”.</p>	<p>The 1998 Agreement sought to prevent deliberate cost-shifting. Clause 19 appears to be a consolidation of similar, numerous references in the 1993 Agreement which had an increased emphasis on ‘cost-shifting’ when compared to earlier Agreements. The 1998 Agreement also recognised some of the complexities of ‘cost-shifting’. The second part of Clause 19 recognises that in acting to restrain or prevent cost-shifting, it is equally important that the Commonwealth and State do not create disincentives to the implementation of more effective health solutions.</p>
Private health insurance	No equivalent clause.	<p>Clause 50 and 51 allow for funding adjustments “in recognition of the relationship between the costs of public hospital services and levels of private health insurance”.</p> <p>It is estimated also, that on the basis of a number of assumptions, “a 1% national uniform fall in private health insurance will provide approximately \$82 million in additional funding nationally”.</p> <p>Further, the Agreement confirms there will be no reductions in grant funding as a result of increases in private health insurance, beyond certain defined thresholds. Clause 52 commits the Commonwealth and WA to “explore the relationship between private health insurance participation and utilisation of hospital services as a private patient.”</p>	<p>The 1998 Agreement was much more acknowledging of the flow-on effects of changes in private health insurance rates and public hospital utilisation.</p> <p>This may be reflective of a more informed or cooperative Commonwealth, or perhaps a more sophisticated health policy setting environment. It is possibly also a reflection of the fact that universal hospital care was now well established within the community.</p> <p>In earlier Agreements, such as the 1975 Agreement, the Commonwealth was more reluctant to make mention of private health insurance, in the interests of ensuring the profile and priority of its universal hospital goal.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Financial Provisions</p> <p>Funding formula</p>	<p>Clause 5.1 outlines the key funding components of the Agreement:</p> <ul style="list-style-type: none"> - “assisting the State in meeting the costs of providing public hospital services (the base grant)” - Bonus payments aimed at improving public hospital service access - Incentive payments to encourage more effective provision of health services - “assisting the State to meet the costs of reforming mental health services” - “assisting the State in meeting the costs of providing other nominated health services subject to agreed outcomes measures”. <p>Detailed funding formulae are set out in Schedules C, D, E, F and G of the Agreement.</p> <p>Indexation factors used are CPI and Award Rates of Pay index as per the 1988 Agreement.</p> <p>Clauses 16.2 and 16.3 indicate that the Commonwealth will review its funding levels “whenever the percentage of the national population who at 30 June 1993 are covered by a supplementary hospital table falls by at least 2 percentage points or a multiple thereof...”</p>	<p>Part 6 and Schedule E of the Agreement outlines the funding provisions. A flat amount is stipulated as a “Base Health Care Grant”; a “Health Care Grant Adjustment”; and quarantined grants for mental health, palliative care, casemix and quality improvement. There is also a quarantined amount made available from the National Health Development Fund to be linked to specific projects.</p> <p>Two indices were stipulated – one for the “Base Grant” and the other for the specific grant components.</p> <p>Index A increased the “Base Grant” annually by changes in WA’s weighted population; “movement in the hospital output cost index”; and an “utilisation growth factor of 1.021”.</p> <p>Clause 37 indicates that the “utilisation growth factor” will take into account changes in private health insurance coverage and demand growth.</p> <p>Index B increased the specific grant components annually by changes in WA’s weighted population; and “movement in the hospital output cost index”.</p>	<p>The 1993 Agreement involved a considerable increase in the detail and complexity of funding formulae. While this was simplified in the later years of the Agreement, funding remained attached to Bonus Pools and performance targets.</p> <p>In comparison, the 1998 Agreement reverts to a simple base grant and several specific or identified grants.</p> <p>The 1993 Agreement attempted to recognise the flow-on effects of changing private health insurance coverage through the 2% review and <i>possible</i> grant adjustments.</p> <p>On the other hand the 1998 Agreement provided more funding certainty for the States in this regard – tying the annual hospital grant index to an ‘utilisation growth factor’ that more directly incorporated the financial effect of changes in private health insurance coverage and demand growth.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Funding formula</p>	<p>No equivalent clauses.</p>	<p>Clause 40 of the Agreement also commits the Commonwealth and State to “work together on the development of a suitable index...to reflect changes in hospital output costs”. Clauses 41 to 42 outline default and minimum indices, in the absence of an agreed ‘hospital cost index’. Clause 44 makes \$23 million available to WA from the National Health Development Fund to fund projects that foster health system restructuring and improved health system performance. The State is required to provide a cash flow projection with projects to be consistent with an “agreed strategic plan”. Clause 45 confirms that grant payments for mental health and the National Health Development Fund are quarantined from fiscal equalisation processes.</p>	<p>There is recognition of the complex factors that drive growth in hospital costs, with the Agreement committing the Commonwealth and States to work on developing a unique ‘hospital cost index’.</p>
<p>Broadbanding</p>	<p>Clause 9.3 (e) requires the Commonwealth and States to “examine Health Specific Purpose Payments with a view to broadbanding on or after 1 July 1994. This would include the development of agreed outcome-based accountability measures”.</p>	<p>Clause 24 brings a number of separate grant arrangements into the 1998 Agreement – the “Artificial Limbs Scheme; the Nationally Funded Centres; and the Australian Bone Marrow Donor Registry”.</p>	<p>The 1998 Agreement continued to promote broadbanding of grants, commenced under the 1993 Agreement (but not well implemented in that earlier term).</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Sanctions</p>	<p>Schedule C Clause 2.3 indicates that the base grant will be reduced if “the level of Commonwealth ... MBS ... expenditure paid in the relevant grant year...is greater than the national average MBS per capita expenditure multiplied by 1.11”.</p> <p>Clause 8 of Schedule E relating to the Incentives Package funding indicates that should a State “not comply with the agreed processes and undertakings set out the Commonwealth may withdraw or withhold payments under this Agreement in part or in full.”</p> <p>Clause 12.5 indicates that the Commonwealth has a right to reduce grant funding “in the event that the State does not provide the kinds of data required ... [in terms of statistics and reporting requirements] ... within the times required or agreed”.</p>	<p>No equivalent clause.</p>	<p>Surprisingly the 1998 Agreement was devoid of sanction clauses, a feature common to most of the earlier Agreements. While there are references to potential grant reductions in the 1998 Agreement, these are not expressed as sanctions or penalties as such, but more as triggers for further investigation, from which grant reductions <i>may follow</i>. Even in these instances, the 1998 Agreement assigns adjudication responsibility mostly to an ‘independent person’ as opposed to the Commonwealth or its agencies.</p>
<p>Setting of budgets and other collaboration</p>	<p>Clause 11 provides for the establishment of a “consultative body or consultative bodies as the need arises to consider matters relating to this Agreement”.</p>		<p>Interestingly the 1998 Agreement omitted references to consultative bodies, instead reference is made to the use of an “independent person”. Since the 1984 Agreement, the Commonwealth progressively removed itself from close involvement in State budget setting. The need for additional consultative policy setting bodies is also likely to have been unnecessary, with other intergovernmental machinery such as ministerial and COAG working groups now well established.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Cross-border patient flows</p>	<p>Clause 7.1 (d) commits the Commonwealth to working with the States to develop better methods of accounting for inter-jurisdictional patient flows. Clauses 7.2 and 7.3 also establish the Commonwealth as an adjudicator in the event of inter-jurisdictional disputes. Clause 8.4 sets out suggested processes for negotiating funding adjustments for cross-border patient flows.</p>	<p>Clauses 61 to 64 deal with cross-border adjustments. Clauses 61 and 62 require the State to develop a “mechanism” with other affected jurisdictions for determining and adjusting for costs incurred in treating inter-jurisdictional patients. Clause 63 and 64 stipulate that in the event of a dispute, the matter will be referred to an independent person (or the Minister or Productivity Commission if an independent person cannot be agreed upon), who will mediate and confirm a resolution between the affected States. Clause 64 additionally provides that where a resolution is not complied with, the Commonwealth will “divert grant payments” to ensure the “outstanding obligations” are met.</p>	<p>In the 1993 Agreement, the Commonwealth assumed a coordinating and leadership role in accounting for cross-border patient flows. Under the 1998 Agreement, the responsibility for cross-border accounting and dispute resolution is left with the State and with an independent person to be appointed by the States concerned. The Commonwealth thus devolved this responsibility, probably having established a suitable framework during the 1993 Agreement.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Financial Provisions (cont.)</p> <p>Setting of patient charges</p>	<p>Clauses 10.2 and 10.3 permit the States to charge private patients fees “determined as prescribed under the relevant State statute”. Also States are permitted to charge private patients, private nursing home type patients, compensable patients and ineligible persons fees for “professional services (including diagnostic services), dental services, prostheses and such other services as may be agreed between the Commonwealth and State Minister”.</p> <p>Clause 8.9 (f) requires the State to ensure that “aftercare services for public patients and outpatient and accident and emergency services do not attract claims for Medicare benefits...”.</p> <p>Clause 8.9 (g) requires the State to ensure that “except in an emergency, a recognised hospital does not issue a prescription to an inpatient on discharge, an outpatient or an accident and emergency patient that would attract” PBS benefits.</p>	<p>Part 9 of the Agreement deals with private patient charges.</p> <p>Under Clause 56, the State is able to charge public non-admitted and public, discharged admitted patients for a range of services including dental services, spectacles and hearing aids, prostheses, pharmaceuticals etc.</p> <p>Under Clause 57, private patients, compensable patients and ineligible persons can be charged as determined by the State, with the condition that pharmaceuticals must be provided free to private admitted patients and not claimed against the PBS.</p> <p>The Agreement under Clause 60 allows the State to charge “residential care charges....as those applicable in a Commonwealth funded nursing home” to patients assessed as “no longer needing acute care” and who qualifies for “nursing home care”. The Clause also stipulates that patients who do not qualify as a nursing home type patient may be charged a “patient contribution as determined by the Commonwealth Minister for Health...”.</p>	<p>The 1998 Agreement continued the approach of earlier Agreements whereby the setting of private, nursing home type and compensable patient charges is left to the discretion of the State. Charges are also permitted for a specific range of services provided to public patients. Further, the Agreement allows charging of public patients classified to be nursing home patients. Notably however, archives reveal that the Commonwealth held indirect influence over private patient fee settings. The Commonwealth was responsible for setting “minimum private health insurance benefits for private patients in shared rooms in public hospitals”. It appears that the States were informally bound to consider these minimum benefit levels with “the Commonwealth ... [suggesting] ...that it ... [would] ... penalise States which increase private patient fees beyond the minimum benefit” (Department of Treasury and Finance 1998h: 3). The emphasis on cost-shifting was still present however with the 1998 Agreement requiring patient charging policies to not result in claims on the PBS.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
Service delivery Matching State Legislation	Clause 3.2 requires the State to either adopt the above principles as service delivery guidelines, or “to make reasonable efforts to” enact “legislation by that date”.	No equivalent clause.	The 1998 Agreement removed the requirement for matching State legislation. It is not clear as to the extent to which this may already have been implemented by the time of the 1998 Agreement.
Minimum service thresholds	No equivalent clause.	Clauses 22 and 23 commit WA to deliver 290.14/1000 weighted public patient separations. The Agreement also stipulates “in subsequent grant years the rate will be increased for utilisation drift of 2.1% per annum”. Should this threshold not be reached by more than 5%, a joint review is triggered to assess if the outcome was caused by an event “beyond the reasonable control of WA including industrial action” or caused by “WA providing public hospital services in other settings”. If not the latter, the Agreement stipulates that the Commonwealth can propose a variation to the Agreement.	The 1993 Agreement used MBS-based thresholds to ensure States maintained or increased levels of public provision. In contrast under the 1998 Agreement, the Commonwealth, because of data enhancements, was able to stipulate minimum levels of hospital activity much more precisely. The Agreement also provided for flexibility in this threshold, with variations to be tied to “utilisation drift”. Further, whereas the 1993 Agreement was less compromising in its threat of sanctions for non-compliance with minimum service thresholds, the 1998 Agreement offers a review process and more considered application of sanctions (grant reductions).

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Patient Charter and Independent Complaints Body</p>	<p>Clause 4 requires the State to establish a Public Patients' Hospital Charter in consultation with the Commonwealth and a Complaints Body that is "independent of the State's hospitals and the State's Department of Health" and has a role "in recommending improvements in the delivery of hospital services in respect of which the Commonwealth provides financial assistance".</p>	<p>Clause 25 continues requirement for a Public Patients' Charter and an independent Complaints Body. Schedule D outlines specific requirements around this such as:</p> <ul style="list-style-type: none"> - A Charter to be available by 1 July 1999; and - Nationally consistent reporting of State health complaints data. <p>Schedule D of the Agreement sets out very detailed guidelines about the role and content of the Charter and Complaints Body.</p>	<p>There is increased prescription around this grant condition in the 1998 Agreement.</p>
<p>Patient election</p>	<p>Clause 8.5 requires the States to ensure that "an eligible person, at the time of admission to a recognised hospital or as soon as practicable thereafter elects or confirms whether he or she wishes to be treated as a public patient or a private patient using a standard set of questions to be agreed between the Commonwealth and the State".</p> <p>Clause 8.5 also requires that the "eligible person is informed of the consequences of electing to be treated as a public patient and not as a private patient or vice versa.</p>	<p>Part 8 of the Agreement deals with patient election processes. Clauses 53 and 54 require the State to ensure all patients are able to freely elect their patient status, before or as soon as possible after admission. The State must also inform the patient of the consequences of his/her choice. Clause 54 additionally stipulates that patient choices should not be "directed by a hospital employee" nor "reversed ... [unless there are] ... unforeseen circumstances". Clause 55 indicates that "agreed national standards of information ... relating to admission and patient election forms will be maintained over the life of the Agreement".</p>	<p>As in the 1993 Agreement, the Commonwealth kept a close monitor on patient election in the 1998 Agreement. The 1998 Agreement included various controls around patient election forms and admission processes to ensure that the State and its hospitals did not manipulate the extent of patients electing to receive universal hospital care.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Casemix development and other hospital governance reform</p>	<p>Clause 7 provides for Commonwealth involvement in a range of improvement projects in the areas of: Area Health Management; Hospital Access (elective surgery) Program; Devolution of Clinical Budgets; Strategic Capital Planning of Hospital Infrastructure; National Quality Assurance Program; Health Communication Network (telehealth); and Casemix Development. Schedule E Clause 2 indicates that a “State Strategic Planning Group” be established on which the Commonwealth is to be represented. Clause 4.1 provides for national coordination of state strategic planning. Clause 5.1 indicates that strategic plan initiatives that are funded by the Commonwealth are on a year- to-year basis only, with the Commonwealth having annual discretion to cease funding if deemed necessary. Schedule E Clauses 2.3 and 2.4 require that planning for mental health reform and casemix development be undertaken with reference to AHMAC (who is overseeing the implementation of the National Mental Health Plan) and the Casemix Project Board who is overseeing casemix development at a national level.</p>	<p>A range of health reforms are outlined in the Agreement under Part 5. The wording is one of collaboration and cooperation – a “measure and share model:</p> <ul style="list-style-type: none"> - Coordinated Care Trials; - Healthcare safety and quality improvement and enhancement; - A National Health Development Fund to foster health system restructuring and improved health system performance; - Information technology reform; and - Pharmaceutical policy reform. <p>Clause 28 of the Agreement stipulates that reform proposals should:</p> <ul style="list-style-type: none"> - “...be consistent with accepted evidence based best practice models”; - “...lead to improved patient outcomes and/or more cost effective care”; - “...be measurable in terms of change in service delivered and costs to the health system as a whole...”; - allow for any net savings to be shared between Commonwealth and the State; - “..have potential to be replicated, be on a scale such that extension can be realistically tested and be evaluated in terms of such extension”. And - “...preserve eligible persons’ current access to MBS services or their equivalent...”. 	<p>The Commonwealth expanded its policy reach into the improvement of micro-efficiency within hospitals in the 1993 Agreement.</p> <p>The 1998 Agreement built on this further but the wording appears much more strategic than the 1993 Agreement which outlined quite prescriptive procedures for approval of reform projects.</p> <p>The 1998 Agreement reflected a more informed health policy and planning environment under which issues such as hospital demand management pressures and health system integration were now a much more accepted part of health service planning and policy setting.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Casemix development and other hospital governance reform (cont.)</p>	<p>Clause 7.1 (h) commits the Commonwealth to provide a “leading and coordinating role in the evaluation of the performance of the Commonwealth and the State on matters covered by this Agreement including the development of performance indicators.”</p> <p>Clause 6 and 7 of Schedule E sets out specific reform requirements. States are required for example to:</p> <ul style="list-style-type: none"> - “move towards funding and management of health service provision on the basis of the assessed health needs of the populations in discrete geographical areas”; - “move progressively to standardised definitions and information systems to allow consistent and comparative reporting on a population’s health status and hospital products and costs”; - “move progressively toward hospital funding arrangements that promote efficiency and micro-economic reform”; - “reform the management of elective surgery booking systems” and provide “nationally consistent and comparable data on waiting lists and waiting times”; - refine “current capital management...processes, with the aim of ...utilising (these) in the most cost effective manner”. 		<p>The Commonwealth continued to play a national coordinating role in the improvement of health data and national performance evaluation.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Service Integration</p>	<p>Clause 7.1 (e) commits the Commonwealth to “work together with the State to ensure that the Commonwealth and State health and related care programs are complimentary”. Further Clause 7.1 (g) commits the Commonwealth to “ensure that the MBS and the PBS or alternative mechanisms assist access to appropriate technology and medical practice”.</p>	<p>No equivalent clause.</p>	<p>The 1993 Agreement formally recognised the need for better integration between Commonwealth-provided health services and public hospital services. While there was no equivalent clause in the 1998 Agreement, the need to improve service integration is implicitly captured in other Clauses. For example, part of the funding provided in the National Health Development Fund was made available to facilitate health system restructuring.</p>
<p>Link to private hospitals</p>	<p>Clause 8.3 allows States to enter into arrangements with private hospitals or other States for hospital services, with States required to advise the Commonwealth of such arrangements.</p>	<p>No equivalent clause.</p>	<p>It is likely that this requirement was now well established, and did not need to be explicitly stated in the 1998 Agreement.</p>
<p>Performance standards</p>	<p>Clause 9.3 (b) requires the Commonwealth and State to “clarify links between different service providers and explore the desirability of establishing national guidelines for appropriate levels of access for outpatient services”.</p>	<p>No equivalent clause.</p>	<p>The various terms and conditions relating to outpatients, MBS payments and cost shifting in the 1993 Agreement were replaced by a more general encouragement of health system restructuring and integration; an acknowledgement of the complexities of cost-shifting; and an apparent willingness to work with the States to investigate and better understand health system flows and linkages. These advances appear to reflect a more informed and developed health system policy and planning environment.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Reporting</p>	<p>Clauses 12.2, 12.3 and Schedule J outline regular reporting requirements. The quarterly reporting of the 1988 Agreement is continued, with bed-day statistics sought in addition to admission statistics. Further, there are data requirements specific to assist with the development of a national casemix system. States are also required to provide data on waiting lists. Under Schedules H and I, the State commits to providing a range of data and cooperating with the Commonwealth, to establish national health outcome indicators to measure access, equity, quality, and efficiency. On the latter, a five year timetable is outlined. Clauses 12.4 and 12.5 require the State to provide expenditure and activity estimates by 31 March each year and updates, within one month of the State Budget.</p> <p>Clauses 12.4 and 13.1 require annual reports to be provided to the Commonwealth on expenditure and activity.</p> <p>Clause 13.3 requires the State to incorporate its Commonwealth reporting in its agency annual reports tabled in the State Parliament. Clause 12.1, similar to Clause 13.1 of the 1988 Agreement requires the Commonwealth and States to mutually comply with any reasonable requests for statistics and information.</p>	<p>Part 10 deals with the Supply of Data and Performance Information. Clauses 65 and 66 commits both parties to complying, in a timely way, for any reasonable request for information on utilisation and cost; and on any data element “identified in the National Health Data Dictionary”.</p> <p>Clause 67 commits the Commonwealth and State to continuing development of performance indicators on “efficiency, quality, appropriateness, accessibility and equity”. More specific areas of focus are outlined at Schedule C.</p> <p>Clause 72 of the Agreement also commits the parties to the development of a “non-admitted patient morbidity data set by 30 June 2003” and expanding the “admitted patient hospital morbidity data set to gain an improved understanding of the components of admitted patient episodes”.</p> <p>Under Schedule C of the Agreement, the State agreed to provide data on emergency department and elective surgery waiting times. Further, the Commonwealth and States agree to share de-identified public and private hospital utilisation data and MBS and PBS utilisation data.</p>	<p>The 1998 Agreement continued the joint efforts in enhancing performance datasets and measures as commenced under the 1993 Agreement.</p> <p>In terms of reporting requirements, the 1998 Agreement appears more collaborative, with mutual sharing of information, including restoration of the Commonwealth’s sharing of data on PBS and MBS payments.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Reporting</p>	<p>Clauses 12.2, 12.3 and Schedule J outline regular reporting requirements. The quarterly reporting of the 1988 Agreement is continued, with bed-day statistics sought in addition to admission statistics. Further, there are data requirements specific to assist with the development of a national casemix system. States are also required to provide data on waiting lists. Under Schedules H and I, the State commits to providing a range of data and cooperating with the Commonwealth, to establish national health outcome indicators to measure access, equity, quality, and efficiency. On the latter, a five year timetable is outlined. Clause 8.7 requires the State to “cooperate in monitoring and reporting on progress towards national health goals and targets”.</p> <p>Clause 8.8 requires the States to “actively participate in the development and implementation of health outcome indicators and measures”.</p> <p>Clause 8.9 (c) requires the State to “contribute to the development of outcomes based accountability”.</p> <p>Clause 8.9 (h) requires the State to “actively participate in the evaluation of the performance of the Commonwealth and the State under this Agreement”.</p>	<p>The Agreement also continues the quarterly reporting requirements of the 1993 Agreement. Schedule E Clause 23 requires the State to provide annual acquittal statements for grants received under the Agreement. Reporting requirements are also specified under Schedule B Clause 12 relating to mental health reform funding provided under the Agreement.</p>	<p>The 1998 Agreement continued the joint efforts in enhancing performance datasets and measures as commenced under the 1993 Agreement.</p>

