Chapter 3

The adequacy of the COAG health reforms

3.1 This chapter will consider the adequacy of the COAG health and hospital reforms in light of the evidence before the committee. It also considers the first eight terms of reference.

Labor promises in 2007

3.2 It needs to be highlighted that the Rudd Government had nearly two and a half years to develop a health policy that would 'end the blame game', including a Summit, numerous Reviews, a Commission and 'hospital road shows'. However evidence provided to the committee indicate that the Prime Minister's health reform policy, *A National Health and Hospitals Network for Australia's Future*, announcement on 3 March 2010 at the National Press Club was rushed and developed by a health taskforce working group in the Department of Prime Minister and Cabinet that met for the first time on 5 February 2010.

3.3 Prior to the November 2007 federal election, the then Leader of the Opposition, Mr Kevin Rudd announced that if in power, the Labor Party would seek a mandate from the Australian people to take financial control of Australia's public hospitals if state and territory governments failed to reach agreement on a national health and hospital reform plan by mid–2009.[1]

> Third, if by the middle of 2009 the State and Territory have not begun implementing a national reform plan, a Rudd Labor Government will seek a mandate from the Australian people at the following election for the Commonwealth to assume full funding responsibility for the nation's public hospitals.
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> The assumption of Commonwealth funding for all public hospitals would require a parallel reduction in Commonwealth outlays to the States and Territories at the point of transfer. There would therefore be no windfall gain of any description to the states and territories.
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> If necessary, Federal Labor will also consider the possibility of conducting a national plebiscite or referendum at the following federal election on the question of any proposed Commonwealth takeover.[2]

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1 Australian Labor Party, *New directions for Australian health – taking responsibility: Labor's plan for ending the blame game on health and hospital care*, August 2007, p. 7, http://parlinfo.aph.gov.au/parlInfo/download/library/partypol/GT1O6/upload_binary/gt1o62.pdf (accessed 14.5.10).

2 Australian Labor Party, *New directions for Australian health – taking responsibility: Labor's plan for ending the blame game on health and hospital care*, August 2007, p. 7.

3.4 Indeed, at Labor's campaign launch on 14 November 2007 Mr Rudd told the Australian public that he had a plan:

> On hospitals, we have put forward a national plan to end the buck-passing between Canberra and the States.
>
> I have a long-term plan to fix our nation's hospitals.
>
> I will be responsible for implementing my plan, and I state this with absolute clarity: the buck will stop with me.[3]

3.5 However, it emerged from Senate Estimates on 10 February 2010, that there appears to have been no plan.[4] In an answer to a question on notice, the Department of Health and Ageing was unable to confirm that it had received any documents other than the Rudd health election policy, *New Directions for Australian Health* when Labor came to office.

The National Health and Hospitals Reform Commission

3.6 In February 2008, the Rudd Government established the National Health and Hospitals Reform Commission (NHHRC). The NHHRC's aim was to develop a national blueprint for health reform. The interim report of the NHHRC released in February 2009 contained several policy proposals for health care services reform.[5]

3.7 At the same time that the NHHRC was undertaking a structural review of the health and hospital system directed at 'long-term system-wide health reform',[6] the reform of the health and hospital system was being considered by the Council of Australian Governments (COAG). The COAG *Communiqué* of 3 July 2008 stated that:

> COAG has an ambitious health and ageing reform agenda proposed for implementation from 2009. This includes a substantial program of hospital reform, improvements to Indigenous health, chronic disease management and preventative health care. When fully implemented, reforms will improve the health outcomes for all Australians, contributing to increased

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3 Australian Labor Party, 'Kevin Rudd - Campaign Launch speech – Brisbane', 14 November 2007, www.theage.com.au/ed.../ALP_Campaign_launch_speech_141107.doc (accessed 22.6.10).

4 Community Affairs Legislation Committee, *Estimates Hansard*, 10.2.10, p. CA 11.

5 National Health and Hospitals Reform Commission, *A Healthier Future for All Australians – Interim Report*, December 2008, http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/NHHRC.pdf (accessed 14.5.10).

6 Australian Government, *A National Health and Hospitals Network for Australia's Future*, March 2010, p. 10.

productivity. The Commonwealth and the States will continue to work cooperatively to progress this vital program of reform.[7]

3.8 The NHHRC's final report was released on 27 July 2009 and contained 123 recommendations directed at both immediate and longer-term reforms. It highlighted the importance of government action to achieve three reform goals:

- tackling major access and equity issues that affect health outcomes for people now;
- redesigning our health system so that it is better positioned to respond to emerging challenges; and
- creating an agile and self-improving health system for long-term sustainability.[8]

3.9 The Government responded to the release of the NHHRC report, by undertaking another consultation process in addition to that undertaken by the NHHRC. The Prime Minister and Minister Roxon embarked on their listening tour or 'consultation process' which involved about 123 visits to hospitals, photo opportunities with the Prime Minister and Australians in myriad hospital situations.

3.10 Evidence at various Senate Estimates refers to about 103 consultations. However the committee found that despite these many months of 'consultation', a large majority of stakeholders reported that they did not fully understand the hospital plan, had not been provided with in-depth detail about its implementation and operation and further details. In this sense, there are specific parallels to the Henry Review where the Rudd Government sat on the review for months and then announced the super profits mining tax with minimal detail and no implementation plan. This parallel extends to health with taxpayers funding a health communication plan (launched the day after the budget) when many proposed changes do not take place for some years and legislation has not yet been presented to Parliament implementing the reforms.

3.11 Despite efforts to ascertain the process by which this 'consultation process' was devised and planned (i.e. who decided where to visit, how were the locations chosen, who was invited), officials of the Department of Health and Ageing would not provide further details about the involvement of the Office of the Prime Minister in this process.[9]

3.12 Indeed, officials from the Department of the Prime Minister and Cabinet (PM&C) denied that PM&C had any role in determining the location of the visits that

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7 Council of Australian Governments, *Council of Australian Governments Meeting 3 July 2008 Communiqué*, p. 6.

8 National Health and Hospitals Reform Commission, *A Healthier Future for All Australians*, Final Report, June 2009, Executive Summary.

9 Community Affairs Legislation Committee, *Estimates Hansard*, 2.6.10, pp CA 12–14.

the Prime Minister undertook stating that the process was 'managed' by the Department of Health and Ageing.[10]

Post COAG December 2009

3.13 At the COAG meeting in December 2009, the Commonwealth, states and territories acknowledged that long-term health reform was required to deliver better and more responsive services.[11]

3.14 The Prime Minister and Minister for Health and Ageing met frequently with state and territory counterparts to discuss health reform ahead of the April 2010 COAG meeting. However formal negotiations commenced on 5 February 2010 with a dedicated Health Reform Working Group, headed by the PM&C Deputy Secretary, Mr Ben Rimmer.[12] Sub-groups were created under the Health Reform Working Group to focus in greater detail on primary health care services, public hospitals, and financing.

3.15 On 3 March 2010, the Rudd Government announced various reforms (contained in the 'Blue Book') which it described as representing 'the biggest changes to Australia's health and hospital system since the introduction of Medicare and one of the most significant reforms to the federation in its history'.[13]

3.16 The reforms purported to be based on a national network, funded nationally and run locally:

- *a national network:* to bring together eight disparate State run systems with one set of national standards to drive and deliver better hospital services;
- *funded nationally:* the Australian Government taking the dominant funding role in the entire public hospital system; and
- *run locally:* Local Hospital Networks bringing together small groups of hospitals.

3.17 It was indicated that the Commonwealth will achieve these aims through the following action:

- taking 60 per cent of funding responsibility for public hospitals by investing one third of GST revenue – currently paid to the states and territories – directly in health and hospitals;

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10 Finance and Public Administration Legislation Committee, *Estimates Hansard*, 25.5.10, pp F&PA 98–99.

11 Australian Government, *A National Health and Hospitals Network for Australia's Future*, March 2010, p. 10.

12 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24*, p. 1.

13 Prime Minister, Treasurer, Minister for Health and Ageing, 'A National Health and Hospitals Network for Australia', Joint Media Release, 3 March 2010.

- taking over responsibility for all GP and primary health care services;
- establishing Local Hospital Networks (LHNs) managed by health and financial professionals and responsible for running their local hospitals, rather than central bureaucracies;
- paying LHNs directly for each hospital service they deliver, rather than just handing over block funding grants to the states; and
- bringing fragmented health and hospital services together under a single National Health and Hospitals Network, through strong transparent national reporting.[14]

3.18 On the same day, the Commonwealth published the policy document, *A National Health and Hospitals Network for Australia's Future*, to ensure clarity of its proposed reform agenda.

3.19 It is important to also note that on 3 March 2010 when Mr Rudd announced the hospitals plan his government was still to respond to the draft Primary Health Care strategy and the National Preventative Health Taskforce report. The Government finally responded to these two reports as part of the Budget announcement.[15]

"Real reform" or just more business as usual with the states?

3.20 It is clear from the evidence at Senate Estimates on 25 May 2010, that the Health Reform Working Group did not commence its formal deliberations until 5 February 2010 and the group only held four meetings.[16]

3.21 Indeed, it is apparent from the Estimates hearings, this inquiry and answers to questions on notice that the hospital plan, the so called 'biggest change to Australia's health since Medicare' was 'hurriedly put together' between 5 February and the 3 March. Despite the Department of Finance and Deregulation claiming to have been 'involved in costings through various stages of the process', the Department conceded that it only started the formal costings process for the plan on 17 February 2010.[17]

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14 Prime Minister, Treasurer, Minister for Health and Ageing, 'A National Health and Hospitals Network for Australia's Future', Joint Media Release, 3 March 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr038.htm (accessed 13.5.2010).

15 The Hon Nicola Roxon MP, Minister for Health and Ageing, 'Three Major Reform Projects Responded to in the 2010-11 Budget', Press Release, 11 May 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr089.htm?OpenDocument&yr=2010&mth=5 (accessed 22.6.10).

16 Finance and Public Administration Legislation Committee, *Estimates Hansard*, 25.5.10, p. F&PA 103.

17 Department of Finance and Deregulation, answer to question on notice, DoFD 18.

3.22 After more than two years of reports, reviews and hospital tours by the Prime Minister and Minister Roxon, the so called 'biggest change to Australia's health since Medicare' took only 19 working days to produce and this included printing of the document, *A National Health and Hospitals Network for Australia's Future*.

3.23 The subsequent documents, (*A National Health and Hospitals Network: further investments in Australia's Health* and *A National Health and Hospitals Network for Australia's Future: delivering better health and better hospitals)* produced at COAG took 33 days to write and print and were necessary due to the additional financial inducements provided by the Prime Minister to gain the approval of the states and territories. WA remains elusive.

3.24 Consequently, the claim by Mr Rudd and Ms Roxon that this is the biggest health reform since Medicare is yet another example of overblown rhetoric. The spectacular dumping of the National Funding Authority, a major plank of transparency and accountability underpinning the 'plan', within barely weeks of the finalising of the agreement between the Commonwealth and the states (except Western Australia), makes a mockery of the whole process. If not for the Senate Inquiry the dumping of the National Funding Authority would have been kept secret. This information was only made public as a result of the Coalition's question on notice, an answer that was slipped out the afternoon of the Press Gallery Mid Winter Ball.

3.25 The recent Senate Community Affairs Budget Estimates hearings and hearings for this inquiry have revealed plans for local hospital networks are lacking in key details: there is no clarity about the precise number of LHNs; where they will be located; how they will interact with other parts of 'the plan'; and perhaps most importantly, that there is no certainty of local involvement in LHNs.

3.26 In his speech at the National Press Club on 3 March 2010, Mr Rudd stated:

> For the first time, Local Hospital Networks, run by local health, financial and managerial professionals, rather than state or, for that matter, federal bureaucrats, will be put in charge of running the hospital system.[18]

3.27 The reality is that the Prime Minister has not followed through on this commitment. Many submissions and witnesses are concerned that the wording of the Intergovernmental agreement indicates that there is no guarantee that local clinicians will be involved in the management of LHNs, to be created by state and territory governments.

3.28 Clause A10 of the Agreement outlines the governance structure of the LHNs. In relation to the crucial medical composition of the LHNs, the Agreement states at A10(b)(ii):

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18 The Hon Kevin Rudd MP, Prime Minister, 'Better health, better hospitals: The national health and hospitals network', Speech to the National Press Club, 3 March 2010, http://www.pm.gov.au/node/6534 (accessed 22.6.10).

ii. clinical expertise, external to the LHN wherever practical.

3.29 This contradicts what Mr Rudd lauded was to be the case on 3 March. If the doctors on an LHN have to come from outside the LHN, they will not be 'run by local' health professionals.

