THE TENSION BETWEEN INTERGOVERNMENTAL RELATIONS AND COOPERATIVE FEDERALISM

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ABSTRACT

Intergovernmental negotiations in Australia have been primarily driven by the financial dependency of the states on the Commonwealth, rather than by shared policy interests or concurrent responsibilities. This asymmetry in bargaining power ensures the Commonwealth is able to achieve many of its objectives in areas of concurrency or state jurisdiction, with or without the cooperation of the states.

Prior to becoming Prime Minister, Kevin Rudd promoted an ethos of Cooperative Federalism. He also stated he had no intention of reducing the structural fiscal imbalance that is arguably the most effective means of levelling the playing field so that states could be equal partners at Council of Australian Governments meetings. This raises the question: What is Cooperative Federalism in practice? Further, is Cooperative Federalism possible without fundamental reform to federal financial arrangements?

This paper explores how Cooperative Federalism has manifested (or not) in the areas of health reform and federal financial relations and finds that as a rhetorical tool, it has been very effective, if expensive, in extending Commonwealth control. As a policy reform tool it has maintained and added to existing institutions with most changes occurring at the level of policy settings.

Has the quest for health reform undermined the spirit of both Cooperative Federalism and the Intergovernmental Agreement on Federal Financial Relations?

INTRODUCTION

Prior to becoming Prime Minister, Kevin Rudd advocated a “Cooperative Federalism” model for Commonwealth and state government relations (any reference to state governments includes territory governments unless otherwise stated). Such a model could be used to “rebuild the Federation...” and to “create a sustainable political and constitutional mechanism to deliver lasting reform...”. He condemned the “dysfunctionality of Federation...articulated through cost shifting...” that characterised intergovernmental relations generally. Federal-state financial relations and health were two areas he identified as undermining the functioning of the federation. For these in particular, Kevin Rudd promoted an approach he called “Cooperative Federalism” (Rudd 2005). This became a powerful theme which Rudd developed throughout his term as Prime Minister.
Arguably, improving the functionality of the federation, federal-state financial relations in particular, requires fundamental reform of the existing fiscal imbalance between the Commonwealth and the states. Addressing this structural inequity would seem a logical first step in Rudd’s Cooperative Federalism and a necessary one if the rhetoric is to match the reality. At the very least, for cooperation to be a real and meaningful possibility between governments, there needs to be more or less equal bargaining power (Sawer 1977). In Australia this would necessitate a significant structural adjustment to financial arrangements to provide states with greater financial and budgetary capacity (Business Council of Australia 2006; Hamill 2006; Twomey 2008a; Twomey 2007; Walsh 1991; Warren 2006) (NB. Budgetary capacity refers to a “state’s ability to access sufficient finance to meet its spending requirements” while fiscal capacity refers to “the ability of a state to determine how, to what extent and for what purpose it will raise revenue and to what purpose, in what quantities and in what way expenditure will be undertaken” (Hamill 2006)).

Kevin Rudd however rejected any reduction in vertical fiscal imbalance (VFI) because clearly, any amelioration in VFI would reduce the Commonwealth’s capacity to influence policy-making in areas under state control (Rudd 2005).

This paper considers the paradox posed by Kevin Rudd’s adoption of Cooperative Federalism as a tool to improve intergovernmental relations, specifically federal-state financial relations, and to achieve intergovernmental policy reform.

The analysis is based on an examination of Kevin Rudd’s expressed views and the approach his government took in pursuing policy reforms in federal-state financial relations and health financing and governance arrangements. The material studied includes Rudd’s speeches, media releases, interviews, intergovernmental agreements and government publications issued from mid-2005 to mid-2010, as well as commentary on the health reform debate. The analysis shows that while the process used by the Rudd Government to engage with the states and negotiate change in these two areas was different, the outcome in both was largely policy continuity rather than reform. Cooperative Federalism has been an effective, albeit expensive, rhetorical tool in expanding the Commonwealth’s control through existing institutions and entrenching states’ financial dependency both at the aggregate level and in the health sector specifically. It has also led to the Rudd Government undoing some of its own (decentralist) reforms to the financial arrangements in order to pursue its (centralist) reforms in health financing and the negotiation of health reform.