Table B.6 Comparison of 1993 and 1998 Agreements (significant changes) (cont.)

CONDITION	1993 WA Agreement	1998 WA Agreement	Comments
<p>Service delivery (cont.)</p> <p>Reporting (cont.)</p>	<p>Clause 9.3 (a) require the State to work with the Commonwealth to establish “uniform data bases on out-patient services that will address access and equity issues and also issues concerned with the interface of the ... [MBS and PBS] ... with the hospital sector and cost-shifting”.</p> <p>Schedule E Clause 4 and 5 outline reporting requirements for the Incentives Package funding component of the grant. The States must provide “comprehensive annual reports to the ... [State Strategic Planning Group] ... quarterly financial reports and quarterly project progress reports consistent with sound structured project management principles. The content of and format of these reports will be as agreed between the Commonwealth and the State. In general, reporting requirements will be the minimum consistent with effective management and accountability at both Commonwealth and State levels”.</p>		<p>The 1998 Agreement continued the joint efforts in enhancing performance datasets and measures as commenced under the 1993 Agreement.</p>

APPENDIX C - HIGH LEVEL CASE STUDY EXAMINATIONS

C.1 HIGH LEVEL CASE STUDY EXAMINATION — 1988 MEDICARE AGREEMENT⁵⁹

Comparative analysis of the 1984 and 1988 Agreements confirms many of the policy control and performance traits evident in the earlier hospital tied grant case studies.

C.1.1 High Level Summary

Table C.1 High Level Assessment 1988 Agreement

Case Study	Balance of Policy Making Power	Performance effects evident
1988 – 1993 Agreement	Neither top-down nor bottom-up	<ul style="list-style-type: none"> Convoluted policy compromises Policy bias towards the larger States Accountability shortcomings Administrative and operational inefficiencies Emphasis on macroeconomic performance

C.1.2 Detailed Analysis — Balance of Policy Making Powers 1988 Agreement

Evidence of top-down control

Having successfully implemented the 1984 Medicare grant arrangement, the 1988 Agreement provided opportunity for the Commonwealth increase its policy making influence. A number of features of the 1988 Agreement indicate a top-down mode of policy making and governance:

Goal clarity

- With the signing of the 1988 Agreement, the Identified Health Grant (an untied grant established during the Fraser era) was absorbed into the Medicare grant. With an estimated value of \$1.8 billion in 1987/88, this reconfiguration increased the Commonwealth’s policy control, with an additional \$1.8 billion now subject to Commonwealth conditions, as opposed to being part of general revenue grants (Department of Treasury and Finance 1988-89).
- The 1988 Agreement included higher goal clarity around the “national’ nature of universal hospital care, compelling the States to ensure the availability of services either through: 1) their own service delivery systems; 2) other State delivery systems; or 3) the private sector (Aust. Government 1988).

⁵⁹ This Appendix should be reviewed in conjunction with Appendix B.4.

Goal setting

- The Commonwealth held clear advantage over the timing of negotiations, unilaterally deciding when bargaining would commence and thus leaving the States uncertain and prone to a reactive stance (Australian Health Ministers and Taylor 1987).
- As apparent in the 1984 Agreement, the Commonwealth appears to have strategically transferred tied grant negotiations into broader Commonwealth-State financing forums. The WA government lamented for example: “if a workable understanding on the determination of adequate Medicare compensation funding cannot be reached with the Commonwealth at the 2 May meeting of Ministers there is a likelihood that the question of Commonwealth funding of health may become an issue at the forthcoming Premier’s Conference” (Department of Treasury and Finance 1988-89).

The use of these broader forums as a setting for negotiations resulted in tied grant deliberations to be convoluted by other competing policy agendas. Additionally, the Commonwealth found it easier to heavy-handedly coerce the States into policy acceptance. For example, correspondence from Commonwealth bureaucrats following a Premiers’ Conference shows the states being pressured by decisions made at the conference and the threat of funding cutbacks. The letter states: “I intend forwarding the draft Agreement to my Minister in the near future for final clearance before seeking to arrange formal ... signature. I need to know if WA is prepared to sign. As mentioned earlier, if your State is not prepared to sign on the basis that you are contesting the Premier’s Conference outcome, I will need to know urgently so that the matter can be taken up with Cabinet. In that event, I have no doubt that both the Commonwealth Treasury and the Department of Finance will wish to continue to pursue their arguments about the relative generosity of both the base grant and the indexation arrangements” (Department of Treasury and Finance 1988-89).

- Compared to the 1984 and 1985 Agreements, the Commonwealth also appears more assertive with its bargaining stance with WA observing that despite intentions “to discuss options and agree a framework” for the new Medicare Agreement at a meeting of Health Ministers, “the Commonwealth position to be put to the Conference..(had already)...been approved by Federal Cabinet” (Department of Treasury and Finance 1988-89). Further, the WA government noted the Commonwealth’s resoluteness at a special meeting of Health Ministers: “Overall there was a general unwillingness to modify the package already proposed. The States were pressed to consider the package on its own merits without reference to the [Financial Assistance Grants]. The indexation factor, the incentives package and the very substantial increase in money for AIDS treatment by public hospitals were seen by the Commonwealth as being particularly generous. In summary therefore the Commonwealth was unwilling to give way on any of the substantive points made by the States”. “The only proviso to this [was] that the Commonwealth Minister ... has undertaken to take back to the Commonwealth Government two proposals for increasing Commonwealth funding for public hospitals. Little encouragement was given, however, that these requests would be acceded to” (Department of Treasury and Finance 1988-89).

- As in other case studies, the States did not always have a consistent bargaining position. In a WA paper, it is noted that: NSW supported Medicare but sought for a “major review of the scheme” to address “major deficiencies”; Victoria supported Medicare but sought for an increase in base funding and a revised indexation formula; Queensland remained opposed to the Medicare grant; SA sought for additional base and capital funding; whilst WA, Tasmania and ACT desired that the Medicare grant be distributed according to CGC relativities. These divergent positions are likely to have diluted the States’ collective bargaining position (Department of Treasury and Finance 1988-89).
- It is apparent that central agencies at the State level may not have been heavily involved in the negotiations, with the WA Under Treasurer implying that better outcomes may have resulted “if Treasuries were involved” (Department of Treasury and Finance 1988-89).

Enforcement

- The 1988 Agreement included a range of unilaterally developed sanctions. Clause 7.2 sets out the circumstances when grants would be reduced: 1) when total public patient bed days in a State fall to lower than 53% of total patient days in both State public and private hospitals; 2) when per capita in-hospital MBS payments rise to more than 5% of national per capita in-hospital MBS payments; 3) when there is any financial advantage secured by the State at the expense of the Commonwealth as a result of not complying with the requirement to provide universal hospital care to all eligible persons; and 4) when the States do not comply with reporting requirements under the Agreement. These are highly prescriptive penalty provisions aimed at better assuring goal implementation by the States.

Evidence of bottom-up control

Offsetting the preceding evidence on top-down control, there is also evidence of bottom-up policy making.

Goal clarity

- In terms of the standards of care, the 1988 Agreement reverted to requirements for an “acceptably” high standard of care and “cost effectiveness” as opposed to the “high” standards of care and “cost constraint” as stipulated within the 1984 Agreement. This indicates a shift of policy control in State favour (Aust. Government 1988).

Goal setting

- Consistent with earlier case studies, the Commonwealth consented to a range of “unpublished” policy concessions to entice States to sign up to the Agreement. WA government files observe that to reach consensus with Victoria, the Commonwealth made: 1) “agreement at officer level for a review to be undertaken of the hospital utilisation measure detailed in the Agreement. This feeds into the operation of the penalty provisions in the Agreement. The review is to commence quickly and to be undertaken by a body under the Health Ministers’ Conference.” Further, to reach consensus with SA, the Commonwealth agreed for: 1) “a review of the penalties

associated with the average level of medical payments for in-hospital patients; 2) no penalty to apply for South Australia's failure to provide out-patient services in a number of major country hospitals ... ; 3) the current protocols in relation to patient election (i.e. whether a private or public patient) ... to be retained" (Department of Treasury and Finance 1988-89).

Goal congruence

- The Incentives Package included within the Agreement appears to have been partially driven by the States. Prior to negotiations commencing, the States repeatedly called on the Commonwealth to cost-share the funding of specific initiatives aimed at reducing elective surgery waiting times in public hospitals. Meeting notes indicate that States: "envisaged that ... [initiatives] ... would include improved day surgery arrangements, domiciliary nursing for long stay patients and more effective use of acute hospital services. The focus ... [should] ... be on specific and cost effective programs which have been successfully piloted and tested by the States" (Australian Health Ministers and Taylor 1987).

The bottom-up policy making apparent was reduced to an extent however by onerous accountability requirements. In implementing the Incentives Package, the Commonwealth adopted prescriptive requirements for projects put forward by States. For example, the Commonwealth insisted that projects demonstrate: "developmental initiative; provision of new services not replacement of existing services; firm measurable objectives; fully developed evaluation mechanisms; ... [and] ... indicate how they will relate to the hospital environment and existing care networks". The WA Minister argued that the Commonwealth's "restrictive interpretation of projects" and delays in approval was "doing great harm to our joint credibility and will severely limit the gains we expected to make from these initiatives in 1988/89 (with the) matter...quickly becoming a potential political problem (Department of Treasury and Finance 1988-89).

Local discretion

- There appears to have been continuing instances of passive resistance by the States. In re-negotiating the 1988 Agreement, the Commonwealth claimed that the States had reneged on their obligations under the universal hospital care goal through the: "closure of outpatient clinics"; charging of "medical services for compensation victims" to the MBS; and closure of "State nursing home beds" (Department of Treasury and Finance 1988-89).
- The 1988 Agreement preserved the fee setting autonomy secured by the States under the 1984 and 1985 Agreements (Aust. Government 1988).
- Apart from the stipulation that private hospitals should be engaged only where services are unavailable or cannot be provided within the public system, the Commonwealth seems to have abandoned its push for greater State regulation over private hospitals, following the lack of cooperation from the States. Queensland specifically called for the clauses relating to control over private hospitals to be deleted

from the 1988 Agreement. (Aust. Government 1988; Australian Health Ministers and Taylor 1987; Australian Health Ministers 1989).

- On patient election procedures, while the 1985 Agreement mandated that privately insured people would be deemed to be private patients unless they specifically elected to be a public patient (an outcome of the 1985 NSW doctors' dispute), the 1988 Agreement leaves the election option open and up to the patient. This shift is a restoration of the original terms of the 1984 Agreement and so represents a reclaiming of policy ground by the States. It is apparent that Queensland specifically called for the patient election clause to be revised so as to override the adjustments that followed the NSW doctors' dispute. The Commonwealth was initially concerned to ensure that there would be manipulation of the system, however ultimately accepted that States are "responsible for guidelines and practices related to deferred and altered patient elections" (Aust. Government 1988; Australian Health Ministers and Taylor 1987; Department of Treasury and Finance 1988-89).

Conclusions: Balance of Policy Making Powers 1988 Agreement

Overall, there were policy gains and losses sustained by both the Commonwealth and States and hence it is considered that policy making associated with the 1988 Agreement was neither top-down nor bottom-up.

- It is evident that the Commonwealth was dominant with regards to the: 1) starting time for negotiations; 2) push for greater goal prescription as implementation progressed; 3) introduction of more clarity around the use of private hospital facilities for delivering universal care; 4) abandonment of capital funding previously made available to appease the medical profession; 5) determination of grant funding and the setting of indexation formulas; and 6) the inclusion of penalty clauses. Further the Commonwealth displayed heavy handedness during negotiations and made very little effort to collaborate or compromise with the States. The States also held different views on the universal hospital care goal which weakened their collective bargaining power. A most significant outcome of the negotiations was that the Commonwealth shifted \$1.8 billion of previously untied grant, into the Medicare Agreement. Finally it is apparent that State calls for greater consideration of "the interface and relationship between public and private sectors" do not appear to have been addressed (Department of Treasury and Finance 1988-89).
- The States on the other hand appear to have won or maintained policy ground with respect to: 1) the incentives package which met their repeated requests for investment in non-hospital alternatives (although funding was quite marginal relative to the main Medicare grant); 2) their call for AIDS treatment funding; 3) the loosening of expected standards of care; 4) various concessions on reporting and the penalty clauses; 5) their continued autonomy in terms of patient charges and regulation of private hospitals; and 6) a resumption of autonomy in terms of patient election procedures. Additionally, there were some clear examples of States' passive resistance to the universal hospital care goal (Department of Treasury and Finance 1988-89).

- On the enforcement or reporting front, there were mixed outcomes evident. The 1988 Agreement removed a requirement to report on hospital bed numbers and services and less frequent reporting on patient utilisation in response to State objections (Aust. Government 1988; Australian Health Ministers and Taylor 1987). Offsetting these gains however was a new Commonwealth requirement for private hospital data. (Department of Treasury and Finance 1988-89).

C.1.3 Detailed Analysis — Reflections on Grant Performance 1988 Agreement

Evidence from the 1988 Agreement reveals similar performance effects to the earlier case studies of public hospital tied grants. For example:

Performance advantages of tied grants

The States remained keen for a collaborative approach on doctors' remuneration similar to the experience of the Whitlam, Fraser and Hawke era case studies. Continuing the approach of the 1985 Agreement however the 1988 tied grant arrangement stepped away from doctors' remuneration reform. Interestingly, the States nonetheless sought for the establishment of an AHMC working party to "investigate methods of limiting as much as possible the flow on of the NSW determination" as being pursued by the AMA at the time (Australian Health Ministers and Taylor 1987).

Performance deficiencies of tied grants

Convoluted policy compromises

As evident during the Hawke era, calls by the WA Government for the Medicare grant to compensate for shortages in primary care and aged care in WA relative to other States – went unheeded, the Commonwealth Treasurer simply referring the State to the Commonwealth Grants Commission process. Thus policy setting around the 1988 Agreement continued to be distorted by other fiscal federal levers and processes.

Policy bias towards the larger States

The minimum service thresholds specified in the penalty clauses of the Agreement appear to have been based on activity levels in the larger States. The Commonwealth confirms: "In 1985-86 about 55% of all public hospital bed days were in respect of Medicare patients. However in Victoria, NSW and ACT public provision was below this level, while all other States provided well in excess of the national average". The WA government observed that Victoria stood "to lose approximately \$58 million in penalties in the first two years" (Department of Treasury and Finance 1988-89).