3.30 When pressed at Senate Estimates about the specific wording of the Intergovernmental Agreement, the Secretary of the Department of Health and Ageing, Ms Halton disagreed with this reading of the document:

> Senator FIERRAVANTI-WELLS—But this Prime Minister has made so much of local hospital networks 'run by' local health. You see them in the advertisements now. Those advertisements refer to 'run locally'.
>
> They have spent so much money on advertising. That is false. Take my local hospital network in the Illawarra, for example—there will be one down there in the Illawarra. What, effectively, this says is that the clinical expertise for the local hospital network that will be based around the Illawarra will not come from the Illawarra; it will come from outside the Illawarra.
>
> Ms Halton—With respect to your 20 years as a lawyer, I have nearly 30 years as a bureaucrat and I can tell you how this will be implemented, and it will be—
>
> Senator FIERRAVANTI-WELLS—That is not what the agreement says, Ms Halton.
>
> Ms Halton—I am telling you how it is to be implemented.
>
> Senator FIERRAVANTI-WELLS—Ms Halton, if that is how it is going to be, perhaps you should have written the agreement, because that is not what is in the agreement. If this is the agreement that the states have signed up to, is there going to be a second agreement, a modified agreement?
>
> Ms Halton—No.
>
> Senator FIERRAVANTI-WELLS—The point is: what is in the agreement and what the states have signed up to, except Western Australia, is a document that says that the clinical expertise will come from outside the Local Hospital Network wherever practicable.
>
> Ms Halton—With respect, my observation is that actually the clinical community will not give a rat's about formal agreements or otherwise. What they will care about is how this is implemented and what they will care about is the arrangements as I have outlined to you, which will be how this will be implemented.
>
> Senator FIERRAVANTI-WELLS—With due respect, the agreement specifies, virtually down to the letter, the obligations of the states in relation to this agreement, and I would have thought that state bureaucracies are going to follow to the letter what they are required to do, presumably under eventual legislation that is going to be established to give effect to this agreement. I would have thought that the parameters of this agreement are going to carry much more weight, Ms Halton, than your interpretation of what potentially might be the situation.

> Ms Halton—I can tell you with absolute confidence that my, as you describe it, interpretation—indeed, let us put it more broadly: the approach to implementation of this has not just been my whim or whimsy but has been discussed between myself and the others, just to confirm that this is indeed how it will be implemented.[19]

3.31 In short, it appears that the Agreement may be implemented in terms different from the plain reading of the terms contained within it. The committee finds it difficult to determine a position on this due to the lack of detail available but notes Ms Halton's statement in this regard:

> Senator FIERRAVANTI-WELLS—We will deal with it in outcome 13, but my point here is that, in what the Prime Minister outlined of these lead clinicians groups, the language is not directive. There is no mention of variation in this speech of the agreement that the states agreed to, in relation to the clinical expertise being external to the Local Hospital Network. That is my point. Even after the Prime Minister gave his speech to the AMA, there is nothing concrete in this speech that I see that varies the agreement with the states. That is the point.
>
> Ms Halton—As I pointed out to you, there is no need to vary this agreement with the states. The arrangements, as I have outlined to you, are how this is to be implemented, and this is the way it will be implemented.[20]

3.32 The committee considers that Ms Halton's comments on this point raise the spectre of what else in this Intergovernmental Agreement will be implemented in a fashion otherwise than specified in the specific terms of the Agreement.

3.33 Various indications have been given that the exclusion of clinicians in the wording of the Intergovernmental Agreement was at the behest of the states, and most particularly, by Victoria. The committee specifically asked this question. The Department of Health and Ageing failed to answer the question and referred the committee to the answer provided by the Department of the Prime Minister and Cabinet (PM&C).[21]

3.34 The answer from PM&C was hardly clear and simply referred to the wording of the Intergovernmental Agreement. In short, the committee was not provided with an answer to this question.[22]

3.35 There was considerable questioning of officials from PM&C about this issue on 25 May 2010. Shortly after this at the AMA conference, Mr Rudd announced $58 million for the establishment of Lead Clinicians Groups. This appears to be an afterthought for which little detail is available. It is clear that their role will be purely

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19 Community Affairs Legislation Committee, *Estimates Hansard*, 2.6.10, p. CA 18.

20 Community Affairs Legislation Committee, *Estimates Hansard*, 2.6.10, pp CA 18–19.

21 Department of Health and Ageing, answer to question on notice, DoHA 10.

22 Department of the Prime Minister and Cabinet, answer to question on notice, PM&C 30.

an advisory role and not the directional one that might be supposed would be the case with local doctors appointed to their LHNs.[23]

3.36 Another concern raised by some members of the committee is the number of hospitals that will be covered by the health reforms. *The Australian* of 22 April 2010 states that the deal excludes 80 per cent of hospitals. The front page article entitled *Rifts open in Rudd's health plan* states:

> Kevin Rudd's claim to have delivered historic health reform is under increasing challenge, with doubts emerging about whether it achieves its aim of sidelining inefficient state bureaucracies.
>
> As the government yesterday confirmed that as few as 165 out of the nation's 764 hospitals would be converted to the activity-based funding model the Prime Minister championed as the key driver of a more efficient health service, Canberra has also agreed to take a hands-off approach to the management of local hospital networks. This would give states total control over appointments to the new bodies.[24]

3.37 In Senate Estimates, Mr Rimmer from PM&C confirmed this:

> … If I recall that article correctly, what it refers to is the number of hospitals that will be funded through activity based funding. There are, as you would know, a large number of very small hospitals in regional and rural Australia where it is not appropriate to provide for hospital services through activity based funding because the small volumes involved make it very difficult to make budgets balanced and to keep hospitals sustainable. So the activity based funding scheme will apply to a number something like that of hospitals, but it is worth pointing out that those 165 hospitals cover the overwhelming proportion of hospital services that are provided in Australia. I think it is roughly 90 per cent, but I would want to ask for further advice about that.[25]

3.38 The Department of Health and Ageing has failed to provide a direct answer to the question as to how many hospitals will have activity based funding and how would this be determined. The committee has been advised that COAG will determine this at some point in the future.[26]

3.39 The Department of Health and Ageing was unable to provide a list of hospitals with block funding in each state.[27]

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23 Department of Health and Ageing, answer to question on notice, DoHA 62.

24 Matthew Franklin, 'Rifts open in Kevin Rudd's health plan', *The Australia*, http://www.theaustralian.com.au/politics/rifts-open-in-kevin-rudds-health-plan/story-e6frgczf-1225856624193 (accessed 22.6.10).

25 Finance and Public Administration Legislation Committee, Estimates Hansard, 25.5.10, pp F&PA 106–107.

26 Department of Health and Ageing, answers to question on notice, DoHA 42 & DoHA 9.

27 Department of Health and Ageing, answer to question on notice, DoHA 63.

3.40 Prior to COAG, there were reports about potential closures of hospitals in NSW as a consequence of the reforms. The Department of Health and Ageing have denied receiving any documents on hospital closures from states and territories in the context of COAG health reforms.[28]

3.41 The committee heard that many stakeholders saw the reforms as a missed opportunity to realise the recommendations of key reports including that of the National Health and Hospital Reform Commission (NHHRC). For example, CHA stated that much of the NHHRC's reform vision which would otherwise 'lead to vast improvements in the health of all Australians', had not been addressed by the government.[29]

3.42 A number of stakeholders voiced concerns in relation to both the proposed overarching and specific management and coordination structures. Coordination was of central concern in relation to the establishment of Local Hospital Networks and Medicare Locals as Primary Health Community Organisations (PHCOs) and of the relationship between them.[30]

3.43 The so called health reform process has been very much driven by Mr Rudd and his Department. This is clear from evidence at Senate Budget Estimates from PM&C on 25 May 2010.

3.44 Not surprisingly, answers to questions on notice highlight the limited involvement that the Department of Health and Ageing had, with only one of its officials participating at the COAG meeting of 19 and 20 April.[31] Ms Halton, Secretary of the Department of Health and Ageing, has routinely attended high level meetings relating to COAG health reform but it has not been possible to ascertain if Ms Halton is the one official referred to above.[32]

3.45 Ms Halton in Senate Estimates advised that there will not be a second or modified Intergovernmental Agreement.[33] In view of the backflip on the National Funding Authority, the proposed implementation of LHNs contrary to the terms of the Agreement and the indication that the 4-hour target in emergency departments is subject to substantial caveats, it again begs the question - what else will be changed before the Agreement is implemented?

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28 Department of Health and Ageing, answer to question on notice, DoHA 64.

29 Catholic Health Australia, *Submission 3*, p. 3.

30 See for example, Mental Health Council of Australia, *Submission 21*, p. 10; The Society for Hospital Pharmacists of Australia, *Submission 9*, p. 2; Australian General Practice Network, *Submission 27*, p. 10.

31 Department of Health and Ageing, answer to question on notice, DoHA 13.

32 Department of Health and Ageing, answer to question on notice, DoHA 11.

33 Community Affairs Legislation Committee, *Estimates Hansard*, 2.6.10, p. CA 18.

Lack of detail and missed opportunity

3.46 Many of the submissions criticised the Government for the lack of detail relating to the reforms. There is no evidence that the detailed implementation work has been done and it is difficult to determine the degree of real reform that will result from this policy. Catholic Health Australia said:

> There is much detail still to be worked through at all levels of government as to how the arrangements will work. In an area as complex as health, the detail will be fundamental in determining the extent to which the reforms will lead to an improvement in the health system.[34]

3.47 The Australian Medical Association reiterated Catholic Health Australia's criticism about the lack of detail provided:

> The Commonwealth Government has committed to considerable new investment in hospitals, including in subacute beds, and provided incentives to State governments and hospitals to increase capacity, but there is no detail explaining how this will be achieved.[35]

3.48 The Australian General Practice Network criticised the lack of clarity and detail in the government's reforms:

> The lack of clarity around which level of Government will be responsible and accountable for key aspects of primary health care and particularly the apparent enhancement of the role of State Government's in primary health care policy. Rather than realise the reform objective of greater coordination and service integration this may lead to additional bureaucracy and fragmentation of services.[36]

3.49 Dr Adrian Sheen from Doctors Action made some pertinent comments in his evidence about this reform taking Australia into unchartered waters:

> The government now wants to embark on changes that take Australians into uncharted waters. I feel they do so at their peril. To import failed schemes from overseas such as superclinics and have them imposed upon the community can only result in increased costs, increased bureaucracy and the extinction of the family doctor. These clinics are similar to polyclinics in the National Health Service in the UK, otherwise known as Darzi clinics, yet these United Kingdom clinics have proven to be an expensive white elephant. Now it is found that the cost per patient treated in these polyclinics is more than twice that of patients being seen in their local general practice. Importantly, these NHS polyclinics have always been GP led, whereas in Australia the GP is being increasingly sidelined.

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34 Catholic Health Australia, *Submission 3,* p. 5.

35 Australian Medical Association, *Submission 10,* p. 4.

36 Australian General Practice Network, *Submission 27,* p. 4.

> Not surprisingly, the only polyclinics in the United Kingdom that are in any way successful are those that are located in areas of doctor shortage, not where they are located for political expediency. Reforms that put taxpayer funded Woolies and Coles style superclinics into competition with private medical practices are inherently bad. The government has announced it wants 450 superclinics. To give you some idea, for every two McDonald's restaurants there will be one superclinic. Superclinics already have started advertising for patients, and the stress that this will cause on nearby practices—not just on doctors, but on their staff, on the local allied health and on local chemists—must never be underestimated.
>
> Is it the role of governments to openly compete with local businesses? As shown by numerous surveys, including a recent one by the AMA published last month, Australians value their relationship with their family doctor. Politicians can underestimate the importance of this relationship. There is no suggestion that any of the government reforms will enhance the relationship between patients and their own doctor. For many people the family doctor is a highly significant person in their lives. Patients rely on their family doctor for diagnosis, for management of their problems, rely on them to help them through the health system, for advice on all sorts of diverse matters, discussion of their history, their secret history, in a confidential and caring environment. No society as wealthy and advanced as Australia can afford to lose this human element in care.[37]

3.50 And the National Primary Health Care Partnership joined the criticism of the lack of detail with the Government's plans:

> The NPHCP supports the general intent of a Commonwealth Government take-over of funding and policy responsibility for all primary health care, however, is concerned about the lack of clarity regarding who will be responsible or accountable for key aspects of primary health care under the funding structure outlined in the Agreement and the seeming enhancement of hospital authority to deliver primary health care services.[38]

3.51 Submitters argued for increased capacity in the system, ending the 'blame game' between the Commonwealth and the states and territories, and providing flexibility to ensure that the system is responsive to local needs.[39] Aged and Community Services Australia (ACSA), for example, argued that there was a 'pressing case for reforming Australia's health and aged care system' and that there are barriers in the current system to 'genuinely patient or client-centred care and obstacles in the way of efficient and effective service delivery'.[40]

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37 Dr Adrian Sheen, Doctors Action, *Committee Hansard*, 7.6.10, pp 71–72.

38 National Primary Health Care Partnership, *Submission 19*, p. 1.

39 See for example, Australian Medical Association, *Submission 10*, pp 1–2.

40 Aged and Community Services Australia, *Submission 17*, p. 1.

3.52 Whilst there is consensus that some reform is needed, there was a divergence of views on the details of the COAG health reforms. Many, including the Australian Medical Association (AMA), support a number of aspects of the reforms in principle, including the development of national standards. However, other aspects were not supported. For example, the AMA raised concerns in relation to the division of responsibility between the Commonwealth and the states, which it noted, has the potential to create disconnect between 'what hospitals are expected to do as opposed to what they are paid to do'.[41]

3.53 Others argued strongly that the reforms are inadequate in the areas of mental health, Indigenous health, dental health, primary care, community health and a number of aspects of prevention.[42] The CEO of the Rural Doctors Association of Australia (RDAA), Mr Steve Sant, noted that in terms of the impact of the reform package on rural Australians:

> We have yet to see whether that have will any effect on the health of rural Australians. We certainly believe that without those specific rural incentives, and specific rural supports, we will not see the health of rural Australians in any way being improved, nor will we see the workforce, those 5,400 nurses, the 1,800 doctors, moving back into rural Australia where they are needed.[43]

3.54 Given the criticism regarding the lack of attention to mental health in the Government's plans, it was not surprising to see the recent front page article entitled *Rudd Adviser Quits* and the comments made by Professor John Mendoza, Chairman of the National Advisory Council on Mental Health after he tendered his resignation in a letter to Minister Roxon last Friday. He is reported as stating:

> It is now abundantly clear that there is no vision or commitment from the Rudd Government to mental health," he wrote.
>
> "The Rudd government is publicly claiming credit for the increased investment in mental health when almost all of this is a consequence of the work of the Howard government".[44]

3.55 The report goes on to state that: 'A sticking point is the Better Access program',[45] which was the subject of considerable discussion at Senate Estimates with the recent decision by the Rudd Government to scrap payments for social workers and occupational therapists who offer one-on-one mental health services. Coalition Senators pressed officials about the angst in the industry following the Government's

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41 Australian Medical Association, *Submission 10*, p. 3.

