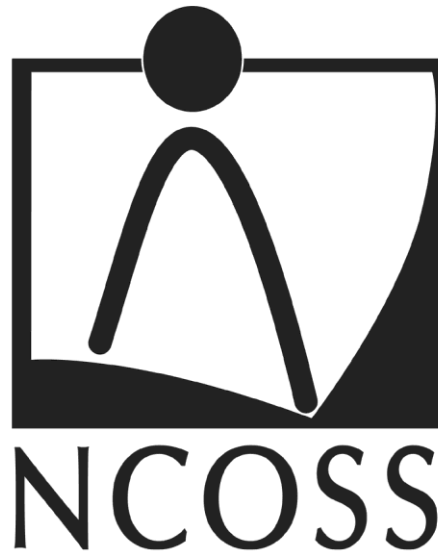


Council of Social Service of NSW (NCOSS)



Briefing paper:

***National health reform - outcomes
of the 29th Council of Australian
Governments (COAG) meeting
19-20 April 2010***

May 2010

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About the Council of Social Service of NSW (NCOSS)

NCOSS is an independent non-government organisation (NGO) and is the peak body for the non-government human services sector in NSW. Our vision is a society where there is social and economic equity, based on cooperation, participation, sustainability and respect.

NCOSS provides independent and informed policy development, advice and review and plays a key coordination and leadership role for the non government social and community services sector in New South Wales.

Through current membership forums, NCOSS represents more than 7,000 community organisations and over 100,000 consumers and individuals

Introduction

The Council of Australian Governments (COAG), with the exception of Western Australia,¹ agreed to a plan for national health and hospital reform at the 29th COAG meeting on 20 April 2010.

The [National Health and Hospital Network Agreement](#) aims to improve health outcomes and the sustainability of the health system through structural and funding reform and increased investment. It establishes a National Health and Hospital Network (NHHN) to deliver a nationally unified and locally controlled health system.

The Agreement addresses five areas:

- Public Hospitals and Local Hospital Networks (LHNs)
- Primary Health Care and Primary Health Care Organisations (PHCOs)
- Financing
- Performance and Accountability Framework
- National governance

To support implementation of the Agreement, Governments² agreed to a package of \$5.4 billion in reforms and investment over the next four years. The Commonwealth also agreed to provide an extra \$15.6 billion in health funding from 2014/15 to 2019/20.

¹ Western Australia has not agreed to the retention of the goods and services tax (GST) or the associated funding governance arrangements and will continue discussions with the Commonwealth.

² The \$5.4 billion package includes a proportion of funding for Western Australia, although Western Australia has not agreed to the additional reform package.

Background to the *National Health and Hospitals Network Agreement*

At the previous COAG meeting in December 2009, Governments agreed that national health reform would be a priority in the coming year. The Commonwealth agreed to develop specific proposals for reform by mid-2010.

The first stage of the Government's reform plan, [National Health and Hospitals Network for Australia's Future](#) was released in March 2010. It proposed the establishment of a single national hospital network. The second stage of the plan, [A National Health and Hospitals Network: Further Investments in Australia's Health](#) released in April 2010, outlined additional proposals to reduce waiting times for hospital services, improve access to GPs and primary health care, grow the health workforce, and enhance aged care.

NCOSS made a [submission](#) to the NSW Government during consultation on the national health reform plan prior to COAG. The submission raised concerns about the focus of the plan on clinical and hospital services at the expense of primary and community based health care, and the lack of attention to the social determinants of health and health inequalities.

In the lead up to the April 2010 COAG meeting there was significant divergence amongst the State and Territory Governments about the national plan, particularly in relation to the retention of GST revenue by the Commonwealth, the mechanism for hospital funding, and additional funding to support the reforms.