Accountability shortcomings

The 1984 Agreement broke the nexus between hospital costs, health needs and grant funding. This approach continued in the 1988 Agreement which adopted the base funding of the prior Agreement, with a growth factor to recognise population growth and ageing (Aust. Government 1988). WA papers noted that "...it becomes more difficult as time passes to directly relate increases in public hospital costs to Medicare..." (Department of Treasury and Finance 1988-89).

Administrative and operational inefficiencies

According to the States, the Commonwealth's unilateral decision to abandon the capital funding clauses of the 1985 Agreement gave rise to a range of performance inefficiencies, for example, shortcomings in medical equipment replacement, aged layout of wards, aged buildings and an inability to shift psychiatric care from institutional to community based settings (Australian Health Ministers 1991). The WA government asserted that the Commonwealth's departure from the capital funding space exacerbated the "rationing" of services and reduced the quality of care (Australian Health Ministers 1989).

Additionally, with the withdrawal of the doctor's remuneration goal in the 1985 Agreement, the Commonwealth reverted to alternative 'blunt' levers in the 1988 Agreement in order to contain cost growth and secure its national economic goals. The aim of the minimum thresholds established for public patient bed days and in-hospital MBS payments was to contain Commonwealth expenditure and ensure that universal hospital care was not discreetly scaled back by the States or medical profession by any untoward favouring of private patients. No doubt these crude controls impacted on States' local flexibility and their capacity to use private patient revenues to assist with the balancing of hospital budgets.

States argued for example that the 53% patient day threshold had no "planning justification" and objected to being held accountable for the volume of medical services in private hospitals. In response the Commonwealth indicated its objective was only to penalise States where there had been an "intentional reduction" in the provision of public hospital services. It is unclear as to how the Commonwealth intended to establish any such "intentional reduction" (Department of Treasury and Finance 1988-89). The Commonwealth concurred that "bed day utilisation is not the sole measure of hospital service provision but it is the only measure currently available" (Department of Treasury and Finance 1988-89).

Emphasis on macroeconomic performance

The Commonwealth's focus on national macroeconomic performance appears to have been successful, the WA government noting: "Medicare appears to have contributed significantly to limiting real growth in health sector costs. Total expenditure on health has been a relatively stable proportion of GDP since 1980" (Department of Treasury and Finance 1988-89). It is apparent however that this broader gain came at the loss of State flexibility and managerial efficiency. For example, the NSW government noted that the Commonwealth made unilateral cuts to the Medicare grant totalling around \$98 million from 1983/84 to 1986/87, through amendments of the grant funding formula (Australian Health Ministers and Taylor 1987). At the 1988 Premiers Conference, all States argued that Commonwealth budget cuts had compelled States to reduce services: "everybody knows that the hospital system is in a mess - an absolute disaster" (WA Govt 1988). Having fostered a hospital-centric health system, the capped funding environment left States with little room to move in terms of pursuing greater innovation and efficiency at the local service delivery level.

Admittedly, in support of greater managerial efficiency, the 1988 Agreement included an Incentives Package aimed at encouraging greater policy emphasis on day procedures, post-acute and palliative care services. As evident in the Fraser era however, the Commonwealth's investment was tokenistic. In comparison to the \$3 billion or so made available for hospital care, just \$56 million was made available for these important reforms (Aust. Government 1988; Department of Treasury and Finance 1988-89). The Commonwealth also pushed for more evidence-based grant funding (Aust. Government 1988). It confirmed: "experience ... has indicated that use of a prospective payment system for hospital services could lead to achievement of significant efficiencies the Commonwealth proposes to encourage development of DRG type systems in cooperation with interested states \$5 million per annum indexed in line with the base grant, has been set aside for this purpose and is not included in the grant offer" (Department of Treasury and Finance 1988-89). Notwithstanding the potential gains in managerial efficiency however, it seems the Commonwealth's motivations were primarily to increase future policy control and macroeconomic performance, the Hawke government proclaiming: "it is proposed to develop an Australian DRG type system ... by 1993, to the extent that it could be used for prospective payment purposes if appropriate" (Department of Treasury and Finance 1988-89).

C.2 HIGH LEVEL CASE STUDY EXAMINATION — 1993 MEDICARE AGREEMENT⁶⁰

Analysis of the 1993 Agreement reveals it to be the most complex and prescriptive grant arrangement in the longitudinal study. The WA Agreement was comprised of 82 pages and 12 attachments (Schedules A to J), including two iterations of Schedules D and F.

C.2.1 High Level Summary

Table C.2 High Level Assessment 1993 Agreement

Case Study	Balance of Policy Making Power	Performance effects evident
1993 – 1998 Agreement	Top-down	<ul style="list-style-type: none"> Convoluting policy compromises Policy bias towards the larger States Accountability shortcomings Administrative and operational inefficiencies Emphasis on macroeconomic performance

C.2.2 Detailed Analysis — Balance of Policy Making Powers 1993 Agreement

Evidence of top-down control

Goal clarity

- Under the 1993 Agreement, the Commonwealth further embedded the goal of universal hospital care into State policy frameworks:
 - The Agreement established a set of “Medicare Principles and Commitments”, to be applied by public hospitals in their provision and design of universal hospital care.
 - The States were required to “make reasonable efforts” to enshrine the Medicare Principles into State legislation or guidelines.
 - The Agreement sought for States to establish a “Public Patients’ Hospital Charter” and an independent “Complaints Body”, both of these initiatives aimed at enhancing community awareness and influence over the quality and content of universal hospital care.
 - After stepping back in the 1985 and 1988 Agreements, the Commonwealth opted to intrude once again into patient election processes, with the 1993 Agreement requiring patient election forms to be designed with its involvement. Presumably this intervention was intended to increase Commonwealth influence over patient admission processes and the numbers of patients choosing publicly-provided care (Aust. Government 1993).

⁶⁰ This Appendix should be reviewed in conjunction with Appendix B.5.

- Finally, the 1993 Agreement outlined a greater role for the Commonwealth in resolving inter-jurisdictional costing disputes around cross-border patient flows, a step perhaps taken to ensure seamless implementation of universal hospital care across States.

In addition to strengthening the policy settings of the 1988 Agreement, the 1993 Agreement also pushed further health and hospital policy and governance reforms:

- A new emphasis was placed on mental health reform, with funding provided to encourage the structural reform of mental health service delivery.
- There was also review work initiated to “consider the possible transfer of functional responsibility for aspects of outpatient services to the Commonwealth”. This latter initiative appears to have been driven by concerns of ‘cost-shifting’ with the Commonwealth seeking to tighten the interface between the hospital sector, MBS and PBS.
- The 1993 Agreement also built on the 1988 Agreement in terms of establishing a strong agenda setting role for the Commonwealth in health policy making. The Agreement committed the Commonwealth to playing a “leading and coordinating role” in the development of national health policy, in partnership with the States.
- The Agreement attempted to increase the Commonwealth’s knowledge of health service policy setting, requiring States to “encourage Commonwealth funded participation in relevant conferences, workshops and other forums”.
- On datasets and performance frameworks, the 1993 Agreement outlined a larger role for the Commonwealth in terms of defining and implementing: a national health goals and outcomes framework and performance targets; a performance framework and targets for mental health services; a casemix management system; and an enhanced performance measurement framework for outpatient services (Aust. Government 1993).

With regards to managerial efficiency, the 1993 Agreement considerably increased the Commonwealth’s policy space. Under the 1988 Agreement, the Commonwealth had sought to influence reform projects (to expand day surgery, post-acute care and palliative care) by requiring federal endorsement of formal project plans and milestone payments. Under the 1993 Agreement, the scope of potential reform projects was expanded considerably with States required to consider improving their: Area Health Management; elective surgery management; devolution of clinical budgets; strategic planning of hospital infrastructure; quality assurance systems; and health communication networks (telehealth). Further, in addition to incentive funding, the 1993 Agreement provided for the establishment of a “State Strategic Planning Group” involving Commonwealth and State representatives to oversee the design and implementation of these reforms. Schedule E of the Agreement outlines the policy and governance reforms in significant detail. States are required for example to:

- move towards population and needs based funding and management;
- progressively adopt standardised definitions and information systems to allow consistent and comparative reporting on health status and hospital products;

- reform the management of elective surgery booking systems” and provide “nationally consistent and comparable data on waiting lists and waiting times; and
- (refine) current capital management...processes, with the aim of ...utilising (these) in the most cost effective manner.

On mental health reform, there appears to have been some renegotiation of the Agreement during the five-year term. In the first iteration, the Agreement required the States to submit an annual strategic plan identifying specific reform initiatives, consistent with national mental health policy. A quantum of funding was also made available (subject to the approval of a project plan) for “projects of national significance” aimed at enhancing innovation and acceleration of mental health service reforms. States were also required to submit annual reports, cooperate in the development of performance indicators and maintain existing spending efforts (‘maintenance of effort’). In the second version, the Agreement additionally tied grant funding to the meeting of agreed performance targets, this appearing to be a tightening of Commonwealth policy control (Aust. Government 1993).

In contrast to the 1988 Agreement which employed an indexed block grant and some project-based funding, the 1993 Agreement involved highly complex funding formula. Clause 5 of the Agreement outlines five separate funding streams:

- a) funding to assist the State to meet the costs of providing public hospital services (the base grant);
- b) Bonus Pool payments aimed at improving public hospital service access;
- c) Incentive payments to encourage more efficient and effective provision of services;
- d) funding to assist the State to meet the costs of reforming mental health services; and
- e) funding to assist the State in meeting the costs of other nominated health services (subject to agreed outcome measures).

With regards to sanctions clauses, there appear to be a number of commonalities between the 1988 and 1993 Agreements. For example, in both Agreements, penalties applied if State share of public bed days fell, or if reporting obligations were not met. Additionally on MBS payments, the 1988 Agreement focused on in-hospital MBS payments and a penalty threshold of 5%, while the 1993 Agreement widened this penalty to include all MBS payments and a penalty threshold of 11% above “national average MBS per capita expenditure”.

The 1993 Agreement also added and removed a number of sanction provisions, when compared to the 1988 Agreement. Presumably to facilitate its push for greater federal involvement in reform of hospital governance, the 1993 Agreement *introduced* new penalties for States which did not “comply with the agreed processes” to access incentive funding. On the other hand, the 1993 Agreement *removed* a penalty clause in the 1988 Agreement under which States could be penalised for non-provision of universal hospital care or ‘cost-shifting’. Notwithstanding the removal of this penalty clause, it is clear that ‘cost-shifting’ remained a significant concern for the

Commonwealth with a number of other safeguards built into the 1993 Agreement. For example, Clause 8.9 of the 1993 Agreement requires States to ensure that “aftercare services for public patients and outpatient and accident and emergency services do not attract claims” for MBS or PBS benefits (Aust. Government 1993).

On reporting obligations, the 1993 Agreement placed increased emphasis on the improvement of datasets and performance frameworks, seeking additional data, exchange of information and “active” development effort from the States. The drivers for this are quite clear. The continued investment in casemix development and the introduction of performance targets (for accessing mental health reform funding and bonus pool payments) in the latter years of the Agreement is evidence of the Commonwealth’s increasing interest in performance-based funding and management.

Comparative assessment of the 1988 and 1993 Agreements also confirms a rise in reporting requirements. For example, in addition to the quarterly data sought under the 1988 Agreement, States were also required to provide bed-day statistics and waiting list data. Further, the 1993 Agreement required States to incorporate Commonwealth reporting in agency annual reports tabled in State Parliament. Notably, whilst the Commonwealth imposed increased reporting burden on States, the 1993 Agreement removed the 1988 Agreement requirement for Commonwealth MBS data to be shared with the States (Aust. Government 1993).

Goal setting—Pre-1993 Agreement

Goal setting negotiations for the 1993 Agreement were heavily dominated by the complicated and convoluted funding formulae that was put forward by the Commonwealth. The unilateral tone was set very early, with WA Government archives indicating that the:

Commonwealth’s proposals initially were outlined in the 1992/93 Budget Papers...(prior to being)...forwarded to the Commissioner of Health...in September (Department of Treasury and Finance 1992-97: 143).

The key focus of contention was the proposed Bonus Pool arrangement and the controversial linking of the Medicare grant to the Commonwealth Grants Commission (CGC) process and Financial Assistance Grants (FAGs).

The Commonwealth claimed that the Bonus Pools were centred on encouraging greater public provision of hospital services, with “those States and Territories that increase public provision the most ... [set to] ... gain the most” (Department of Treasury and Finance 1992-97: 207).

However the Commonwealth’s announcement triggered unrest in the smaller States for a number of reasons. Firstly, the ‘carrot’ embodied within the arrangement was of minimal attraction to States such as WA which had “an already high proportion of public patients in...(their)...public hospitals...(and thus stood)...to gain comparatively little..” (Department of Treasury and Finance 1992-97: 206-10). Secondly, the sanctions and redistribution features of the Bonus Pool were considered most inequitable. The proposal stipulated that States would be penalised for “any decline in public patient provision compared to the defined base public share”, with the penalty funds to be

redistributed to other States (Aust. Government 1993). The WA Government noted that the penalty provisions could mean that:

it could incur a significant penalty even if its level of public provision remained one of the highest in the country. It would seem highly iniquitous to transfer money from a high performance State in respect to public patient access to lower performing States (Department of Treasury and Finance 1993-96: 8).

Finally, there was the Commonwealth's intention to modify the CGC process. It was confirmed that the Bonus Pool payments would:

replace and expand the current process whereby the Commonwealth Grants Commission makes some allowance for differences in the mix of public and private bed-days in the way it distributes General Revenue Assistance Grants between the States and Territories in the hospitals category ... (and under which) the State receives \$32.4 million to compensate for a smaller private sector (or a higher than national average proportion of public patient bed days) (Department of Treasury and Finance 1992-97: 206-10).

The Commonwealth also signalled that it would instruct the CGC to "ensure that the intent of Commonwealth policy, in relation to these additional (bonus) funds, is not diluted" and to "over-ride the...(Commission)...if it does not" (Department of Treasury and Finance 1992-97: 207, 10). The WA Treasury warned the State Government in August 1992:

Unless the States concerned receive full compensation for these disabilities through an appropriate share of the bonus pool, the proposed bonus pool arrangements would be highly inequitable in that the States with the large non-State services disabilities in the hospital services area (such as WA) would no longer be compensated for these disabilities through fiscal equalisation, and would only receive small portions of the bonus pool, leaving them worse off. By contrast, States which benefit from having relatively small public health sectors (such as NSW) would no longer have this benefit redistributed through fiscal equalisation and would receive an additional benefit through relatively large payments (on a per capita basis from the bonus pool) (Department of Treasury and Finance 1992-97: 206-10).

The association made with the CGC process appears to have been driven by Commonwealth health officials who wanted to prevent fiscal equalisation from undermining "the priorities behind SPPs" including the uniform, national establishment of universal hospital care (Department of Treasury and Finance 1992-97: 206-10; Pearse et al. 1997: 5). Nevertheless the difficulty posed for the smaller States was that the proposal carried the risk of significant fiscal redistribution over time. Extracts from the Senate Hansard of 11 December 1992 reveal discussion that the Commonwealth's proposal could cause "...a very major shift of money to NSW and Victoria away from all the other States of the order of about \$300m or \$400m.." (Department of Treasury and Finance 1992-97: 112).

The concern of the smaller States to the Commonwealth's proposal comes as no surprise when one considers the wider fiscal federal landscape at the time. The June 1992 Premiers' Conference preceding the Commonwealth's announcement of the Bonus Pool arrangements had reinforced a trend at the time, of significant fiscal redistribution from the larger to smaller States. Examination of the NSW Budget Papers confirms that dissatisfaction with fiscal equalisation had been brooding for a number of years within the larger States. The NSW Government pointed out that NSW and Victoria "...subsidise the other States and Territories by approximately \$2.5 billion per annum", and "since 1987/88 the cross subsidy has increased by over 40 per cent or around \$730 million.." (NSW Government 1992: 7_6, 10_8, 10_9). Muddying the policy

setting waters was the fact too that there were a number of reviews of the CGC process underway at the time. A review by the Heads of Treasury was due to report in early 1993, whilst the CGC was conducting its own five-yearly methodology review. Additionally, NSW and Victoria had commissioned their own independent review (NSW Government 1992: 10_10, 7_9). The emerging findings of these reviews was creating a division of views between the smaller States (“Queensland, WA, SA, Tasmania, Northern Territory and ACT”) and the larger States (NSW Government 1993: 7_15). With the Commonwealth’s proposal arriving prior to any of these reviews being finalised, there was understandably considerable uncertainty, on the part of the smaller States.

Further, the negotiations certainly do not seem to have been assisted by the Commonwealth’s urgency in signing up the States. In early December 1992, the Commonwealth’s undue haste was observed by the Senate: “...this agreement does not have to be signed until 30 June 1993 and there is no need for the Government to bully the States into signing forthwith....why is it ramming this through....unfortunately the Commonwealth approach has had elements of coercion for the States, although the States have indicated a genuine willingness to work cooperatively...”(Parl Comm. 1992c). Prior to the Commonwealth’s offer, both the large and small States sought for a major review of universal hospital care and the role of private health insurance (Parl Comm. 1992b). However the Commonwealth defiantly held its ground, refusing to budge from its intended direction. Interestingly, it is claimed that the WA Health Minister went so far as to resign from his position to protest against the Commonwealth’s uncompromising approach⁶¹. In November 1992, Minister Wilson asserted: “The Commonwealth laid down the terms and the States were (being) blackmailed into signing by the threat of ‘ no sign, no money’” (Parl Comm. 1992c).

On 11 December 1992, the Commonwealth presented its official offer to the WA Government, insisting that:

Changes to the distribution of FAGs are an integral part of the Commonwealth proposal As a result of the whole package, and depending upon WA’s response to the incentives contained in the package, the Commonwealth estimates that WA would receive an additional \$47 million in 1993-94 based in current parameters ... The additional increase under the new arrangements is made up of the estimated FAGs redistribution effect (-\$70 million) and the estimated change in health and aged care funding (\$117 million) to give an overall impact of an additional \$47 million. The FAGs and health dollars cannot be taken separately but need to be seen as complimentary components of the new hospital funding arrangements” (Department of Treasury and Finance 1992-97: 102).