FEDERAL-STATE FINANCIAL RELATIONS

Prior to the November 2007 election, Kevin Rudd as the new Opposition Leader committed to “ending the blame game” between the Commonwealth and state governments, particularly in health and education. He also committed to “a major realignment of each government’s duties” and “negotiations with premiers to eliminate waste, freeing up more resources for delivering services” (Franklin 2006).

Kevin Rudd’s agenda for Cooperative Federalism, federal-state financial relations in particular, was articulated in 2005 prior to becoming Opposition Leader. He was in fact Shadow Minister for Foreign Affairs, Trade and International Security when he gave a speech entitled “The Case for Cooperative Federalism”; a topic that was not obviously within his portfolio but nonetheless one on which he spoke with some conviction. In that speech, Rudd declared himself a “committed federalist”, articulating the problems with the federation, particularly the increasing expansion of Commonwealth powers. He affirmed however that “[n]o Commonwealth government, either conservative or Labor has any intention of retreating to the status-quo ante” (Rudd 2005). That is, VFI is not on any Commonwealth Government's agenda.

This raises two key questions:

1. What is Cooperative Federalism in practice?
2. Is Cooperative Federalism possible without fundamental reform to the financial arrangements?

A brief sojourn into the Rudd Government’s federal-state financial and health reforms provides a possible explanation.

**A New Policy Framework**

After he became Leader of the Opposition in December 2006, Rudd appointed Bob McMullan as the Shadow Minister for Federal/State Relations in recognition of the parlous state of intergovernmental relations that had evolved. Mr McMullan MP commissioned an ALP Advisory Group to recommend a set of principles for Labor to pursue when in government. Inevitably the principles that were developed related not just to the mechanics of intergovernmental relations, but to the federal-state financial relations that sit at the core of intergovernmental relations.

When elected into office the Rudd Government engaged the states with a passion hitherto unseen. This was needed in large part due to the Government’s extensive reform agenda in areas of policy and service delivery that are under state control. Wayne Swan as Treasurer set about negotiating a “new architecture of cooperative funding arrangements” which would “provide a solid basis for far-reaching microeconomic and social reform in Australia”(Swan 2008a). The new arrangements reflected some of the options and best practice principles identified by the ALP Advisory Group (Keating 2007). The key components of the new framework were:

- A dramatic reduction in the number of Specific Purpose Payments (SPPs) from over 90 to 6 each with a list of jurisdictions’ roles and responsibilities;
- More flexibility for states in their fiscal capacity with fewer Commonwealth prescriptions;
- More budgetary certainty for the states as SPPs became ongoing rather than five year agreements;
- Transparent, and to some extent public, performance reporting through the COAG Reform Council (CRC); and
- Voluntary incentive and reward payments in the form of National Partnership Payments (Swan 2008a).

The overarching framework for these changes was a new Intergovernmental Agreement on Federal Financial Relations (IGA) (COAG 2009) which, in the tradition of intergovernmental agreements, espoused cooperation and reform. There was moreover, a Federal Financial Relations Act 2009 (Australian Parliament 2009a) that would bring all financial transfers to the states under the one piece of Commonwealth legislation and provide certainty for state treasuries. The overriding motif was that the reform of financial arrangements would be the key mechanism for the reform of the federation (Swan 2008a, b).

There was some early critiquing of the proposed changes. In 2008, Anne Twomey noted that while the new arrangements foreshadowed a more cooperative approach, the Commonwealth had chosen to retain its ability to control both the budgetary and fiscal capacity of the states. As already noted and proclaimed by many others, a truly cooperative regime would be one in which the states’ revenue-raising powers are commensurate with their expenditure responsibilities (BCA 2006; Twomey 2008b; Walsh 1991; Warren 2006).

**Cooperative Federalism in Federal-State Financial Relations**

In terms of creating a collaborative environment and framework for intergovernmental relations and financial transfers, the IGA itself established a much more positive, one might even say, mature tone. Unlike the very public and political health reform negotiations, the federal-state financial relations negotiations occurred primarily among officials in a much less politicised atmosphere.

Nearly two years on from the culmination of those negotiations, the number of SPPs has indeed been significantly reduced, core funding increased and indexation adjusted to reflect more closely
the real increases in costs (McQuestin 2010b). The reduction in SPPs has however been almost matched by the profusion of National Partnership Agreements. Similarly, while the level of prescription had been almost eliminated in the initial batch of agreements, a number of jurisdictions have noted a certain tendency on the part of line agencies — at both levels of government — to revert to old habits as the volume and pace has continued unabated (McQuestin 2010a, b, c).