42 See for example, Professor D Penington, *Submission 7*; Professor P McGorry, *Submission 8*; Australian Medical Association, *Submission 10*; The Royal Australian and New Zealand College of Psychiatrists, *Submission 12*.

43 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 66.

44 'Rudd Adviser Quits', *The Sun Herald*, 20 June 2010, p. 1.

45 'Rudd Adviser Quits', *The Sun Herald*, 20 June 2010, p. 1.

decision. Officials conceded that the 'department did not consult with social workers and OTs before the government's decision'.[46]

3.56 A considerable number of stakeholders contended that there was a lack of clarity regarding the details of the reforms, which made it impossible to establish how they will work in practice. For example, ACSA stated:

> The COAG reforms refer to three different networks: hospitals, primary care and aged care but the announcements provide little detail about these or how they are to work together – as they must to provide coordinated and efficient person-centred care.[47]

3.57 The position of the AMA in relation to the *National Health and Hospitals Network Agreement* (NHHN Agreement or IGA) also reflected these concerns:

> There is still considerable detail to be developed about how many of the reforms and initiatives will be implemented…Their success will depend on this detail and how much flexibility there is in how they are implemented.[48]

3.58 Mr Martin Laverty of Catholic Health Australia (CHA) contended that CHA 'cannot speak to the implementation' but can only recommend that those outside of government service delivery are involved in the design of the system. This would enable those with experience and another perspective 'ensure that the principles are achieved, that local governance can be achieved, if there is that opportunity for transparent scrutiny as to how these systems are established. At the moment it is uncertain to us'.[49]

3.59 Others contended that such lack of clarity was creating uncertainty and in some areas, anxiety and confusion.[50] The AMA noted for example:

> Even within this framework of additional funding, there continues to be uncertainty about how this funding will be used and the impact it will have. For example, where funding has been announced to create beds, it is still unclear how this will be guaranteed and demonstrated to have happened.[51]

3.60 The Royal District Nursing Service commented that despite current talk of a shift to focusing on out-of-hospital care and thus preventing or reducing the need for

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46 Community Affairs Legislation Committee, *Estimates Hansard*, 3.6.10, p. CA 48.

47 Aged and Community Services Australia, *Submission 17*, pp 1–2.

48 Australian Medical Association, *Submission 10*, p. 3.

49 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 7.6.10, p. 53.

50 See for example, Dietitians Association of Australia, *Submission 5*, p. 1; The Society for Hospital Pharmacists of Australia, *Submission 9*, p. 2.

51 Australian Medical Association, *Submission 10*, p. 13.

hospitalisation as a long term solution for the health system, 'the majority of funds and new spending appears to continue to be allocated to existing programs'.[52]

3.61 Those most critical of the reforms suggested that they amount to 'little more than a refinancing package for our public hospital system'.[53]

3.62 Concerns were raised that the COAG health reforms offer an inadequate investment for long-term gains and genuine improvements.[54] Professor John Dwyer stated:

> The additional money for hospitals is welcome but still inadequate; and the structural reforms needed for improved equity, cost effectiveness and a focus on health maintenance are missing in action.[55]

3.63 While CHA endorsed the use of activity based funding 'because that is very much the way in which our public hospital systems work today and have worked for many years',[56] other submitters viewed the use of activity based funding with considerable concern. In particular, it was argued that there is insufficient data to calculate a single national price whilst there are differences across the states in the costs of procedures and superannuation and problems in adjusting the formula to account for differences in Aboriginal and Torres Strait Islander and rural populations.[57] Activity based funding is discussed further below.

3.64 The committee also received evidence that there is a lack of focus on preventive health. CHA noted that COAG could have adopted the World Health Organisation (WHO) framework on the social determinants of health to prevent ill health in the community and therefore reduce future health costs.[58] It noted, however, that whilst the Commonwealth has accepted the principles enunciated by the WHO, the approach being taken by government at all levels in addressing the social determinants 'remains fragmented and piecemeal'.[59] Mr Martin Laverty, CEO of CHA

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52 Royal District Nursing Service, *Submission 11*, p. 1.

53 Croakey, 'Senior advisor attacks "mad" health reform for its neglect of mental health', 3 May 2010, http://blogs.crikey.com.au/croakey/2010/05/03/senior-advisor-attacks-mad-health-reform-for-its-neglect-of-mental-health/ (accessed 20.5.10).

54 Fiona Armstrong, 'Good climate for proper reforms: health reforms, *The Australian*, 8 May 2010, http://www.theaustralian.com.au/news/health-science/good-climate-for-proper-reforms-health-reforms/story-e6frg8y6-1225863743994 (accessed 20.5.10).

55 John Dwyer, 'Health plan needs a few dollars more', *Australian Financial Review*, 11 May 2010, http://parlinfo/parlInfo/download/media/pressclp/LKNW6/upload_binary/lknw60.pdf;fileType%3Dapplication%2Fpdf (accessed 20.5.10).

56 Mr C Laverty, Catholic Health Australia, *Committee Hansard*, 7.6.10, p. 53.

57 See for example, Australian Medical Association, *Submission 10*, p. 5.

58 Catholic Health Australia, *Submission 3*, p. 3.

59 Catholic Health Australia, *Submission 3*, p. 5.

stated further that improving the health of low-income earners implied addressing the social determinants and that:

> We are unashamed in saying that we will not address the disparities in health outcome between high-income Australians and low-income Australians until such time as health policy also incorporates an understanding of the role of education, the role of housing and the role of income support.[60]

3.65 Similarly, the Royal District Nursing Service (RDNS) argued that a considerable number of the reforms are 'more of the same' with new funding provided through existing funding streams which amount to a missed opportunity to address the social determinants of health including education, employment, and housing on the health status of the community. The RDNS went on to comment:

> A more holistic approach which considers all elements of the individual and community is required, rather than focusing on the present (medical model) domain and the focus on mainstream health service.[61]

3.66 The Australian Health Care Reform Alliance (AHCRA) was disappointed that there was no underlying guiding principles or overall agenda for health care reform. The AHCRA stated:

> COAG's failure to articulate the underlying values of our health system make it difficult for stakeholders to assess the individual proposals in terms of their contribution to improving the health system overall.[62]

3.67 Others raised concerns regarding the long-term viability of the health and aged care sector in Australia given the country's ageing population. This was raised in the context of the provision of care in the home by unpaid family carers. Carers Australia lamented the lack of provision for the country's almost 2.6 million carers in the health and aged care sector, and the community care, mental health and palliative care systems and highlighted that decisions regarding health should not be based on the assumption that family carers will continue to provide unpaid care without appropriate support or inclusion in the health sector.[63] Carers Australia argued that without such support:

> No future health, aged, mental health or community care system will be able to respond to the changing demographics and health needs, clinical practices and societal influences in the long term without carers.[64]

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60 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 7.6.10, p. 56.

61 Royal District Nursing Service, *Submission 11*, p. 3.

62 Australian Health Care Reform Alliance, *Submission 30*, p. 7.

63 Carers Australia, *Submission 25*, p. 5.

64 Carers Australia, *Submission 25*, p. 12.

3.68 Mr David Crosbie, CEO of the Mental Health Council of Australia (MHCA) also highlighted the centrality of community carers to the health sector. Mr Crosbie stated:

> The other aspect of that is that you have a lot of carers in the community who are ageing. When I go out and talk to carers their biggest concern is what happens to their 50-year-old child as their capacity to care diminishes. There is real concern in the aged care community that they are getting younger people coming in who previously might have been cared for at home, but it has got to the point where the ageing parent can no longer provide that care and they have ended up in aged care homes in their fifties. I think that is an emerging need.[65]

3.69 One of the points that has been highlighted by various submissions, is the analogy with the National Health Service in the United Kingdom. The post COAG publication, *A National Health and Hospitals Network for Australia's Future: Delivering better health and better hospitals* stresses that better treatment in the community will help keep Australians healthy and out of hospitals.[66]

3.70 The management of today's major chronic diseases needs expert advice from GPs together with commitment from patients to make healthy lifestyle changes. It could take years and decades before any benefits from improved chronic disease management reduces demand on hospitals. There is no guarantee that the promise of the Prime Minister's plan to keep people healthier and reduce demand on hospitals will be delivered in the near or even distant future. The demands of health spending and expectations are driven by many factors not just an individuals or populations' health status.

Term of reference (a): New financial arrangements and the dumping of the National Funding Authority

3.71 One of the key features of the 'plan' was the need for accountability and transparency. The centrepiece of this was the National Funding Authority. This was set out in *A National Health and Hospitals Network for Australia's Future: Delivering better health and better hospitals:*

> **Reforming funding arrangements for public hospitals**
>
> The Commonwealth will create a National Health and Hospitals Network Fund comprising;
>
> - funding sourced from the National Healthcare Specific Purpose Payment;
> - an agreed amount of GST revenue, which would then be allocated to health and hospitals reform; and

65 Mr D Crosbie, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 103.

66 Australian Government, *A National Health and Hospitals Network for Australia's Future: Delivering better health and better hospitals*, 2010, Section 1.2, p. 9

- additional top-up funding to be paid by the Commonwealth, reflecting the Commonwealth's greater responsibility for financing growth in hospital costs.

Commonwealth funding for public hospitals will be made from this Fund.

Commonwealth and state funding for public hospital services will be clearly identified, and delivered transparently and directly to Funding Authorities in each state. Jointly governed by the Commonwealth and the relevant state, Funding Authorities will transparently report on the number of services provided and paid for, introducing new levels of transparency in how hospital funding is distributed, and giving greater confidence to governments and the community that scarce health dollars and going directly to hospital services.[67]

3.72 However, the real reason for setting up the Fund was to ensure that there was no diversion of funds for other purposes or simply to fund additional bureaucracy:

> Commonwealth funding will flow automatically through Funding Authorities directly to Local Hospital Networks based on service actually provided. States have also agreed to transparent about their funding contribution for each public hospital service, by making payments on an activity basis through Funding Authorities. There will be no scope to divert these funds for other uses, and no scope for health departments to use the money for bureaucracy. This will give hospitals more funding certainty than ever before. Transparent funding arrangements will also support transparent performance reporting and drive continuous improvement within each public hospital.[68]

3.73 The information regarding the Government's scrapping of the National Funding Authority was released in response to the following question to the Department of Finance and Deregulation regarding the formal establishment of the National Funding Authority and its staffing:

> I understand that the National Funding Authority falls under the Financial Management and Accountability Act 1997, in this respect will the staff be employees of the Australian Public Service and if so how many staff will be employed?

3.74 Notwithstanding the information provided at Senate Estimates by the Department of Finance and Deregulation at Senate Estimates about the National Funding Authority, it chose not to answer the question and instead advised that 'this question is being handled by the Department of Prime Minister and Cabinet as the more appropriate agency to provide a response'.[69]

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67 Australian Government, *A National Health and Hospitals Network for Australia's Future: Delivering better health and better* hospitals, 2010, p. 49

68 Australian Government, *A National Health and Hospitals Network for Australia's Future: Delivering better health and better hospitals,* 2010, p. 49.

69 Department of Finance and Deregulation, answer to question on notice, DoFD 10.

3.75 The answer provided by the Department of the Prime Minister and Cabinet was both a major surprise as well as representing a significant change to the plan:

> Following further discussions between the Commonwealth and States and Territories it has been agreed that the National Funding Authority is not required and will not be established.
>
> Payments from the National Health and Hospital Network (NHHN) Fund to State NHHN Funding Authorities, and through them to Local Hospital Networks, will be reported transparently in Commonwealth Budget documentation.[70]

3.76 Consequently, the decision by the Government to scrap the National Funding Authority brings into question the effectiveness of transparency and accountability measures in the plan, given that the National Funding Authority was portrayed as being so integral to it.

3.77 Minister Roxon was questioned about this 'backflip' on a major component of the reform plan at a press conference on 17 June 2010:

> Reporter: I guess the only thing is though, why was it in the agreement in the first place if it wasn't necessary and isn't it one - sort of one less annual report that one less layer of scrutiny that we have, you know, on the current system?
>
> Roxon**:** [Laughs] Well I suspect if I was giving you a different answer today you'd say isn't that one more layer of bureaucracy we don't need? We are not going to set up a separate authority where the function is to make sure that we can transparently account for funding. This will deliver that. There will need to be people who can process essentially the cheques that need to be paid through to local hospital networks, but it doesn't require an authority.
>
> We've had these negotiations with the states and territories following the agreement that was reached at COAG and essentially, of course, this comes from a compromise that was reached with the states putting up this change, them also putting their money into this pool. We think that's a benefit for the community all round and remain very unapologetic about this being a good outcome and still having plenty of ability, much more than we currently have to track where the money is going, and also of course with the establishment of the performance authority to make sure we're also looking at the performance that comes from those extra investments.
>
> Reporter**:** Why wasn't it agreed to in the first place then? What has changed since the time the premiers and the Prime Minister signed the agreement?
>
> Roxon: Well, look, we're going to be able to find a whole range of things throughout the introduction of this very complex health reform agenda where we will find that there are better or more strategic or more streamlined ways to do things.