The offer proposed a shift of FAGs funding totalling \$243 million from the smaller to larger States, offset by a compensating transfer of \$145 million of Medicare grant and aged care funding from NSW and Victoria to the smaller States. The redistribution of Medicare grant funding to the smaller States was effected through the Bonus Pools: 1) Pool A - a base funding provision, incorporating ‘guaranteed’ funding of \$437 million subject to the smaller States maintaining their level of public provision; and 2) Pool B - an annual adjustments pool to be used to reward, penalise and redistribute funding, to and from States, in which public provision rose or fell outside of predefined thresholds.

⁶¹ A WA Parliamentary record confirms that Minister Wilson’s resignation arose from a “troubled with conscience over WA fight with federal government over health funding” (Parliamentary Library of Western Australia 2010: 2)

- Notwithstanding the funding guarantees made available to the smaller States, the WA Treasury noted that the complexity and unpredictability of the Bonus Pool funding reduced the certainty of grant funding from 97 to 70 per cent (Department of Treasury and Finance 1992-97: 150). The Commonwealth's proposal nullified any prospect of a transparent link between the hospital grant and the unique funding needs and performance of local hospitals, with a large part of the grant instead being "dependent upon the performance of other States" (Department of Treasury and Finance 1992-97: 154-5). A sample clause from the Agreement, Clause 5.2 (v) of Schedule D provides a good indication of the complexity associated with accessing Bonus Pool payments:

if a nominated guarantee State does not meet the guarantee conditions then the allocation from the pool for that State will be the lesser of the guarantee entitlement or the level of entitlement the State would have received based on the State's share of public beds days which count towards the pool as if it had never been entitled to a guarantee. If the entitlement is less than the guarantee then the difference between the guarantee and the entitlement based on the State's share of beds days is transferred to the Annual Adjustments Pool.

- The reluctance of any State to sign up to the Agreement is certainly understandable. The NSW government "blamed the Medicare deadlock on (the) complicated mathematical formulae which the Commonwealth had used to 'cook the books'" and confirmed that "the dimension of the December 11 offer has taken the NSW Treasury weeks to analyse". The larger States attributed the complexity of the proposed arrangements to policy compromises secured by the smaller States. The NSW government claimed:

the Commonwealth was cornered in negotiations with the smaller States over the funding implications linked to the bonus pool operation. They were concerned that action taken by the big States to boost their public-private ratio would reduce their shares of the bonus pool. The Commonwealth responded with a guarantee commitment...that none of the States would be worse off because of bonus pool unpredictability and then financed the offer shifting \$400 million out of the base grant into the bonus pool...the \$400 million shift unilaterally overrode the Grants Commission process(Anderson, P. (Australian Financial Review 30 December 1992) as cited in Department of Treasury and Finance 1992-97: 131).

- While the stalemate with the States continued over the coming months, the Commonwealth pushed on aggressively with its agenda. In February 1993, the Commonwealth amended the Terms of Reference to be applied by the CGC in its five yearly review of relativities. The Queensland Under Treasurer observed: "while there is little we as bureaucrats can do to correct the position, I still wish to register Queensland's objections to the apparently unilateral and heavy-handed interference in the Commonwealth Grants Commission's deliberative assessments of States' health funding needs.." (Department of Treasury and Finance 1993-96: 17-20). The WA Treasury also argued that the Commonwealth's proposal represented "gross interference with the independence of the (CGC)..." (Department of Treasury and Finance 1992-97: 143-4).
- The looming 13 March 1993 federal election seems to have been a significant factor in the negotiations. Perhaps feeling defeated by the long period of coercion by the Commonwealth, including the unilateral directions given to the Grants Commission, or perhaps out of concern of a change of federal government and ideology, all States had signed up to the Agreement by February 8 - with the exception of WA.

Archives confirm that the newly elected Court government of WA was optimistic that its bargaining position would be strengthened by the election of a Liberal federal government. Having weighed up the political stakes, the WA Health Minister recommended on 8 March 1993 that it was mainly the Bonus Payments and Incentive funding that were at risk, and thus the State should hold out “up to the last possible moment (to) achieve the best possible deal for WA” (Department of Treasury and Finance 1993-96: 62).

The early sign up of the States, particularly NSW and Victoria, appears to have caught the WA Government by surprise, given “...the strong stance taken by both States against the refusal of the Commonwealth to provide tangible recognition and encouragement for private health insurance and private hospitals”. The sign-up of NSW and Victoria in fact involved costly fiscal compromises on the part of the Commonwealth, as the WA Government rightfully speculated at the time:

the dilution of Grants Commission coverage of health expenditure and the offer of additional money outside of the Medicare agreement provided these States with offers they couldn't refuse. Also no doubt, they would have taken the view that securing a favourable result from the Federal Labor Government would enhance their bargaining position in respect to health funding and fiscal equalisation (which they strongly oppose) with an incoming Federal Coalition government (Department of Treasury and Finance 1993-96: 76).

More details on the eleventh hour ‘deals’ emerged following the election. In June 1993, the returned Labor Commonwealth government confirmed:

In the context of negotiations ... a series of guarantees were made relating to the expected effect of the new arrangements on the distribution of FAGs to the States. These guarantees fall into 2 categories – 1) guarantees to those states... which were expected to have reduced FAGs as a result of the new arrangements; 2) guarantees to NSW and Victoria whose FAG allocations were expected to increase under the new arrangements.

For NSW and Victoria...assurances were given that “once the CGC...(had)...determined its relativities from the 1993 review, and in light of the direction given to the CGC in relation to the new Medicare agreement...(these States would)...receive in their FAGs, an additional amount at least equal to that which the Commonwealth has indicated that they can expect from that direction. This is \$131m/\$112m in the case of NSW/Victoria” (Department of Treasury and Finance 1993-96: 118-20). Both NSW and Victoria ensured that the promised \$243 million would be paid to them, “irrespective of the outcome of the Grants Commission review” (NSW Government 1993: 7_12). NSW bureaucrats working in the system at the time, confirm that the guarantees arose because the Commonwealth needed to reach consensus with the larger States prior to the federal election and the outcome of the CGC review (1997: 6-7).

The successful signing of the other States naturally placed the WA Government under pressure and reduced its capacity to hold out for additional concessions (Department of Treasury and Finance 1993-96: 76). The Commonwealth was also unrelenting, pushing for the Agreement be signed by 30 June as “there is no capacity under the legislation for retrospective payments to be made” (Department of Treasury and Finance 1993-96: 106-10). The Commonwealth was also not at all swayed by the State's concerns over the inequality of the Agreement. The Commonwealth insisted that:

past efforts by WA in maintaining a relatively high public share are recognised in Pool A. Pool B is targeted at improvements in public share and can only be accessed for that purpose. While other States with lower base public shares may appear to have more scope to make improvements, they still face the problems of dealing with the structural and cultural rigidities that are associated with their past performance..(Department of Treasury and Finance 1993-96: 106-10).

- A further area of concern for the WA Government appears to have been the incentives package and other governance reforms. The WA Treasury observed: “there is the potential for the Commonwealth to by-pass State health departments and deal directly with hospitals...with this funding” (Department of Treasury and Finance 1996-97a: 77). Additionally, the WA Government was highly concerned over the “detailed conditions... laid out in terms of being able to access the funding ... including reporting requirements, requirements for implementation plans, maintenance of effort and establishment of quality assurance processes”.
- The archives show the WA Government objecting to a range of enforcement requirements:
 - In October 1992, the WA Health Minister advises the Commonwealth “...I have more than a little concern about the amount of data and level of detail which the Commonwealth...may expect to receive from the State under the terms of the new Medicare Agreement. I believe we need to be more than a little circumspect about the propensity for bureaucracies to build data mountains which end up casting more shadows than light over management and clinical needs”.
 - Further the Minister argues in relation to incentive funding, “it should be allocated on a per capita basis to the States in relation to progressing strategic objectives contained in the respective State strategic plan which would be attached to the Medicare agreement....I do not see the value of developing elaborate and duplicate administrative procedures to oversight relatively small amounts of funding...WA does not agree to a system of funding by individual project submission to the Commonwealth..” (Department of Treasury and Finance 1992-97: 78-84).
 - The Department also lamented the requirements for the provision of “specific health service statistics to State Parliament; and Commonwealth “involvement...in the development and wording of the Public Patients’ Charter” (Department of Treasury and Finance 1993-96: 14)
- Ultimately however, the impasse was overcome, the WA Government signing up to the Agreement in June 1993. The Health Minister claimed: “I have been able to achieve a much better Medicare funding deal than was originally in prospect for WA”. He asserted that with intensive negotiations, WA had secured: 1) “Guaranteed funding, excluding indexation, of \$447 million in 1993/94, \$443 million in 1994/95 and \$439 million in the last three years of the Agreement ...”; 2) “A significantly improved base year position which will greatly assist the State in competing each year for a share of additional Bonus funding (Pool B) of at least \$190 million”; 3) “A commitment after the first year of the Agreement to use growth in public patient admissions rather than bed days to calculate shares of Bonus Pool B funding ... [as it] ... has been acknowledged that the calculation of bonuses based on growth in bed days is not conducive to

encouraging efficiency improvements”; 4) “the facility to bring forward funds from the last 3 years to 1993/94 and 1994/95 to provide up to \$21.2 m in forward funding”; and 5) “access to other Commonwealth health funding” including funding for palliative care and wait list reductions. The Minister also maintained that the requirements for State Medicare legislation, patient charter, complaints body and Commonwealth participation in health services planning groups “are not, in the main, incompatible with the direction of State policy” (Department of Treasury and Finance 1993-96: 146-50).

A more subdued response came from the WA Treasury which advised Government that the Agreement is “probably as good as could be achieved in the circumstances and the limited timeframe under which it was negotiated”, with funding levels remaining somewhat of an uncertainty and dependent on the “outcome from the Premiers’ Conference” (Department of Treasury and Finance 1993-96: 137-8).

Goal setting — Post-1993 Agreement

As discussed previously, the Commonwealth provided NSW and Victoria with funding guarantees in order to secure their sign-up to the Agreement prior to the federal election. The financing source for these guarantees was not confirmed at the time of the deal. At the July 1993 Premiers Conference, conflicting views prevailed between the Commonwealth, NSW and Victoria over the financing of the guarantee. In order to preserve the deal struck with these States, the Commonwealth was forced to commit to significant new grant funding, and to the ire of the other States, instigate further redistribution of general purpose grant funding. The NSW Budget Papers reveal:

Initially the Commonwealth offer provided for the Medicare guarantee to NSW and Victoria to be funded entirely from the grant pool. This approach would have resulted in NSW funding \$63 million of the guarantee payments to NSW and Victoria. This was inconsistent with the Agreement signed by NSW. Guarantees to the smaller States...on the distribution of FAGs had also been previously given by the Commonwealth as a result of the adjustments in the CGC’s relativities arising from the Medicare Agreement. Interpretations of these guarantees differed among the States and between the States and the Commonwealth.

At the Premiers’ Conference, a compromise was reached whereby part of the Medicare guarantee to the two larger States would come from the pool and the Commonwealth would absorb the remainder. For NSW, this amounted to \$72.5 million from the pool and an additional \$63 million to be provided by the Commonwealth....In the four years following 1993-94 of the Medicare Agreement, the Commonwealth...agreed to fund \$54.4 million of the cost of meeting the guarantee to NSW and Victoria, the remainder to be met by redistribution of the grant pool away from the other States...(NSW Government 1993: 7_21).

The redistribution of funding required for the Medicare Guarantee payments to NSW and Victoria was a significant irritation to the smaller States for a number of years to come. In August 1993, the WA Government considered challenging the Guarantee payments through the High Court. This was quickly negated by the Crown Solicitor who warned that a confrontation with NSW and Victoria would potentially place at risk, fiscal equalisation benefits of around \$200 million per annum, in contrast to the \$35 million cost of the Medicare guarantees. It was recommended that a more astute option would be to “redress the funding loss” through “political means” (Department of Treasury and Finance 1993-96: 166). There was however no early turnaround on the issue, with archives indicating that by 1996/97, NSW and Victoria were receiving a net

total increase in their general revenue grants of \$240 million, with a “reduction in financial assistance grants to other States...(financing)...75 per cent of this amount and the Commonwealth (the remaining) 25 per cent” (Department of Treasury and Finance 1996-97a: 13-14).

In addition to wearing the fiscal cost of the redistributive effects of the 1993 Agreement, the States also faced fiscal pressures from a range of other Commonwealth unilateral decisions. The archives show that:

- As part of the 1995-96 Budget, the Commonwealth confirmed its intentions to reduce around \$85 million from the hospital grants to States over 4 years. It was argued that the cut was intended to: “to prevent the shift of hospital costs from State budgets to consumers, private health insurance funds and the Commonwealth Contrary to the terms of the Medicare Agreements, there have been moves in some States to shift costs from State hospital budgets to the Commonwealth, through actions like ‘privatising’ public hospital out-patient clinics and making claims on the MBS for individual services. These and other activities also result in increased outlays under the ... PBS ... and out of pocket costs for consumers and increased costs for private health insurers...Effectively this transfer of costs is an exercise in double dipping and places the burden on taxpayers.....The Commonwealth will investigate instances where cost shifting appears to be occurring. Where it is clear that penalties are justified, adjustments will be made to...relevant States and Territories in accordance with the provisions of the Medicare Agreement” (Department of Treasury and Finance 1993-96: 227). Pearse et al (1997: 12) observe that the increased interest in cost shifting arose from Commonwealth concerns over significant growth in MBS payments in the early 1990s.
- Following the election of the Howard government, the Commonwealth again embarked on a range of cost-saving initiatives as part of its 1996-97 Budget. The WA Department of Health noted various measures including: penalties for cost shifting; 3% efficiency dividend (to rise by “1% per year cumulatively thereafter”); a 10% reduction of non-hospital specific purpose grants in anticipation of administrative cost savings to come from broadbanding; and cessation of the dental program from January 1997”. A number of policy decisions involving the wider health system were also expected to bring ‘flow-on’ pressures to the public hospitals including the Commonwealth’s: cap on pathology expenditure; fee freeze for MBS items in 1996/97; and reform of the financing of nursing home care (Department of Treasury and Finance 1996-97b: 72-79).

On the cost-shifting penalties, the WA Health Department observed: “savings from the measure are expected to be \$74 million in 1996/97...(however when the Commonwealth was questioned as to the methodology for determining) the 1996/97 reduction and ... relative States’ shares ...[given] ... there were no figures available ... the answer provided was it was not known, but an assessment would be done of the extent to which different States are cost-shifting. The Department asserted: “the Commonwealth’s arguments that States are cost-shifting pre-

admission and post-admission for medical care to the MBS is extremely dubious ... this subject has been the matter of extensive discussions between the Commonwealth and States, with the previous Commonwealth government deciding to take no action”.

On the broadbanding related budget cuts, the Minister for Health expressed his concern to the Commonwealth that the “current work by health officials on broadbanding is heading in a direction to replace one set of cumbersome administrative arrangements with another ... clearly it is not fair for the Commonwealth to obtain a 10% dividend unless and until the suggested unnecessary administrative burden on the State is lifted” (Department of Treasury and Finance 1996-97b: 75-77, 86). According to Pearse et al (1997: 21), the broadbanding cuts were eventually abandoned by the Commonwealth following negotiations with the States.

- Commonwealth heavy-handedness is also apparent. For example, with regards to an earlier amendment of the 1993 Agreement where the Commonwealth conceded to escalate Pool A funds by state, rather than national population, the Commonwealth simply refused to comply. The WA Treasury confirmed that: “...when the Commonwealth was approached about this at officer level, it responded that the variation was a mistake and that it intended to make future payments of ‘Pool A’ funds on the basis of the previous escalation arrangements....(this is)...a disturbing precedent...(of)...ignoring conditions in an agreement...(that has been)...signed” (Department of Treasury and Finance 1996-97b: 83).
- The universal hospital care goal was increasingly under fiscal strain as the Commonwealth moved to implement a policy preference for greater private health care - by stealth (Pearse et al. 1997: 16). The WA Department of Health noted for example: “In reporting on its growth in expenditure for Hospital Services, the Commonwealth has indicated there will be a 10.6% increase in 1997/98....76% of the increase arises from the introduction of the private health insurance incentives. If funding for the incentives is excluded from the figures, the increase is only 2.5%. It is very dubious whether the insurance incentives expenditure should be counted under hospital expenditures (Department of Treasury and Finance 1996-97a: 76).

Goal congruence

- From a State level goal congruence perspective, it is apparent that the States’ bargaining position was weakened by the Commonwealth’s linking of the 1993 Agreement negotiations with CGC and FAG outcomes.
- In WA, at various stages during the negotiations, there were conflicting views held by the Minister for Health and the State’s central agencies, the former seeking to optimise the Medicare grant and the latter more concerned about the implications on FAGs.

For example, the WA Treasury argued that the Medicare offer:

would substantially weaken fiscal equalisation....(and)...will effectively remove health from the Grant Commission’s assessment (i.e. remove almost 24% of the State’s budget expenditure)....there is a danger that any weakening of fiscal equalisation at this time would jeopardise our ability to hold the

line on fiscal equalisation when this issue is considered at next year's Premiers' Conference. The Premiers' Conference will be considering major reports on the future of fiscal equalisation and there will be great pressure for modifications to fiscal equalisation which will significantly reduce WA's share of Commonwealth funding (Department of Treasury and Finance 1992-97: 132).

In addition it was noted that: "The Health Ministers' Office and departmental officers have been, and presumably still are, somewhat disinterested in the Grants Commission implications of the Offer and we are unlikely to obtain much support from that quarter" (Department of Treasury and Finance 1992-97: 141). In response, the WA "Minister for Health...indicated his belief that Treasury's (policy stance) ...(made)...it virtually impossible for WA to continue with the Medicare Agreement negotiations". The tensions between the different portfolios required the WA Premier to intervene (Department of Treasury and Finance 1992-97: 129-30).

Evidence of bottom-up control

Offsetting the preceding evidence of top-down control, there is also evidence that the States were not completely overtaken.

