Local Government Association of NSW and Shires Association of NSW

Submission to Inquiry into Health Funding

conducted by House of Representatives Standing Committee on Health and Ageing

Introduction

The Local Government Association of NSW and the Shires Association of NSW welcome the opportunity to offer comment to the House of Representatives Standing Committee on Health and Ageing *Inquiry into Health Funding.*

The Local Government Association of NSW and the Shires Association of NSW represent all general purpose councils, county councils and Regional Aboriginal Land Councils in NSW. The mission is to be credible, professional organisations representing local government, providing services to councils and facilitating the development of an efficient, effective, responsive, community-based system of local government in NSW.

The Associations are pleased to comment having expressed vocal concern about the state of medical and related health services across NSW and especially in rural and remote areas since the early 1990s. In terms of medical and health related services, we mean not only public hospitals and associated community health services, but also such services as General Practice, dental and emergency and non-emergency health related transport services.

The Associations understand that the Terms of Reference are as follows:

> The Committee shall inquire into and report on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.
>
> The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.
>
> The Committee shall give particular consideration to:
>
> a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;
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> b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;
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> c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;
>
> d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and
>
> e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

The Associations are not in a position to address all the points set out in the Terms of Reference and will limit comment to the first three.

Background:

The Associations recognise and generally support the observations of the Chairman of the Standing Committee, Hon Alex Somlyay in launching the Inquiry.

The Chairman said

> 'It is worth noting that Australia's health system is among the best in the world. Our life expectancy is ranked fifth in the world, but ever-increasing pressures in funding and expectations are causing the system to buckle.'

The ABS recently released new summary indicators that look at whether life in Australia is getting better. Entitled *Measures of Australia's Progress: Summary Indicators 2005*, the indicators give information on national progress over the past 10 years. These indicators present the latest data available for 15 areas of progress including health.

MAP Summary Indicators 2005 Health section shows that during the past decade, Australians' health improved in terms of life expectancy. The ABS notes life expectancy at birth is a measure of how long someone born in a particular year might expect to live if mortality patterns for that year remained unchanged over their lifetime. Life expectancy is a widely used indicator of population health, even though it can only focus on length of life rather than quality.

Australian life expectancy improved from 1993 to 2003. A boy born in 2003 could expect to live to be nearly 78, while a girl could expect to reach nearly 83 - increases since 1993 of three and two years respectively.

While Australians are living longer than ever before, there is debate about whether life expectancy will continue to increase. However, there is no doubt that there is more room for improvement among some groups of the population than among others. In particular, Indigenous Australians do not live as long as other Australians and the difference is marked.

Further the World Health Organisation (WHO) states:

> "evidence shows that people can remain healthy into their seventh, eighth and ninth decades by following an optimal diet, maintaining regular physical activity and not using tobacco. Extensive research has provided a good and growing understanding of optimal diets and the health benefits of physical activity, as well as the most successful individual and population-based public health interventions. While more research is needed, current knowledge warrants urgent public health action" (November 2003, pages 5 & 6).

WHO notes a profound shift in the balance of the major causes of death and disease is underway in most countries. WHO notes how in most countries a few major risk factors account for much morbidity and mortality, and for non-communicable diseases the most important risks include high blood pressure, high concentrations of cholesterol in the blood, low intake of fruit and vegetables, being overweight, physical inactivity and tobacco use. There are serious challenges for both acute services and preventative strategies in these risk factor trends.

The Associations also agree the system is buckling. Public hospitals are often in the media and

the focus of community concern. Issues include funding, waiting lists, bed closures, Australian Government/State and Territory Government relations (colloquially known as the blame shifting game), public-private mix, private health insurance and rationing of services (see Biggs, 2003, Glasson, 2005). Key causes of increasing costs in this area include technology, the population ageing, increasing demand for and use of services, the impact of wage and salary increases and the ability of hospitals to adapt their physical and staffing structures, procedures and care strategies to the demands of modern medicine (see Biggs, 2003, Glasson, 2005). Whilst the entire health system (not just hospitals) may not be in crisis it is certainly under stress.

The Associations acknowledge both the Australian Government and the NSW State Government are aware of this stress as is acknowledged by the many inquiries and investigations over the recent past. However, a renewed hard investigation is necessary as the stresses continue to build.