It is tempting to suggest that the changes in federal-state financial relations are in fact modest. Notwithstanding the extraordinary workload they entailed, to a large extent what was altered was the level and nature of administrative detail. With the exception of increased financial commitments, the concessions cost the Commonwealth little (McQuestin 2010c). This is not to trivialise the impact of the changes but merely to give them some proportionality and materiality. Essentially, the Commonwealth restored federal-state financial arrangements to a mutually acceptable and more financially sustainable position by:

- recognising existing funding levels were inadequate;
- relaxing controls, removing redundant penalty provisions that were rarely acted on and allowing states to determine for themselves how they were going to achieve the agreed outcomes (McQuestin 2010c);
- increasing certainty of revenue streams; and
- not least, by being willing to work with states and negotiate terms rather than dictate them (McQuestin 2010b; Swan 2008a).

For their part, the states were willing to submit to rigorous and public reporting on their progress and to participate in an incentive or reward arrangement like that which underpinned the successful National Competition Policy reforms (Swan 2008a). Officials involved in the federal-state financial reforms speak of a cultural change or paradigm shift. The goodwill engendered by the Commonwealth’s willingness to work with the states has been almost palpable (McQuestin 2010a, b, c).

The new financial arrangements are currently under review by Heads of Treasuries (HoTs) who will report to the Council of Australian Governments (COAG) by the end of the year on the effectiveness of the various agreements in achieving their policy objectives (Australian Government 2010). There has already been a raft of reports by the CRC on the progress of states according to various sectoral policy intergovernmental agreements and these have laid bare the challenges of institutionalising the changed financial regime and implementing and evaluating national reform (COAG Reform Council 2009a, b; 2010a).

Policy Continuity or Change?

Based on the evidence, the new federal-state financial framework is essentially first order change (Hall 1993); that is, it represents a change to the policy settings through streamlined administration, simplified agreements and updated revenue payments. The changes to SPPs were to the levels of funding, input controls, reporting and transparency as well as to the timeframes (settings) and to the number of instruments. The more significant change is in the underlying shift in the Commonwealth’s attitude.

One aspect of the new arrangements that has not received much attention is the Federal Financial Relations Act 2009. Its key purpose is to “provide ongoing financial support for the delivery of services by the States....” (Australian Parliament 2009a). To achieve this, the Act brings together the various types of Commonwealth-state transfers under one piece of legislation. Prior to the Act, payments to states were fragmented across various statutes, including GST legislation (Australian Parliament 1999, 2009b), sectoral specific legislation and annual appropriations of the Commonwealth Parliament.
The Federal Financial Relations Act 2009 is that part of the Rudd Government’s new financial framework designed to give states greater certainty over future funding. Without overstating the nature of the change, it is important to note the implications of this consolidation. It effectively:

- Situates all payments within the broader Commonwealth financial management and accountability framework that governs other Commonwealth expenditure;
- Increases the scope for strategic oversight and scrutiny of state transfers;
- Enhances the potential for a one size fits all regime by removing the capacity for idiosyncratic or sector-specific arrangements;
- Formalises state transfers as just another expenditure item in the Commonwealth budget that must compete for funds; and
- As is generally the case with mergers, it provides a mechanism for finding savings.

From an administrative efficiency, accountability or tax payer viewpoint, these are eminently sensible and desirable consequences. They do however increase the Commonwealth’s managerial command over revenues to the states; revenues which are already subject to their own accountability and reporting requirements.

This trend towards greater management control is also evident in other acts, such as the Commonwealth’s Appropriation Act (No. 2) 2008-09. This act provided that if the expenditure amount that appears in a state agency’s annual report is less than originally allocated then the allocation will be reduced accordingly, by operation of law. Previous appropriation acts limited payments but did not allow for reductions. The act also provided that unspent monies from past appropriations would be “extinguished” rather than re-determined. This removes the possibility of previously unavailable appropriations being spent (Australian Parliament 2008a, b; Webb 23 May 2008). Further, by consolidating state transfers into one instrument, the Commonwealth has made future changes to state funding arrangements much simpler.