Goal setting—Pre-1993 Agreement

- It is apparent that the funding guarantees secured by the smaller States as discussed earlier, was in fact at least partly won through bargaining and resistance. The offer letter from the Commonwealth advises that: "in response to concerns expressed by smaller States that, in the later years of the agreement in particular, they may be worse off than under the current... (grant) ... arrangements a guarantee mechanism is included to ensure that no State loses from the new agreement". Further, the Commonwealth's Bonus Pool structure seems to have been influenced by State bargaining, the Commonwealth confirming: "the strong preference expressed by most States in negotiations was to operate two pools, one to reflect existing levels of public effort and another to reflect change through the life of the agreement" (Department of Treasury and Finance 1992-97: 107-08).
- In addition to the guarantee payment concessions extracted, the States also managed to secure a range of desired policy adjustments, namely:
 - Inclusion of a 'catastrophe' clause - the WA Government, and presumably other States, sought to include a clause to enable renegotiation of the Agreement under circumstances where there was "substantial increase in the cost of hospital Medicare ... outside of the States' direct control". The types of circumstances cited included a "specific fall in private health insurance coverage at an individual State or overall national level"⁶² and the "availability of new treatments in respect to which there is a very substantial cost of provision because of volume of treatments to the provided or because of the very high cost of individual treatments". The Commonwealth, was not receptive initially but eventually consented to the clause (Department of Treasury and Finance 1992-97: 74).

⁶² Interestingly it was a Senate amendment (possibly influenced by State government lobbying) that resulted in the inclusion of Clauses 16.2 and 16.3, which stipulate that funding levels will be reviewed "whenever the percentage of the national population who at 30 June 1993 are covered by a supplementary hospital table falls by at least 2 percentage points or a multiple thereof" (Aust. Government 1993; Parl Comm. 1992a)

- Incentive payments – the Commonwealth initially proposed to make the “payments direct to institutions in States which do not cooperate” however archives show that this condition of the Agreement was “dropped”, presumably following State resistance (Department of Treasury and Finance 1992-97: 75).
- Complimentary legislation – while the Commonwealth was quite adamant in its pursuit of this policy condition, both State objections and pragmatic issues forced the Commonwealth to retreat. The Commonwealth adjusted its Medicare Agreements Bill 1992 to provide for “either adoption of the Principles and Commitments by the States, or reasonable efforts towards adoption as a condition established by the Bill.” Further, the Commonwealth noted that “...this change addresses the concern of some State Ministries about the requirement of passage of complimentary legislation” (Department of Treasury and Finance 1992-97: 59).
- Adjustment of penalty clause – it seems the Commonwealth initially began with a \$200 per day penalty provision but this was scaled up to \$400 per day after “some States...pointed out that this level of penalty is too low relative to the marginal cost of opening additional public beds to provide an incentive to increase the number of public beds” (Department of Treasury and Finance 1992-97: 106)
- Recognition of private health care and private health insurance – the evidence indicates that States such as NSW, Victoria and WA sought to have the role private health care formally acknowledged within the Agreement, with the larger States seeking for this to be incorporated into the Medicare Principles. Review of the Agreement indicates a compromise was reached, with the States’ desired amendment being included as part of an Explanatory Statement preceding the Medicare Principles and Commitments (Department of Treasury and Finance 1992-97: 78-84; Parl Comm. 1992b).

There is evidence too of more passive, tactical resistance. In March 1993, the WA Health Minister contemplated:

the most effective means of nullifying the Commonwealth’s attempts to progressively intrude into the strategic and operational management of the State’s health system will be for the State to take the initiative in instituting essential reforms to the structure and operation of the State’s health system ... It will be important that our reform and development agenda for the ... system ... is publicly announced and commenced before we arrive at the point where accommodation has to be made with the Commonwealth Government...”(Department of Treasury and Finance 1993-96: 63)

Goal setting — Post-1993 Agreement

In 1995-96, the Commonwealth finally conceded to ongoing criticism from the States, of the operation of the Pool B under which “each State’s share of these funds ... [was] ... quite erratic because ... [of heavy dependence] ... on the performance of other States”. The amendment of the Agreement was triggered by a number of factors: 1) volatility of the pool distribution; 2) results of the first of the 2% Reviews conducted; and 3) Commonwealth concerns over State funding contributions to universal hospital care and cost shifting (Pearse et al. 1997: 7,9).

The Agreement was amended in mid-1996 such that State share of Pool B was fixed in real per capita terms, albeit subject to the meeting of specified performance targets. On the latter inclusion, the States appear to have held the upper hand, the WA Health Department claiming: the targets would “not be difficult to meet within the current budget. With respect to targets for the remaining 2 years, Victoria has advised the Commonwealth that its agreement to the proposed variations to the Medicare agreement is conditional on officer level agreement on indicative targets for 1996/97 and 1997/98. WA ... [will] ... take the same approach”.

The revamped Pool B also had the benefit of absorbing grant funding previously quarantined for the Incentive Package and other specific reforms. Further with regards to the amended penalty provisions, the Department confirmed that penalties were highly unlikely on the basis of the targets set, and notwithstanding this, the quantum of penalty had been “reduced by negotiation” (Department of Treasury and Finance 1996-97b: 2-3).

The WA Government noted that the amendments were likely to result in an increased share of both Pool A and Pool B funding. It was also observed that the amended arrangements were an improvement over the former which had “significantly favoured NSW and Victoria the most populous States” (Department of Treasury and Finance 1996-97b: 11). Pearse et al (1997: 13) also confirm that the revised arrangements came “at a price” for the larger States, increasing Commonwealth leverage and financial risk for these States.

In the end, the Commonwealth’s ‘experimentation’ in associating the Medicare Agreement funding with CGC determination of FAGs was unravelled and ultimately, abandoned. It is certainly noteworthy that the 1999 CGC review of relativities “did not continue the 1993 Review approach of trying to align the Commission’s assessments of the relative costs of health services with the terms of those agreements” (Aust. Government 2009: 121-2).

Goal congruence

Like the goal congruence conflicts at the State level, there was also instability at the federal level.

- The 1993 Agreement was subject to resistance from other federal policy players, this serving to constrain the Commonwealth’s policy control. For example, the WA Treasury confirmed: “...the Medicare legislation has been introduced into Federal Parliament but...it could face some resistance from the Australian Democrats (apparently because of pressure by NSW and Victoria) (Department of Treasury and Finance 1992-97: 74).
- Surprisingly, Commonwealth health bureaucrats appear to have initially adopted an accommodating approach, advising in September 1992:

“The new Agreement will differ from the current one in that it will have elements that will develop over a five year period and which will be subject to ongoing review and discussion between the Commonwealth and the States. It will be a dynamic agreement that has some of the features of a Strategic Plan for reform of the health sector” (Department of Treasury and Finance 1992-97: 215).

“A major focus of the Agreement will be to move the focus away from inputs to the health system and towards outcomes”. “States and Territories have specifically requested that such a focus on outcome based accountability be incorporated in new arrangements and the Commonwealth is likewise keen to develop this approach”. “The Commonwealth proposes that funding for four health programs will be broadbanded...with no reporting requirements....subject to certain undertakings from States discussed below”. “ In the absence of any major problems in the nominated areas there will therefore be no further Commonwealth scrutiny of expenditure or activity. States will be free to use funding flexibility to achieve agreed results” (Department of Treasury and Finance 1992-97: 215, 22).

The Commonwealth advises that its agreement....”is to be seen as a basis for initiating discussion at our forthcoming bilateral meetings” (Department of Treasury and Finance 1992-97: 211).

These promising statements appear to have been over-ridden by Commonwealth economic and budget pressures as formulation of the Agreement progressed.

In terms of goal congruence from a federal-state perspective, there is evidence that States concurred with some of the policy directions in the Agreement:

- All Ministers agreed in November 1991 that: “the enhancement of area/regional health management arrangements offered an opportunity for promoting the separation of funder and provider; and the introduction of casemix funding and management for inpatient public hospital services would improve productivity” (WA Govt 1991: 41).
- In April 1992, all Health Ministers consented to the: inclusion of the “National Mental Health Policy, Plan and Agreement within the new financial arrangements”; “a move towards area/regional planning and service agreements within the life of the Agreement”; “adoption of uniform national casemix classifications and groupers, and cost and service weights”; “a shift in responsibility for medical and pharmaceutical outpatient services to the Commonwealth”; “the organisation and financial arrangements for multi-purpose services”; “the identification of initiatives to be taken in relation to infrastructure funding”; “development of incentive programs including those for strengthening management efficiency and clinical accountability”; and “development of national data standards for monitoring and evaluation” (Department of Treasury and Finance 1992-97: 182).
- In October 1992, the WA Government indicates that in relation to the improvement of hospital efficiency and effectiveness, it seeks to retain “full discretion over how it organises and operates the State’s health services” but is “willing to enter into arrangements with the Commonwealth where Commonwealth funding for health ... [is] ... linked to the achievement of outcomes and outputs”. The States “would be willing also to enter into a regular process of liaison with the Commonwealth on the progress being made towards the achievement of specific health system outcomes” (Department of Treasury and Finance 1992-97: 78-84) .
- On a variation to the Medicare Agreement pertaining to Mental Health, the WA Treasury observed that the objectives of the new arrangements were agreed by all Health Ministers “so they do not constitute the imposition of Commonwealth policy onto the States”; and the new arrangements are less restrictive than the previous

system in which application was made for funding for individual projects sometimes leading to delays”(Department of Treasury and Finance 1993-96: 284-5).

Conclusions: Balance of Policy Making Powers 1993 Agreement

In summary, there is a range of evidence pointing to a top-down mode of governance and policy control, namely the:

- complexity of the Agreement itself;
- conditions included to further embed universal hospital care into State policy frameworks;
- increased prescription around governance reforms and development of hospital datasets, although some of these requirements were ultimately watered down, either through direct amendment of the Agreement or by passive resistance from the States;
- significant increase in reporting requirements;
- continuation of sanctions from the 1988 Agreement with some additional sanctions around the use of incentive funding;
- push for speedy sign-up by States prior to federal election, including the unilateral issuing of instructions to the CGC. A heavy-handed approach was also evident during implementation with the evidence suggesting that the Commonwealth backtracked on commitments previously agreed with the States;
- conflict between the State’s line and central agencies over the relative priority to be attached to the hospital grants and fiscal equalisation grants, which would most likely have weakened the State’s policy response;
- adoption of a highly convoluted funding formula which attempted to directly link the hospital grant with fiscal equalisation processes. The Commonwealth’s approach caused State hospital funding to become dependent on the relative performance of other States, rather than tied to the unique needs of their local communities.

Admittedly, the Commonwealth’s dominance in this area was partially offset by the three rounds of concessions secured by the States over the first two years of the Agreement: 1) the initial concessions made for smaller States prior to December 1992; 2) the special concessions granted to NSW and Victoria just prior to the 1993 federal election; and 3) the further concessions to NSW and Victoria made during the July 1993 Premiers Conference (partly funded by the smaller States and by the Commonwealth). Nonetheless, one cannot overlook that the concessions were ultimately inequitable and came with a degree of uncertainty for the States.

- budget cuts in the latter years of the Agreement including an efficiency dividend, cost-shifting penalties and a premature cut for broadbanding. These cutbacks were not backed by strong evidence; and
- shrinking Commonwealth financial commitment to universal hospital care and an expansion of private financing, particularly with the election of the Howard government.

There is also range of evidence pointing to a bottom-up mode of governance and policy control, namely the:

- initially accommodating approach of the Commonwealth health bureaucrats. It must be noted however that this was quickly overshadowed by political factors (for example the 1993 federal election) and the Commonwealth's broader budget pressures;
- States managing to incorporate a number of their preferences and requirements into the Agreement, including a catastrophe clause; a requirement for a review of the Agreement when private health insurance coverage fell by 2%; recognition of the need for health grant broadbanding; and recognition of the role of private health care in the Explanatory Statement supporting the Medicare Principles and Commitments. It is important to note that some of these features were not always upheld by the Commonwealth including the broadbanding and 2% private health insurance review provisions, making the States' input ultimately ineffective;
- States managing to avert or minimise the impact of a range of policy interventions by the Commonwealth including: the payment of incentive funding direct to institutions (by-passing the State governments); the requirements for complimentary legislation; and the pace and shape of hospital governance and managerial reform which remained firmly in State control;
- States being supportive of a number of the policy and governance reforms included in the Agreement such as Area Health Management, casemix management, incentive funding, national datasets and the National Mental Health policy. Notwithstanding this support however, the Commonwealth's tendency for over-prescriptiveness often resulted in a loss or watering down of State support during the implementation of the Agreement;
- rework of the Bonus Pool arrangements in the last three years of the Agreement which made the distribution of funds more equitable and efficient. Although the Commonwealth attached performance targets to the new arrangements, the evidence confirmed these to be of a passive nature, with the States retaining policy control. The Commonwealth also stepped away from its goal to link the determination of the hospital grant and fiscal equalisation grants. Despite this policy win for the States however, it is important to note that the inequities of the funding guarantees were not in fact fully addressed; and
- resistance faced by the Commonwealth from the Senate and Democrats in passing the associated legislation. The evidence indicates that some of this resistance may have been fuelled by State lobbying.

All in all, while there were gains made by the States through bargaining and resistance, this analysis of the 1993 Agreement reveals the Commonwealth to have dominated the policy setting.

The Commonwealth increased prescription around the grant funding formulae, policy and reform conditions, and reporting requirements – whilst reducing its funding contribution towards universal hospital care over time. In contrast, the States managed to secure some

of their policy preferences and were also able to avert or minimise some of the Commonwealth's terms and conditions. Additionally, in the latter years of the Agreement, State resistance led the Commonwealth to revise its Bonus Pool arrangements and forgo its desire to link the hospital grant with fiscal equalisation processes. There was also little inroad made into improvement of hospital governance and managerial efficiency, this remaining under State discretion. Ultimately however, the Commonwealth's overly prescriptive and hurried approach and fluctuating funding commitment left the States with considerable funding uncertainty, negotiating burden and additional administrative cost. Further some of the 'gains' made by the States proved to be ineffective in practice, with the Commonwealth holding the upper hand in terms of the extent to which some of the amended terms and conditions were adhered to. Thus the overarching assessment gained is of a top-down mode of governance.

C.2.3 Detailed Analysis — Reflections on Grant Performance 1993 Agreement

Performance deficiencies of tied grants

Convoluted policy compromises

- As discussed earlier, the provision of funding guarantees to the smaller States, followed by the separate guarantees to the larger States convoluted the grant funding formulae and skewed funding distribution. The larger States argued that: "the Commonwealth was cornered in negotiations with the smaller States over the funding implications linked to the bonus pool operation". On the other hand, the smaller States asserted that NSW and Victoria had negotiated "a good deal for themselves in the bilateral negotiation of the current Medicare Agreement" (Anderson, P. (Australian Financial Review 30 December 1992) as cited in Department of Treasury and Finance 1992-97: 131; Department of Treasury and Finance 1996-97a: 13).

The problem appears to have arisen from the Commonwealth seeking for a 'one size fits all' solution to the different policy compromises required to secure State sign-up. A letter from the WA Health Minister to the Shadow Federal Health Minister confirms that "in negotiations with the Commonwealth prior to the calling of the WA State election and the Federal election ...[a] ... figure of \$50 million was acknowledged...as a reasonable additional funding request. The problem arose when the Commonwealth health bureaucracy attempted to develop a funding formula which would apply to all States while at the same time overcoming the acknowledged shortfall in Commonwealth public hospital funding to WA.." (Department of Treasury and Finance 1993-96: 44).

"They failed to do this and in the process constructed a formula which has the potential to reduce Commonwealth public hospital funding to WA even if WA retains a level of public patient provision which is the second highest in the country after the NT. Furthermore under the proposed new Medicare agreement funding formula, the amount of additional funding to WA in respect to an increase in public patient access

will be largely determined by what happens in the other States, in particular NSW and Victoria” (Department of Treasury and Finance 1993-96: 45).

With regards to the 1993 Premiers’ Conference outcome where the smaller States were ultimately forced to finance part of the guarantee payments to NSW and Victoria, the Queensland government argued: “if the current offer stands, it will cost Queensland, for example, a further \$42 million. If this had been on the table during the original negotiations, we would not have signed the Agreement. I make the point that Queensland was the first State to sign the Medicare agreement, while NSW and Victoria held out until the last, and have been allowed ... to distort the intent of the Medicare agreement to provide incentives to increase public bed provision ... It is therefore particularly galling Prime Minister, to come here today and be given the bill to pay for these side deals when the Deputy Prime Minister promised us in writing that we would not be disadvantaged if subsequent deals were done with other States” (WA Govt 1993: 25).

The SA Government had a similar response, indicating: “we signed in good faith. We took those figures ... and we factored them into all our expenditure patterns in good faith – now to find, if we do not get this matter changed, that we were fools. Frankly that would mean that there would be an excess of caution applied in any future request to sign a negotiated agreement” (WA Govt 1993: 32).

The end outcome was also not assisted by a lack of coordination by the various federal agencies. For example, the WA Minister for Health noted in July 1993 (after WA’s loss of general purpose grant funding to compensate for the Medicare Guarantee payments to NSW and Victoria) that the “Commonwealth Health Department was unaware of any intention to take money away from us at the Premiers’ Conference” (Department of Treasury and Finance 1993-96: 156).

Policy bias towards the larger States

- The Commonwealth’s establishment of the Bonus Pool payments and its linking of the hospital grant to FAG processes appear to have been driven by a desire to increase the provision of universal hospital care. This policy end however was at that time, more relevant to the larger States. For example, the WA government noted in relation to the bonus payments that “the small gain is subject to considerable uncertainty and could be eroded in the future because the funding distribution is – highly sensitive to small movements inherently unreliable statistics; and disproportionately rewards States which improve their low commitment to Medicare at the expense of States such as WA which already have a high commitment to Medicare” (Department of Treasury and Finance 1992-97: 140).

Admittedly, the smaller States managed to obtain funding guarantees. However in the end, the financing of Medicare Guarantee payments to NSW and Victoria ultimately came at the expense of the smaller States who were forced to contribute to these payments through a reduction of their own general purpose revenue grants. The States continued to fight these inequitable arrangements into the negotiation of the 1998 Agreement. For example a WA Treasury submission to the “Commonwealth Inquiry into

the Administration of Commonwealth-State Agreements for Specific Purpose Payments in February 1995 observes:

The new Medicare Agreements applying from 1993/94 contain formulas of unrivalled complexity for allocating grants to the States. Yet these formulas provide neither efficiency nor equity....to illustrate the equity problems, the WA Treasury has examined the net benefit to each State (after adjusting for each State's different health needs) of the current system of Commonwealth health outlays, including the Grants Commission's health allowances, the Medicare grants to the States, the 'Medicare guarantees for NSW and Victoria and the Medicare and pharmaceutical payments by the Commonwealth to individuals....NSW is a substantial net beneficiary of these arrangements while most of the smaller population States are substantially penalised" (Department of Treasury and Finance 1993-96: 235).