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70 Department of the Prime Minister and Cabinet, answer to a question on notice, PM&C 33.

> I don't think anyone in this room, let alone in the community, would want us to establish an extra authority for no particular purpose. We believe that we can get the transparency that is needed, that we can actually track the way the money will be spent and passed onto local hospital networks without establishing a separate authority and of course that flows from the agreement that the states and territories or the proposal that the states and territories put to us throughout that COAG negotiation which included their concession or compromise or proposal to put their health money into these pools also, and that changes the nature of whether you need to have a separate commonwealth authority to do it and we are determined to make sure that we are investing our money in more doctors and nurses and front line staff and not in more bureaucrats.[71]

3.78 It is interesting to note that the prospective scrapping of the National Funding Authority was not disclosed at the hearings for this inquiry. In Budget Senate Estimates, the Department of Finance and Deregulation was questioned about the establishment of the National Funding Authority and gave no indication that it was about to be axed.[72]

3.79 Its scrapping was disclosed in an answer from the Department of the Prime Minister and Cabinet and not the Department of Health and Ageing. It was not made as a public announcement. This reflects yet again that the main driver of the 'reform process' has been the Prime Minister and his Department. Minister Roxon's response at her press conference on 17 June 2010:

> Reporter**:** Minister, when was the decision made and why did you choose to release it in the way that you did in an answer to a question or notice? Why didn't you publicly announce it?
>
> Roxon**:** Well, look, it has not been a secret. We have been absolutely clear and commenting whenever asked about the way this funding process will work. I'm afraid you'd have to put the question to PM&C about why they decided to release it at a particular time last night, that's not something that was in our remit.
>
> But I would hasten to tell you that actually the Prime Minister and Cabinet and the Department of Health and Aging are answering questions on notice every single day, I think following estimates, my department has something like 400 plus questions to be answering. We do that in a normal way and they get released at various times.
>
> I don't know why it was particularly released yesterday, but it certainly hasn't been a secret from our point of view and we have been asking and answering questions when they've been asked about this process and

71 The Hon Nicola Roxon MP, Minister for Health and Welfare, Transcript of Press Conference, Canberra, 17 June 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/tr-yr10-nr-nrsp170610.htm?OpenDocument (accessed 22.6.10).

72 Finance and Public Administration Legislation Committee, *Estimates Hansard*, 26.5.10, p. F&PA 34.

> describing the funding, warehousing arrangements, the change that came about with the states and territories putting this proposal forward.
>
> Reporter**:** Was this a PM&C decision or was this your decision? Who made this decision, given PM&C released it?
>
> Roxon**:** PM&C were asked and they released it to a - a question on notice that was asked in the Senate, I understand as part of the Senate Estimates process, I stand to be corrected on that.
>
> Of course we've also been asked, both our departments, a lot of questions during the Senate inquiry on health reform, so there's been plenty of opportunity, there's plenty of information coming out.
>
> PM&C and health, myself and the Prime Minister are intimately involved in all of these discussions and decisions so it's been made as a collective decision. I simply can't tell you why it is that PM&C has put out that answer now but I think that there's been a lot of similar questions asked and we have provided those same answers from the Department of Health as well.[73]

3.80 The above exchange raises important questions about what else is now going to be dumped from the Intergovernmental agreement. Indeed, had this specific question not been asked, would this major 'backflip' remained undetected, given questions were asked about it only weeks earlier? Either this information has been withheld or it is another example of the Agreement not actually representing the terms of the Government's health reforms. It poses the questions: what else is being withheld and what else will be dumped or altered?

3.81 Concerns have also been raised throughout the Inquiry in relation to the management of funding and coordination arrangements. Services for Australian Rural and Remote Allied Health (SARRAH) for example, raised three concerns:

- the lack of clarity regarding ultimate responsibility for key aspects of primary health care under the *National Health and Hospitals Network Agreement*;
- the need for funding to reflect a coordinated primary health care services approach to meet rural and remote community needs; and
- the need for consultation with primary health care service providers in the development of new funding and program guidelines.[74]

3.82 The Society of Hospital Pharmacists of Australia (SHPA) and National Primary Health Care Partnership articulated similar concerns. They argued that with the Commonwealth assuming funding responsibilities for a number of health care services, it was not clear where accountability lay for the effective provision of many

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73 The Hon Nicola Roxon MP, Minister for Health and Welfare, Transcript of Press Conference, Canberra, 17 June 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/tr-yr10-nr-nrsp170610.htm?OpenDocument (accessed 22.6.10).

74 Services for Australian Rural and Remote Allied Health, *Submission 6*, p. 2.

services and how they will relate to the planning and coordination role expected of the Primary Health Care Organisations (PHCOs).[75] The SHPA continued:

> It is therefore unclear how this offers an improvement over current arrangements and whether it will confer the potential benefits associated with national funding and regional coordination. There is no clear integration between PHCOs and Local Hospital Networks (LHNs).[76]

3.83 This concern was also echoed by the AMA which argued that the Agreement did not end prospects of 'the blame game' continuing. The AMA President, Dr Andrew Pesce contended that:

> The 60-40 funding split, I am afraid, has potential not to end the blame game. It will just provide different opportunities and different scenarios to undermine and game the system.[77]

3.84 The AMA continued that:

> The IGA provides for new performance reporting and monitoring to ensure that States are accountable. However, it is yet to be seen whether this will provide sufficient leverage in the short term or sufficient political clout in the long term, given that performance monitoring of the health system is difficult to do fairly and accurately, without introducing perverse incentives that compromise patient care. The IGA focuses on States' performance rather than hospitals' performance.[78]

3.85 The AGPN similarly voiced concern regarding duplication and accountability as a consequence of the proposed health funding structure by arguing that:

> The dispersal of primary health care responsibility and authority across States and LHNs will perpetuate current problems with service duplication and poor service integration, so promulgating the blame game and fragmentation that these reforms are intended to overcome.[79]

3.86 The ACSA questioned how the linkages between services are to be ensured to work effectively for clients given that management of hospital networks and system-wide planning of hospitals will remain a state responsibility while aged care services and primary health care will be Commonwealth responsibilities. The ACSA noted:

> It is not clear how seamless service delivery, including to older people with complex and chronic needs, is to be planned for and supported in these arrangements. The NHHN Agreement suggests that the Primary Health Care Organisations will 'assist with patients' transitions out of hospital, and

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75 The Society of Hospital Pharmacists of Australia, *Submission 9*, p. 2; National Primary Health Care Partnership, *Submission 19*, p. 1.

76 The Society of Hospital Pharmacists of Australia, *Submission 9*, p. 2.

77 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 107.

78 Australian Medical Association, *Submission 10*, p. 3.

79 Australian General Practice Network, *Submission 27*, p. 10.

> where relevant into aged care'. How this is to occur or how other linkages between services are to be ensured is not yet clear.[80]

3.87 The AMA also held the view that the NHHN Agreement or IGA does not 'accurately reflect the most important health care issues'. It recognised the need for a staged approach in implementing health reform but questioned the prioritisation of the COAG reforms, arguing that a comprehensive national approach to mental health, aged care and Indigenous health are 'first stage' priorities which it noted, have 'not been adequately addressed'.[81] It also argued that, there 'appears to be only a weak connection between the Commonwealth Government's contribution to funding and the agreed planning and purchasing of services under the IGA (where State governments undertake the planning and purchasing of hospital services and Medicare Locals undertake the planning and purchasing of primary care services)'. The AMA commented further:

> The Commonwealth Government has no commensurate responsibility for ensuring bed capacity or service delivery or infrastructure organisation. While it is taking on more funding responsibility, it will have little say on the development of these input measures and will rely on broad level performance targets to ensure it expectations are met.[82]

3.88 Concerns about the blame game continuing are best summed up in this succinct quote from the AMA's submission:

> As a result, it is unlikely that the new arrangements will see any end to the 'blame game'.[83]

3.89 It must be stressed that the LHNs will be determined by the states, whereas Medicare Locals will be created by the Commonwealth. Many submitters emphasised that the relationship between the LHNs and Medicare Locals was unclear. Indeed, there is no information about how the proposed independent LHNs and Medicare Locals will improve integration and coordination at the local level.

3.90 The Rural Doctors Association of Australia (RDAA), also questioned the relationship between the Medicare Locals and LHNs and emphasised the need for an alignment in the boundaries between them particularly in smaller rural communities. The RDAA argued:

> In many rural communities, there is no line drawn between primary care and secondary care. This is particularly the case in smaller communities where GPs provide coverage for obstetrics and anaesthetics, or perform specialist procedures, at the local hospital and provide after hours medical care through the local hospital's Emergency Department. Where this is the

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80 Aged and Community Services Australia, *Submission 17*, p. 2.

81 Australian Medical Association, *Submission 10*, p. 4.

82 Australian Medical Association, *Submission 10*, p. 13.

83 Australian Medical Association, *Submission 10*, p. 13.

> case, it will be critical that accountability and performance indicators are at such a level that they measure the health of the community rather than just through [in]put of the hospital.[84]

3.91 In terms of moving towards a national structure with streamlined standards, the Australian Institute for Health and Welfare noted that national standards required national performance reporting arrangements. It held that such arrangements should be established which provide a 'single flow of data, from hospitals and other health care providers, through their governing bodies, to a single national repository, with data being validated before it is reported'.[85]

Increase in bureaucracy

3.92 The Government has undertaken that it will ensure that there is no net increase in Commonwealth bureaucracy as a proportion of the ongoing workforce and no net increase across state and territory bureaucracies.[86] Yet, again, no detail is provided on how this guarantee will be fulfilled given the new layers of oversight and additional reporting and infrastructure.

3.93 In raising the distinction between funding for the reforms and funding required to support the implementation of the reforms, the AMA questioned whether there was adequate funding or whether the additional bureaucracy will add real value. The AMA continued:

> For example, the recent Federal Budget included $91.8 million to establish and run the Independent Hospital Pricing Authority and $163.4 million to rollout activity based funding. Establishing and running Medicare Locals and after hours primary care will cost $416.8 million over five years but it isn't clear how much of this will actually involve delivering health care services.[87]

3.94 Mr Steve Sant, Rural Doctors Association of Australia (RDAA), also viewed any increase in the level of bureaucracy as a concern. Mr Sant stated:

> Our members would certainly see that as a major risk, that we could end up with more people between them and the patient. That is an area about which a number of members have come back to us and expressed concern. Again, I think it is absolutely critical that we get the formation of those new organisations absolutely right, that we make sure that those organisations reflect their local community of interest and that the local clinicians who understand the system, along with the local community, are involved in the management and are part of the boards of those organisations, and have a

84 Rural Doctors Association of Australia, *Submission 22*, p. 3.

85 Australian Institute of Health and Welfare, *Submission 26*, p. 3.

86 Department of the Prime Minister and Cabinet, answer to a question on notice, PM&C 31.

87 Australian Medical Association, *Submission 10*, p. 4.

> real role rather than just being window dressing at the side, that is, we have consulted you about this.[88]

State-based health funds pool

3.95 Concerns have been raised regarding the GST pooling mechanism whereby a compromise was reached with the states at the April 2010 COAG meeting to pool health funds. Dr Christine Bennett, who chaired the NHHRC, raised concerns that the state-based pools may amount to another level of decision-making and governance and stated that:

> I can understand the concern that many are voicing, whether it's going to increase the bureaucracy and complicate and overly focus on the hospital part of our system.[89]

Sub-acute beds

3.96 In Senate Estimates, the Department of Finance and Deregulation gave evidence about costings of the COAG plan, although it did take considerable information on notice relating to assumptions.[90] The Department did state that that it was not responsible for $800m costing agreed at COAG meeting.[91]

3.97 Whilst some stakeholders including Catholic Health Australia[92] were satisfied with the provision of additional sub-acute beds, Mr John Mendoza commented that even if all of the 1,300 sub-acute beds went to mental health, and had an appropriate model of step-up step down care:

> …we would still be a 1,000 short of the number of sub-acute beds that existed in the mid-1990s and we would again be putting another patch on a broken system.[93]

3.98 Professor Patrick McGorry argued that it was unclear what proportion of the sub-acute care services would be dedicated to the needs of those with mental ill-health.[94] Similarly, the AMA questioned how the new incentives to state governments and hospitals to increase capacity will work. It raised the concern that despite the

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88 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 62.

89 Dr Christine Bennett in Julian Drape, 'Health deal 'may boost bureaucracy', *The Age*, 22 April 2010, http://news.theage.com.au/breaking-news-national/health-deal-may-boost-bureaucracy-20100422-tdyk.html (accessed 14.5.10).

90 Finance and Public Administration Legislation Committee, *Estimates Hansard*, 26 May 2010, pp F&PA 36–37.

91 Department of Finance and Deregulation, answer to a question on notice, DoFD 11.

92 Catholic Health Australia, *Submission 3*, p. 7.

93 John Mendoza quoted in 'Senior advisor attacks "mad" health reform for its neglect of mental health', *Croakey*, 3 May 2010.