The retention of a portion of the GST for health reform also changes the landscape. The requirement for agreement by jurisdictions to changes to the rate and the base of the GST is preserved in the amended GST legislation although the Federal Financial Relations Act 2009 provides only that the Treasurer have regard to the Intergovernmental Agreement which specifies the requirement for jurisdictional support (Australian Parliament 1999, 2009b). While the Commonwealth has not sought to remove these clauses, the most recent incursion into the GST revenues has set a precedent for quarantining of what was general purpose — untied — revenue. Having shown its willingness to use its control over revenues in this way — and been largely successful — the Commonwealth may well decide that its own imperatives outweigh any notional commitment to consult states in the future. It does, after all, have the ability to amend the legislation and remove any requirement to consult. Politically, this might be a more attractive and less public option than undertaking intergovernmental negotiations.

The unwritten arrangements that pre-date the current ones gave states no surety, but nor did they give the Commonwealth unilateral control over the instrument governing the quantum and regularity of payments. The effect of the Federal Financial Relations Act 2009 has been not only to strengthen states’ certainty over Commonwealth funding, but also to entrench the latter’s control.

This too is first order change rather than reform, but its significance lay in its continuation of the centralist drift.

THE QUEST FOR NATIONAL HEALTH REFORM

Before the 2007 election, Kevin Rudd promised to take over state hospitals if there was no improvement in services by June 2009. In his first question in Parliament on his first day as Opposition leader (4 December 2006) Rudd focused on health and hospital reform, asking: "What action will the Prime Minister take to stop the blame game in health between the Commonwealth
and the states?”, then subsequently pushed the issue all the way to Labor’s election victory in 2007 (Davis 2010).

In February 2008, the Rudd Government established the National Health and Hospital Reform Commission (NHHRC) to provide advice on practical reforms to Australia’s health system. In July 2009, the Commission released a 300-page report with more than 100 recommendations, including that “First Ministers agree to a new Healthy Australia Accord that will clearly articulate the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for the Australian population” (NHHRC 2009: 27). Significant structural reform was recommended, including that the Commonwealth assume full responsibility for the policy and public funding of primary health care services, and that the Commonwealth and states move to more transparent and more equitable funding arrangements for public hospitals.

On 7 December 2009, COAG agreed that health reform would be a central priority for 2010 (COAG, 2009). Four months later, on 3 March 2010 at the National Press Club, Prime Minister Kevin Rudd (2010b) made a unilateral announcement about the Commonwealth Government’s plan for national health reform. The same day, the Commonwealth released *A National Health and Hospitals Network for Australia's Future* (Department of Health and Ageing, 2010). The Prime Minister announced: “These reforms represent the biggest changes to Australia’s health and hospital system since the introduction of Medicare, and one of the most significant reforms to the federation in its history” (Rudd, 2010a).

Kevin Rudd said his government’s decision to take on the dominant funding role for the entire public hospital system was designed, among other objectives, to “end the blame game” (Rudd, 2010b). Yet from the outset, there were indications that the process of interaction (or lack thereof) between the Commonwealth and state governments posed the risk of prolonging, even exacerbating, the “blame game”, rather than promoting Cooperative Federalism. The PM threatened:

> *If the states and territories will not agree to these reforms, we will take this reform plan to the people at the next election - along with a referendum by or at that same election to give the Australian Government all the power it needs to reform the health system* (Rudd, 2010a).

Thus, the debate opened with coercion (rather than cooperation) and increased Commonwealth control: “For the first time in history the Australian Government will take on the dominant funding role for the entire public hospital system”, the PM announced (Rudd, 2010b).

**Funding the Reforms**

In any government, health constitutes the largest proportion of budgetary spending. The Australian Institute of Health and Welfare reports that Australian governments spent $104 billion on health care in 2007-08; accounting for 9 per cent of gross domestic product or $4874 for every man, woman and child (Davis 2010).

To fund the new reforms, the Commonwealth announced it would dedicate one-third of GST revenue directly to health spending, amounting to a takeover of funding responsibility from the states (Rudd 2010c). Effectively, the Commonwealth was to rob Peter (the states) to pay Paul (the health system), then take the credit for extra spending on health.

In the wake of the PM’s announcement at the National Press Club, a barrage of media releases (Rudd, 2010c-f) appeared, each painting the Federal Government as the saviour, rescuing the Australian people from the erstwhile incompetence of the states in delivering the health services they so craved and deserved. The Prime Minister argued that the proposed changes would “end the
blame game, eliminate waste, and shoulder the burden of funding to meet rapidly rising health costs” (Rudd, 2010e).