The signing up of the NSW and Victorian governments prior to the 1993 federal election also reduced the bargaining power of the smaller States.

- In terms of operational issues, here too there is evidence of policy making that is biased towards the larger States. In December 1996, the WA Health Minister wrote to the Commonwealth on federal Budget measures to "restrict and ... prevent practice by temporary resident doctors (TRDs) and ... further reduce medical school intakes" He argued that while such measures may be necessary for "addressing the oversupply of doctors in Sydney and Melbourne", there was potential to "exacerbate the shortage of doctors in WA's rural and remote areas which are heavily reliant on TRDs (Department of Treasury and Finance 1996-97b: 87).

Accountability shortcomings

- The lack of a meaningful connection between hospital costs and funding needs, and the complexity of the 1993 Agreement funding formulae were both key administrative and accountability weaknesses.

For example, in April 1993, the WA Treasury hypothesised over possible interpretations of Clause 5.2 (a) (v) which stated:

If a nominated guarantee State does not meet the guarantee conditions then the allocation from the pool for that State will be the lesser of the guarantee entitlement or the level of entitlement the State would have received based on the State's share of public bed days which count towards the pool as if it had never been entitled to a guarantee. If the entitlement is less than the guarantee then the difference between the guarantee and the entitlement based on the State's share of bed days is transferred to the Annual Adjustments Pool" (Department of Treasury and Finance 1993-96: 96).

The WA paper first explains that the:

bed days which 'count towards the pool' are the bed days in 1990/91 which each State provided to public patients in excess of 51.5% of total bed days in the State. Pool A is split between the States in proportion of these excess bed days (Victoria does not receive a share of Pool A because its public bed days in 1990/91 were less than 51.5% of total bed days), subject to guarantees.

The paper proposes that one possible interpretation of Clause 5.2 (a) (v) as:

If the share of funds which a State would receive in the absence of its guarantee is less than the guarantee, that State will have its share increased to the guarantee. This will reduce the funds available for distribution to other States. Consequently, the shares of other States are recalculated after any guarantees are applied. This (iterative) process is repeated until no State's share is below its guarantee (Department of Treasury and Finance 1993-96: 96).

- The multiple government funding sources for State public hospitals and the lack of transparency, resulted in a politically-charged ‘blame game’ between the Commonwealth and the States. For example, in November 1995, the Commonwealth Minister for Health aggravated the States by claiming that: “while the Commonwealth has been steadily increasing its health funding, the States have been slashing theirs ... for example ... in 1993-94, though the Federal Government increased health funding by 6.2%, State governments reduced their expenditure by 3.9%. Clearly this is the result of the massive state health cuts of Coalition Governments particularly in Victoria, SA and WA. Jeff Kennett has slashed his health budget by \$260 million over 2 years. Dean Brown has cut health funding in SA by \$66 million and in WA, Richard Court has ripped \$160 million from the public health sector”(Department of Treasury and Finance 1993-96: 243).

In response, the WA Treasury pointed out: while it is true that “from 1992/93 to 1994/95, there was a significant real increase in health grants from the Commonwealth to WA which was not matched by an increase in total State health expenditure ... blaming the State Government for cutting its health spending is misleading as the State was also affected by changes in its general purpose grants. From 1992/93 to 1994/95 WA’s general purpose grants declined in nominal terms by \$69 million or 4.3% (after allowing for the untying of roads grants and revised arrangements for nurse education funding)” (Department of Treasury and Finance 1993-96: 245).

Administrative and operational inefficiencies

- The archival evidence confirms there to be a range of inefficiencies emanating from the 1993 Agreement.
- From a service delivery perspective, the insufficient focus on non-hospital policy solutions continued to leave States with “more hospital beds per head than most comparable countries, and as a result less financial flexibility to invest in ‘new’... services” (Department of Treasury and Finance 1993-96: 211). This policy bias is a consistent one beginning from the 1975 Agreement.
- On grant administration, a number of observations are made. The WA Department of Health noted that the “Medicare agreement..(had) around 15 different funding components ... [and was the] ... best example of (tied grant) complexity”. On the Incentives Package, the Department confirmed: “In WA some projects to be funded through the Strategic Capital Planning program...have taken almost 12 months to approve. With this delay, project proponents may have relocated or priorities for the project may have changed. Further delays may then be encountered while project proposals are reviewed and updated as required”. The Department also notes that on reporting requirements: “in some cases, program reporting requirements are altered after the program has commenced, for example, the Medicare agreement now requires detailed reporting of non-inpatient performance” (Department of Treasury and Finance 1996-97b: 23-26).
- Consistent with earlier case study findings, the Commonwealth faced difficulties in enforcing the terms and conditions of its 1993 Agreement due to data limitations.

For example, in enforcing the reward and penalty provisions associated with the Bonus Pool arrangements, it was noted in 1996 that “the first 2 years of the current bonus pool arrangements have shown up major problems in administering the arrangement in a way that is fair to all States. Because of the substantial time lags in the provision and verification of the data required to calculate the individual state shares of the available Bonus Pool funds, it is not feasible to reward hospitals for increased throughput in the expenditure year. The calculation for Bonus Pool shares for 1993/94 has not been finalised by the Commonwealth.” (Department of Treasury and Finance 1996-97b: 8).

By way of another example, the Commonwealth also found itself unable to precisely identify or confirm incidences of cost-shifting by the States. In February 1985, the Commonwealth noted that while it believed “cost shifting ... [had] ... occurred in all States to a greater or lesser degree ... [it had to accept] ... that the data analysis that is currently available has severe limitations and that for the time being, it will...have to rely on broad judgements and/or case by case analysis in determining possible adjustments” (Department of Treasury and Finance 1993-96: 222).

In May 1997, the State noted it would have difficulties meeting its performance targets under the revamped Pool A arrangement. The State confirmed that the targets were “overly ambitious” as a result of “past problems in calculating numbers of non-inpatient services” and non-implementation of “data systems for emergency departments”. In response, it appears that the Commonwealth was “sympathetic to (the) case for revisions to the targets”, this act validating the difficulties faced by the Commonwealth in enforcing performance targets in an atmosphere of data inconsistency and weakness (Department of Treasury and Finance 1996-97a: 65).

Despite the Agreement’s requirement that State outpatient services do not attract MBS and PBS claims, it appears that in practice, “this degree of distinction between accident and emergency and outpatients and MBS/PBS..(was not)..achieved”. Archives note that “outpatient services are at the centre of...cost shifting controversy and the distinction is especially blurred in regard to hospital doctors’ rights of private practice”. The inability of the Commonwealth to monitor implementation appears to be data related, with archives confirming that “definitions of non-admitted patient services used, and the scope of services counted have changed ... [over time] ... and continue to vary across jurisdictions (Department of Treasury and Finance 1997b: 163-4).

Finally in meeting the Agreement requirement to review grant funding levels with a greater than 2% change in private health insurance coverage rates, it was observed that the first ‘2% Review’ conducted “derived six alternative estimates of increased cost to the public hospital system attributable to the 2.1% drop in insurance participation from June 1993 to September 1994” (Department of Treasury and Finance 1996-97b: 132-34). The archives also reveal the Commonwealth and States disagreeing over the use of marginal or average costs (Department of Treasury and Finance 1996-97a: 16). Pearse et al (1997: 10) also note that the “shortcomings in available data was a considerable constraint” in the total of three 2% reviews that were triggered during the life of the Agreement.

Emphasis on macroeconomic performance

- In line with earlier hospital grants, the Commonwealth commenced with strong intentions to enhance managerial efficiency within the public hospitals, but in the end, its policy attention reverted to its macroeconomic objectives.
- The extent to which the Commonwealth began neglecting the financing of universal hospital care is also evident from some statistics cited by the Victorian government: “the 1994 Commonwealth Budget Papers show that Medicare outlays on doctors’ fees will be increasing 38% and pharmaceutical benefits 49% in the next 4 years. Hospital funding grants to the States are to rise only 7%. Medical and pharmaceutical costs are breaking the Commonwealth budget. The Commonwealth is (in turn) squeezing state hospital funding to offset its own fiscal difficulties” (Department of Treasury and Finance 1993-96: 210).

C.3 HIGH LEVEL CASE STUDY EXAMINATION — 1998 AUSTRALIAN HEALTH CARE AGREEMENT⁶³

When the Commonwealth and States came to negotiate the 1998 Agreement, universal hospital care was well and truly embedded into Australian health policy settings. Additionally, health datasets and health policy setting machinery had evolved considerably in sophistication and depth. There was also much more open acknowledgement of the need for improved integration between the hospital system and the wider health system.

C.3.1 High Level Summary

Table C.3 High Level Assessment 1998 Agreement

Case Study	Balance of Policy Making Power	Performance effects evident
1998 – 2003 Agreement	Bottom-up	<ul style="list-style-type: none"> Convoluted policy compromises Accountability shortcomings Administrative and operational inefficiencies Emphasis on macroeconomic performance

C.3.2 Detailed Analysis — Balance of Policy Making Powers 1998 Agreement

Evidence of top-down control

Goal clarity

- A number of aspects of the 1998 Agreement indicate a more top-down mode of governance. For example the Agreement (Aust. Government 1998):
 - retained the Commonwealth’s Medicare Principles established in the 1993 Agreement, although some of these were re-worded;
 - continued the Commonwealth’s policy focus on mental health, palliative care and casemix management. On mental health reform, there appears to be increased goal prescription, with the State required to ‘maintain a mental health advisory group’, separate budgeting of mental health services and maintenance of spending effort;
 - continued to control and influence levels of service provision. While the 1993 Agreement had referred to PBS and MBS payment levels, the 1998 Agreement was much more specific, establishing a minimum *weighted separation* threshold;
 - increased prescription around the requirements for a Public Patient Charter and Independent Complaints Body, and around patient election procedures; and
 - continued Commonwealth involvement in hospital managerial reforms, although the 1998 Agreement appears somewhat more strategic, with less prescriptive procedures around the approval of potential reform projects.

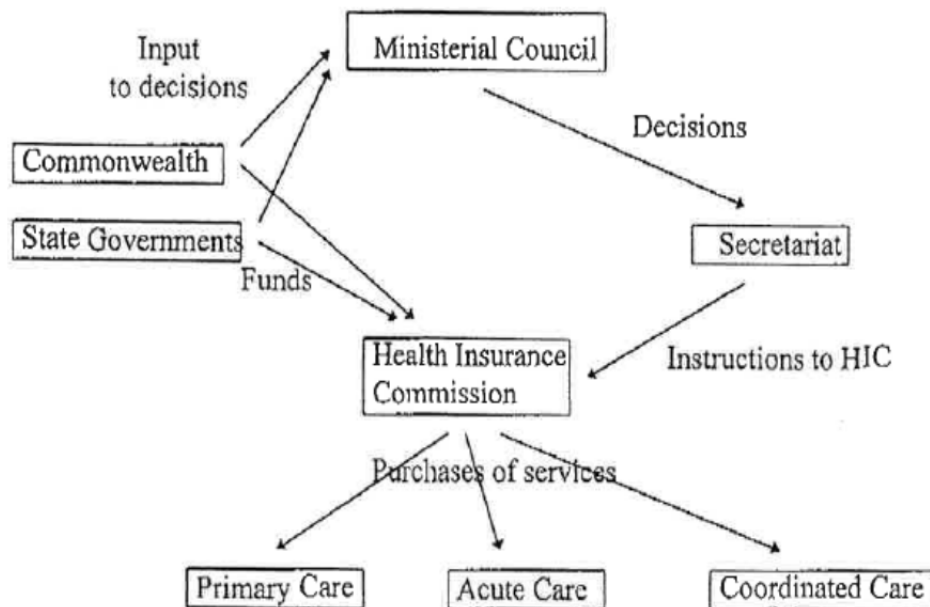
⁶³ This Appendix should be reviewed in conjunction with Appendix B.6.

Goal setting

- The first few months of negotiations occurred in an atmosphere of cooperation, with Commonwealth and State Health Ministers jointly driving a considered policy setting process. This approach was short-lived however, with negotiations disintegrating into a protracted and politically-charged impasse over funding levels, as the States fought to be compensated for breaches of the 1993 Agreement which they argued had left them financially short-changed.
- Negotiation of the Agreement began in May 1997 when Ministers re-confirmed “their commitment ... to universal coverage and access to services on the basis of health need”. Additionally, Ministers decided to change the name of the Agreement to the Australian Health Care Agreement to reinforce a health system, rather than purely hospitals focus in the negotiations. Further, it was agreed that negotiations should be underpinned by five principles, these being (briefly): 1) integrated, coordinated and patient focussed care particularly for frequent users of the system; 2) outputs and outcomes based funding arrangements; 3) a focus on continuous improvement, innovation and best practice, including structural changes to reduce cost pressures on acute care; 4) cost effective management and improved risk sharing, with appropriate recognition of the co-existence of public and private health sectors; and 5) the collection of information to assist policy analysis, service planning and delivery (Department of Treasury and Finance 1997b: 11,13, 81-85; 1997a: 28).
- Having agreed conceptually on a policy framework for conducting the renegotiations, the next step in the goal setting process appears to have been the development of Discussion Papers, independently, by both Commonwealth and States. The Discussion Papers were intended to facilitate the reaching of a consensus, between all jurisdictions, over the key features of the new Agreement, during 1997/98 (Department of Treasury and Finance 1997b: 52).
- The Commonwealth commenced with the issue of five discussion papers in July 1997. Key features of the Commonwealth’s proposal included (Department of Treasury and Finance 1997b: 6, 22-29; 1997a: 11-12, 20, 47, 52):
 - three separate funding streams, for admitted, non-admitted and other services;
 - the use of casemix funding for admitted services, with a cap on the number of cases funded and agreed standards for the quality of care. Also “suggested” was the use of “normative cost weights” to “create incentives for best practice”. (The Commonwealth acknowledged there were complexities in implementing casemix based funding including costing practice variations and data shortcomings across jurisdictions. To partly address this issue, a consultancy was established to examine these variations and data concerns);
 - potential indexation for: population growth and ageing, changes in private health insurance, price increases, efficiency gains, technology improvements and residual utilisation growth (where this was due to specific Commonwealth policies);
 - a ‘measure and share’ approach under which the Commonwealth and States committed to ‘measuring’ and ‘pooling’ funding spread across disparate program areas; and ‘sharing’ in cost savings that resulted from better integration of services;

- as shown below (Department of Treasury and Finance 1997a: 47), the Health Insurance Commission to “become the single Australian purchaser of health services and operate an integrated database”. It was suggested that the Commonwealth and States “would pool their respective contributions ... [from which] ... the HIC ... would then make the decisions on purchasing” whilst States would be responsible for “planning and management of service delivery”. In terms of implementation, the Commonwealth appears to have envisaged a phased approach, proposing to commence such arrangements firstly for mental health services and for veterans’ health services;

Figure C.1 Purchaser-Provider Model Proposed by the Commonwealth



- continuation and improvement of current funding arrangements for palliative care;
- discontinuation of any funding for private patients in public hospitals (the Commonwealth argued that States should not be using its funding contribution to subsidise the cost of services to private patients). This policy feature was offset by the Commonwealth’s somewhat vague offer that it may potentially consider allowing increased cost recovery from private patients, and the charging of outpatient services;
- a specific bonus pool “directed at supporting quality outcomes at hospital provider level”. The Commonwealth suggested that States could maintain full discretion over the allocation of this funding, provided they demonstrated a “satisfactory ... [allocation] ... process”;
- some performance based funding for the “achievement of appropriate standards of waiting time for access to services”;
- potential separation of Agreement funding into capital and recurrent pools;
- potential segregation of teaching, training and research services so that these are “not overridden by funding incentives to favour other identified outputs”; and
- broadbanding of a number of separate tied grants into the hospital grant.

- At a meeting of Health Ministers in August 1997, consensus was reached on a number of ‘building blocks’ to underpin the new agreement: 1) “protocols to support ‘measure and share’ arrangements; 2) integrated information; 3) an output and outcome focus based on agreed targets and performance measures; and 4) risk management arrangements based on appropriate sharing of risk”.
- At this early stage, State consensus remained predominantly conditional. For example, the WA Treasury commented: “whether or not the building blocks are in our interest (will depend) largely on how they are interpreted”. Further, it was observed that “political pressure appears essential if States are to succeed” (Department of Treasury and Finance 1997a: 54, 56-7).
- Face to face bilateral meetings followed the Ministerial level consensus and the Commonwealth/State discussion papers. Here, the negotiation dialogue became noticeably ‘top-down’ with the Commonwealth dictating the scope and tone of the bilateral discussions. For example, at one such meeting between the WA Government and Commonwealth officials in September 1997, the Commonwealth confirmed there would be no significant increases in funding and refused to accept the State’s claims of a “real crisis in hospital funding”. The Commonwealth also insisted that the federal Cabinet could not confirm funding levels before November 1997, this placing the State at a negotiating disadvantage.

Additionally, the Commonwealth: rejected the findings of the 2% Reviews; insisted that casemix funding would not be linked to actual costs but would be used more as a means of capping the Commonwealth’s funding exposure; sought for assistance from States as to the setting of minimum service thresholds for outpatient services; and indicated an unwillingness to discuss and address policy issues raised by State officials such as ‘utilisation drift’. The Commonwealth also flagged possible measures to address cost-shifting (choosing to overlook the ‘measure and share’ proposals it had tabled earlier); and proposed a reduction in recurrent casemix funding to support the establishment of a separate capital funding pool (Department of Treasury and Finance 1997a: 59-69).

- A formal offer from the Commonwealth was presented in December 1997 and was promptly rejected by the States. Thereafter, the negotiations more definitively entered a combative phase, often played out in the public arena. The Commonwealth Health Minister threatened to “deny funding to States which ... [refused the] ... Medicare offer”. Personal attacks were also launched on State Health Ministers, the Commonwealth labelling the SA Minister as “the country’s least experienced Health Minister” and the NSW Minister as a “monkey”.

Also as in earlier case studies, the Commonwealth resorted to the use of financial sweeteners, establishing a \$100 million national fund for hospital waiting lists to be made available only “to those States which accepted...the offer”. This tactic was promptly rewarded, the ACT Government choosing to sign an Agreement with the Commonwealth on 15 January 1998. The ACT showed no remorse for breaking with the other States, arguing it had been after the “best deal for Canberra” and “could not remember a time when the States held out for the ACT”. As a further enticement, the

Commonwealth promised the ACT government that it would not be “any worse off financially than any other State” and would be automatically compensated for any additional concessions agreed to with other States. The Health Minister declared he was “determined to reverse the usual pattern of Medicare negotiations in which the States that held out the longest gained the most. Increasing pressure on the other States, the Commonwealth went to great lengths to stress that if no other State signed, the ACT would reap the full benefit of the \$100 million incentive money that had been made available (Department of Treasury and Finance 1998g: 17, 29-30).