Overview of the National Health and Hospital Network Agreement

Establishment of a National Health and Hospitals Network (NHHN)

- **Local Hospital Networks (LHN) will be operational managers** responsible for a small number of public hospitals with a geographical or functional connection. The States will determine the number and location of LHN's, with around 30 planned in NSW. LHNs will be paid for the physical delivery of services through activity based funding. Block funding will continue for some small regional and rural public hospitals.
- LHNs will be governed by a Chief Executive Officer and a professional Governing Council with an appropriate mix of skills and expertise. Members will be appointed by State Health Ministers following a public recruitment process.
- **States will be systems managers** responsible for overall hospital service policy and planning, purchasing services from LHN through Service Agreements, major capital planning and management, and overseeing LHN performance.
- **Commonwealth will be the majority funder** funding 60% of the national efficient price of public hospital services or block funding for smaller rural hospitals, and 60% of recurrent expenditure on research, training, and capital. States will be responsible for meeting all residual costs.
- A **national Funding Authority** will distribute Commonwealth funding for hospitals services based on a national efficient price to separate Funding Authorities in each State. Commonwealth funding for block grants, research, training, capital, and Commonwealth-funded GP and primary health care services will be paid directly to the States.
- **State-based Funding Authorities** will provide activity based funding to LHNs from pooled Commonwealth and State funds.
- An **Independent Hospital Pricing Authority** will set the national efficient price for public hospital services and determine the quantum of the Commonwealth's funding to the States and State-based Funding Authorities.
- A national **Performance and Accountability Framework** will be introduced with national standards, performance indicators, and reports on hospitals, LHNs, and Primary Health Care Organisations undertaken by a new **National Performance Authority**.

Primary Health Care and Aged Care

- **Commonwealth Government will have full funding and policy responsibility** for some categories of GP and primary health care services. This includes community health centres primary care services, primary mental health care for common mild to moderate disorders, hospital avoidance programs for non-acute care, prevention and early intervention programs for patients with chronic disease in the community, immunisation, and cancer screening programs. States will continue to operate GP and primary health care services funded by the Commonwealth.
- States will have funding and policy responsibility for specific **services excluded from transfer to the Commonwealth**, including ambulance services, existing public dental services, health care for prisoners, school and workplace primary care programs, acute care hospital avoidance programs, and specialist sexually transmitted infection services and general sexual health services.
- Other GP and primary care services that will be considered for **future transfer** to the Commonwealth include community health promotion and population health programs including preventive health, drug and alcohol treatment services, child and maternal

health services, community palliative care, and specialist community mental health services for people with severe mental illness.

- New **Primary Health Care Organisations** (PHCO) will be established to improve the integration and delivery of services at the local level. The Commonwealth will determine the numbers and boundaries of PHCOs. Services will be provided by the PHCO according to a service contract agreed with the Commonwealth.
- Commonwealth Government will have full funding, policy, management and delivery responsibility for a **national aged care system**.

Funding and investment

- A package of **\$5.4 billion over the first four years** to implement the Agreement, including \$3.4 billion to improve access to public hospital services; \$436 million for primary care; \$643 million for the health workforce; \$739 million for aged care; and \$174 million to improve the mental health system.
- An additional **\$15.6 billion in top-up funding** from 2014-15 to 2019-20 to ensure that no State is worse off under the Agreement.

Implementation

- A final **work plan** for implementation of the Agreement will be developed by Senior Officials by 30 June 2010. A provisional work plan is outlined in the Agreement Appendix.

Other areas of COAG agreement

- **Cancer care** - Victoria and the Commonwealth will lead work to develop cancer diagnosis, treatment and referral protocols and report back to COAG in 2011.
- **E-Health** - COAG will prioritise discussions over the coming months to move towards the implementation phase of a National Individual Electronic Health Record system.