One commentator suggested: “There is actually no additional or new money; the 60% we all clearly know is to be achieved by a Federal grab of 30% of the States GST revenue. This is a takeover of State revenue” (Capolingua, 2010).

Meanwhile, John Menadue (2010), a former Secretary of Prime Minister and Cabinet, suggested: “A change from 40/60 Commonwealth/state funding to 60/40 funding for hospitals, doesn’t change the division of responsibility and the blame game”.

Sally McCarthy, president of the Australasian College of Emergency Medicine, said the split in funding responsibilities between the states and the Commonwealth would perpetuate the blame game (cited by Maher 2010), while the Australian Medical Association (AMA 2010) argued that “the only way to end the blame game in health was to have a single public funder for public hospitals”.

Perpetuation of the “blame game”

Health policy has long been considered the main bastion of the “blame game” due to blurred roles and responsibilities, complex funding formulas and the associated lack of understanding among users of the health system about which level of government is responsible for different aspects of health service delivery. As one commentator put it: “The blame game is what happens when we let policy-making go in both directions at the same time, and leave elected federal and state politicians to wrestle each other to a compromise” (Sibillin 2010).

In 2006, a House of Representatives inquiry into health funding reported:

_A common complaint to Members of Parliament is that, when people are unhappy about their health care, both the Commonwealth and the states blame each other for the failings of the health system. While the associated political grandstanding often makes for some good headlines, the blame game does not benefit patients...

Addressing the blame game will involve a national approach to developing and funding health care. This will require leadership from the Australian Government, cooperation by the states and a joint commitment to end the blame game. The complexity of health delivery and financing, the rate of development of new health technologies and rising community expectations mean that ongoing reform is needed (Foreword, vii)._  

More recently, “cost and blame shifting as a result of the current system of governance and funding” have been re-identified as “the central problems with the health care system” (Armstrong 2009). On commenting on the Commonwealth’s national health reform plan, one of the key architects of Medicare was asked: “Will all this reduce the blame game?”

_Of course not. This policy document is full of it. There is some conflict with the concept of federalism agreed by the Council of Australian Governments (COAG) in 2008, under which the federal government would set outcome targets for broad programs only, leaving the states free to manage them (Deeble 2010: 1)._  

On announcing the new reforms, Rudd promised: “The Australian Government will work with states and territories to determine the network structure that best meets the needs of communities and the challenges of managing multiple small hospitals” (Rudd, 2010d). While admitting that “some 441,000 hospital admissions [nearly one in 10 in the past year] could have been avoided through providing better care in the community”, the PM did not admit liability for the
shortcomings in general practice and aged care (for which the Commonwealth has responsibility) for the partially avoidable burden on ambulance services, emergency departments and hospital admissions, for which the states bear responsibility. The COAG Reform Council (2010b) subsequently reported that two million Australians had visited hospital emergency departments in 2007-08 with illnesses or injuries that could have been treated by general practitioners (GPs). This figure represented more than 40 per cent of all emergency department activity and a significant amount of cost-shifting between areas of responsibility.

The road to the COAG Agreement

Seven weeks of negotiations between the Commonwealth and states culminated in a COAG meeting in April. John Deeble (2010: 1) had commented that it was a “big ask” to expect the states to accept the proposal within a few short weeks. For the most part, state and territory leaders had little choice but to reach some form of agreement with the Prime Minister on national health reform, but their public servants in central and health agencies were put to the test and pushed to their limits in analysing and costing the Commonwealth proposals, particularly given the initial unilateral announcement, followed by the drip filter of sketchy detail in which the proposals were announced.

To complicate matters, both South Australia and Tasmania were in caretaker mode for much of the debate, each facing elections on 20 March, with neither able to participate fully in meetings with their state and territory counterparts, none of whom could politically afford an outright rejection of the promise of health reform.

Most observers would be unaware of the important (albeit behind-the-scenes) role played by the Council for the Australian Federation (CAF) in facilitation among States and Territories in the lead-up to negotiating terms with the Prime Minister. Indeed, many are unaware of its existence. CAF was established in October 2006 to support and enhance Australia's federal system by providing an intergovernmental forum for State and Territory leaders in Australia. The governments of the six States and two self-governing mainland Territories of Australia are members of the Council, represented by their Premier or Chief Minister. The chairing jurisdiction rotates each October, with CAF currently chaired by NSW Premier, Kristina Keneally.