Where NSW Local Government sits in health and related health services

At the outset it needs to be recognised that NSW Local Government has no formal role in health and related services if tightly construed to focus on hospitals and related health services.

Firstly under the Australian system, State and Territory governments have primary responsibility for the provision of health services, including public hospital services. The provision of public hospital services in each State and Territory is governed by that jurisdiction's legislation.

But following a 1946 referendum, the Constitution was amended inserting section 51(xxiiiA), which gave the Commonwealth the power to legislate on:

> the provision of maternity allowances, widows pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.

This provision has enabled Commonwealth governments to become increasingly involved in the funding of public hospital services while the primary responsibility for the delivery of the services has remained with States and Territories. Health Care Appropriation Acts give legislative effect to the Commonwealth's funding commitments for public hospital services under Australian Health Care Agreements.

This division of responsibilities between the jurisdictions has never been fully clarified and has enabled successive Commonwealth and State/Territory governments to shift the blame to each other for shortcomings in the funding and provision of public hospital services. As these issues were explored in the relatively recent Senate Community Affairs Committee's reports on the inquiry into public hospital funding, we do not propose to examine them again except where they are pertinent to the present Terms of Reference.

Further there is an argument that the Australian Health Care Agreements are becoming a poor vehicle for dealing with health funding (cp Lavelle, 2004). Lavelle notes Professor John Dwyer, University of NSW and chairman of the Australian Healthcare Reform Alliance states 'The agreements are all about giving money on the basis of how many hospital beds the states can fill'.

But health is about more than filling hospital beds. Dwyer notes 'an acute hospital bed should be the last resort in the health care.' Money needs to be directed at keeping people out of hospitals - to community health, services for an increasingly aged population, health education, indigenous health, and mental health according to Dwyer. None of these issues are addressed in the Australian Health Care Agreements. Leading up to the 2003 AHCA, groups of doctors, nurses, consumer groups as well as state health ministers proposed a national health policy be included as part of the agreement. But in the end the Australian Government favoured a traditional funding model which ties funds to hospital beds (Lavelle, 2004).

Licensing and approval of private hospitals is the responsibility of the State and Territory governments. The Commonwealth government plays a significant role in the regulation of private hospitals through the *National Health Act 1953* and the *Health Insurance Act 1973*.

So it is clear that NSW Local Government has no direct legislated role in hospitals and related health services. However, it must be recognised that NSW Local Government has important roles in population health when viewed from health protection and health promotion perspectives and in rural areas has an important role in supporting medical and related health services.

Therefore it is important to paint an accurate picture of the NSW situation for the Committee, before dealing with the Terms of Reference.

NSW Local Government's Charter

NSW Local Government's charter involves providing directly or on behalf of other governments adequate, equitable, appropriate, efficient and effective services, and facilities, after consultation (see Section 8 *Local Government Act* 1993 as amended).

The charter highlights principles relating to: community leadership, cultural and linguistic diversity, management, development, restoration and conservation of the area's environment, the cumulative effect of decisions, trusteeship of public assets, and 'stakeholder' participation.

The Charter makes it clear that Local Government is a sphere of government with a legitimate role in providing a wide variety of services that local residents require.

NSW Local Government's Service Functions

NSW Local Government can choose to involve itself in the provision, management or operation of the following 'service' functions: community services; public health; cultural, educational and information services; public transport; sport, recreation and entertainment; housing; environment conservation, protection and improvement; waste removal, treatment and disposal; pest eradication and control; water, sewerage and drainage; land and property development; industry development and assistance; and tourism development and assistance (see Chapter 6 *Local Government Act* 1993 as amended).

Obviously service functions such as public health; water, sewerage and drainage; waste removal, treatment and disposal; and pest control are important direct contributors to population health.

Aspects of community service, public transport and recreation functions can have direct impacts on population health.

Further it is worth noting what we know about NSW Local Government's direct provision of or support of other organisations in the provision of medical and related health services. From the Associations' research in 2004 we can say rural and remote NSW councils are called upon by their communities to deal with a variety of medical and related health services (Baum, 2004). Eighty five (85) councils responded to the survey in this research. This was just over 80% of all members and associate members of the Shires Association at December 2003.