NHHN funding**National funding³**

	Total funding (\$m)
Funding 2010-11 to 2013-14	\$5362
Public hospital services	\$3370
<i>Elective surgery</i>	\$800
<i>Emergency departments</i>	\$750
<i>Sub-acute Care</i>	\$1620
<i>Flexible Funds</i>	\$200
Primary care	\$436
Health workforce	\$643
Aged care	\$739
Mental health	\$174
Growth funding 2014-15 to 2019-20	\$15600
Total funding 2010-11 to 2019-20	\$20962

NSW funding

	NHHN Plan (\$m)	Additional COAG (\$m)	Total funding (\$m)
Funding 2010-11 to 2013-14	503	722	1722
Emergency departments	162	146	308
Elective surgery	211	49	260
Multi-Purpose Services	39		39
Long stay older patients	91		91
Sub Acute care (e.g. rehabilitation)		268	268
Additional acute services		259	259
Funding for delivery of Commonwealth responsibilities			497
Growth funding 2014-15 to 2019-20			4893
Total NSW funding 2010-11 to 2019-20			6615

Source: NSW Government, COAG National Health and Hospital Reform – NSW Funding, 20 April 2010

³ Western Australia did not agree to the additional reform package at COAG, however the \$5.4 billion package includes a share of funding for Western Australia.

Analysis of the NHHN Agreement

What will change under the NHHN?

Local Hospital Networks

In NSW, it is expected that the eight Area Health Services (AHS) will be restructured into around 30 smaller LHNs responsible for a small number of hospitals based on geographic or functional connection. A similar structure existed in NSW in the mid-1980's, with 23 Area Health Service regions. This structure was superseded in 2005 by the current regional-level AHS structure to improve economies of scale, reduce inefficiency, and strengthen governance.

While the AHSs are criticised for being over-centralised, the Garling Report⁴ into NSW public hospitals found that the key cause for complaint is not due to their geographical scope but rather from the lack of local decision-making power and clinical input. Crucially, the Inquiry specifically recommended against making any changes to the size or numbers of AHS due to the damaging effects of continuous reform. This 'restructure fatigue' presents a significant challenge to NSW Health in establishing the new LHNs.

The LHNs will be run by Governing Councils and a CEO, with the aim of decentralising hospital management, increasing local control and improving service responsiveness. While there is a clear need to increase the engagement of clinicians and the community in the NSW health system, Garling also recommended against the re-introduction of governing boards. NSW has previously had governance by both hospital boards and Area Health Service boards. Both have subsequently been replaced in favour of Chief Executives due to the politicisation of Board appointments, lack of accountability, and ineffectiveness.

The Ministerial appointment process proposed for the Governing Councils of LHNs runs the risk that membership will be comprised of those who already have influence at the expense of those who do not. The provision for appointments on the basis of "other skills and experience" also leaves open the risk of political appointments, as occurred under the previous system in NSW.

The health economist, Professor Gavin Mooney, also identifies a number of problems with the Governing Councils. He notes that the power imbalance between different Board members, e.g. clinicians and consumers, may limit the Board's effectiveness. Having clinical representatives may also give rise to potential conflicts of interest, such as resource allocation decisions for non-clinical health services. He also questions the competence of clinicians in professional organisational governance, given that their primary area of expertise is in medical diagnosis and treatment.⁵

While the introduction of LHNs and local Councils are intended to foster increased local control and decision-making, there is little with regards to consumer or local community engagement and participation. Consumer and community input into the governance and operation of the health system is critical to ensure that services are appropriate and responsive to local health needs. It also supports greater transparency and accountability in the service planning, funding and delivery.

While there is scope for general community representation on the local Boards, there are no identified positions for consumer representatives. The Agreement also lacks any measures

⁴ Garling P, Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, NSW Government on behalf of Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, Sydney, 2008

⁵ Mooney G, *Why the AMA is happy about Rudd's Plans, and the rest of us should be worried*, Croaky, posted 4 March 2010 12.01pm

to empower individuals and communities to participate in decision-making, such as health literacy training, a key enabling factor identified in the Marmot Review.

The extent of 'local control' that the Governing Councils and LHNs will be able to exercise appears to be relatively limited. As the 'system-managers', the States will be responsible for overall service planning, policy, and purchasing. They will also retain control of the mix and quantity of services to be delivered in each local area through *LHN Service Agreements*. It does not appear, on paper at least, that the proposed division of responsibilities will significantly alter from the current division of responsibilities between the NSW Department of Health and the Area Health Services.

