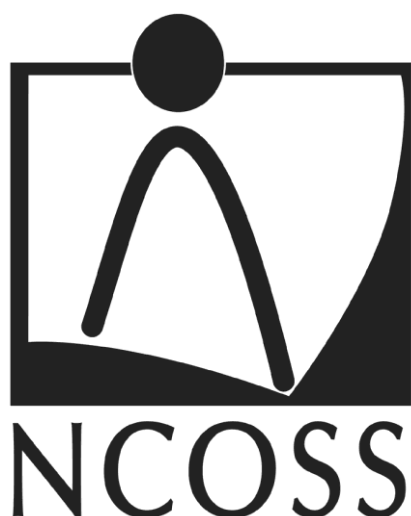


Council of Social Service of NSW (NCOSS)



BRIEFING PAPER

National health reform: Outcomes of the 30th Council of Australian Governments (COAG) meeting, 13 February 2011

February 2011

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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

1. INTRODUCTION

The Commonwealth and all State and Territory Governments reached a new agreement on national health reform at the Council of Australian Governments (COAG) meeting on 13 February 2011.

All Governments signed a [Heads of Agreement on National Health Reform](#) and a revised [National Partnership Agreement on Improving Public Hospital Services](#). The Heads of Agreement is an in-principle commitment only, with a number of issues subject to further negotiation between the parties. Governments have committed to resolving these issues and signing a full National Health Reform Agreement by 1 July 2011.

2. BACKGROUND

An agreement to reform Australia's health system was originally made by COAG in April 2010. The *National Health and Hospital Network Agreement (NHHN)* was signed by all States, except Western Australia, which primarily objected to relinquishing 30% of its GST revenue in exchange for greater hospital funding by the Commonwealth.

Following a change in State Government in late 2010, Victoria subsequently withdrew its support for the Agreement. The NSW Coalition indicated that it too would not agree to the GST transfer if it won office in March 2011. The lack of general consensus for the funding arrangements underpinning the reforms made the NHHN Agreement unviable.

3. OVERVIEW OF THE NEW HEALTH REFORM AGREEMENT

3.1. Purpose

The new Heads of Agreement is Governments' in-principle agreement to a revised range of health reform initiatives. It outlines new financial arrangements for public hospitals, and confirms the previous NHHN Agreement in relation to local hospital governance, primary health care, and aged care.

3.2. Public Hospitals

Funding responsibility

Base funding for public hospital services will continue as set out in the *Intergovernmental Agreement on Federal Financial Relations* and the *National Healthcare Agreement*. Efficient growth funding will be shared equally between the States and the Commonwealth.

Efficient growth funding will comprise of increases in the efficient price of services, and increases in the quantity of services delivered. An Independent Hospital Pricing Authority will set the 'efficient' price of hospital services.

Public hospital services funded for efficient growth will be those provided on an activity-basis, regional or highly specialised block funded hospitals, teaching, training and research, and public health programs.

From 2014-15, the Commonwealth will initially contribute 45 per cent of efficient growth funding rising to 50 per cent from 2017-18. The States will be responsible for any 'inefficient' costs above and beyond the Commonwealth's contribution.

This replaces the provision in the NHHN Agreement for the Commonwealth to assume responsibility for 60% of all public hospital costs.

Funding administration

The Commonwealth and State Governments will each pay their share of base funding and efficient growth funding into a single national pool. The national funding pool will be administered by an independent national body, to be operational from 1 July 2012. The national body will disburse funds into discrete State accounts, and from there to Local Health Networks. This replaces the 8 individual state-based funding authorities established under the NHHN Agreement.

Hospital management and administration

The States' role as systems managers with responsibility for system-wide hospital service planning, policy and operation is re-affirmed.

Local Health Networks (LHNs) role as operational managers of hospitals under the NHHN Agreement is maintained.

Performance standards and reporting

States have agreed to national standards to reduce waiting times and increase access to elective surgery, emergency department and subacute care services in the *National Partnership Agreement on Improving Public Hospital Services*.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) will have a greater role in developing and implementing national clinical standards.

The National Performance Authority will report on hospital and primary health care services from 1 July 2011, as outlined under the NHHN Agreement. In addition, performance information about individual hospitals and LHNs will be published on the *MyHospitals* website.

3.3. Primary Health Care

The new agreement confirms the focus of primary health care reform on General Practice. The establishment of Medicare Locals to improve coordination and integration in primary health care services under the NHHN Agreement will be brought forward. Their role will initially focus on facilitating access to GP services, with the Commonwealth bringing forward after-hours GP care reforms. The agreement signals the potential for Medicare Locals to have an expanded role in the future, with the Commonwealth to empower Medicare Locals with more flexible funding over time.

The Commonwealth's long-term intention to take full policy and funding responsibility for primary health care signaled in the NHHN is tempered in the new agreement. Instead, the Commonwealth has a lead role in reform of primary health care. There is no clarification about the status of State primary health care services previously identified for possible transfer to the Commonwealth, such as specialist community drug and alcohol services. The Commonwealth and the States agree to collaboratively develop system-wide policy and state-wide planning for primary health care services.

3.4. Aged care, mental health and dental health

All Governments commit to reforms in mental health, dental health and aged care over the next three years, although there is no detail about the nature of these reforms.

As proposed in the NHHN Agreement, the Commonwealth will have full responsibility for the policy, funding and delivery of aged care services. The split of Home and Community Care services will also proceed in all States except Victoria and Western Australia, which will work with the Commonwealth to determine potential changes by the next COAG meeting.