The most significant efforts of responding councils in providing medical and related health services in rural and remote communities were as follows:

- 30 councils provided 45 centres for 59 doctors at an annual cost of $465,065
- 26 councils provided 48 houses for 53 doctors at an annual cost of $541,528
- 12 councils provided 13 centres for 13 dentists at an annual cost of $228,800
- 10 councils provided equipment for 18 doctors at an annual cost of $63,500

But it was also worth noting other council effort included:

- relocation expenses for GPs (6 councils), vehicles for GPs (5 councils), centres for other health professionals (5 councils)
- equipment for dentists (3 councils), housing for dentists (2 councils), housing for other health professionals (2 councils),
- direct salaries for GPs (1 council), housing for nurses (1 council), direct salaries for nurses (1 council), relocation expenses for dentists (1 council), vehicles for other health professionals (1 council)

The most significant efforts of responding councils in supporting medical and related health services run by others in rural and remote communities were as follows:

- 11 councils subsidised 17 houses for 14 doctors at an annual cost of $106,414
- 9 councils subsidised 11 centres for 14 doctors at an annual cost of $85,247
- 8 councils subsidised pre-service training for GPs through scholarships and bursaries to 9 people at an annual cost of $27,350
- 4 councils subsidised equipment for 8 doctors at an annual cost of $37,000
- 3 councils provided salary subsidies for doctors at an annual cost of $89,098

It is also worth noting other council effort included:

- subsidising operations of travelling services (e.g. BreastScreen; 5 Councils) and subsidising community transport (5 Councils)
- subsidising pre-service training for Nurses through scholarships and bursaries (3 councils), subsidising Centres/surgeries for Dentists (3 councils)
- subsidising vehicle for GPs (2 councils), Subsidising in-service training for Nurses by donations (2 councils), subsidising relocation expenses for Nurses (2 councils), subsidising equipment for Dentists (2 councils), and subsidising pre-service training for other health professionals through scholarships and bursaries (2 councils)

- subsidising relocation expenses for GPs (1 council), subsidising salaries for Nurses (1 council), subsidising relocation expenses for Dentists (1 council), subsidising centres for other health professionals (1 council), subsidising vehicle for other health professionals (1 council), subsidising 'local' hospital through general donations (1 council), and subsidising Area Health Service through general donations (1 council)

This survey did not set out to detail capital works for medical and related health services for say the last 5 or 10 years because of the methodological difficulties involved. Nonetheless councils volunteered information which underscores the level of effort. It is worth noting these examples to assist in partial appreciation of this complex situation.

Indication of capital contribution by councils over time

Past capital commitments	
Bland: 1996/97 Purchase medical centre and three residences and equipment	$692,154
Carrathool: medical centre, two residences and vehicle	$880,000
Cobar: premises for doctors and dentists	$1,100,000
Coolamon: medical centre	$550,000
Coonabarabran: 1996 purchase and refurbishment of medical centre	$161,936
Coonamble: houses for doctors	$500,000
Culcairn: construct new residence for doctor ($50,000 community contribution)	$225,000
Gunnedah: furnished house and 2 flats	$400,000
Hume: construction of doctor's rooms and surgery	$200,000
Lockhart: 2003 medical centre	$600,000
Murrumbidgee:1990 constructed doctors surgery $120,000, 2002 purchase surgery and residence $362,000 and 2003 equipment $74,000	$556,000
Narrabri: donated land	$65,000
Total	$5,930,090
Forward capital commitments	
Junee: multidisciplinary medical centre	$900,000
Narromine: purchase land, construct and fit-out new medical facility	$950,000
Scone: purchase land and buildings, build purpose built facility for GPs, specialists, pathology and area health, lease to medical practice over 30 years (grant of $.25m)	$1,650,000
Total	$3,500,000

Finally there is less direct council activity. For example a majority of responding councils:

- have a Council Social or Community Plan which incorporates medical and related health issues (79%)
- facilitate development of new medical or related health facilities and services (58%)
- participate in Area Health Service Public Health Unit discussions on direction (56%)
- have council Management plan that covers Medical and Related Health strategies (53%)

Further a significant number of responding councils:

- work closely in and with NSW Rural Doctors Network (RDN) initiatives (46%)
- participated in setting up Health Council (Area Health Service) (41%)

- serves on Health Council (Area Health Service) (41%)
- facilitate Area of Need applications (33%)

From all this data it is clear rural councils are spending significant amounts each year providing or subsidising medical and related health services that are arguably the role of central governments to provide.