94 Professor P McGorry, *Submission 8*, p. 2.

additional investment, there was no guarantee that such funding would result in new acute beds.[95]

3.99 In relation to bed occupancy, the AMA stated that:

> The AMA considers there should be a maximum 85% bed occupancy in public hospitals in order to meet emergency department and elective surgery demand, and for hospitals to operate at internationally accepted, safe bed occupancy levels. There is strong evidence that patient safety and quality of care are compromised when hospitals consistently run at higher average occupancy rates. Our current estimates are that, nationally, an additional 3870 new beds are needed to meet this.[96]

Term of reference (b): $5.4 billion funding

3.100 Term of reference (b) of the committee's inquiry required the identification of what amounts of the $5.4 billion Commonwealth funding is new spending, what is re-directed from existing programs/areas, the impact on these existing programs and what savings are projected in existing health programs across the forward estimates from these new financial arrangements, including the inputs, assumptions and modelling underpinning these funding amounts. The joint submission provided by the Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation and the Treasury stated:

> Details of the Government's funding for initiatives announced at the 20 April 2010 COAG meeting are provided in the 2010–11 Budget Paper No. 2. Further, Appendix B – Summary of Measures of the '*A National Health and Hospitals Network for Australia's Future:* Delivering Better Health and Better Hospitals', released on 12 May 2010, provides details of all National Health and Hospitals Network initiatives, including those announced after the COAG meeting of 19 and 20 April 2010.[97]

3.101 As indicated earlier, the Department of Finance and Deregulation did not commence its formal costing efforts until 17 February 2010.[98]

3.102 While the documents noted in the joint submission do provide information on the reforms, they do not identify the detail required under the committee's terms of reference. In answer to specific questions regarding the $5.4 billion funding, Ms Jane Halton, commented:

> I am happy to give you that in a bit more detail, rather than just referring to the budget papers. I can tell you that there has not been—as you put it—a raid on any programs. The only saving that I would point you to that is

95 Australian Medical Association, *Submission 10*, p. 4.

96 Australian Medical Association, *Submission 10*, p. 4.

97 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation and the Treasury, *Submission 24*, p. 3.

98 Department of Finance and Deregulation, answer to a question on notice, DoFD 18.

> significant in the portfolio is the saving in relation to the Medicines Agreement with Medicines Australia, which, as you are probably aware, will generate a net $1.9 billion, and the saving from the Pharmacy Agreement. Those are the significant redirections in the portfolio.[99]

3.103 When pressed for a breakdown of every item of the $5.4 billion, Ms Halton responded:

> It is not possible to do a line-by-line redirection table, because budgeting does not work like that. It is the case that there is a macro position for the portfolio. There are some savings in various places. They have all been declared in the budget papers. To say that a green dollar from here has gone over there is not quite how we work this. In some cases existing programs have been changed—I will acknowledge that—but in terms of the macro position, we can do that for you, yes.[100]

3.104 The committee notes that answers to many questions regarding the financial details of the Agreement questions remain illusive. Furthermore, many answers to questions on notice simply do not address the information sought.

3.105 Submitters commented on issue of redirected funds. The AMA raised concerns that the reduction of funding in the 2010–11 Budget from high care residential care to long stay older patients in public hospitals and high level community based care 'suggests there may be no net increase in high level aged care places'.[101]

3.106 Professor McGorry corrected his submission that shows a majority of mental health funding redirected:

> In addition to the questions above, I would also like to correct one section of my written submission, in light of recent clarifying evidence by DoHA officials about headspace funding.
>
> Section 2.2 of my submission should now read:
>
> 2.2. Of the $173m mental health funding announcements, the entirety of the $57m for flexible care packages is pre-existing funding. Therefore the actual increase in mental health funding in the COAG agreement is $116m or approximately 2% of the total new funding announced as part of the COAG agreement. This represents in effect a widening of the gap between mental and physical health care funding.[102]

3.107 Allied Health Professions Australia (AHPA) was of the view that there was a disproportionate allocation to acute hospital services and 'not enough funding

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99 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 33.

100 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, pp 33–34.

101 Australian Medical Association, *Submission 10*, p. 10.

102 These corrections to the submission are reflected in the updated version of the submission. See Professor P McGorry, *Submission 8*, p. 2.

dedicated towards management of chronic diseases in the community through comprehensive primary health care initiatives'. The AHPA commented that:

> It is well recognised that the ageing of the population and the increasing prevalence of chronic diseases in the community will place the Australian health care system under enormous strain in the coming years – one of the key drivers of the health reform.[103]

3.108 The AHCRA also argued that there was too much focus on hospitals at the expense of primary health care and prevention. Of its view, it argued that:

> These sectors are the key to improving the health status of the community and reducing the reliance on hospitals in the future. AHCRA advocates a health system oriented around primary care and we believe that the COAG reforms will maintain the current centrality of hospitals within our health system, and hence a continued over-focus on the bottom of the cliff, rather than more humane, strategic and sustainable mending of the fences at the top.[104]

Term of reference (c): Additional/new services in elective surgery, emergency department treatment, diabetes spending measure, GP treatments in aged care facilities

3.109 Information provided by the Department of Finance and Deregulation that shows that the 'funding envelope of $251.4 million was determined by the Department of Health and Ageing'. The $251.4 million over five years is to expand capacity within the hospital system for emergency department treatment.[105]

3.110 This demonstrates, again, the limited involvement of the Department of Finance and Deregulation in costing key elements of this package.

Emergency department treatment

3.111 In *A National Health and Hospitals Network: Further Investments in Australia's Health*, the following commitment is made:

> To improve timely treatment in emergency departments, for the first time the Government will introduce a four hour National Access Target. Anyone presenting to a public hospital emergency department anywhere in the country will be admitted to hospital, referred for treatment, or discharged within four hours, where it is clinically appropriate to do so.[106]

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103 Allied Health Professions Australia, *Submission 28*, pp 2–3.

104 Australian Health Care Reform Alliance, *Submission 30*, p. 7.

105 Department of Finance and Deregulation, answer to a question on notice, DoFD 16.

106 Australian Government, *A National Health and Hospitals Network: Further Investments in Australia's Health*, 2010, p. 9.

3.112 To help public hospitals meet these targets, the Government was to provide the states with $500 million as facilitation and reward funding. Its implementation is couched in the following terms:

> This four hour National Access Target and reward funding will drive improved access to timely and safe emergency department services for patients. Patients and their families will have the peace of mind of knowing that when they or their loved one need emergency department care, they will no longer have to spend the night sitting in the waiting room or waiting for a bed.[107]

3.113 In the *Communiqué* of 19 and 20 April, there was an agreement for:

> Additional funding for emergency department services to implement a new four-hour National Access Target to ensure patients are admitted, referred or discharged within four hours of presentation to an emergency department. This will support the delivery of around 805,000 emergency attendances in 2013-14.[108]

3.114 CHA noted that meeting the targets in relation to patients presenting at public hospitals for emergency or elective surgery will be determined by the ability of new resources, both financial and personnel, to be directed towards ensuring targets are met.[109]

3.115 The AMA supported the introduction of performance targets for emergency care as a means of driving improvements in hospital service delivery (given that delays in emergency departments are almost always due to capital constraints elsewhere in the system), but noted their limitations by arguing that:

> …any efficiencies driven by these targets can only provide a one-off capacity gain. It cannot substitute for ongoing bed capacity in our hospitals. There are also potential risks if a focus on meeting targets over-rides appropriate patient care.[110]

3.116 The Royal District Nursing Service held that the four hour treatment target for emergency departments (ED) may have unintended consequences:

> The recent promise of a 4-hour treatment period in EDs has the potential to increase demand (and therefore delays) in EDs as it will encourage people in recent years may have been discouraged to attend EDs because of lengthy waiting times and/or offered more suitable alternatives, to perhaps move back to a reliance on EDs for more minor ailments. This may be

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107 Australian Government, *A National Health and Hospitals Network: Further Investments in Australia's Health*, 2010, p. 9.

108 Council of Australian Governments, *Council of Australian Governments Meeting 19 and 20 April 2010, Communiqué*, p. 1.

109 Catholic Health Australia, *Submission 3*, pp 4–5.

110 Australian Medical Association, *Submission 10*, p. 6.

> particularly so where attendance at a public hospital ED is a free service and alternatives may require a fee or co-payment.[111]

3.117 The RDAA raised concerns that the proposals for better access to after hours care may interfere with existing arrangements for accessing after hours care in rural and remote areas. The RDAA commented that:

> The key issue for accessing after hours services in rural areas does not centre on identifying who is providing after hours services and where those services are located. Rather it is centred on the availability of workforce (i.e. the number of rural doctors available in the community to provide after hours care).[112]

3.118 However, in an answer to questions on notice, it seems that the 4 hour 'target' is subject to substantial caveats:

> Work will be undertaken to develop the national access target in consultation within the clinical community, and with reference to national guidelines on the circumstances in which it will be clinically appropriate to hold someone for longer than four hours in an emergency department.[113]

3.119 Despite no previous mention of national guidelines, the committee is advised of the following caveat where the clock on the 4-hour limit will be reset:

> There are two further caveats to the Four Hour Target. EDs will retain the right to refer patients to a primary care setting, such as GP clinics, again where it is clinically appropriate to do so. Should a patient decline to be referred and exercise their right to be treated in the ED, this could result in the 4-hour clock being reset to zero.[114]

3.120 Furthermore, for regional and rural communities, the 4-hour target would appear to be all but abolished even before it is implemented. For remote areas, it will definitely be business as usual as the target is designed around existing inadequacies rather than ensuring these are addressed:

> Also, application of the four hour target will be moderated in remote and other areas of Australia where there is a significant undersupply of GPs and significant impediments to accessing a GP (and therefore where people are more likely to rely on doctors working in emergency departments for GP-type care). Application of the target in these circumstances will be agreed between the Commonwealth and individual jurisdictions and be subject to periodic review.[115]

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111 Royal District Nursing Service, *Submission 11*, p. 1.

112 Rural Doctors Association of Australia, *Submission 22*, p. 3.

113 Department of Health and Ageing, answer to question on notice, DoHA 56.

114 Department of Health and Ageing, answer to question on notice, DoHA 56.

115 Department of Health and Ageing, answer to question on notice, DoHA 56.

Diabetes measure

3.121 Submissions from medical professionals reflected a specific concern that the diabetes measure undermined important aspects of the current Medicare arrangements.

3.122 In evidence at the hearing, Dr Adrian Sheen from Doctors Action stated:

> I am sure we have always heard that, but there was always a whittling away at the service. Of course the reforms have changed the fee-for-service practice, the same as the diabetic reforms, and that is just the tip of the iceberg. They are also talking in the Bennett report about other grants not only for diabetes but for lots of other things, such as bowel cancer, breast cancer, respiratory disease and osteoporosis. In fact, the government is just dipping its toe in the water with these diabetic reforms. To say that you have a grant for looking after a patient; there are many questions that need to be answered about this grant.[116]

3.123 The Dietitians Association of Australia commented that the diabetes spending measure 'appears to be merely re-packaging of an existing portion of the Medicare Chronic Disease Management program particularly in relation to the allied health component'.[117] It noted that if this initiative and existing arrangements are to co-exist, there is room for confusion as a consequence.

3.124 The National Primary Health Care Partnership (NPHCP) also questioned the funding for this measure and raised concerns regarding its adequacy. It stated:

> It is unclear the extent to which the measure contains new funding. The NPHCP understand that this measure will involve 'cashing out' MBS items for patients who voluntarily enrol for this measure, including for PHC services not directly related to their chronic condition. The NPHCP has concerns that if the annual payment to general practices and for allied health services are insufficient, the measure will fail to support better access to team care: there will not be a sufficient business case for general practice to enrol patients, particularly those with more complex care needs, and those who are enrolled will be unlikely to have better access to team care if the real amount of funding for these services has not increased.[118]

3.125 The AMA's Dr Pesce contended that there was no evidence that demonstrated that people will get better care if they are 'stripped of their Medicare entitlements and funded through an annual capped payment'. He asserted that:

> A systematic review of published evidence by the Cochrane Collaboration concluded that there is no evidence of improved patient outcomes in care

116 Dr A Sheen, Doctors Action, *Committee Hansard*, 7.6.10, pp 76–77.

117 Dietitians Association of Australia, *Submission 5*, p. 1.

118 National Primary Health Care Partnership, *Submission 19*, p. 2.

> provided through capitation payments compared to fee-for-service payments.[119]

3.126 The RDAA raised a number of concerns regarding the diabetes program, stating that whilst it agreed with the Health Minister's contention that diabetes patients who enrol with a medical practice are likely to achieve better health outcomes, it does not 'support the use of a pure capitation model to fund the program'.[120] Of this, the RDAA stated:

> A key concern is that a pure capitation model of funding may result in fewer visits by diabetes patients to their GP, less continuity of care and lower levels of compliance with the recommended best practice treatment regimes for patients with diabetes.[121]

3.127 Given the potential negative outcomes, Mr Steve Sant, CEO of the RDAA contended that the government modelling of changes in relation to the diabetes capitation model 'may not be accurate'. Mr Sant argued that:

> The RDA considers that the funding reforms announced in themselves will not significantly improve access to healthcare in rural Australia, nor significantly improve the health outcomes of people who live in the bush.[122]

3.128 For those in rural and remote communities, moreover, the RDAA argued that if a pure capitation model is adopted, enrolled GPs will be asked to underwrite the financial risks associated with variations in demand for health care from enrolled patients and that such variation may often be attributed to factors outside the GP's control. It held that the management of these financial risks is problematic, particularly if the pool of enrolled patients for the general practice is not representative of the population average in terms of health care needs and that in rural and remote areas, the option managing this demand variation risk by referring complex patients to a specialist service from the outset, or once the cost of providing care begins to exceed the quantum of the capitation payment, is not likely to be available.[123]

3.129 The RDAA suggested an alternative encompassing a 'blended funding model' or fee-for-service Medicare payments supplemented by specific support payments for diabetes-related treatments with a rural loading which it argued would better accommodate the economic and clinical elements of general practice.[124]

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119 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 107.