3.5. Funding enhancements

The Commonwealth guarantees to contribute no less than \$16.4 billion in efficient growth funding for public hospital services to the States from 2014-15 to 2019-20. This is an \$800

million increase on the \$15.6 billion guaranteed under the NHHN Agreement. For NSW this means an extra \$260 million, in addition to \$1.2 billion under the NHHN Agreement.

While the Commonwealth has increased the amount of growth funding to the States over the first four years, the States retain a greater proportional liability for future hospital funding than under the NHHN.

The Commonwealth will also fund \$3.4 billion under the *National Partnership Agreement on Improving Public Hospital Services*, and will bring forward \$200 million in incentive payments. For NSW, this means about \$26 million in 2010/11 and \$40 million in 2011/12 for emergency departments and elective surgery.

3.6. Implementation

The Heads of Agreement is an in-principle commitment only. It will form the basis of negotiations for a New Health Reform Agreement, to be developed and signed by 1 July 2011.

4. SUMMARY OF CHANGES FROM THE NHHN AGREEMENT

Reform area	Heads of Agreement on National Health Reform (February 2011)	National Health and Hospital Network Agreement (April 2010)
Public hospital funding	Base funding to continue as per IGAFFR and NHA. Commonwealth to fund 50% of efficient growth costs.	Commonwealth majority funder (60%) of public hospital services.
Top-up funding (2014/15 – 2019/20)	\$16.4bn	\$15.6bn
Activity based funding	Unchanged	Funding based on nationally efficient price of service. Block funding in smaller regional/rural hospitals
Independent Hospital Pricing Authority	Unchanged	Set national efficient price for public hospital services
Funding mechanism	Commonwealth and States to contribute all hospital funding into single national pool. Allocated to State accounts by independent national funding body.	Commonwealth funding paid to National Funding Authority. Distributed to separate Funding Authorities in each State.
Performance standards and reporting	National standards revised. Increased role for Australian Common on Quality and Safety in Health Care (ACQSHC) in clinical standards. Reporting via MyHospitals website.	Performance standards for elective surgery, emergency department and sub-acute care services. New National Performance and Accountability Framework, including reports on hospitals and health care services. New National Performance Authority to report on performance
Local Health Networks	Unchanged	Separate legal entities responsible for providing public hospital services, overseen by Governing Council. States remain system managers.

Medicare Locals	Continued. Numbers increased and establishment brought forward. Flexible funding to target services to meet local need over time.	New independent entities responsible for coordinating and integrating primary health care services in local communities
Primary health care	Status of some services still unclear. States have lead role in public health.	Commonwealth to have full funding and policy responsibility for <i>some</i> categories of GP and primary health care services. Some areas TBD, e.g. mental health
Aged care	Unchanged	Commonwealth to have full funding, policy, management and delivery responsibility for a national aged care system

5. NCOSS ANALYSIS

5.1 Strengths

Unlike the NHHN Agreement, the new proposal has the in-principle support of all Governments, which will support national implementation of reforms.

The introduction of a national funding pool and activity-based funding will provide greater consistency and transparency in the way that hospitals are funded. Coupled with stronger national standards, performance monitoring and reporting, these initiatives should drive improvements in hospital efficiency.

For the first time Governments have acknowledged the need for reforms in dental health (along with mental health and aged care), however there is no detail as to the nature of these reforms or whether they will be supported by any funding.

5.2 Weaknesses

The agreement maintains the focus of reform on public hospitals, rather than structural change to the health system. While the additional funding for public hospitals will help meet immediate demands on the system, a more comprehensive package is required to address future demand by shifting the focus of the health system to prevention and wellness. Without this structural reform, the capacity of the States to continue servicing the majority of hospital costs is also questionable given the current strain on their health budgets.

Although the reforms aim to provide seamless care, as it currently stands the Agreement will do little to deliver an integrated, person-centred health system. The fragmented responsibilities between the Commonwealth and States remain. There is no further clarity about those areas of primary health care identified in the NHHN Agreement for potential transfer from the States to the Commonwealth, such as some drug and alcohol services.

There is also no enforceable mechanism for Medicare Locals to overcome the existing service provider silos and coordinate care between hospitals, primary health care, allied health, non-government and private providers.

While the Commonwealth has committed to empowering Medicare Locals with flexible funding in the future, their immediate capacity to identify and address local service gaps is very limited, and will likely be restricted to general practice services.

The agreement also fails to address equity issues such as access to services for people in rural areas or increasing out-of-pocket expenses and co-payments by consumers.

5.3 Conclusion

It may be that this agreement is the start of a long-term reform process that will deliver greater structural change over time. A number of health commentators, such as Professor Stephen Leeder, have noted that systemic health care reform takes decades, and rarely occurs all at once as a 'big bang'.

As a first step, this agreement has the potential to provide increased consistency and transparency in hospital funding, and stronger performance monitoring and reporting that will drive efficiency. Whether it can deliver more coordinated and integrated care remains to be seen.

However, without a clearly articulated vision of the health system we want in the future (and a plan of how we will get there) there is a risk that reforms will never progress beyond populist initiatives focused on hospitals and GPs. As Governments consider the provisions of the formal agreement to be signed in mid-2011, it is hoped that some of these issues will be addressed in a more comprehensive and long term reform plan.

6. FOR MORE INFORMATION

Council of Australian Governments (COAG) [communiqué](#) 13 February 2011

[Heads of Agreement on National Health Reform](#) (February 2011)

[National Partnership Agreement on Improving Public Hospital Services](#) (February 2011)

[National Health and Hospital \(NHHN\) Agreement](#) (April 2010)

[NCOSS Briefing Paper – Analysis of the National Health and Hospital Network Agreement](#) (April 2010)