Given this information it is easy to see why NSW Local Government welcomed the Australian Government's Rural Medical Infrastructure Fund (RMIF). The RMIF is being developed as a national programme worth $15m over 3 years to enable councils to offset the costs they face in their bid to keep doctors in the bush. The Departments of Transport and Regional Services and of Health and Ageing are responsible for delivery of funding. It will fund the establishment and maintenance of premises and equipment to assist rural councils to establish medical facilities. The RMIF will help to increase regional community sustainability, increase the ability of regional areas to attract, recruit and retain GPs and contribute to health outcomes at the community level. The RMIF will help achieve effective outcomes for the community by being flexible to suit local circumstances; allowing an integrated approach; and not replicating or replacing existing services.

Next it is critical to recognise that NSW Local Government is required to enact regulatory functions that protect or otherwise affect people's health and health services to people. The various and important State legislation include *Public Health Act, Food Act, Noise Control Act Swimming Pools Act* and from a wider perspective the *Environmental Planning and Assessment Act.* Some areas such as food regulation have benefited from a serious re-examination (through a partnership between State and Local Government within a national framework) of the roles and responsibilities of the State and Local Government with clearer interaction likely as a result early in 2006. However, other functional areas would benefit from a similar approach.

There are financing issues regarding these regulatory functions. In the Associations recent *Local Government Public Health Survey* (in progress) councils, particularly rural ones, have consistently raised the inadequate level of resources to perform regulatory roles. There are issues relating to not having enough staff, to the devolution of roles from the NSW Government, and to the withdrawal of State health protection staff. Further from the survey it is apparent that only 16% respondent councils receive Area Health Service funding for health promotion projects. One of best ways for councils to do this work is with dedicated staff jointly funded by Area Health Services. Councils believe there is a case for the Australian Government to also contribute.

Finally it is worth stressing that NSW Local Government's concern about hospital and related health services flows largely from its role as a sphere of government reflecting that their local communities are deeply concerned about the adequacy of hospital and related services. These concerns have long been reflected in policy positions and Conference resolutions.

The Associations' Policy positions:

The Associations have existing Policy Statements on a variety of important matters. Health and

medical services feature amongst those Policy Statements. Both Associations policies are as follows:

Health and medical services

Local Government recognises the need to provide equitable and accessible health services across all areas of the state.

In recognising the problems faced by regional, rural and isolated communities in obtaining and retaining medical and health services, Local Government seeks:

- The establishment of a bipartisan Commonwealth, State and Local Government mechanism to examine international and interstate practice and develop evidence based strategies to deal creatively with the issue.
- the implementation of appropriate Commonwealth and/or State policies such as: i) a compulsory 3 year country service clause for all medical graduates in NSW with such service being offset by fees reduction and priority return to a hospital of choice, ii) including a short period of compulsory country service in all medical and other health degree courses iii) the geographical allocation of Medicare Numbers, iv) the introduction of a scale of fees for the provision of Medicare Provider Numbers taking into consideration the difficulties of attracting Medical Practitioners to regional and rural areas, and v) taxation incentives that take into consideration the difficulties of attracting Medical Practitioners to regional and rural areas.
- enhanced Commonwealth and State funding programs with incentives for experienced General Practitioners and allied health professionals to practice in country areas and with incentives for experienced General Practitioners and other health professionals to undertake locums in country areas.

For more detailed concerns on a variety of health matters raised by councils through the annual conferences of each Association and aimed at either or both the Australian and NSW Governments see Appendix 1: Recent conference resolutions relating to health.

Simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, especially hospitals

NSW Local Government agrees with the public health experts that assert that the Commonwealth/State split-system of funding and administration with ongoing conflict and confusion is a management nightmare. It leads to duplication of services, poor coordination between services and cost shifting, where patients are shifted from a state to federally funded services or the reverse for financial reasons. The end result is poor services that cost more than they should (Lavelle, 2004).

Professor Dwyer, Australian Healthcare Reform Alliance argued for a coordinated national policy that integrates all the various elements in health, not just hospitals. Professor Dwyer argues it would address the Australian Government/State and Territory Government divide, by setting up independent regional statutory bodies, funded by both spheres of Government that would take responsibility for health services (Lavelle, 2004).