Also sharing a familiar trait to the negotiations of the past, looming Commonwealth and State elections appear to have impacted on bargaining behaviours. It was observed for example that the “deal with the ACT ... [was expected to] ... put pressure on NSW and the other States to sign up ... giving the Government a clear run on health policy for this year’s expected federal election”. Additionally, the NSW government claimed that the ACT government had only signed because they have an “election next month”. In fact, the ACT government signed just hours before entering caretaker mode. (Department of Treasury and Finance 1998g: 30).

By February 1998, the intergovernmental discourse was a highly politicised struggle over funding levels. The States sought for Commonwealth breaches to be addressed (for example, the refusal to honour 1993 Agreement clauses relating to changes in private health insurance coverage; the financing of the 1993 Guarantee Payments though changes to distribution of fiscal equalisation grants; and the unilateral levying of ‘cost-shifting penalties). The Commonwealth however as a policy and funding partner, had no interest in decisions of the former Labor government and pushed aside State concerns as irrelevant.

The debate also became increasingly hostile, the Commonwealth using the media to publicly intimidate the States. In a press release of 17 March, the Commonwealth claimed “States play politics while patients wait in pain”. Later, the Commonwealth insisted, “the States’ demand is not serious, it is not necessary. It is financially irresponsible and for some States it is just a device to make fundamental ideological opposition to Medicare”. Rejecting State assertions of ‘demand’ pressures, the Commonwealth maintained that “the States have admitted themselves that almost two thirds of the money they ‘need’ is to compensate them for signing a bad agreement with the Keating Government in 1993” (Department of Treasury and Finance 1998f: 3-7).

Another factor that became a “high profile ... [and contentious] ... issue” in the negotiations was that of relative Commonwealth-State spending shares, with both levels government putting forward their own versions of this data, to support their respective arguments. Interestingly, following one such Commonwealth representation reported by the media, the Commonwealth Grants Commission (CGC) wrote to the Commonwealth requesting that such representations not be referenced as ‘CGC data’ where the data had clearly been adjusted by Commonwealth officers (Department of Treasury and Finance 1998e: 20, 225, 28).

Goal congruence

- The Commonwealth appears to have struggled with balancing two divergent objectives: 1) a managerial efficiency objective to fund States by the level of outputs produced (casemix funding); and 2) a macro-economic objective to achieve equity in overall grant distribution across States.

Rather than opt for a single objective, the Commonwealth attempted to address both, leading to confusion and ineffectiveness. The States noted in early 1998 that while funding levels would be determined on an output basis, the Commonwealth also planned to “arbitrarily” adjust funding levels in 1998/99 “to ensure all States ... [got] ... an equal share of the available funding”. These proposed adjustments were of great concern to the States who argued that while the “amount of funding ... [to be received would] ... bear no relationship to ... [their performance targets, states would] ... still be expected to deliver the targeted rate of separations and ... be financially penalised if they do not”.

It is clear that the determination of health funding and the preservation of a meaningful relationship to actual hospital costs, became convoluted in the conflict between these two competing policy objectives (Department of Treasury and Finance 1998h: 9, 119).

- Throughout the negotiations, the CGC impact of the 1998 Agreement was an ever present consideration for the States. With no transparent link between the timing of CGC reviews and the settlement of the hospital funding grant, the States faced ongoing uncertainty as to their overall federal fiscal outcomes. In this regard, the Commonwealth seems to have held the upper hand, having the authority to determine whether grant funding would be included or excluded from the CGC process. As evident in the 1993 Agreement negotiations, the disconnect between the two grant determination processes was used strategically by the Commonwealth — in this instance to portray a misleading picture of State expenditure on hospital services (Department of Treasury and Finance 1998h: 45-49, 57-58, 91).
- Also as apparent in earlier case studies, policy setting conflict arose between the Health Ministers and central agencies. For example, at a Heads of Treasury meeting in March 1998, the Tasmanian and WA Treasuries confirmed that “the position ... put collectively to the Commonwealth was for distributional aspects of the Australian Health Care Agreements to be largely determined at (the) Premier’s Conference”. Hence apart from Health Ministers and health bureaucrats, grant outcomes were also heavily influenced by the priorities and needs of Premiers, Treasurers and their bureaucrats (Department of Treasury and Finance 1998h: 117-18).

Evidence of bottom-up control

While there were quite aggressive demonstrations of top-down control, the States were by no means were completely overtaken. There is also convincing evidence to show that the States exerted policy resistance in various forms as discussed below.

Goal clarity

- A review of the WA Agreement and goal clarity indicates there were a range of areas where the State seems to have either maintained or increased policy discretion and control, compared to the 1993 Agreement. For example, the 1998 Agreement:
 - continued the ‘catastrophe clause’ which at least technically, provided a financial safeguard for the State;
 - allowed for an independent reviewer to resolve disputes lasting more than three months. The reversion to an independent party presumably gave the State more assurance of an unbiased outcome than one where the Commonwealth Minister was the sole and final arbiter, a feature of the earlier Agreement;
 - formally acknowledged the flow-on effects emanating from changes in private health insurance coverage and utilisation rates in public hospitals. The Agreement in fact provided for increased funding with national uniform falls of 1% in private health insurance and committed both levels of government to further exploring the relationship between private health insurance take-up and public hospital utilisation for private patients.
 - In terms of enhancing system integration, a long standing qualm of the States, it is notable that the 1998 Agreement provided quarantined grant funding for system integration projects, with a not insignificant amount of \$23 million being made available for WA alone. This level of investment from the Commonwealth was not evident in earlier case studies;
 - adopted funding formulae that was significantly simpler than the 1993 Agreement. The five different funding streams and complex Bonus Pool arrangements of the initial 1993 Agreement was replaced by an indexed Base Grant, and indexed component grants (for mental health, palliative care, casemix, quality improvement and structural reform). The indices adopted not only adjusted for age, population and labour cost movements, but also incorporated an “utilisation growth factor” (which recognised changes in private health insurance and demand growth) and a “hospital output cost index” (recognising that CPI and labour cost indices were inadequate as measures of hospital cost growth). Although the “hospital cost output index” was still under development at the time the Agreement was signed, its incorporation clearly signals better acknowledgement of the unique nature of hospital cost growth;
 - consolidated a number of tied grants. Thus broadbanding was formally implemented in this Agreement compared to its predecessor which only committed both parties to further examination;
 - reduced the use of sanctions and also provided for a more considered approach in the levying of sanctions. For example, while a sanction or grant reduction could apply if *weighted separation* activity fell below the specified threshold of 290.14/1000 *weighted public patient separations*, the Agreement allowed for the circumstances of the fall to be fully investigated, before any sanctions were issued. The utilisation measures used were also more precise, the 1998 Agreement referring to *weighted separations* and private health insurance coverage rates, compared to the MBS/PBS payment rates of the 1993 Agreement which was a more blunt measure of utilisation; and

- continued joint effort towards improving of health data sets and performance frameworks. Notably the 1998 Agreement restored the requirement for the Commonwealth to share PBS and MBS data with the State.
- Examination of goal setting should confirm the extent to which these bottom-up policy gains were achieved through State bargaining and resistance.

Goal setting

- In negotiating the 1998 Agreement, State health policy making capacities seem to have significantly increased. Rather than reacting to the Commonwealth’s offer, they were much more strategic by countering with comprehensive policy responses. In the second half of 1997, after the Commonwealth tabled its initial Discussion Papers, the States responded with their own policy positions. Health officials from five States (NSW, Victoria, Queensland, South Australia and Tasmania) opted to prepare a collective policy paper. Additionally, in July 1997, the Tasmanian Treasury, “concerned that State Treasuries were not having sufficient input into the process...presented its own proposals” to State Treasuries.
- Initially, there were marked variations in jurisdictional views. Tasmania sought for a simple block grant, whereas Victoria preferred for this block grant to also “cover past decreases in private health insurance (rates) and for the States to be no worse off”. Further, whereas Tasmania adopted a “hard line” against the use of performance targets and penalties, Victoria indicated it would be “prepared to consider these, depending upon the details”. In contrast, Queensland also supported a block grant but “with suitable indexation” and like Tasmania, was wary of performance targets, believing this to be a potential threat to the financial and policy autonomy of the States (Department of Treasury and Finance 1997b: 107-15).
- Ultimately however, the five collaborating States settled on the following key features (Department of Treasury and Finance 1997b: 64-69; 1997a: 21, 38, 56; 1997-98: 41-44):
 - a single grant as opposed to multiple funding pools so as to provide “opportunities for integration, coordination and substitution across services”;
 - the use of casemix funding as a measurement tool, but not as a funding tool, as this would change the role of the Commonwealth from a ‘funder’ to a ‘purchaser’;
 - no segregation of recurrent and capital funding, with States to retain full discretion over infrastructure developments;
 - indexation to compensate States for demand changes arising from population growth and ageing, unavoidable cost pressures including technology and private sector policy changes, and the decline in private health insurance participation rates since 1993/94 and into the future;
 - limited use of ‘reasonable’ performance targets, for example, up to six key performance indicators. States also sought for capped penalties where targets could not be met, to ensure there was equitable risk sharing. Further States proposed that a “base level of performance” be set for each indicator over the term

of the Agreement, with adjustments made for demographic shifts and for changing service delivery patterns;

- a ‘measure and share’ approach under which funding would be pooled to improve integration across tied grant, MBS and PBS funded services;
- cooperation on the improvement of data systems to enable the exploration of ‘measure and share arrangements’;
- open and transparent data sharing between jurisdictions and the development of “nationally consistent data”;
- State control over health system reforms with national monitoring;
- development of a “medium to long term policy position on the role of the private sector” and joint examination of “private health insurance issues of national competition policy implications and equivalence”;
- a “clear and unambiguous understanding of the relationship between the...(CGC)... process and the new health care agreement funding”.

- Interestingly, the WA Government opted not to participate in the preparation of the ‘five States’ discussion paper, believing that this would be perceived “tactically...(as) playing the Commonwealth game”. The WA Government argued that the Commonwealth’s proposals were too vague and that the States were better advised to push the Commonwealth “for more detail ... [on policy] ... and the amount of funding ... [to be made available]”, as opposed to developing an alternative model.

Unbeknown to these other States, the WA Government had in fact decided it would seek to “charge the Commonwealth for the cost of health services provided”, this strategy seen to be a more effective means of compelling the Commonwealth to assume its rightful share of the costs and risks of providing universal hospital care. Nonetheless, despite having adopted this stand-alone position and commenting that the ‘five States’ paper “goes too far in accepting some of the Commonwealth’s principles”, the WA Government also recognised the practicalities, admitting that ultimately, “we may have no option but to go with the consensus” (Department of Treasury and Finance 1997b: 107-15; 1997a: 39-40, 55).

- In addition to formulating a clear bottom-up policy position, the States also delayed their responses to Commonwealth proposals. Although they were now dealing with a different federal government, the States remained highly suspicious of the Commonwealth, after their experiences with the 1993 Agreement.

Archives confirm that States were cautious of the Commonwealth’s push for a purchaser-provider funding model, discussing the longer term potential for this to lead to states becoming simply service managers; and the purchase of services privately, rather than through the funding of public hospitals. Further, although there was consensus over the merits of casemix funding as a management tool, the States sought further details on the proposed caps to be applied to the numbers of cases, indexation rates and the possible use of ‘normative’ cost weights. Most interestingly, Commonwealth officials seem to have verbally advised that they had no interest in specifying States’ casemix expenditure, and that in fact the official policy position was being driven by “a number of special interest groups” which were applying “pressure

for the Commonwealth to become more involved in prescribing service delivery methods”).

While Health Ministers had all agreed to the ‘measure and share’ concept, as implementation loomed, the States were uneasy that the concept may have been “marketed” in this form, only to secure States acceptance, and that ultimately it would be used by the Commonwealth to address cost-shifting concerns.

Overall, the States’ vigilance is understandable. While Discussion Papers had been issued, the Commonwealth remained doggedly vague about its funding contribution, saying that this “would be determined having regard to overall fiscal policy objectives” and a potential “efficiency dividend”. In response, the States were equally adamant that increased funding of between \$86 million to \$288 million per annum was required to compensate for falls in private health insurance coverage since the signing of the 1993 Agreement (Department of Treasury and Finance 1997a: 12, 14, 53).

A further means of counterattack used by the States was to pro-actively develop greater policy detail around the various proposals being discussed, ahead of the Commonwealth.

In September 1997 for example, the States, led by NSW, undertook further research and issued a detailed discussion paper on potential indexation formulae. This paper examined various indexation approaches and underlying data sources and limitations. Additionally, Victoria led the preparation of a detailed paper on funding models which compared a range of options with the Commonwealth model; and outlined a range of implementation issues requiring consideration (Department of Treasury and Finance 1997a: 72-93).

The SA Government led the preparation of a paper on potential risks of the new arrangements to the Commonwealth and States (Department of Treasury and Finance 1997a: 96-105). Finally, the WA Government issued a paper on funding shares, and options for improving equity in the division of funding and functional responsibilities between Commonwealth and States (Department of Treasury and Finance 1997a: 107-15). In all of these papers, it is very clear that the States held the implementation ‘know-how’ with the extent of policy and implementation detail in their papers far exceeding the more conceptually inclined papers issued by the Commonwealth.

The resistance mounted by the States to that point appears to have been successful. For example, Victoria noted in September 1997 as bilateral meetings were held, that “the Commonwealth seems to have moderated its position...compared to the paper (it) presented to Health Ministers in August 1997 ... [appearing to] ... focus more on the use of casemix at an aggregate level, rather than the direct purchasing model” (Department of Treasury and Finance 1997a: 72-93).

Further, State pressure for early advice of CGC treatment had some impact, with the Commonwealth formally “outlining ... [its] ... thinking” to States in September 1997 and seeking comment on a draft Terms of Reference for the CGC 1998 Update. Importantly for the States, the Commonwealth confirmed its intentions to unwind the Medicare Guarantee Payments and the Bonus Pool system. The States appear to have made best use of the early advice, appointing consultants to examine potential bargaining

positions to be pursued (Department of Treasury and Finance 1997a: 121-3, 25-27, 32-42). Also, by the end of October 1997, although the Commonwealth remained non-committal as to a detailed funding offer, it agreed to “more generous escalation arrangements” (Department of Treasury and Finance 1997a: 142).

The Commonwealth’s first official funding offer in December 1997 confirms further policy retreat by the Commonwealth.

The original proposal for a purchaser-provider model to operate through the HIC was watered down and replaced with a broader output-based funding model for admitted (casemix-adjusted separations), non-admitted and other health services. Non-admitted services would continue to be funded on a population based funding model until data systems permitted a more output-based model across jurisdictions. While funding was to be capped, the Commonwealth agreed to a more detailed indexation formula and the development of a “national hospital output index”.

The Commonwealth also appears to have backed down in the use of penalties for reductions in hospital activity, agreeing to discuss activity shortfalls with States with reference to ‘measure and share arrangements’. In terms of cost-shifting the Commonwealth now offered to address this “through improved information sharing” and a new independent agency to monitor and report on the issue. Further, in addition to funding admitted and non-admitted services, funding streams were also offered for palliative care; mental health services; quality enhancement; and system restructuring. Although the Commonwealth ignored State requests to be compensated for past decreases in private health insurance coverage rates, consensus was given to fund future drops in coverage. Further, the Commonwealth indicated it would consider State proposals to increase the rate of cost recovery for services provided to private patients in public hospitals (Department of Treasury and Finance 1997-98: 27-35).

In spite of these compromises however, the States continued their resistance, rejecting the official offer. The main dilemma was funding, States estimating that the offer left them with an annual funding shortfall of \$1.6 to \$1.9 billion. The States also confirmed their concerns with the:

- emphasis being placed on *weighted separations*, arguing that this would create “perverse incentives” for admitted as opposed to other more cost effective services;
- use of 1996/97 workloads as the basis for determining activity targets to 2002/03;
- conditions around funding for quality initiatives. Although the conditions appeared benign, the States noted that they could easily be adapted to facilitate closer Commonwealth involvement in operational issues;
- lack of firm guarantees that States would not be “disadvantaged by ... the CGC 1998 Update and 1999 Review”; and
- Commonwealth’s intention to cease contributing to the costs of private patients, whilst continuing to regulate fees for private patients.

Amidst the objections, there were several aspects of the proposal that won the approval of the States including: 1) the continuation of palliative and mental health

funding; and 2) the establishment of a “National Health Development Fund” to facilitate joint service delivery reform (Department of Treasury and Finance 1997-98: 50, 62, 72-3, 84, 91, 105-06).

Unmoved by their initial response, in early January 1998, the Commonwealth tabled further details of its funding offer and invited the States to a teleconference. The States, frustrated with the lack of appreciation of their funding pressures, opted to take control of the negotiations and refused to attend the teleconference. Instead, they arranged their own two day meeting in Canberra, with the Commonwealth invited to attend on the first day to clarify its proposal. Formally rejecting the Commonwealth’s offer as “being totally inadequate to meet both the existing and future demands on Australia’s already strained public hospitals”, the States warned that its call to meet with Commonwealth officials should “in no way be perceived as indicating any softening of our position”. Further they threatened to involve the Prime Minister in the reaching resolution on funding levels and CGC treatment at a Premiers Conference scheduled for March 1998. The Commonwealth, equally infuriated, declined the invitation, publicly labelling the States’ response as a “political stunt...and childish games” (Department of Treasury and Finance 1997-98: 97, 103, 05-06, 21; 1998g: 39).

Collaborating to arrive at their official response, the States agreed to counter-claim for the following (Department of Treasury and Finance 1997-98: 118):

- funding of \$6.4 billion to restore the “real value” of the “base” grant;
- annual indexation for ageing, population growth, private health insurance changes, cost increases, utilisation growth and changes in clinical practice;
- limited number of key performance indicators (no more than six);
- cooperation with the Commonwealth on service delivery reform, using funding from the National Development Fund and quality initiatives;
- exploration (rather than implementation) of ‘measure and share’ approaches with the Commonwealth; and
- joint effort to enhance the “sharing and analysing (of) data”.

