

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals
7 June 2010

Question no: 21

OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti asked:

What happens if an LHN runs out of funding?

Answer:

- The governing councils of LHNs will have an obligation to manage within funds available to them.
- States will be responsible for negotiating LHN Service Agreements.
- LHNs will have strong financial management skills on the governing councils.
- States and territories may agree with LHNs to renegotiate or amend LHN Service Agreements, should circumstances arise where that is appropriate.
- States and territories will notify the Commonwealth and the Funding Authorities, quarterly or as otherwise agreed, of any adjustments to the LHN Service Agreement agreed with the LHN that will affect the level of upcoming payments funded by the Commonwealth.
- LHNs will receive funds from both the Commonwealth (through the National Health and Hospitals Network Fund) and State governments, and will directly pay Local Hospital Networks on an activity basis for public hospital services. This will deliver complete transparency about what funding is provided to public hospitals, and the services they deliver to the community.

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Inquiry into COAG reforms relating to health and hospitals
7 June 2010

Question no: 22

OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti asked:

What happens if an LHN is required to do more activity than was provided for under the service agreement?

Answer:

States will be responsible for purchasing services from LHNs under a LHN Service Agreement, which will include:

- a. the number and broad mix of services to be provided by the LHN
- b. the level of funding to be provided to the LHN under the LHN's Service Agreement through ABF and block funding

Should circumstances require this, LHNs may to renegotiate their LHN Service Agreements with states.

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Question no: 23

OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

Notwithstanding that employment terms and conditions will be state-based, how will staff (medical/nursing etc) be able to move to other hospitals if they are employees of a particular LHN? What are the implications for employee entitlements and continuity of employment?

Answer:

- States will be responsible for state-wide public hospital industrial relations functions; including negotiation of enterprise bargaining agreements and establishment of remuneration and employment terms and conditions to be adopted by LHNs.
- LHN staff will be the responsibility of the LHN in line with remuneration and employment terms and conditions established by State governments in workplace relations agreements.
- The Commonwealth anticipates that current arrangements relating to mobility of staff would continue to apply.

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7 June 2010

Question no: 24

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

The IGA includes agreement that there will be no net increase in bureaucracy across Commonwealth and state governments as a proportion of the ongoing health workforce – how will this be monitored? What is the penalty for the States and Territories not complying with this agreement?

Answer:

I refer you to the response the Department of the Prime Minister and Cabinet have provided.

Senate Finance and Public Administration Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals
7 June 2010

Question no: 25

OUTCOME

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

When did the Commonwealth government agree to allow state governments to have full responsibility for appointments to the LHN governing councils? Will state and territory governments call for nominees from relevant professional and consumer bodies?

Answer:

I refer you to the response the Department of the Prime Minister and Cabinet have provided.

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HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals
7 June 2010

Question no: 26

OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

Will the independent pricing authority be truly independent when the IGA (and presumably the enabling legislation) states that there will be reserve powers for the Commonwealth to over-ride their determinations?

Answer:

The Independent Hospital Pricing Authority will be established as an independent Commonwealth statutory authority, under the *Financial Management and Accountabilities Act 1997*.

The National Health and Hospitals Network Agreement states that the Commonwealth Health Minister and Treasurer will have reserve powers that will only be used in exceptional circumstances. The Commonwealth Health Minister and Treasurer would only exercise the reserve power when the Prime Minister and the First Ministers of 4 States and Territories, including at least 3 States, have agreed, prior to exercise of their reserve power and tabling any direction or decision in the Commonwealth Parliament.

Senate Finance and Public Administration Committee

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Inquiry into COAG reforms relating to health and hospitals
7 June 2010

Question no: 27

OUTCOME 12 - Health Workforce Capacity

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What will be the impact of LHNs on the rotation of doctors in training through different hospitals?

Answer:

It is not anticipated that there will be any impact on the rotation of doctors in training through different hospitals. Health Workforce Australia will continue with its overarching role.

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HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals
7 June 2010

Question no: 28

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

Questions in relation to the Commonwealth's diabetes measure:

- a) The Government's diabetes management program initially specified that patients would need to enrol with practices, but the COAG communiqué now specifically states that patients will enrol with their GP. Which one is correct?
- b) You have talked about patients voluntarily enrolling in these arrangements, but how many doctors do you anticipate will participate?
- c) Why just diabetes and which other chronic diseases is the Commonwealth planning to extend this model of care to?
- d) Is the amount paid to the general practice supposed to cover all the medical care that the enrolled patient gets (not just care related to diabetes)?
- e) What happens if the funding for the patient's treatment (medical or other services) runs out? Will there be access to additional funding?