The role of CAF in reaching an agreement at the April COAG meeting was acknowledged by the Prime Minister at the post-COAG press conference. This forum enabled states and territories to negotiate additional funding, as was the case in the negotiations on FFR, in which the CAF forum enabled states and territories to broker a better deal from the Commonwealth. On behalf of the other states, Kristina Keneally announced at the post-COAG press conference that the Prime Minister’s commitment of additional $800 million for sub-acute hospital beds was “what sealed the deal” (ABC Radio, 2010).

On 20 April 2010, a two-day meeting of the Prime Minister, State Premiers and Territory Chief Ministers culminated in an agreement by the States and Territories (with the exception of Western Australia) to sign the National Health and Hospitals Network Agreement (COAG, 2010). Western Australian Premier Colin Barnett found the Commonwealth’s plan to withhold one-third of GST “not acceptable to Western Australia” (ABC Radio, 2010):

*The GST is just 10 years old. When it was introduced it was introduced as a substitute for other state taxes that had been either foregone or transferred to the Commonwealth over the years. It was as it was presented then the long-term growth tax and solution to state finances. I am not about to compromise the integrity or the importance of the GST to my state of Western Australia.*
One size will never fit all

Under the Rudd government, through a range of intergovernmental agreements and national partnerships, there has been welcome progress in delineating roles and responsibilities across a range of policy areas. However, as long as one level of government holds the financial resources, while another bears the responsibility for service delivery, the potential for the perpetuation of the “blame game” will continue.

Furthermore, generic processes for allocating funding and monitoring service delivery responses are not suitable for all Australian jurisdictions, given the significant diversity across geography and population distribution, as well as cultural and economic differences (so that what works for Tasmania, may not work for Western Australia). As such, funding parameters and associated performance measures need to make allowances for these variances, as one size will never fit all.

CONCLUSION

The Thin Edge of the Wedge?

The Cooperative Federalism approach taken by the Rudd Government in these two dissimilar but inextricably entwined areas of financial relations and health reform has been different, but ultimately the effect in both cases has been to entrench even further the Commonwealth’s fiscal dominance and the states’ dependence. The quarantining of the GST represents another avenue for centralisation of financial and policy control. All this was achieved by the Rudd Government through promotion of an idea - Cooperative Federalism - used counter-intuitively to promote an outcome not a process. Recent research in the renewable energy market has shown that it is not only in these areas that the Rudd Government has been successful in maintaining existing institutions and further entrenching Commonwealth control using a rhetoric of Cooperative Federalism (Jones 2010). According to Jones (2010), the intergovernmental process for developing renewable energy targets was characterised by Commonwealth control of the consultation and decision-making processes. To the state participants the outcome appeared pre-determined, failed to address weaknesses of the existing scheme and preserved the power of current interests and players. Despite the rhetoric of reform and Cooperative Federalism state governments were not treated as policy partners and the result was incremental, not transformational change (Jones 2010).

In federal-state financial relations the Rudd Government restored minimum provisions (flexibility, capacity and certainty for states) but in the process extended its own managerial control. In pursuing the health reforms, the Prime Minister chose the more political course of negotiation by brinkmanship: he challenged the states to reject his plan knowing the electoral antipathy that would ensue if they failed to “cooperate”. The outcome was policy concessions by the Commonwealth and a “reform” that maintains existing institutions and instruments, adds a new layer of management and adjusts some of the settings through increased funding and greater reporting. This is Cooperative Federalism in practice.

What then can we conclude about the Rudd Government’s Cooperative Federalism and whether it can occur without fundamental financial reform? Clearly it can. Cooperative Federalism has been a powerful and effective rhetorical tool that wedged the states and further embedded structural inequity. From a financial perspective, it has also been an expensive one: the additional funding through the National SPPs and the April COAG agreement was significant ($12.5b) although many would argue, necessary from a state perspective (COAG 2008, 2010). As a policy reform tool, the concept of Cooperative Federalism has failed to engender real change or to restore any balance to
the federation. The outcome in policy and political terms has been continued centralisation without effective reform.

As observed by Brian Galligan (1998) more than a decade ago: “It is simply implausible to expect the Commonwealth to have the states’ best interests at heart in dictating the ongoing terms and conditions of intergovernmental fiscal relations which it controls.”

In the words of the Right Honourable James Hacker MP:*

“I mean obey my commands. That's what cooperate means when you're Prime Minister.”

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