Further, the States issued a “strongly worded open letter” to the Commonwealth and moved to engage a Labor Party powerbroker, Graham Richardson, as a “consultant and lobbyist for a nationwide media campaign” (Department of Treasury and Finance 1998g: 17).

Although the Commonwealth’s position was momentarily boosted when the ACT government opted to sign the Agreement on 15 January 1998, the States remained persistent, stalling negotiations. (Department of Treasury and Finance 1998h: 41-43).

Frustrated, the Commonwealth sought to tempt the remaining States with a \$120 million sweetener for wait list reductions in February 1998. It was declared that the incentive money, to be quarantined from CGC processes would be released each week and able to be “drawn upon as ... States ... sign Health Care Agreements” from 16 March 1998 (Department of Treasury and Finance 1998h: 85).

- The States however continued their defiance. Assiduous in their opposition, the States cited evidence of: cost pressures arising from growth in public patients (76% to 85% since 1993/94); health inflation which had “outstripped current indexation arrangements”; the impacts of inadequate capital investment funding; and the Commonwealth’s inappropriate levying of cost-shifting penalties. At the heart of their claim was a request for \$1.1 billion additional funding per annum, comprised of \$622 million compensation for reductions in private health insurance coverage; \$400 million for cost increases; and \$80 million to restore inappropriate cost-shifting penalties.
- Quite remarkably, State Ministers genuinely believed the federal Minister was being misinformed by his Department. To clarify their position directly, they invited him to a meeting on 10 March 1998, vowing to “commence a public campaign against the Commonwealth Medicare offer” should the Minister decline the invitation (Department of Treasury and Finance 1998h: 59-60, 63, 65-67, 73, 109).

Left with little choice, the Commonwealth accepted, using the meeting to table a revised offer of \$330 million over five years (or \$280 million according to the States). Again rebutting the offer as highly inadequate, the States acted on their earlier threat to take the issue to the Premiers Conference on 20 March 1998. By 12 March 1998, the States had begun formulating options for the Premiers Conference, including a range of “fall back” positions in the event their claim of \$1.1 billion was not met (Department of Treasury and Finance 1998h: 134-5, 90-94).

- The March Premiers’ Conference however brought no resolution to the stand-off, with discussions collapsing “due to the Commonwealth’s refusal to move on its Medicare offer”. By 25 March 1998, the States were threatening to withdraw their contributions to the national deficit reduction scheme and run an ad campaign against the Commonwealth in the lead-up to the federal election. The Commonwealth, also uncompromising in its stance, threatened to run its own ad campaign to “offset a united attack” by the States.

On 6 April 1998, as a further demonstration of its resoluteness, the Commonwealth pushed the Agreement Bill through the Parliament, inclusive of a new section 28 that would allow grant payments to be continued beyond 30 June 1998 so that “patients (would not) be disadvantaged”. The Commonwealth’s tenacious pursuit was stymied by the Senate, which assigned the Bill to a Committee and confirmed it would seek submissions from the States (Department of Treasury and Finance 1998e: 17, 71, 79).

- At this stage, the stalemate appeared impassable. The WA Treasury observed that the policy setting process was now solely centred on funding levels, quite an interesting dynamic when considered alongside their other observation that there was “no direct link between the health expenditure budget and the hospital funding grants”.

As 30 June loomed, the States attempted to forge a way forward. In April 1998, the Victorian government put forward a “compromise offer” to the Commonwealth which scaled back the request for funding considerably. The Premier insisted that it was “absolutely necessary that the Commonwealth comes back to the table and negotiate the base rate” if the States were to avoid a dramatic reduction in services.

Following this, the WA government also tabled its own compromise to “half ... our claim in 1998/99” with no offsetting reduction of general purpose grants and full flexibility to be allowed in the use of funding. The WA Government’s preference was for a multilateral, as opposed to bilateral deal on funding. Archives show State officers speculating that a bilateral deal could “cause friction” with other States, and also increase the risk of a significant change to the distribution of general purpose grants. Further, archives show the WA government offering, and the Commonwealth considering, “alternative ways of effectively increasing funding to Western Australia ... [such as the] ... forgiveness of \$300 million in financial agreement debt”; an increase in the share of Northwest Shelf royalties or a new tied grant to compensate for the State’s lower share of MBS and PBS funding. These types of fiscal federal compromises were by no means new to the Commonwealth, as evident in earlier case studies (Department of Treasury and Finance 1998e: 9, 53, 55, 74, 85-6, 104).

Whilst Victoria and Western Australia were pushing for a down-scaled offer, Tasmania remained fully committed to the original claim and threatened to bring in “public hospital charges” if the claim was not met. Queensland on the other hand, opted to break with the other States and sign the Agreement. The deal was apparently reached after the Commonwealth agreed to make “some changes in (the timing) of funding”; allow further flexibility in the use of National Health Development Fund monies; and move to “full cost purchasing for veterans services”.

The break-through in Queensland had little outward impact on the negotiations. The remaining States continued to fight for their policy claims, arguing against: maintenance of effort clause in the draft Agreement; the appointment of a Health Care Information Commissioner; and the proposed indexation formula. The States also remained fiercely opposed to \$152 million of ‘cost shifting penalties’ levied in 1996-97 and 1997-98, arguing that “the ... [Commonwealth] ... remains unable to provide substantiated evidence ... [as to] ... why these penalties have been imposed and ... built into the base of the new agreements”. Further, a ‘moral’ argument was mounted, with States arguing that the negotiations had not been “conducted in good faith” with no opportunity provided to “comment on the Bill before it was tabled in the House” (Department of Treasury and Finance 1998e: 74, 91-93, 95-96, 101, 29, 205, 08; 1998d: 37, 73).

By the end of April 1998, the Commonwealth was forced to table yet another offer, well below the State requests, but including further sweeteners in the form of additional wait list funding and State-specific initiatives. A deadline of 1 June 1998 was placed on the incentive funding. Additionally, the media was used to aggressively leverage public opinion against the States. The Commonwealth insisted on 4 May 1998 that the “WA government has forfeited more than \$24 million by not signing on 16 March ... this is particularly unfortunate and unfair because the argument between the States and the federal government is mostly political ... [and States should] ... stop using their patients as bargaining chips in a political argument”.

Having little success with its 1 June deadline, the Commonwealth then imposed a second and final deadline of 10 June 1998. This was also ignored by the States who

instead issued an 'alternative' Agreement on 8 June 1998 and opted to forfeit the promised wait list monies. Perhaps to the Commonwealth utter surprise, the "lion's share" of this sweetener, \$103 million, went solely to Queensland, a massive windfall, which it was claimed, would enable that State to "wipe out its public hospital waiting lists". (Department of Treasury and Finance 1998d: 10-11, 13, 61, 118, 25, 28; 1998c: 5).

- As the federal election approached, the importance of a settlement escalated considerably for the Commonwealth and negotiations were increasingly conducted through the Office of the Prime Minister (Department of Treasury and Finance 1998c: 19). This brought no change to the State responses, with another new offer from the Prime Minister on 30 July 1998 being quickly rejected by the WA Government.
- Although the deals struck with Queensland and the ACT were not fully transparent, the States were keen to ensure they were not short-changed. For example they claimed that Queensland: "obtained a commitment that no clawback would apply unless private health insurance coverage rises above ... [levels in] ... June 1995"; and that half of the National Health Development would be added into base funding. Also the States wanted to avoid the problems already being experienced by these States: "in regard to penalties ... the ACT has reported that they agreed in principle with the Commonwealth that ...[there would be no penalties] ... but in negotiations since, the Commonwealth has avoided the agreement by simply switching terms from 'penalties' to 'adjustments'" (Department of Treasury and Finance 1998c: 19, 48-49).
- Financially, the tireless and extensive opposition of the States was not without reward. Whereas the original Commonwealth offer had proposed a funding base that was \$78 million lower over five years compared to 1993 Agreement funding, by this stage of the negotiations, the States had managed to curtail this funding shortfall back to a figure of \$3 million over five years. Further, with the anticipated untying of part of the National Health Development funds, the WA government estimated it would gain a further \$22 million over five years. Admittedly however, these gains did not fully address State concerns over the base funding inadequacies carried over from the 1993 Agreement.
- From a policy perspective, it is apparent that State defiance resulted in some important gains (Department of Treasury and Finance 1998e: 198-216; 1998b: 32, 34; 1998c: 54-57):
 - the original proposal included a detailed service scope and an expanded version of health care principles. Under the final agreement, the principles were restored to the level of prescription in the 1993 Agreement, and the service scope omitted altogether;
 - a more detailed description of roles and responsibilities of the Commonwealth and States was replaced by a less prescriptive version in the final agreement;
 - indexation formulae was brought closer to the position that was sought by the States;

- the setting of private patient fees remained largely with the States despite an original push for fees to be set in consultation with the Commonwealth;
 - a significant increase in prescription around patient election processes and the patients’ charter was wound back as a result of the resistance from the States;
 - the settlement of cross-border disputes originally rested with the Commonwealth, however by the final agreement, the States seem to have manoeuvred for an independent person to play this role, to be appointed by the disputing States;
 - the Commonwealth’s desire to unilaterally reform hospital pharmaceutical charging policies was resisted by the States who sought for more time to “explore” such arrangements. The final Agreement provides for “pharmaceutical policy reform” but leaves the operational detail to be further worked through by the Commonwealth and States; and
 - the appointment of a Health Care Information Commissioner to collect and monitor patient level information (a role to be played by the HIC) was firmly countered by the States who argued that the initiative was not centred on improving data quality, but about minimising cost-shifting.
- On 6 August 1998, after more than a year of intense and at times, quite hostile deliberation, the WA government finally struck an ‘in-principle’ deal with the Commonwealth. Fully conscious that the Commonwealth’s final offer remained well below that sought by the States and spurred by political pressure, the WA Liberal Premier firmly stressed that the acceptance was a conditional one. In replying to the Prime Minister, the Premier made it clear that the in-principle deal would be valid only if: the base allocation remained free of any major administrative control by the Commonwealth; and funding levels were reviewed upon any deterioration of private health insurance coverage rates.

The final deal also allowed for half of the National Health Development Fund monies to be added to the base grant, and a significant softening of clauses relating to sanctions in the event of increased private health insurance coverage. Further, the Commonwealth agreed to extend eligibility for the veteran’s Gold Card to an estimated 50,000 veterans in WA. These policy gains were similar to the deal that had been reached with Queensland. As a further carrot, the WA government was also promised an additional \$8 million for State-specific initiatives. The ‘in-principle’ deal did not signal the end of negotiations, with archival evidence showing considerable bartering between Commonwealth and State officials to the end of August 1998, as the finer details of the 1998 Agreement were resolved (Department of Treasury and Finance 1998c: 69, 71, 87-92; 1998a).

Goal congruence

- The Commonwealth’s aggressive push for policy dominance was not without obstruction within the federal landscape. Of most interest is the Commonwealth Treasury’s sharing of State views in late 1997, saying that it “was concerned that the ... Commonwealth Health Department’s proposal would increase bureaucracy...and (that it) would be happy for States to give it reason to oppose additional Commonwealth interference in service delivery” (Department of Treasury and Finance 1997b: 107-15).

- Further, as noted earlier, in attempting to pass the necessary supporting legislation in April 1998, the Commonwealth faced resistance from the Senate. These contrasting views and developments not only brought into question the Commonwealth's policy stance, but also provided States with other avenues through which to resist the policy and funding settings being proposed (Department of Treasury and Finance 1998e: 17, 71, 79).

Conclusions: Balance of Policy Making Powers 1998 Agreement

In summary, there is a range of evidence pointing to a top-down mode of governance and policy control, namely the:

- survival of the universal hospital care goal in face of the strong and prolonged opposition from States as to the inadequacy and inequity of the Commonwealth's funding contributions;
- unilateral approach adopted in dealing with pertinent policy issues raised by the States. For example the Commonwealth quite blatantly disregarded State concerns around: 1) its failure to meet the recommendations of the Medicare 2% Reviews conducted; 2) the absence of a meaningful link between hospital costs and grant funding; and 4) its aggressive imposition of cost-shifting penalties without clear evidence of cost-shifting;
- successful use of sweeteners in the signing of the ACT and Queensland governments;
- Commonwealth's capacity to influence: 1) the CGC treatment to be assigned to aspects of its funding contribution such as the incentive monies offered, and 2) the degree of integration and transparency between hospital funding grant determinations and general purpose grant determinations;
- use of media and public opinion to pressure the States to sign (although this could be said to have been effectively countered by the States' own use of media);
- inclusion of minimum activity thresholds (although this was a much diminished condition, when compared to the casemix and funding bucket prescriptiveness originally envisaged by the Commonwealth); and
- increased prescription around patient election processes, patient charter and the independent complaints body (although again, this was scaled back from the proposal first put forward by the Commonwealth).

There is also range of evidence pointing to a bottom-up mode of governance and policy control, namely the:

- capacity of States, to issue comprehensive policy papers, often much more detailed than the Commonwealth's, which allowed them to counter and dispute Commonwealth policy positions quite effectively;
- successful and ongoing use of various forms of negotiating resistance by the States including: the repeated rejection of Commonwealth funding offers; media pressure; ignorance of incentive monies; referrals to Premiers' Conferences; and open refusal to attend multilateral meetings. Undoubtedly, the States were very effective in their tactics, forcing the Commonwealth to come back with better offers on a number of occasions;

- abandonment of the full purchaser-provider based funding model initially proposed by the Commonwealth and also the more complex funding model of the 1993 Agreement including the controversial Bonus Pool arrangements;
- adoption of a more comprehensive indexation formula with formal recognition given to the financial impact created by changes in private health insurance coverage;
- greater awareness created around the potential impact of CGC processes on the hospital funding grant. Unlike the 1993 Agreement, the Commonwealth was less able to revert to this external lever to manipulate funding flows to States;
- securing of a much improved funding contribution from the Commonwealth, compared to its original proposal, including an important concession to incorporate of 50% of the National Health Development Fund monies into State base grant funding;
- provision of a significantly higher quantum of funding for system integration and other system reform projects (with a lower level of prescriptive control than originally proposed by the Commonwealth);
- securing of a range of policy gains including the referral of disputes to an independent reviewer, rather than the Commonwealth; the winding back of requirements relating to pharmaceutical policy reform; and the omission of a requirement for an Information Commissioner, all of these secured through State resistance; and
- continued commitment to joint enhancement of health datasets and information systems as desired by the States.

The overwhelming conclusion on the 1998 Agreement negotiations is of a more bottom-up mode of governance.

The States' stronghold over the Commonwealth during the fifteen or so months of negotiation was mostly impenetrable, apart from the decisions of the ACT and Queensland governments to break from the union, and the WA government's choice not to participate in the preparation of the five states' policy response.

Without doubt, the States controlled the negotiating timeframe and agenda for a large part of the deliberations. The Commonwealth's attempts to aggressively push through its draft Agreements were stymied numerous times, by not only the States, but also by the Senate and perhaps also indirectly by the federal Treasury. In fact, the Commonwealth was compelled to repeatedly come back to the States with improved offers, with this pattern broken only when several of the States decided to lower their bargaining positions.

The financial gain secured by the States through their persistent and strategic manoeuvring was significant. Although the States did not manage to correct the funding shortfalls which they argued to be implicit within the base grant, it must be acknowledged that this in fact was a carryover issue from the 1993 Agreement, and hence should not diminish the quite apparent success of their bargaining tactics for the 1998 Agreement.

The Commonwealth was forced to offer substantial financial sweeteners, wind back policy conditions and withstand political pressure and crucial delays, before it finally reached a deal with the States. Admittedly, the Commonwealth did gain some financial ground through its ignorance of the Medicare 2% Review, its unilateral imposition of cost-shifting penalties and its misinterpretation of clauses during implementation of Agreements (for example the ACT Agreement). However these advantages are considered to be definitively

overshadowed by the final policy position won by the States, in which they retained dominant control over local resource allocation, gained a more comprehensive indexation formula and significant new funding for reform projects; and successfully unravelled some prescriptive policy intrusions desired by the Commonwealth.

C.3.3 Detailed Analysis — Reflections on Grant Performance 1998 Agreement

Performance deficiencies of tied grants

Convoluted policy compromises

- Consistent with earlier case studies, the Commonwealth was forced to offer sweeteners and other policy compromises in order to entice the States to sign up. (Department of Treasury and Finance 1998g: 17, 29-30; 1998h: 85; 1998d: 10-11, 13, 61, 118, 25, 28; 1998c: 5).

Accountability shortcomings

- As apparent in earlier findings, the 1998 Agreement and its funding arrangements had little to do with actual hospital service costs. The allocation of funding was driven by Commonwealth affordability, a push for distributional equity and various financial compromises necessary for securing State sign-up.

Administrative and operational inefficiencies

- The establishment of a robust performance-based funding formula was hindered by data limitations and the complexities of health policy setting. For example, a funding formula outlined in the initial December 1997 offer was heavily criticised by the States:

the model is complex and full of contradictions. The way the model is structured, it would be beneficial to States to encourage healthier people not to take out private health insurance and to actively encourage older people to join...States would be financially penalised for moving patients from acute care settings to community settings – non admitted services is subject to an efficiency index where admitted patient services is not and in fact allows for a limited growth factor...

The same difficulties were faced in quantifying concepts such as ‘cost-shifting’ and ‘utilisation drift’(Department of Treasury and Finance 1997-98: 89). Further, data limitations also constrained the Commonwealth’s enforcement of the grant. For example in mounting an argument about falling State funding shares, it was observed that “the multiplicity of data sets that can be used to prepare statistics on this issue underlines the difficulty in ... being able to conclusively determine the ‘right answer’ (Department of Treasury and Finance 1998g: 20-21).

Emphasis on macroeconomic performance

- As discussed earlier, the Commonwealth continually struggled to balance its desire for distributional equity with the need to improve local managerial efficiency. For example in its initial offer of December 1997, the Commonwealth suggested it would quarantine “distributional changes in 1998/99 ... [and let] ... the Premiers Conference decide in future years”. The WA Treasury observed: “we cannot give clear meaning to this proposal and hence cannot assess the implications (Department of Treasury and

Finance 1997-98: 95; 1998h: 45-49, 57-58, 91). The flexible approach preferred by the Commonwealth was intended to optimise its capacity to manage its macroeconomic and social objectives. However the resulting uncertainty in total health funding no doubt made it difficult for States to plan and optimise local managerial efficiency.