Primary Health Care

The Commonwealth will take over full funding and policy responsibility for GP and primary health care services in order to reduce access gaps in services and to improve efficiency by locating responsibility within one level of government. The transfer only applies to selected categories of services, such as primary mental health services for mild to moderate illness and immunisation. Some other services, such as public dental, will continue to be a State responsibility, while others are subject to further negotiations. It is difficult to envisage how this fragmented transfer of services will effectively address access gaps and support greater service continuity and alignment.

Another mechanism aimed at supporting the delivery of more integrated care is the establishment of Primary Health Care Organisations (PHCOs). PHCOs will have responsibility for commissioning and coordinating primary care services to meet local needs and address service gaps. It is unclear how this will operate in practice as the Agreement does not contain any specific details about the governance, management, accountability or operation of the PHCOs.

One specific function of the PHCOs is to work as partners with LHNs to improve care coordination. However, there is no formal mechanism in the Agreement to ensure the strategic alignment of PHCOs with LHNs beyond a requirement for engagement protocols and cross-representation on Governing Councils "*where possible*". There is also no guarantee of on-going operational alignment through common boundaries with LHNs, as the States control the size and number of LHNs, while the Commonwealth determines the PHCO's. Without common governance, policies, or areas of operation, the extent to which PHCOs will be able to facilitate more seamless care, particularly around hospital discharge, is questionable.

Performance and Accountability Framework

A positive outcome of the NHHN Agreement is the introduction of a new performance and accountability framework including nationally consistent standards, performance indicators and more transparent reporting on hospital and primary health services. This will help people make more informed choices about their health services, drive service quality, and support the spread of effective practices.

While it is important to have an efficient, well-performing service system, it is equally important (if not more so) to have an *effective* health care system. The Agreement focuses heavily on waiting times and costs, with specific benchmarks set for emergency departments and elective surgery. However, there are no measures of health outcomes, which are a crucial indicator of whether the system is delivering the services that people actually need.

Funding

A new nationally consistent system for funding public hospitals will be introduced based on the national efficient price of services. Through 'activity based funding' LHN's will be

reimbursed for the cost of the physical public hospital services they deliver rather than receiving annual block grants in order to promote greater transparency and efficiency. As part of the Commonwealth's concessions to the States at COAG, block funding will be retained for some small rural and remote hospitals. This could result in as few as 165 out of 764 hospitals transferring to the new funding system, significantly limiting the potential efficiency gains. Activity based funding has also been criticised for creating perverse incentives for hospitals to over-service patients to increase their revenue, making the system more inefficient overall.

To allocate funding, two separate multi-level processes have been created involving three new bodies:

- An Independent Hospital Pricing Authority (IHPA) will set the national efficient price of services and determine the quantum of the Commonwealth's funding contribution based on 60% of the efficient cost. The States will meet the residual 40% of public hospital service costs, including any costs above and beyond the national efficient price.
- A National Funding Authority will distribute the Commonwealth's 60% share of funding for hospital services to state-based Funding Authorities. It will also distribute the Commonwealth's 60% share of funding for block grants, capital, training, and research directly to the States on the basis that these funds are best managed centrally.
- State-based Funding Authorities will pay LHNs for the services they provide from pooled Commonwealth and State funds.

While the new funding system was intended to provide greater clarity and efficiency, it creates additional bureaucracies and process. The Commonwealth argues that establishing the Government as the majority funder for public hospitals will stop cost-shifting and put an end to the 'blame game'. However, given that funding accountabilities continue to be shared and the multiple bodies across different jurisdictions that will be involved in the process, it seems highly unlikely that the political side-stepping and buck-passing will be eliminated.

To support implementation of the Agreement, the Commonwealth has agreed to fund a package of \$5.4 billion over the first four years, with an additional \$15.6 billion in top-up funding from 2014-15 to 2019-20 to ensure that no State or Territory is worse off under the Agreement. These funds will provide a much needed short-term boost to the health system to meet existing service demand. However, the majority allocation of funding to hospital services means that the additional funds will do little to mitigate the rising demand for services in the long term.

What is missing from the NHHN Agreement?