120 Rural Doctors Association of Australia, *Submission 22*, p. 4.

121 Rural Doctors Association of Australia, *Submission 22*, pp 4–5.

122 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 60.

123 Rural Doctors Association of Australia, *Submission 22*, p. 5.

124 Rural Doctors Association of Australia, *Submission 22*, p. 5.

3.130 The Australian Diabetes Educators Association raised concerns regarding accountability for services between the PHCOs and state governments stating that:

> …how services will be planned and coordinated across a region, leaves the door open to exacerbating the current problems of cost-shifting and decreasing access to diabetes care.[125]

3.131 The AMA supported additional funding for diabetes management but raised concerns that the Commonwealth's diabetes management plan had been announced without consultation with doctors and that as a consequence, there were many elements of the plan that 'may not work as intended'.[126] It also highlighted its opposition to the movement away from a fee-for-service model to one that introduces fund-holding, fund capping and patient enrolment because it:

> …removes patient choice; limits access to services; compromises the independence of doctors' clinical decision making (financial considerations versus clinical need); creates perverse incentives that may diminish access to, and the quality of care; and adds to the red-tap burden on GPs. There is no evidence that supports the change from the current proven model to a new approach and there are possible negative consequences for patients and doctors.[127]

3.132 The Australian Diabetes Society (ADS) highlighted the importance of the Diabetes Centres which, have 'made a massive difference to reducing patient hospital admission for diabetes and continues to provide key support in ambulatory patient care'.[128] The ADS raised concerns that these centres are now 'under severe stress, with increasing demand and very little increase in resources over the last 10 years, and in some places, especially in NSW, reductions in staff'.[129] The ADS emphasised that such centres require federal enhancement funds provided directly to them to sustain their services.

3.133 The AMA questioned the focus on diabetes as opposed to all patients with chronic and complex conditions, arguing that it had developed an alternative which would provide coordinated multidisciplinary care to all patients with chronic and complex conditions which would 'reduce the number of available hospital admissions and generate long term savings for the health system'.[130] Similarly, the Australian General Practice Network supported an extension to other groups of people with chronic disease.[131]

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125 Australian Diabetes Educators Association, *Submission 16*, p. 2.

126 Australian Medical Association, *Submission 10*, p. 8.

127 Australian Medical Association, *Submission 10*, p. 8.

128 Australian Diabetes Society, *Submission 4*, p. 1.

129 Australian Diabetes Society, *Submission 4*, p. 2.

130 Australian Medical Association, *Submission 10*, p. 8.

131 Ms R Yates, Australian General Practice Network, *Committee Hansard*, 7.6.10, p. 87.

GP treatment in aged care facilities

3.134 According to CHA, incentives alone are 'unlikely to fully address GP access issues in aged care homes where there is an overall shortage of GPs in the first place'.[132] Drawing on its own survey findings, CHA held that the main restraint on GPs in their interaction with residential care was that of time pressures. It continued:

> The most common issues raised include home visits difficult to arrange; timeliness of visits; reluctance to take on new or difficult patients; poor or inadequate documentation; inadequate after hours and emergency access; rushed consultations; and poor communication and information sharing.[133]

3.135 According to the AMA, the incentives, whilst attempting to address a clear deficiency in current arrangements, 'are unlikely to be sufficient to make a real difference'.[134] The AMA recommended as an alternative, reforms in which aged care providers are funded to develop service agreements with local doctors to provide medical care to residents on an ongoing basis and an increase in the medical rebates to better reflect the 'complexity and time of providing medical care to residents'.[135]

3.136 The Royal Australian College of General Practitioners argued that whilst it welcomed the initiative to increase financial incentives for GPs to provide services to aged care facility residents, the budgetary provision was 'unlikely to be sufficient'.[136] The RACGP also commented on the difficulty of looking after aged care patients in the community because the MBS item numbers do not recognise the complexity and time that is required to look after people in their homes and in aged care settings.[137]

3.137 The Dietitians Association of Australia raised its concern that whilst there were incentives for GP participation, there were no similar incentives for allied health, arguing that the maximum of five allied health visits per year currently available under the Chronic Disease Management program was inadequate. The association continued:

> It is not possible to provide health care consistent with current best practice for Australians with multiple chronic conditions within the existing funding which has not been addressed in the reform.[138]

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132 Catholic Health Australia, *Submission 3*, p. 12.

133 Catholic Health Australia, *Submission 3*, p. 12.

134 Australian Medical Association, *Submission 10*, p. 10.

135 Australian Medical Association, *Submission 10*, p. 10.

136 Royal Australian College of General Practitioners, *Submission 12*, p. 3.

137 Dr M Rawlins, Royal Australian College of General Practitioners, *Committee Hansard*, 8.6.10, p. 37.

138 Dietitians Association of Australia, *Submission 5*, p. 2.

Term of reference (d): Top-up payments

3.138 The joint Commonwealth department submission noted that the top-up payments reflect what is required, over and above the healthcare Specific Purpose Payment and the fixed dedicated share of GST, to fund the Commonwealth's 60 per cent hospital funding contribution outlined in provision 4 of the National Health and Hospitals Network Agreement and 100 per cent of GP and primary health care services. It was noted that the top-up payments arise because the new Commonwealth responsibilities are projected to grow more rapidly than growth in the Healthcare SPP and the dedicated share of the GST.

3.139 The Commonwealth has guaranteed that the top-up payments will amount to no less than $15.6 billion between 2014–15 and 2019–20. If the amount required to fund the Commonwealth's hospital and primary care commitments is less than $15.6 billion, then the residual funds will be paid into the National Health and Hospitals Network Fund for distribution to the states and territories.[139]

3.140 However, Ms Halton of the Department of Health and Ageing stated that it was not possible to give a breakdown of the $15.6 billion:

> To say that it is broken down at this point is not possible. We can talk about the expenditure in each of these domains, but you cannot break down the $15.6 billion at this point across each of those domains.[140]

3.141 The committee is waiting for more detailed information to be provided by the Treasury.

3.142 The Australian Psychological Society stated that a significant portion of these funds should be dedicated to primary health care and with GP services as only one component of the expenditure.[141]

Term of reference (e): New statutory bodies, organisations or other entities

Independent Hospital Pricing Authority

3.143 Answers to questions on notice raise concerns about the degree of independence of the Independent Hospital Pricing Authority. The Agreement outlines that the Commonwealth will have a reserve power to over-ride the determinations of the Authority. In answer to a question on notice, the committee is advised that:

> …the Commonwealth Health Minister and Treasurer will have reserve powers that will only be used in exceptional circumstances.[142]

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139 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24*, p. 5.

140 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.5.10, p. 34.

141 Australian Psychological Society, *Submission 31*, p. 4.

142 Department of Health and Ageing, answer to question on notice, DoHA 26.

3.144 However, again there is no further detail as to what may constitute 'exceptional circumstances'.

3.145 The CHA stated that whilst it supports the establishment of an independent statutory authority (or IHPA) to determine the 'efficient price' of hospital services, it suggested that the actual price paid to a particular Local Hospital Network would need to be based on a nationally struck price that would be easily modified to account for a range of factors known to impact on the cost of service provision but which are not within the immediate control of a hospital. CHA commented that:

> These factors include the size, scope and comprehensiveness of the range of services provided by the hospital, demographic and socio-economic characteristics of the patient cohort (in addition to the co-morbidities inherent in the DRG system) and remoteness of location from major metropolitan location.[143]

3.146 The AMA also raised questions about the development of a national 'efficient' price by an independent hospital pricing authority in relation to activity based funding of hospital services particularly in relation to the interjurisdictional differences in service delivery and cost. It articulated that:

> …the AMA has ongoing questions about how activity based funding will be introduced, particularly since the Productivity Commission reports of December 2009 and May this year highlighting the paucity of data available on which to base an efficient price.[144]

3.147 Dr Andrew Pesce, President, AMA, commented further:

> The AMA was very quick to point out that activity based funding would not work well in all areas all the time, and there are some low volume hospitals, remote and rural hospitals, hospitals with a very high teaching component where activity based funding would put them at a significant disadvantage, and we really need to be very careful to balance activity based funding so that it provides good outcomes where it can and balance it with other methods of funding to make sure that funds are delivered to places where the volume is not right or there are special needs.[145]

3.148 Ms Jane Halton of the Department of Health and Ageing responded to concerns about activity based funding by stating that:

> Activity based funding as the advantage of being very clear about what price should be paid for an efficiently delivered service. It has the advantage of focusing the minds of service deliverers on how they deliver those services, but it also has the capacity to be varied depending on complexity of the service and geographical location of the service. It gives you the advantage of driving efficiency, which we argue is important, but it

143 Catholic Health Australia, *Submission 3*, p. 8.

144 Australian Medical Association, *Submission 10*, p. 5.

145 Dr A Pesce, AMA, *Committee Hansard*, 7.6.10, p. 110.

> also gives you the capacity to acknowledge where a service can and should be provided in order to meet the community's needs.[146]

3.149 Many submitters raised questions of aspects of the reforms in relation to general practice and primary care. SARRAH, for example, held the view that:

> …the proposed funding and administration arrangements are not clear in the Agreement in regard to primary health care services which the Commonwealth will become responsible for during 2011. Issues such as how funding will be provided to deliver services and through which body will the funds be administered and contracts monitored need to be resolved.[147]

3.150 The ACSA questioned the relationship between the IHPA and aged care services noting that there was 'no relationship' suggested but that if 'appropriate price signals are to be sent across the care system, perhaps one should be'.[148] It had similar concerns regarding the Australian Commission on Safety and Quality in Health Care and noted:

> We are not suggesting that aged care services should necessarily be part of the remit of these bodies – aged care is about more than just health care – but the inter-relationship between health and aged care (and other parts of the care system) in terms of performance, noted by the Productivity Commission…, nonetheless need to be addressed. Consideration of how these new bodies might relate to the aged care system is warranted.[149]

Australian Commission on Safety and Quality in Health Care

3.151 Professor David Penington raised concerns regarding what he termed 'centralised reporting' and questioned whether, even if the ACSQHC could make useful judgements on the basis of performance indicators, 'it is unclear how these will translate into changes in individual hospitals'. He further noted that:

> The COAG Agreement refers to ACSQHC making assessments on their data *'prior to reward payments being made'*. There is, however, no clear provision for such reward payments elsewhere in the documents or in the systems governing funding transfers to institutional service providers.[150]

146 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 19.

147 Services for Australian Rural and Remote Allied Health, *Submission 6*, p. 4.

148 Aged and Community Services Australia, *Submission 17*, p. 2.

149 Aged and Community Services Australia, *Submission 17*, p. 2.

150 Professor D Penington, *Submission 7*, p. 5.

Medicare Locals

3.152 Concerns were raised in relation to a number of issues particularly the coordination and accountability of the proposed Medicare Locals.[151] The AMA noted that there remained unanswered questions pertaining to the structure, management and coordination of the Medicare Locals. For example:

> …what mechanisms will be put in place to ensure effective and ongoing coordination with general practitioners, Divisions of General Practice, Local Hospital Networks and aged care services?[152]

3.153 Ms Leanne Wells, Executive Director of the AGPN articulated a similar concern when she commented:

> At some points in the agreement there is a lack of clarity about the level of government that will be responsible for and accountable for some aspects of primary healthcare and how this will relate particularly to the planning, coordination and funding responsibilities, and hence accountabilities of primary health care organisations.[153]

3.154 Central to concerns regarding coordination and management was the lack of clarity relating to responsibility and accountability for key aspects of primary health care. The AGPN raised these concerns in relation to the 'apparent enhancement of the role of State Government's in primary health care policy' which it argued may lead to additional bureaucracy and fragmentation of services rather than greater coordination and service integration.[154] The AGPN called for clarity of policy responsibility for primary health care, particularly in relation to the role and function of the PHCOs and their relationship to the LHNs.[155] Ms Leanne Wells, Executive Director of the AGPN stated in this regard:

> I guess our key point is that the dispersal of primary healthcare responsibility and authority across PHCOs and LHNs may perpetuate current problems. What we want to see in an ideal system is a close regional relationship between local hospital networks and primary healthcare organisations for joint planning, coordination and accountability.[156]

3.155 This view was supported by Catholic Health Australia which expressed concern that as many of primary health services are currently provided by hospitals, there was a risk of:

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151 See for example, Royal District Nursing Service, *Submission 11*, p. 2; National Primary Health Care Partnership, Submission 19, pp 2–3.