Dwyer says there have been attempts at reform in the past but they have ended up in the too hard basket. It was back on the agenda as a national election issue in 2004. As part of its election policy, which also included additional funding for hospitals, Labor said it would establish a National Health Reform Commission to report within 12 months on ways to improve the funding and delivery of health services, including hospitals, specialists, GPs, community health services and aged care services. The Coalition admitted there were problems in the system such as a shortage of health workers and overcrowded emergency departments, which could be addressed by training and recruiting new health workers, and by establishing GP clinics near hospital emergency centres. But the Coalition took the view broader health reform was not necessary (see Lavelle, 2004).

After the election, the Australian Government set up a health taskforce headed by former public service commissioner Andrew Podger, to examine aspects of the issue (see Uren, 2005). We understand the taskforce has presented options to the Government, including the Australian Government taking over State/Territory public hospitals and more importantly has suggested the Government introduce competition for government funds to the health sector. The taskforce has argued that the key to the overhaul centres on changing the way funds are spent rather than shifting the management of health from the states to the Australian Government (Uren, 2005).

The Associations do not view the situation as one where shifting the management of health from the States and Territories to the Australian Government will solve the problems. Commentators from the Australian Minister for Health, Hon Tony Abbott to Dr Bill Glasson President of the Australian Medical Association have highlighted the impossibility or the pitfalls of such an approach. Dr Glasson in commenting that a single health system is a debate the community has to have, notes the British system which is a single level system does not necessarily deliver improved health services and has a noticeably large bureaucracy.

Further, the Associations do not believe introducing a funder purchaser provider model will necessarily solve the problems. Experimentation with the funder purchaser provider model in the early and mid-1990s showed it was no panacea. Further, the Associations concur with the NSW Premier Hon Bob Carr when he said suggestions a new regional system for funding hospitals bypassing State Governments could be introduced would involve a new layer of bureaucracy. As Premier Carr stated "I don't think that's going to solve it. We want a simpler, stronger system, not a more complex one." (see Dodson and Davies, 2005)

NSW Local Government supports a mechanism such as an Australian Health Reform Commission to thoroughly investigate tangible long-term options for reforming the health system. This Commission should involve all spheres of government and other critical health stakeholders. This Commission should be required to report within a reasonable period on improved funding and delivery of health (viewed as an integrated paradigm). In terms of improved funding and delivery of health the investigation should include hospitals, specialists, GPs, community health services, health related aspects of aged care, population health strategies, regulatory health protection activities and health promotion programs.

In supporting such an integrated exercise in looking for new solutions for the health funding and service delivery system, the Associations are not leaping to support of the idea of pooling all

funds. The Associations note the Australian Government did not support pooling of the Medicare Benefits Schedule, Pharmaceutical Benefits or Public Health Outcome Funding Agreements (PHOFAs), when responding to the Senate Community Affairs References Committee 2001 report on *Public Hospital Funding 'Healing Our Hospitals'* for sound reasons and is unlikely to change that position (see Commonwealth Department of Health and Aged Care, 2001, p4; Hon Tony Abbott 2005, p2). We are advocating that the health system be rigorously re-examined to establish what legislative, regulatory, policy, program and funding settings can be altered to improve the system.

Perhaps it is stating the obvious but NSW Local Government does not need or seek legislated roles and responsibilities in the health system as it relates to hospitals and related services. To provide NSW Local Government a greater legislated mandate would further unnecessarily complicate a system that is arguably too complex already and would immediately raise the spectre of cost shifting to Local Government.

NSW Local Government needs and seeks enhanced financial assistance from the Australian Government to carry out its established roles in providing or supporting medical health and related services in regional, rural and remote areas. The Associations support the Australian Government's Rural Medical Infrastructure Fund (RMIF) as an important first step in enhanced financial assistance from the Australian Government in helping rural and remote councils provide or support these medical and related health services. The Associations strongly support the idea of flexibility in RMIF to take account of local circumstances. As the Associations have said in giving input on the design of the RMIF, it is important that there is a very strong understanding of local government's views of 'flexibility' which is considerably different to the limited flexibility that seems to prevail under centralised health funding models. This program needs to be genuinely flexible and the fund administrators within Department of Transport and Regional Services and Department of Health and Ageing need to understand the range of perspectives that different councils will bring to this problem for their local area. Whilst it is very early days for the RMIF the experience of NSW councils suggest that it will need to be enhanced and made recurrent to deal with the ongoing demands in regional, rural and remote Australia.