Social model of health

The NHHN Agreement's focus on public hospitals and GP services reinforces the traditional biomedical model of health. This approach has shaped our healthcare system around identifying and treating the symptoms of disease, rather than more contemporary approaches based on a social model of health that focus on wellness and promoting good health. However, the rising costs of providing healthcare and the growing demand for acute services over recent decades has highlighted the inadequacy of this prevailing approach.

By concentrating the majority of new funding in acute care system, the Commonwealth is applying a band-aid solution that will not reduce the long term demand pressures on the system, and will only perpetuate public perceptions of healthcare as equating to hospitals. To be effective, a long term approach must address the underlying causes of ill health, the social determinants of health, in order to minimise future demand for services.

The link between the social determinants of health and health outcomes is well established in international literature and research, and was re-affirmed in the recent Marmot Review of health inequalities in England post-2010⁶, and in a new research report by the York University in Canada, “*The primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience. These conditions have come to be known as the social determinants of health.*”⁷

In Australia, the National Health and Hospital Reform Commission (NHHRC) recognised the importance of the addressing the broader social and environmental influences that shape health in *A Healthier Future for all Australians*. The report recommends national action on the broader determinants of health. This approach is also supported by ‘*Closing the Gap*’ and the Government’s social inclusion agenda.

The Marmot Review argues that action to effectively address the social determinants of health must be undertaken across a range of policy areas, including early childhood development, education, employment and income, housing, transport, urban planning, environment and community building. It requires measures that go beyond hospitals and the formal healthcare system.

Efficient, high quality health services are essential to provide treatment to people when they do become sick or injured, they alone do not prevent people from getting ill or acquiring chronic health problems in the first place.

Disappointingly, the NHHN Agreement makes no reference to the social determinants of health, does not acknowledge shared responsibility for good health beyond the formal healthcare system, and does not contain any mechanisms to promote health equity in all policies. Without addressing the determinants of health and well-being, the reforms are unlikely to improve the overall health outcomes of Australians and reduce our growing demand for health services.

Lack of investment in health promotion, prevention and early intervention

There is a substantial and growing evidence-base within NSW⁸, Australia⁹, and internationally¹⁰ that the prevention of problems, and intervening early when problems do arise will manage the growing demand for acute services and contain rising health care costs. However, as part of the \$5.4 billion in new funding to implement the Agreement, only a small proportion of funding (around 10 per cent) has been allocated to very targeted early intervention and prevention services. This included a new chronic disease management scheme in the community for people with diabetes and expansion of an Early Psychosis Prevention and Intervention Centre model. By comparison, over \$3.4 billion has been allocated to public hospital services.

The Commonwealth’s *National Preventative Health Strategy* argues that preventative health should be incorporated into all elements of the healthcare system, “...including within the acute care and hospital setting, community health and across primary healthcare.” Yet preventative health remains on the periphery of the NHHN Agreement as an ‘add-on’ to the main activity of hospital services, rather than at the core of the health system. The role and

⁶ Strategic review of health inequalities in England post-2010, *Fair Society, Healthy Lives - The Marmot Review Final Report*, The Marmot Review, London, 2010

⁷ Juha Mikkonen and Dennis Raphael, *Social Determinants of Health: The Canadian Facts*, York University, Canada, 2010.

⁸ Owen A et al., *Community health: the evidence base: A report for the NSW Community Health Review*. Centre for Health Service Development, University of Wollongong, 2008

⁹ National Health and Hospitals Reform Commission, *A Health Future for All Australians: Final Report*, Canberra, 2009

¹⁰ The Marmot Review, *Strategic review of health inequalities in England post-2010, Fair Society, Healthy Lives - The Marmot Review Final Report*, London, 2010

responsibility of PHCO's for health promotion and prevention are vaguely defined, and it is unclear how they will be able to facilitate the integration of health promotion and prevention across the service system.

Health NGOs

The Australian health system is more than just public hospitals and GP's. It includes private hospitals, community health services, allied health services, and a range of services provided by non-government organisations (NGOs). In NSW alone there are around 390 health NGOs, yet the NHHN Agreement is silent on the role of NGO service providers in the new system and their interface with LHNs and PHCOs.