152 Australian Medical Association, *Submission 10*, p. 9.

153 Ms L Wells, Australian General Practice Network, *Committee Hansard*, 7.6.10, p. 88.

154 Australian General Practice Network, *Submission 27*, p. 4.

155 Australian General Practice Network, *Submission 27*, p. 4.

156 Ms L Wells, Australian General Practice Network, *Committee Hansard*, 7.6.10, p. 88.

> …increasing fragmentation and blame and accountability shifting unless there is a close alignment and integration between Medicare Locals and LHNs. The funding models will be critical in ensuring the new arrangements lead to a more, rather than less, integrated system.[157]

3.156 Professor Philip Davies has raised further concerns of duplication in regard to Medicare Locals by stating that:

> Much of what Medicare Locals will be expected to do is already core business for the better-performing Divisions of General Practice but some important questions remain about the ownership and governance of the new organisations. Divisions would certainly have to evolve quickly if they were to become Medicare Locals.
>
> More fundamentally, the interfaces between the established National Health Call Centre, the new network of Medicare Locals and the individual practices and GPs who'll be called upon to deliver services at night and weekends will take some working out. Coupled with the fact that there are already well-established and well-functioning after hours arrangements in many parts of the country it would seem aspects of this measure may be more spin that substance.[158]

3.157 The Victorian Healthcare Association commented on the need for flexibility in the evolution of the Medicare Locals, noting that:

> Primary healthcare has evolved in each State/Territory in a unique way. The creation of new PHCOs should not be a "one-size-fits-all" approach for every State/Territory, but should build on the strengths of current primary healthcare arrangements.[159]

3.158 Mr Sant of the RDAA raised the concern that many Medicare Locals may be centred in large regional centres and that they will focus much of their attention on those larger regional areas whilst the smaller towns will 'lose out in that at the end of the day'. Of this concern, he stated:

> That seems to be what has happened with many of the divisions at the moment; they are focused mainly in their local area and the outlying areas have been left out in the cold to some degree.[160]

3.159 Submitters and commentators pointed the lack of detail in relation to Medicare Locals. Professor Mark Harris stated that there remain 'many unanswered questions from the patch work of announcements about PHCOs'. He contended that:

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157 Catholic Health Australia, *Submission 3*, p. 11.

158 Philip Davies in 'We need to ensure the extra investment in health is put to the best use', *Croakey*, 12 May 2010, http://blogs.crikey.com.au/croakey/2010/05/12/we-need-to-ensure-the-extra-investment-in-health-is-put-to-the-best-use/ (accessed 25.5.10).

159 Victorian Healthcare Association, *Submission 18*, p. 2.

160 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 62.

> There is a high level [of] uncertainty among community health staff who see their services being "absorbed" by these new organisations but lack clarity about their place in these structures. Resolving these issues is no doubt very difficult given the range of parties and interests involved. However, it is important to resolve this uncertainty as soon as possible.[161]

3.160 Mr Bo Li, Australian Health Care Reform Alliance, commented in a similar vein:

> …we do not know the operational details of these Medicare Locals. For example, will they simply be rebranded divisions of general practice, will they be fund holders or service providers or both? If they are both, there does seem to be a fundamental conflict of interest in that you are both receiving money and dispensing it at the same time. And what will happen to the existing models of best practice in primary health care? For example, in Victoria…there are some very robust and workable solutions at a local level that are delivering good primary health care to consumers. We are concerned that some of these national reforms may overshadow, if not eliminate, some of those models of best practice that are already happening. The engagement of consumers is also a concern of the alliance, particularly at the local hospital network level and also at the Medicare Locals level.[162]

3.161 The Mental Health Council of Australia (MHCA) held a similar concern regarding Medical Locals in relation to mental health, noting that there was 'too little detail of this initiative to determine its potential effectiveness'.[163] The MHCA noted that there were a number of challenges in accessing mental health care through GPs trained to provide it including declining rates of bulk billing and difficulties in identifying GPs with training in mental health care. Moreover, mental health consumers undergoing a mental health crisis have great difficulty in accessing GPs at short notice. The MHCA emphasised the importance of the initiative working with clinicians and the primary care services with focus on clinical care such as GPs and medical clinics and acute hospital services as well as a whole range of community supports. The MHCA noted that:

> These include community services that provide assistance and support with day to day living activities such as the Personal Helpers and Mentors Program and Home and Community Care services, as well as providing links to employment and accommodation services. People who do not have ready access to GP services, such as those who are homeless or those in rural areas, may also be more likely to be able to access Medicare Locals through these other mechanisms.[164]

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161 Mark Harris in 'What will the new national primary health care strategy mean?', *Croakey*, 12 May 2010, http://blogs.crikey.com.au/croakey/2010/05/12/what-will-the-new-national-primary-health-care-strategy-mean/ (accessed 25.5.10).

162 Mr Bo Li, Australian health Care Reform Alliance, *Committee Hansard*, 8.6.10, p.

163 Mental Health Council of Australia, *Submission 21*, p. 7.

164 Mental Health Council of Australia, *Submission 21*, p. 7.

3.162 SARRAH warned that the PHCOs must be given sufficient authority and be responsible for the health policy and planning of all communities including those in rural and remote Australia.[165] The Victorian Healthcare Association argued that the PHCOs must provide evidence of service gaps to enable regional health service coordination and development rather than operate as service providers per se whilst warning that the creation of the PHCOs cannot involve a 'one-size-fits-all' approach across the states and territories.[166]

3.163 The National Primary Health Care Partnership raised concerns that the membership structure of the PHCOs was unclear by arguing that:

> The NHHN agreement is silent regarding the preferred membership structures for PHCOs. Membership structures will be critical not only to the effective and efficient function of these new organisations but also in determining health professional and service provider support of this new primary health care system. It is critical that membership arrangements are determined through broad consultation with stakeholders, including primary health care professional and service provider organisations and health consumer groups.[167]

3.164 Many stakeholders raised concerns with the name 'Medicare Locals'.[168] The Dietitians Association of Australia (DAA) submission represented this concern by noting that:

> This name is strongly associated with Medicare Australia and the current Medicare Benefits Schedule. DAA strongly contends that further consultation with health professionals as well as consumers is required to ensure that the name 'Medicare Locals' promotes a positive image and does not confuse understanding of the role and function of these new organisations.[169]

3.165 The DAA argued that many of the services provided under the auspices of the new PHCOs will not be part of any Medicare program particularly in relation to allied health services and that:

> It is likely the majority will fall under user pays (with or without private insurance) and will also encompass DVA funded services. Calling the new bodies 'Medicare Locals' is likely to raise the (false) expectation in

165 Services for Australian Rural and Remote Allied Health, *Submission 6*, p. 3.

166 Victorian Healthcare Association, *Submission 18*, p. 2.

167 National Primary Health Care Partnership, *Submission 19*, p. 3.

168 See for example, Services for Australian Rural and Remote Allied Health, *Submission 6*, p. 4; National Primary Health Care Partnership, *Submission 19*, p. 3; Australian General Practice Network, *Submission 27*, p. 13; Allied Health Professions Australia, *Submission 28*, p. 4.

169 Dietitians Association of Australia, *Submission 5*, p. 2.

> consumers that they will, or should, be received fully or partially subsidised services.[170]

3.166 Allied Health Professions Australia (AHPA) stated that there is an underlying assumption that the Medicare Locals will be fund-holders and therefore a critical point of referral and access by consumers to other providers and services. AHPA highlighted that:

> There is no recognition of or details on how consumers will have equitable access to other primary health care providers and organisations such as community health centres (where there is often no GP presence) or private allied health providers.[171]

3.167 The National Primary Health Care Partnership raised concerns about the role of the National Performance Authority in monitoring the performance of the Medicare Locals based on healthy community reports and held that:

> …this will not provide a reasonable measure of PHCO performance unless they are given sufficient responsibility and resources to impact on population health at regional levels.[172]

Term of reference (f): Involvement of non-signatory and part-signatory states

3.168 The Consumers Health Forum of Australia argued that the states which have not signed up, or have only partly signed up, to the COAG agreements should not be disadvantaged. It contended that:

> Those states which have not signed up or fully signed up should be encouraged to adopt new national standards to increase national consistency, as uniformity across states and territories will benefit consumers.[173]

3.169 Others submitters, including the National Primary Health Care Partnership, emphasised the importance of a nationally consistent approach which it argued was 'more likely to support a high performing system monitored through a consistent national performance and accountability framework'.[174] The Australian General Practice Network shared this view and raised concerns that, as Western Australia is not party to the *National Health and Hospitals Network Agreement*, Public Health Care Organisations (PHCOs) may not be established in the state whilst at the same

170 Dietitians Association of Australia, *Submission 5*, p. 2.

171 Allied Health Professions Australia, *Submission 28*, p. 3.

172 National Primary Health Care Partnership, *Submission 19*, p. 3.

173 Consumers Health Forum of Australia, *Submission 2*, p. 2.

174 National Primary Health Care Partnership, *Submission 19*, p. 4.

time, funding to the existing General Practice Network is due to cease on 1 July 2012.[175]

Term of reference (g) and (h): Local Hospital Networks and hospital funding

3.170 Submitters raised concerns that there was a lack of detail regarding how the new system would operate. CHA, for example, stated that whilst it was supportive of local governance of hospital networks and activity based funding for appropriate hospitals, with 'so little known as to how the changes will work', it is too early for CHA to form a view as to how the reforms will contribute to improved patient care.[176]

3.171 The RDAA raised concerns regarding the states' role. RDAA CEO Mr Steve Sant stated that the new arrangements 'proposed with the state governments to continue to act as a filter for hospital funding also runs the risk of states retaining much control over what services are to be funded'.[177] Dr Pesce of the AMA contended that the fear was that the 'states will remain in the drivers seat on the roll-out of these reforms and in many ways it could be business as usual in our hospitals'.[178]

3.172 Professor David Penington also raised concerns regarding the funding arrangements proposed by the Commonwealth:

> Devolving national responsibility for hospital management all the way to small Local Hospital Networks, with Australian Government performance indicators and casemix funding of 60% of "efficient costs", will leave many hospitals in dire straits in those states where unit costs are far higher than in Victoria (the model for casemix funding). States will have to pick up the tab for much more than the 40% envisaged in order to keep many hospitals solvent. Even in Victoria, there are 40 regional hospitals that have to operate on block grants because casemix cannot adequately recognise services they need to provide for their communities.[179]

3.173 A number of concerns were raised in relation to national reporting. Professor Penington, who argued that the COAG agreement will do 'little to improve quality of healthcare in Australia's public hospitals, argued that it imposes a 'centralised process for reporting on quality that will be expensive and largely ineffective'.[180] He contended that the Commonwealth's function in promoting quality healthcare under

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175 Australian General Practice Network, *Submission 27*, p. 14.

176 Catholic Health Australia, *Submission 3*, p. 3.

177 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 61.

178 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 107.

179 David Penington, 'Prime Minister Rudd's plan for reforming Australian public hospitals', *Medical Journal of Australia*, 192, No. 9, 2010, http://www.mja.com.au/public/issues/192_09_030510/pen10243_fm.html (accessed 20.5.10).

180 Professor D Penington, *Submission 7*, p. 4.

the COAG agreement will be primarily restricted to setting national standards against quarterly reports required from every public and private hospital and every PHCO along with 'healthy community' reports. He noted that these reports will be based on existing performance indicators associated with the Australian Healthcare Agreement of 2008 and newly modified sets of performance indicators approved by COAG on the advice of such bodies. Dr Penington went on to state:

> This massive commitment to central reporting is, in my view, likely to have little effect on the way services are actually delivered to people in hospitals or in the community.
>
> Under similar sets of indicators, the Bundaberg Hospital in Queensland, the Alfred Hospital in Victoria, and some NSW hospitals were adequate performers on the usual budgetary or other numerical performance indicators, despite manifest issues with quality that emerged.[181]

3.174 Mr Laverty of CHA also raised the question of whether the establishment of nationally consistent reporting processes will avoid replication or serve as another layer of bureaucracy.[182]

Local Hospital Networks

3.175 Central to the reforms announced by the Prime Minister and Minister Roxon is the establishment of Local Hospital Networks (LHNs). The evidence received by the Committee pointed to a number of concerns with this part of the plan, in particular the lack of certainty around the number of LHNs. Commonwealth agencies appearing before the inquiry failed to provide any certainty around this number. [183]

3.176 On the question of final approval of the number and size of LHNs in each state and territory, the Department of Health and Ageing did not provide a specific response and simply referred the Committee to the wording of the Intergovernmental agreement.[184]

3.177 The AGPN suggested that the public health care role for LHNs as established in the *National Health and Hospitals Network Agreement* 'detracts from, rather than boosts' public health care capacity as well as 'risks duplication and poor coordination'. The AGPN further commented that:

> History shows that systems run from hospitals put hospitals first; reorienting the system towards primary health care requires the primary health care sector to play the leadership role.[185]

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181 Professor D Penington, *Submission 7*, p. 5.

182 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 7.6.10, pp 58–59.

183 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 3.

184 Department of Health and Ageing, answer to question on notice, QON 8.

185 Australian General Practice Network, *Submission 27*, p. 9.

3.178 CHA held that the right balance needed to be struck between 'local decision-making and effective strategic level planning at a wider population level – particularly in the provision of very expensive and complex services such as organ transplant units'.[186] Mr Laverty also contended that state and territory governments were likely to pursue their own LHN construction in a different manner. He stated that:

> It does not appear that there is likely to be a consistency in how LHNs are established as to perhaps their size or even the service mix that they will entail.[187]

Governance of LHNs

3.179 The AMA raised concerns regarding the governance structure, holding that there are inconsistent descriptions of the role of local doctors in the LHNs in government publications. The AMA contended that:

> The IGA specifies that LNH governing councils will include members with clinical expertise but this would be 'external to the LHN wherever practical'. The AMA opposes a model that does not allow direct representation of local practicing doctors.[188]

3.180 Dr Pesce further emphasised the need for local representation on the governing councils, without which, 'they will be less effective in helping to improve our hospitals'.[189] He contended that:

> Firstly, I believe that without good local input often strategic decisions might be made which are not necessarily well founded. Secondly, if doctors, nurses and other people working in the hospital system are excluded from representation on the council, they will feel no ownership of those decisions, no commitment to support those decisions and we all know how good doctors can be at standing outside and just criticising. It is very important, as a two-way process, for the councils to get proper input but also for the clinicians to have ownership of those decisions so that they will feel more committed to implementing them.[190]

3.181 The announcement of Lead Clinicians Groups shortly after concerns emerged regarding the involvement of local clinicians does not provide certainty that local clinicians will be involved decisions in LHNs.

