

# Summary analysis of the COAG *National Health and Hospital Network Agreement*, 20 April 2010

## Introduction

After months of political posturing, brinkmanship and intense negotiations, Governments reached agreement (with the exception of Western Australia) on the Commonwealth's proposal for national health reform at the COAG meeting in April 2010. The *National Health and Hospital Network (NHHN) Agreement* was trumpeted by the Prime Minister as the most important health reform since the introduction of Medicare. While many details about how the Agreement will operate in practice are still to be fleshed out, it is questionable whether it will result in any significant change to the health care system.

### **Snapshot: *National Health and Hospital Network (NHHN) Agreement***

#### Establishment of a National Health and Hospitals Network

- **Local Hospital Networks (LHN) will be operational managers** of a small number of public hospitals. 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 with block funding for some smaller hospitals.
- **States will be systems managers**, responsible for overall policy and planning, purchasing services from Local Hospital Networks through Service Agreements, major capital planning and management, and overseeing LHN performance.
- **Commonwealth to be the majority funder** of public hospitals, funding 60% of the national efficient service price or block funding, and 60% of research, training, and capital. A **National Funding Authority** will distribute Commonwealth activity based funding to separate Funding Authorities in each State for payment to LHNs. The NFA will pay States directly for block funding, research, training, and capital.
- A **Performance and Accountability Framework** with national standards, performance indicators, and national hospital and community health service performance reports.

#### 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 and all aged care services.
- **States will continue to operate existing GP and primary health care services** to be funded by the Commonwealth, and will have funding and policy responsibility for services specifically excluded from transfer to the Commonwealth (e.g. Public Dental).
- New **Primary Health Care Organisations** will be established to improve the delivery and integration of services at the local level.

#### Additional funding and investment

- An **implementation package of \$5.4 billion** over the next four years.
- 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.

## **Impact of the National Health and Hospital Network (NHHN)**

### ***Local Hospital Networks (LHNs)***

In NSW, the eight Area Health Services (AHS) will be restructured into around 30 smaller LHNs run by Governing Councils and a CEO, with the aim of decentralising hospital management, increasing local control and improving service responsiveness. A similar governance structure existed in NSW in the mid-1980's, but was replaced by the current regional-level structure to improve economies of scale, reduce inefficiency, and strengthen governance.

While the AHSs are criticised for being over-centralised, the Garling Report into NSW public hospitals specifically recommended against making any changes to the size or numbers of AHS due to the damaging effects of continuous reform. This 'restructure fatigue' will present a significant challenge to NSW Health in establishing the new LHNs.

While there is a clear need to increase the engagement of clinicians and the community, Garling also recommended against the re-introduction of governing boards for health services 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 Agreement also lacks any measures to empower individuals and communities to participate in decision-making.

### ***Primary Health Care***

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

Primary Health Care Organisations (PHCOs) will be established to more coordinated and integrated care in partnership with LHNs. However, there is no formal mechanism in the Agreement to ensure the strategic or operational alignment of PHCOs with LHNs, beyond a requirement for engagement protocols and cross-representation on Governing Councils "*where possible*". 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 by a new independent National Performance Authority. This will help people make more informed choices about their health services, drive service quality, and support the spread of effective practices.

### ***Funding***

A new nationally consistent system for funding public hospitals will be introduced based on the national efficient price of services in order to improve transparency and efficiency. 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. However, block funding will be retained for some small rural and remote hospitals which could result in as few as 165 out of 764 hospitals transferring to the new funding system. Activity based funding has also been criticised for creating perverse incentives for hospitals to over-service patients to increase their revenue, which makes the system more inefficient overall.

While greater efficiency may be the intention of the new funding system, the mechanism created to support it establishes multiple new layers of bureaucracy. Three new bodies will be established :-

1. Independent Hospital Pricing Authority to set the national efficient price of services
2. National Funding Authority to distribute Commonwealth funds to state Funding Authorities for hospital services, and to the States directly for block funding, capital, training, and research.
3. State-based Funding Authorities to distribute Commonwealth and State funds to LHNs

The Agreement proposes that establishing the Commonwealth as the majority funder for public hospitals will limit cost-shifting and put an end to the 'blame game'. However, with funding accountabilities continuing to be shared and the involvement of multiple bodies across different jurisdictions, it seems highly unlikely that the political side-stepping and buck-passing will be eliminated.

Additional funding of \$5.4 billion over the first four years and \$15.6 billion from 2014-15 to 2019-20 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.

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-2010, and in a new research report by the York University in Canada. These argue that addressing the social and economic inequalities that underpin the determinants of health, rather than just focusing on the role of the health system in treating illness, will have multiple benefits for individuals through improved life expectancy, lower burden of disease and better quality of life; and for society through decreased health care spending, reduced welfare payments, increased productivity and workforce participation, and fairer, more cohesive and inclusive communities.

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.

### ***Lack of investment in health promotion, prevention and early intervention***

There is a substantial and growing evidence-base 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, only a small amount of funding (\$5.4 million) was allocated to targeted early intervention and prevention services, including a new chronic disease management scheme in the community for people with diabetes and the expansion of an Early Psychosis Prevention and Intervention Centre model. By comparison, over \$3.4 billion was allocated to public hospital services.

### ***Health NGOs***

The Australian health system is more than just public hospitals and GP's. It also 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 PCHOs.

There are also no details about how NGO 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 these issues are not appropriately addressed during implementation of the Agreement.

### ***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* was facing 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.

Yet the starkest gap in the NHHN reforms is oral health. The shocking inequalities in oral health outcomes in Australia was 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. However, the NHHN Agreement contains no provisions for reform of the oral health care system or for increased investment in public dental services. Whether the Commonwealth will make a separate announcement about oral health at a later date is uncertain. In the mean time, thousands of Australians continue to suffer the pain and indignity of decaying teeth and gums.

## **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.

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 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 will tell whether the National Health and Hospital Network produce any significant changes to the way health care is currently 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](http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/index.cfm?CFID=837198&CFTOKEN=52761588)

For a more detailed overview and discussion of the NHHN Agreement, see the full NCOSS analysis of the COAG meeting on the NCOSS website: [www.ncoss.org.au](http://www.ncoss.org.au)