The Commonwealth's original reform plan, *A National Health and Hospital Network for Australia's Future*, proposed that PHCO's would have responsibility for planning and commissioning services, including those provided by NGOs. However there are no details in either the plan or the NHHN Agreement about how services will be funded or contracted, what will happen to services currently commissioned on a state-wide rather than local area basis, or to those NGOs that operate services across areas of both State and Commonwealth funding and policy responsibility.

NCOSS believes there is a risk that NGO's will be subject to greater administration and 'red-tape' if appropriate consideration is not given to addressing these issues during the further development and implementation of the NHHN Agreement.

The NSW Health draft review report into the Health NGO Program identifies a number of recommendations based on consultation with NGO service providers and best practice about how to simplify and streamline the grants administration and management process in NSW. NCOSS believes these recommendations, along with the principles of *Working Together for NSW*, should inform the development of the new system in NSW. Further consultation with Health NGOs during the development and implementation phase is also essential.

Health inequalities

One of the key priority areas outlined in the National Health and Hospital Reform Commission (NHHRC) report, *A Healthier Future for all Australians*¹¹ is tackling inequalities in Aboriginal health, mental health, oral health and rural/remote health. Despite this, the NHHN Agreement contains scant reference to addressing health inequalities beyond creating fairer access to hospitals in remote areas and for Indigenous Australians through the new funding model.

While a small amount of new funding (\$115 million) has been allocated to mental health services and initiatives under the Agreement, it is questionable whether they will reach those most in need. The majority of the NHHRC recommendations have still not been responded to, and service fragmentation is likely to continue until the Commonwealth determines its position in relation to specialist community mental health services.

The starkest gap in the NHHN reforms is oral health. The shocking inequalities in oral health outcomes in Australia were a central concern of the NHHRC, which recommended the introduction of a universal 'Denticare' scheme to give all Australian's access to basic dental care as a priority. However, the NHHN Agreement contains no provisions for reform of the oral health care system or for increased investment in public dental services. Rather, existing public dental services are specifically excluded from transfer to the Commonwealth and will remain a state responsibility.

¹¹ National Health and Hospitals Reform Commission, *A Health Future for All Australians: Final Report*, Canberra, 2009

Person centred health care system

The focus of the NHHN Agreement on traditional health services and clinicians does not promote the development of a person and family centred service system recommended by the National Health and Hospital Reform Commission. There is a lack of measures to support individuals to take control of their health and to live healthier lives. There are also limited mechanisms for local communities to participate in service planning and delivery, and no measures to empower individuals to engage with and influence the services they want in their local community.

Conclusion

Although many details of the NHHN Agreement are still to be worked out, it appears to be a service-driven response that addresses short term demand issues through increased investment and structural re-alignment, rather than significant systemic reform to improve health outcomes long term. The designer of Medicare, Professor John Deeble, argues that the Agreement will do little to fundamentally change the way health services operate.¹²

Senior Officials are now charged with finalising a work plan for the Agreement by 30 June 2010. Following the limited scope of consultations prior to COAG, NCOSS has written to the NSW Government urging for consultation with all key stakeholders in the NSW health system, including non-government health service providers and consumers, and not just clinicians to ensure that effective implementation is planned and delivered across the whole of the service system.

NCOSS is currently liaising with other members of the COSS Network to determine our response at the national level. We will continue to monitor the further development and implementation of the Agreement in NSW, particularly the implications for Health NGOs.

Time (and the Australian Senate) will tell whether the National Health and Hospital Network produces any significant changes to the way health care is delivered in Australia, or whether Rudd's rhetoric about reform is just that - rhetoric.

For more information

A full copy of the NHHN Agreement and the COAG Communiqué can be accessed at:
http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/index.cfm?CFID=837198&CFTOKEN=52761588

¹² *The Australian*, Thursday 22 April 2010, Creswell A & Maher S, "Rampant bureaucracy 'disaster' in waiting", p7