Answer:

- a) Under the Coordinated Care for Patients with Diabetes program, patients with diabetes will be able to voluntarily enrol with their usual general practice. The general practice will be responsible for the enrolled patients ongoing primary health care, including management of their diabetes.
- b) It is expected that over 4,300 accredited general practices covering around 60% of all general practices are expected to sign-on to the Coordinated Care for Patients with Diabetes program in its first year of operation (2012-13).
- c) The Coordinated Care for Patients with Diabetes program introduces a new way of funding the flexible delivery of primary health care services through general practice for the treatment and ongoing management of people with chronic disease, starting with diabetes. This program will be evaluated after its implementation and it will be determined whether the flexible funding model should be extended to include other chronic diseases.

- d) The general practice will receive package of care funding which can be used flexibly. This will take into account the range of care needs across patients with both high, more complex needs and those with lower care needs.

General practices can use the flexible funding to provide primary care services for patients with diabetes enrolled with the practice. This includes personalised care plans and reviews, care coordination, ongoing GP primary health care and nursing services. High needs patients will also be able to receive care coordination services to assist them to manage the complex arrangements for their care.

- e) The detailed design of the program is not yet finalised. Implementation of the program will involve substantial stakeholder consultation, as well as design and development of a number of the key elements of the program including patient enrolment, new service and funding arrangements and a performance framework.

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Question no: 29

OUTCOME

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What resources will be required to run the diabetes program? How will allied health professionals be remunerated? Will the GP contract allied health professionals or will allied health professionals bill Medicare directly?

Answer:

Detailed arrangements for the Coordinated Care for Patients with Diabetes program are to be developed in consultation with the medical profession and other stakeholders. Implementation of the program will involve substantial stakeholder consultation, as well as design and development of a number of the key elements of the program including patient enrolment, new service and funding arrangements and a performance framework.

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OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What time frame is being applied for the introduction of activity-based funding?

Answer:

Paragraph 3 of Appendix 2 of the National Health and Hospitals Network Agreement provides that:

3. Key timeframes in the transition to nationally consistent ABF will be as follows:

- a. over 2010–11:
 - i. the Commonwealth will work with State governments to determine the current and projected future costs of delivering public hospital services, to calibrate the financial transfers required to meet 60 per cent of recurrent expenditure as outlined in provision 4;
 - ii. the IHPA will commence assessment and classification of outpatient services, as outlined in provision E13;
 - iii. costing methodologies for block funding will be finalised and agreed, as outlined in provisions E11-E12; and
 - iv. funding methodologies for training and research activities will be finalised by the IHPA;
- b. from 1 July 2011, the Commonwealth will increase its funding contribution to 60 per cent of actual recurrent expenditure on public hospital services, research and training, and capital under agreed arrangements in the transition to the user cost of capital approach;
- c. over 2011-12:
 - i. the Commonwealth's payments will be made to State governments to provide to public hospitals and LHNs where they have been established;
 - ii. the IHPA will commence development of the national efficient price and relevant cost weights for admitted acute patient services, as outlined in provision E8;

- iii. the IHPA will commence calculation of block funding levels according to the agreed costing methodology, as outlined in provision E11-E12; and
- iv. the IHPA will commence calculation of funding for training and research activities;
- d. from 1 July 2012, for admitted acute patient services the Commonwealth will shift its funding to payment on an ABF basis against state-specific prices to be paid to LHNs through the Funding Authority in each State;
- e. over 2012-13:
 - i. the IHPA will develop advice on the process of transition to the national efficient price, as outlined in provision E10; and
 - ii. the IHPA's assessment and classification of outpatient services will be finalised as outlined in provision E13, and ABF for those relevant services will begin; and
- f. from 1 July 2012, for emergency department, outpatient, sub-acute and non-acute services, the Commonwealth will shift its funding to payment on an ABF basis using proxy-based state-specific prices and moving, as this becomes feasible, to payment on an ABF basis against state-specific prices to be paid to LHNs through the Funding Authority in each State.