NSW Local Government needs and seeks enhanced financial assistance from the Australian Government to carry out its well established roles in population health, regulatory health protection and health promotion. As importantly NSW Local Government needs and seeks enhanced financial assistance from the NSW Government to carry out population and public health roles, although this is not a matter the Committee can address directly.

Emerging evidence indicates population ageing will have a significant impact on NSW Local Government public health roles especially those aimed at preventing chronic non-communicable diseases (e.g. cardio-vascular disease, cancer). Local Government will need financial assistance from central governments to play the roles that central governments are keen to allocate to it in an effort to divert people from high use of hospital and related health services.

WHO proposes an extensive strategy on diet, physical activity and health (pages 7-18). But key elements which over the next decades that will impact on local government in some way are that the strategies have to be:

- comprehensive, incorporating both policies and actions together and addressing all major causes of chronic diseases together
- multisectoral, involving all aspects of society together
- multidisciplinary based on the best available scientific research and evidence and
- take a life-course perspective and be considered as part of a larger, comprehensive and coordinated effort on diet, physical activity and public health (page 7).

WHO says Health Ministries have an essential responsibility for coordinating and facilitating the contributions of many other ministries and government agencies with special emphasis on ministries and government agencies with responsibility for food, agriculture, youth, recreation, education, industry, finance, transportation, media, social affairs and environmental/ sustainability planning, as well as local authorities and those responsible for urban development (pages 9-10).

Similarly the Commonwealth (2003) report on *Healthy Weight 2008* emphasises that overweight and obesity is now a major cause of preventable health problems in Australia and lays out a national action agenda to begin to deal with this. Local government is allocated a central role under the setting of Neighbourhoods and Community Organisations.

In this context it is worth noting the findings of the Productivity Commission in its final report on the *Economic Implications of an Ageing Australia.* Amongst the key points on Local Government and regional impacts the Commission found:

- ageing of the population will place increasing pressure on expenditure
- local government revenue is unlikely to increase at a greater rate than the growth of GDP
- accordingly in common with other spheres of government there is likely to be an emerging fiscal deficit at the local government level under current policy settings

In responding ALGA noted Local Government needs access to fair federal funding if it is to properly provide for the needs of an ageing population. The ALGA President Cr Paul Bell said: "The report makes it clear that as the population ages, local government will face serious budgetary pressure as it struggles to keep pace with increasing demand for human services. Half of local government expenditure is now related to the provision of human services, such as welfare, housing, health, community amenities, recreation and culture. The report strongly underscores ALGA's case for reform of Federal-Local Government financial relations. We need to move away from the archaic system of financial assistance grants to one that provides local government with a fair share of national taxation revenue."

The Associations strongly support ALGA's continued call for access to one per cent of national taxation revenue and in particular support the case made out in ALGA's submission to the present inquiry regarding 'Resolving the problems with current arrangements' including 'Cost shifting' and 'Reforming local government financing'.

Whether we rely on WHO, *Healthy Weight 2008* or the Productivity Commission there is clear case for enhanced Australian Government funding to enable NSW Local Government to pursue public health roles aimed at preventing non-communicable diseases.

Accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved

The Associations have long held the policy position that no matter how the Australian and State Governments organise to fund public hospitals and related health services, there is a strong need for mechanisms that facilitate local input into how such public hospitals and services are managed and that facilitate their accountability to those local communities.

NSW Local Government needs and seeks formal involvement in the mechanisms that either continue or are put in place to ensure local input into how public hospitals and medical services are managed and to ensure their accountability to local communities.

NSW Local Governments main interest in the accountability question is at the level where the Hospital and related health services operate and can best engage with their communities. This is and will probably remain the province of the NSW State Government and is probably beyond what the Committee can hope to address.