3.182 CHA also raised concerns of management citing the example of a health service trust in the United Kingdom where excess deaths and serious lapses in patient

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186 Catholic Health Australia, *Submission 3*, p. 9.

187 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 7.6.10, p. 53.

188 Australian Medical Association, *Submission 10*, p. 7.

189 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 111.

190 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 111.

care and hygiene resulted from the local board and hospital management focusing more on meeting performance and cost cutting targets than on actual patient care.[191]

3.183 Professor Penington also noted that there will need to be continuing state health department roles to supplement the new federal health bureaucracy in each state with LHNs responsible to both. Thus, he contended that:

> The NHHRC thought it had ended the "blame game", but with two tracks of funding and decision making on every issue, including major equipment, hospital capital and maintenance, let alone separate tracks for the many aspects of aged care, there is huge potential for blame shifting.[192]

3.184 Professor Penington further criticised the LHN structure because of its failure to 'mandate structures involving medical practitioners and university medical school and health science faculties in hospital clinical governance shown to be necessary by international experience'.[193]

3.185 The AMA raised concerns regarding the fact that the states will be responsible for negotiating service level agreements with each LHN. The AMA stated:

> The AMA considers that these service agreements will be a key factor in the success or otherwise of much of the health reform initiatives contained in the IGA. For example, if funding is insufficient due to unrealistic prices or poorly estimated service volumes, no matter how efficient the hospital and the potential number of services it could provide, performance targets will not be met and/or quality standards may suffer.[194]

3.186 The AMA further questioned how the Commonwealth will ensure that the states will set 'realistic, transparent and achievable hospital-level targets and standards for LHNs and provide sufficient funding to achieve them'.[195]

3.187 Ms Halton also emphasised that all state Auditors-General will have a role in investigating the data and behaviour of the LHNs.[196]

3.188 Concerns about limits on the ability of the Commonwealth Auditor-General have been discussed in other fora, specifically in recent times in relation to the Building the Education Revolution program.

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191 Catholic Health Australia, *Submission 3*, p. 8.

192 David Penington, 'Prime Minister Rudd's plan for reforming Australian public hospitals', *Medical Journal of Australia*, 192, No. 9, 2010, http://www.mja.com.au/public/issues/192_09_030510/pen10243_fm.html (accessed 20.5.10).

193 Prof D Penington, *Submission 7*, p. 3.

194 Australian Medical Association, *Submission 10*, p. 8.

195 Australian Medical Association, *Submission 10*, p. 8.

196 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 48.

3.189 In 2010 Budget Estimates hearings, the Auditor-General confirmed the limits of his powers to undertake audits:

> Also, it is very clear when you look at the sections of our act that I may undertake a performance audit of a 'Commonwealth entity'. It is very clear.[197]

3.190 The limits on the powers of the Auditor-General in relation to undertaking performance audits of the LHNs being established under the ambit of state and territory powers was further examined at hearings with the Commonwealth Departments. The concerns of the Coalition Senators in relation to the inability of the Auditor-General were confirmed by the Secretary of the Department of Health and Ageing, Ms Halton:

> I think the answer is, as I have already indicated, it is not intended at this point to change the boundaries of the Auditor-General's powers, but I think the Auditor-General does believe his powers extend slightly more broadly than have been necessarily understood in the past, but that is a matter for him to decide.[198]

3.191 The committee sought the advice of the Commonwealth Auditor-General. The Auditor-General noted that the LHNs will be established under by State governments as separate legal entities under State legislation and commented 'if this is the case, the Commonwealth Auditor-General would not have the authority to audit the performance of LHNs, as the *Auditor-General Act 1997* focuses on the performance of Commonwealth entities'.

3.192 The Auditor-General went on to comment that there are provisions within the NHHN Agreement for the establishment of a National Performance Authority (NPA).The NPA is to be established from 1 July 2011 as an independent Commonwealth statutory authority under the *Financial Management and Accountability Act 1997*. As such, the NPA would fall within the Australian National Audit Office's mandate to access data and information held by the NPA and to conduct performance audits of its performance. But this does not extend to the bodies reporting to the NPA when they are created under state legislation (ie the LHNs).

3.193 There is also a question regarding the funding of LHNs. In answer to a question about what would happen if an LHN exhausted its funding, the committee is advised that governing councils of LHNs have an obligation to manage funds available to them. However, this specific question was not directly answered.[199]

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197 Finance and Public Administration Legislation Committee, *Estimates Hansard*, 25.5.10, p. F&PA 44.

198 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 45.

199 Department of Health and Ageing, answer to question on notice, DoHA 21.

Committee comment

3.194 The committee acknowledges that the role of the Auditor-General relation to the NPA provides some confidence as to the data regarding LHN performance. As the Auditor-General noted:

> …the ANAO could provide assurance in relation to whether the NPA is fulfilling its role and, in doing so, is providing performance information that allows the Commonwealth Government, over time, to judge whether its policy directions are being implemented effectively.

3.195 However, the Committee is concerned by the scope of the powers of the Auditor-General being limited to the NPA. The NPA is reliant on data from LHNs, which are outside the direct scope of the Auditor-General's authority. The Committee does not believe that reliance on State Auditors-General is an appropriate mechanism to oversee the substantial amounts of Commonwealth funding being directed to LHNs. This lack of oversight by the Commonwealth Parliament and its key accountability agent is a significant flaw in the package.

3.196 The Committee notes that there are parallel developments in the education portfolio, through the Building the Education Revolution program, which point to the new arrangements emerging in Federal public administration, particularly those under the auspices of the Council of Australian Governments. These new arrangements mean that the Parliament must also look to new ways to safeguard its role in ensuring the accountability of the executive and the scrutiny of the expenditure of taxpayers' money.

3.197 The ANAO has provided the Joint Committee of Public Accounts and Audit with options to enhance external accountability arrangements in response to these developments in Federal public administration. The Committee supports the Auditor-General's contention that benefits would arise in 'extending the Auditor-General's mandate to allow the ANAO to "follow the money trail" in certain circumstances; particularly where, in the opinion of the Auditor-General, flowing the money trail would be significant in the context of an audit of a Commonwealth entity'.

Location and size of LHNs

3.198 Despite the terms of the Intergovernmental Agreement, there remains a distinct lack of detail around key features of the package, such as basic details such as the number and location of the LHNs. This was highlighted in Senate Budget Estimates hearings on 25 May 2010:

> Senator FIERRAVANTI-WELLS—I want to ask about the local hospital networks. Could you go into some detail about how they work and how many there will be. Did the Prime Minister actually work out how many there would be before he announced that we would all go to these local networks?

> Mr Rimmer—The exact number of local hospital networks is something that will be resolved by the end of 2010. We have within the Commonwealth a planning assumption that there will be something like 100, but that is subject to ongoing development and refinement over the course of 2010.[200]

3.199 When pressed, it was apparent that substantial details remain to be negotiated and developed:

> Senator FIERRAVANTI-WELLS—In the provisional work plan, appendix 4 of the future work plan, which was part of the agreement, it says that the establishment of the local health networks will be set up as separate legal entities under state or territory legislation. It is to commence 2010-11 and it is to be undertaken by state governments. Then determining the size and allocation has to be resolved as well. That is all going to happen by the end of the year, is it?
>
> Mr Rimmer—No, Senator. The plan is that, by the end of 2010, the number and geographic boundaries of local hospital networks will be agreed between the Prime Minister and each Premier or Chief Minister on a bilateral basis. That agreement will also take into account the concurrent development of boundaries for Medicare Locals so that we can arrive at a situation where Medicare Locals and local hospital networks have as consistent geographic boundaries as is possible in the circumstances. They will not always be consistent, but consistency is the objective. That resolves one aspect of the material that you referred to. The actual implementation of local hospital networks will take some time. States and territories will commence implementing those really from 1 July 2011, and the agreement that COAG has reached is that all local hospital networks will be fully established before 1 July 2012, which is when the activity based funding arrangements come into effect.[201]

3.200 The Committee could not ascertain further specific detail about the number of LHNs. While Budget Paper No. 1 states that there will be 150 LHNs,[202] the Secretary of the Department of Health and Ageing, Ms Jane Halton, contended, however, that 'up to 150' LHNs would be a more accurate figure.[203] In response to questions regarding this contention around the number of LHNs, Ms Rosemary Huxtable, Deputy Secretary of the Department of Health and Ageing, confirmed that the 'finalisation of the number of hospital networks would be a matter that would continue to be discussed between the Commonwealth and the states and territories'.[204]

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200 Mr Rimmer, Department of the Prime Minister and Cabinet, Finance and Public Administration Legislation Committee, *Estimates Hansard*, 25.5.10, p. F&PA 106.

201 Mr Rimmer, Department of the Prime Minister and Cabinet, Finance and Public Administration Legislation Committee, *Estimates Hansard*, 25.5.10, p. F&PA 107.

202 Australian Government, *Budget Paper No. 1, 2010–11*, p. 647.

203 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 3.

204 Ms R Huxtable, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 4.

3.201 The Consumers Health Forum of Australia (CHF) noted that there had been reports which have suggested that the Northern Territory and Tasmania will be served by single state-wide LHNs based in capital cities. CHF emphasised the need for LHNs to be able to engage with local communities and stated:

> CHF would not support Local Hospital Networks that cover whole states and are run from metropolitan areas, as these are highly unlikely to be able to adequately address the needs of local communities, or to engage with local consumers.[205]

3.202 The Committee is profoundly concerned at the prospect of state and territory-wide LHNs in Tasmania and the Northern territory respectively.

3.203 CHA commented that, at least at this stage, there has been a 'lost opportunity' to allow cross border LHNs which may have 'addressed some of the difficult issues of cost and service dysfunction near the boundaries of state/territory borders'.[206] The RDAA held a similar view, arguing that the boundaries of the LHNs need to be located where there are 'synergies between patient flows and communities' which may be located in different states.[207] The RDAA went on to comment that:

> State boundaries should not prevent the creation of the most appropriate configuration of a LHN. If LHNs are unable to span State boundaries, disputes will arise between States over the funding of patient care where patients are referred across State boundaries for hospital-related care.[208]

3.204 CHA also commented that the Budget Papers indicated that approximately 150 LHNs would be established and this would translate into each LHN serving a population base of around 150,000. CHA suggested that this size of LHN may result in poor provision of services:

> This is well short of the population bases of similar networks in overseas countries and many health policy commentators have expressed concern that networks of this size would fall short of providing a critical mass of services and would also lead to a considerable increase in bureaucracy – with each network having its own administrative underpinning. There is much commentary in the literature to suggest a population base of at least twice the number originally envisaged would be more efficient, effective and importantly address equity concerns.[209]

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205 Consumers Health Forum, *Submission 2*, p. 3.

206 Catholic Health Australia, *Submission 3*, p. 9.

207 Rural Doctors Association of Australia, *Submission 22*, pp 3–4.

208 Rural Doctors Association of Australia, *Submission 22*, p. 4.

209 Catholic Health Australia, *Submission 3*, p. 9.

Relationship with the private sector

3.205 The committee notes comments by Minister Roxon that the LHN will be able to purchase services from another public hospital or a private hospital if a patient does not undergo elective surgery within the clinically indicated timeframe. There is concern that the LHN would prefer to purchase from a public hospital as the funding would stay with the State. This reflects the scant detail within the package regarding the role of the private sector.

3.206 CHA also raised the question of the role of private hospitals noting that they provide 40 per cent of total hospital episodes (including 60 per cent of surgery).[210] Of this, CHA stated that:

> Ideally, the Commonwealth will move to enunciate a clear role for private hospitals in Local Hospital Networks, whereby their ability to deliver hospital services to private patients at no direct cost to government is better recognised.[211]

3.207 CHA also raised particular concerns regarding the role of Catholic hospitals within the LHN system given that they operate within a 'moral framework that preclude them from providing some services'.[212] Mr Martin Laverty, CEO, CHA commented on these concerns:

> There are a few fundamentals that we have put to the government and COAG that are relevant in the design and implementation of this system. The first is that the governance of those existing Catholic hospitals must be respected and able to continue into the future. As I have said, Catholic hospitals operate very much like local hospital networks at present. Some of those hospitals must be able to be affirmed as local hospital networks into the future. Where it is not appropriate for them to be classified as LHNs in their own right, because of their scale and size, we are hopeful that within the design of LHNs the independence of those Catholic hospitals is retained and, most importantly, that, in the operation of those LHNs, they not be in any way disadvantaged or thought of last. The key to that is that in the establishment of both the LHNs and the national governance oversight there is a real commitment to transparency around how funds are allocated and how they are administered so that we can have confidence that through LHNs public hospital funding is administered equitably, and just because a hospital within an LHN happens to be Catholic it is not somehow disadvantaged.[213]

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210 Catholic Health Australia, *Submission 3*, p. 10.

211 Catholic Health Australia, *Submission 3*, p. 3.

212 Catholic Health Australia, *Submission 3*, pp 9–10.

213 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 7.6.10, pp 51–52.