Nonetheless the Associations believe that the following principles should guide the community participation structures and processes set up by the individual Area Health Service Boards (or other provider configurations that may arise):

- The community participation should go beyond awareness raising and consultation to genuine participation. This means that the local community participation structures should have some power in the decision-making process because it is meaningless to set up extensive structures to help inform an Area Health Service or other provider and then not be obliged to take any notice of the advice that is given. None of this should be taken to diminish the importance of awareness-raising or consultative roles.
- The local community participation structures should have the autonomy to enact the role of public comment, outside reporting to the Health Board.
- The extent of decision-making that is to be shared by the Board with the local community participation structures should be clear and set down in plain language and subject to regular review and renegotiation.
- The catchment areas for local community participation structures within an area should focus on natural and historical communities of interest, be as local as possible and avoid dissecting and reassembling Local Government areas. This will enable genuine engagement of the local communities. It is important to recognise that community participation is enhanced if it is based on natural or long held geographic boundaries, rather than centrally derived and often artificial subregional, area or regional boundaries. Each community with a hospital or with an identified level of local health service should have a local community participation structure.
- The membership of individual local community participation structures should be structured to recognise that communities of interest can be geographic and/or target group based. The process for getting members should ensure that the most competent people are secured to represent local health consumers, rather than filling target group positions in a token manner.
- The process for selecting members should promote local confidence in the genuiness of this participation model. The Board should not have sole control over the selection and appointment process. In process terms, this can be achieved through involving Local Government in facilitating the establishment of the community participation structures and the securing of members. A good starting point would be a public meeting called jointly by

the Board and the council to explain the suggested participation process, obtain input from locals on the composition and maximise local ownership.

Conclusion:

From the NSW Local Government perspective the entire health system may not be in crisis but it is certainly under stress.

The Associations acknowledge both the Australian Government and the NSW State Government are aware of this stress as is demonstrated by the many inquiries and investigations over the recent past. But a renewed hard investigation is necessary as the stresses continue to build.

As the Associations have stressed NSW Local Government's concern about hospital and related health services flows largely from its role as a sphere of government reflecting that their local communities are deeply concerned about the adequacy of hospital and related services.

The concerns also flow from the increasing role NSW Local Government has had to play in providing or supporting medical and related health services in rural areas, and its wider long established role in health protection and health promotion.

NSW Local Government supports a mechanism such as an Australian Health Reform Commission to thoroughly investigate tangible long-term options for reforming the health system, with this Commission:

- involving all spheres of government and important health stakeholders,
- reporting on improved funding and delivery of health where health is an integrated paradigm including hospitals, specialists, GPs, community health services, health related aspects of aged care, population health strategies, regulatory health protection activities and health promotion programs.

NSW Local Government does not need or seek legislated roles and responsibilities in the health system as it relates to hospitals and related services, as providing NSW Local Government a greater legislated mandate would further unnecessarily complicate the system and immediately raise the spectre of cost shifting to Local Government.

NSW Local Government needs and seeks enhanced financial assistance from the Australian Government to carry out its established roles in providing or supporting medical health and related services in regional, rural and remote areas (which could be built from the platform created by the Rural Medical Infrastructure Fund (RMIF)).

NSW Local Government needs and seeks enhanced financial assistance from the Australian Government to carry out its well established roles in population health, regulatory health protection and health promotion.

NSW Local Government needs and seeks formal involvement in the mechanisms that either continue or are put in place to ensure local input into how public hospitals and medical services are managed and to ensure their accountability to local communities.

APPENDIX 1:
RECENT CONFERENCE RESOLUTIONS RELATING TO HEALTH

Resolutions on health from the 2004 Shires Association Annual Conference

That the Shires Association reaffirm its commitment to pressing the Commonwealth and State Governments to improve funding levels, resource allocation models, legislative settings and programs for public and private health services in rural and remote areas, and continue to use the information from the 'Survey of council support of medical and related health services' to bolster local government arguments for a better deal from central governments in ensuring these health services are provided to communities.(resolution 16 - from The Executive)

Local Government recognises the need to provide equitable and accessible health services across all areas of the state. In recognising the problems faced by regional, rural and isolated communities in obtaining and retaining medical and health services, Local Government seeks:

- The establishment of infrastructure funds for local government to assist rural areas become more competitive with urban areas through providing collaborative structure for health care providers to have "easy entry, gracious exit" models of practice.
- The implementation of whole of government strategies toward increasing exposure of all health professions to rural areas during both their undergraduate and vocational training years, including:
    - expanding programs to supply accommocation
    - expanding HECS reimbursement schemes to all health professions (in return for rural service)
    - extend compulsory periods of rural training to all health professions, with financial assistance for accommodation and travel for all students
    - preference, and adequate resources, be given to rural hospitals for any new training posts created for medical and health professions
- A range of incentives for health professionals working in rural areas including financial incentives such as award structures, taxation concessions and retention payments; career incentives such as preferential entry into training positions and programs; and family assistance such as childcare and spouse retraining opportunities
- A state wide approach toward locum relief programs for all health professionals to avoid clinician burn-out, and to enable ready access to education and Quality Assurance programs. (resolution 24.5 - from Gunnedah)

That the Shires Association vigorously pursue both the Federal and New South Wales Governments in relation to the allocation of adequate funding for the provision of satisfactory health services in rural New South Wales. (resolution 17 - from Cobar and Western Division)

That the Shires Association make representations to the Treasurer and the Minister for Health pointing out the dire situation faced for health funding across New South Wales and seeking action to ensure that this funding situation is addressed. (resolution 18 - from Cabonne Shire Council and E Division)

That the Shires Association request the State Government to reform funding arrangements for

the NSW Health System as recommended by the Independent Pricing and Regulatory Tribunal of NSW (IPART). (resolution 21 - from A Division)

That the Shires Association make representations to both Federal and State Governments with a request that joint funding be allocated by both Governments for major Capital Works associated with public hospitals in New South Wales. (resolution 22 - from A Division)

That the Shires Association seek to have the NSW government reduce the eligibility criteria for regional patients to access financial assistance when receiving medical treatment via the federal funded Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) and further, the Shires Association seek to have the federal funded IPTAAS management placed into the jurisdiction of the Medibank system (also federal funded/controlled)
That the Shires Association asks that the eligibility criteria for Isolated Patient Travel and Accommodation Scheme be changed to allow patients to visit their doctor/hospital of their choice, in particular cancer patients.
That the distance eligibility be reduced in NSW from 200kms to 50kms as in Queensland, or 100kms as in Victoria. (resolution 20 - From Inverell)

That the NSW Government help to address the critical need for dental services in the western areas of the state by declaring dental positions in those towns unable to attract a resident dentist as area of needs positions. (resolution 24.1 - From Hay and Western Division)

That this Conference calls on the Premier and Minister for Health to ensure effective consultation with local communities regarding any proposed boundary changes to existing area health boards prior to any definitive action being implemented and that the Shires Association reaffirm its total opposition to any reduction in area health boards in this state (resolution 24.4- from Gunnedah).

Resolutions on health from the 2004 Local Government Association Annual Conference

That the Local Government Association make representations to State and Federal Governments for increased funding for health related community transport (resolution 18 – from Canterbury)

That the Federal Government be requested to correct the inequitable situation where married pensioners can accumulate 52 scripts per year between them and a single pensioner must also accumulate 52 scripts per year on their own, before benefits apply (32 – Blacktown).

That the Local Government Association make representations to State and Federal Governments for funding to provide an increase in the number of physical activity opportunities to increase the health and well-being of local residents to prevent the onset of age-related health complaints (resolution33 – from Canterbury).

That the Local Government Association petition the Minister for Health, The Hon. Morris Iemma MP to provide funding for the ongoing maintenance of fluoridation systems (resoluton 34 – from Coffs Harbour).

That the Federal and State governments overseeing recreation, health and urban development, as

part of the fight against increased obesity in the community, be asked to increase the level of funding to local government for the development and maintenance of sport and recreation infrastructure (resolution 35 – from Manly).

That the Local Government Association supports the issue of Penalty Infringement Notices for offences under the Public Health Act 1991 (resolution 36 – from Campbelltown).

That the Local Government Association lobby the State Government for the introduction of penalty infringement notices for minor offences under the Food Act (resolution37 – from Pittwater).

That the State and Federal Governments significantly increase funding to address the continued loss of life through suicide. Such funds to be utilised for research into preventative solutions, educational and awareness programs and any other proactive initiatives that will reduce the occurrence of this community tragedy (resolution 39 – from Gunnedah)

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